National Institute for Health and Care Excellence

Intrapartum care for women with existing medical conditions or obstetric complications and their babies

[J] Evidence review for information for women with obstetric complications or no antenatal care

NICE guideline <TBC at publication>

Evidence reviews for women at high risk of adverse outcomes for themselves and/or their baby because of obstetric complications or other reasons

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Draft for consultation

Developed by the National Guideline Alliance hosted by the Royal College of Obstetricians and Gynaecologists

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Contents

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) 7
Review question 7
Introduction 7
Summary of the protocol 7
Clinical evidence 9
Summary of clinical studies included in the evidence review 10
Quality assessment of clinical studies included in the evidence review 13
Economic evidence 14
Summary of studies included in the economic evidence review 14
Economic model 14
Evidence statements 15
Recommendations 18
Rationale and impact 18
The committee's discussion of the evidence 19
References 24
Appendices 25
Appendix A – Review protocol 25
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) 25
Appendix B – Literature search strategies 31
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) 31
Appendix C – Clinical evidence study selection 82
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) 82
Appendix D – Excluded studies 83
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) 83
Clinical studies 83
Economic studies 102
Appendix E – Clinical evidence tables 103
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) 103
Appendix F – Forest plots 132

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 132
Appendix G – GRADE-CERQual tables ... 133
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 133
Appendix H – Economic evidence study selection ... 154
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 154
Appendix I – Economic evidence tables ... 154
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 154
Appendix J – Health economic evidence profiles ... 154
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 154
Appendix K – Health economic analysis ... 154
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 154
Appendix L – Research recommendations ... 154
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons) ... 154

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

Review question

What are the information needs of women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period?

Introduction

The overarching aim of this review is to determine what information makes a positive difference to women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period, and what information makes a positive difference to their babies. There are two sub-objectives:

- to explore the areas of information that would make a positive difference to women and their birth companions
- to evaluate the effectiveness of various information strategies or packages.

Areas of information, and information strategies or packages, to be included in the review will be relevant to quality of care in the intrapartum period (although they may be discussed or implemented in the antenatal, intrapartum or postnatal period). The review will consider women's reports of what information they would have liked to have received, and what information would have been helpful for their families

Summary of the protocol

See Table 1 for summaries of: the population, interest and context (PICo) characteristics for qualitative aspects of this review; and the population, intervention, comparison and outcome (PICO) characteristics for quantitative aspects.

Table 1: Summary of the protocol (PICO table)

Population	Women at high risk of adverse outcomes in labour due to obstetric complications covered by the guideline scope that arise: • before the intrapartum period • during the intrapartum period. Relevant obstetric complications include: • pyrexia • sepsis (suspected or diagnosed) • intrapartum haemorrhage (that is, haemorrhage occurring during the course of labour and birth) • breech presenting in labour • a small-for-gestational age baby • a large-for-gestational age baby

<table>
<tr><td></td><td>

- previous caesarean section
- labour after 42 weeks of pregnancy.

Women who present in labour having had no antenatal care will also be included</td></tr>
<tr><td>Phenomenon of interest (for sub-objective 1) or intervention (for sub-objective 2)</td><td>

<u>For sub-objective 1</u>

Phenomenon of interest:

- information about obstetric complications covered by the scope that arise before or during the intrapartum period, associated risk of adverse outcomes, and management of complications during labour and birth.

Themes will be identified from the available literature, but expected themes are:

- antenatal provision of information about the likelihood of obstetric intrapartum complications by type of complication
- antenatal provision of information about the risks for the woman and the baby associated with obstetric complications, including the likelihood of admission to ITU or NICU
- antenatal, intrapartum and postnatal discussions about the management of obstetric complications with the woman and her birth companion
- different ways to deliver information, for example:
  - different formats such as oral, written, video, online, audio, multiple languages
  - use of social media, apps and technology.
- ongoing opportunities to talk about the risk of obstetric complications and their management
- opportunities to tour the ITU and neonatal unit
- checklists to remind women and healthcare professionals about information that should be discussed
- optimal timing of information including the effectiveness of postnatal debriefing
- impact of complications on choice of infant feeding
- involvement in decision making (informed decision making that is non-biased, and shared decision making)
- engagement with and trust in the healthcare team
- continuity of contact with healthcare professionals.

<u>For sub-objective 2</u>

Intervention:

- any intervention or package of care designed to provide specific or additional information about labour and birth for women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period</td></tr>
<tr><td>Comparison</td><td>

<u>For sub-objective 1</u>

- N/A

<u>For sub-objective 2</u>

- Absence of information
- Usual information provision</td></tr>
</table>

	• Different interventions or packages of care
Outcomes	For sub-objective 1 • N/A For sub-objective 2 For the woman: • woman's satisfaction with involvement in decision making (informed decision making that is unbiased, and shared decision making) • mortality • woman's experience of pregnancy, labour and birth, including experience of the birth companion • major morbidity – physical morbidity and antenatal, intrapartum and postnatal psychological outcomes (any, including post-traumatic stress disorder, depression and anxiety) • mode of birth For the baby: • major morbidity • mortality

1 *ITU: intensive therapy unit; N/A: not applicable; NICU: neonatal intensive care unit*

2 For further details see the full review protocol in Appendix A – Review protocol. The
3 search strategies are presented in Appendix B – Literature search strategies.

4 Clinical evidence

5 Included studies

6 Six qualitative studies and 1 cross-sectional survey were included in this review (see
7 'Summary of clinical studies included in the evidence review').

8 The qualitative studies were relevant for sub-objective 1. Of these, 3 (McKenna 2014,
9 Nilsson 2017, Wang 2006) provided qualitative evidence about women who
10 experienced labour after a previous caesarean section, 2 (Homer 2015, Petrovska
11 2017) provided qualitative evidence about women who experienced labour with a
12 breech presentation and 1 (Reid 2014) provided qualitative evidence about women
13 who experienced labour with a macrosomic baby.

14 The cross-sectional survey was relevant for sub-objective 2. This study (Renner
15 2007) provided quantitative evidence about women who experienced labour after a
16 previous caesarean section.

17 Evidence from the studies included in the review is summarised below (see 'Quality
18 assessment of clinical studies included in the evidence review').

19 For sub-objective 2, in relation to women with a previous caesarean section, data
20 was reported on the important outcome, woman's experience of pregnancy, labour
21 and birth. There was no evidence identified for the following outcomes for the
22 woman: satisfaction with involvement in decision making (critical outcome), mortality
23 (critical outcome), major morbidity (important outcome), mode of birth (important
24 outcome), or the following outcomes for the baby: major morbidity (critical outcome)
25 and mortality (outcome of limited importance).

There was no evidence identified for sub-objective 2 on women with breech presenting in labour or women with large-for-gestational age babies. There was no evidence identified, for either sub-objective, on women with pyrexia, sepsis (suspected or diagnosed), intrapartum haemorrhage, small-for-gestational age babies, labour after 42 weeks of pregnancy, or presentation in labour having had no antenatal care.

See also the study selection flow chart in Appendix C – Clinical evidence study selection.

Excluded studies

Studies not included in this review with reasons for their exclusion are listed in Appendix D – Excluded studies.

Summary of clinical studies included in the evidence review

Table 2 provides a brief summary of the included studies.

Table 2: Summary of included studies

Study	Aim of the study	Participants	Study design and methods
Women with previous caesarean section			
McKenna 2014 Qualitative study UK	To explore women's reasons for requesting water VBAC and women's experience of the process	N=8 women, all of whom had a water VBAC	• Sample selection: all women who had a water VBAC in a Scottish midwife-led unit between 2008 and 2011 were contacted • Data collection: semi-structured interviews
Nilsson 2017 Qualitative study Finland, the Netherlands and Sweden	To investigate women's views on factors of importance for improving the rate of VBAC among women in high VBAC countries	N=22 women who had experienced VBAC	• Sample selection: in Finland and Sweden, women were identified via hospital registers and invited by mail; in the Netherlands, women were contacted by telephone and informed about the study by their former midwife Data collection: in Finland, 8 individual interviews; in the Netherlands, 1 group interview with 6 participants and 3 individual interviews; in Sweden, 1 group interview with 3 participants and 2 individual interviews
Renner 2007 Cross-sectional study (survey) USA	To examine how information that women with previous caesarean section receive about VBAC and repeat caesarean section affects their preferences and satisfaction	N=37 postpartum women who had a previous caesarean section • 19 had VBAC • 18 had an emergency	• Sample selection: women were approached on the postpartum unit of a large teaching hospital • Data collection: questionnaires were completed 1 to 4 days after birth

Study	Aim of the study	Participants	Study design and methods
		caesarean section following an attempted VBAC	• Outcome: woman's experience of pregnancy, labour and birth
Wang 2006 Evaluation research (before-and-after study; the article includes relevant qualitative quotations) Taiwan	To develop a web-based education programme about VBAC and to compare knowledge about and attitude towards VBAC before and after attending the programme.	N=10 women with a previous caesarean section and who participated in the online educational programme for at least 60 minutes when pregnant • 9 women attempted VBAC, of whom 8 achieved a VBAC	• Sample selection: not reported; announcements on the website and hospital, bulletin board system publicity were used to recruit participants in a regional teaching hospital • Data collection: quotations relevant to this review are from telephone interviews conducted with women after they gave birth
Women with breech presenting in labour			
Homer 2015 Qualitative study Australia	To explore the experiences of women who had planned a vaginal breech birth (VBB)	N=22 women who chose to attempt a VBB when the baby remained in breech position after an attempted external cephalic version. • 55% achieved a VBB • 45% had a caesarean section after labour had started	• Sample selection: women who had planned a VBB in the previous 7 years were chosen from the database of 2 maternity hospitals that supported VBB • Data collection: interviews were guided by a series of trigger questions
Petrovska 2017 Qualitative analysis of responses to open questions in an online survey Multiple countries	To examine the experiences of women who sought a vaginal breech birth	N=204 women who sought a vaginal breech birth. Mode of birth: • vaginal, n=104 • emergency caesarean section,: n=60	• Sample selection: link to the survey distributed via closed-membership Facebook groups from the USA, UK and Australia; membership of the groups was not limited to women from these countries • Data collection: the survey took approximately 30 minutes to complete

Study	Aim of the study	Participants	Study design and methods
		• did not disclose, n=40	
Women with macrosomic babies			
Reid 2014 Qualitative study UK	To explore women's perceptions and experiences of pregnancy and childbirth following birth of a macrosomic baby (birthweight ≥ 4000 g)	N=11 women with a macrosomic baby. Mode of birth: • 'normal' (unassisted) vaginal birth, n=5 • emergency caesarean section, n=4 • Barnes Neville forceps, n=1 • elective caesarean section, n=1	• Sample selection: women were selected for interview in a Health and Social Care Trust in Northern Ireland based on type of childbirth and complications, to ensure that different experiences were captured in the sample; recruitment stopped when data saturation was reached • Data collection: women were interviewed at 13 to 19 weeks after birth; an interview schedule was used; the schedule changed over time as new interviewees introduced new themes

1 *CS: caesarean section; VBAC: vaginal birth after caesarean section; VBB: vaginal breech birth*

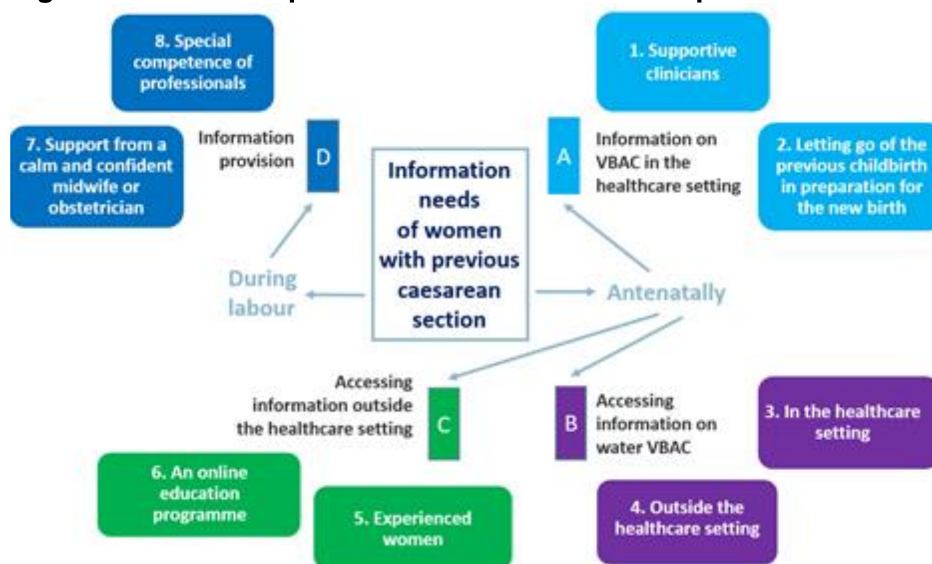
2 See also the study evidence tables in Appendix E – Clinical evidence tables.

3 A theme map summarising the qualitative evidence for women with previous
4 caesarean section is presented in Figure 1. The letters A to D indicate overarching
5 categories, whereas the numbers 1 to 8 indicate themes within categories. Sub-
6 themes are not presented in the theme map but are presented in the corresponding
7 GRADE-CERQual tables (see 'Quality assessment of clinical studies included in the
8 evidence review').

9 Theme maps for women with breech presenting in labour and women with
10 macrosomic babies were not produced because there was only 1 theme for each of
11 these groups of women (these are referred to as themes 9 and 10).

12 No meta-analysis was undertaken for this review (and so there are no forest plots in
13 Appendix F – Forest plots).

Figure 1: Theme map – evidence for women with previous caesarean section



Abbreviations: VBAC: vaginal birth after caesarean section

Quality assessment of clinical studies included in the evidence review

The clinical (GRADE-CERQual) evidence profiles for the qualitative studies included in this review are presented in Appendix G – GRADE-CERQual tables.

Evidence from the non-comparative quantitative study included in this review is summarised in Table 3. No clinical (GRADE) evidence profile is presented for this study because the data were descriptive rather than comparative.

Women with previous caesarean section (quantitative evidence)

Table 3: Quantitative evidence for women with previous caesarean section, level of information for women having a trial of labour

Study	Results					Quality	Importance
	Outcome: woman's experience of pregnancy, labour and birth						
	Topic	Level of information: % of women					
		Not addressed	Too little	Just right	Too much		
Renner 2007 UK	Uterine rupture (N=34)	2.9	20.6	67.6	8.8	Low	Important
Renner 2007 UK	Forceps or vacuum extraction (N=34)	44.1	29.4	26.5	0.0	Low	Important
Renner 2007 UK	Recovery time from	11.8	14.7	67.6	5.9	Low	Important

Study	Results					Quality	Importance
	Outcome: woman's experience of pregnancy, labour and birth						
	Topic	Level of information: % of women					
		Not addressed	Too little	Just right	Too much		
	vaginal birth (N=34)						
Renner 2007 UK	Bleeding with vaginal birth (N=32)	14.7	26.5	52.9	5.9	Low	Important
Renner 2007 UK	Blood transfusion following vaginal birth (N=32)	40.6	34.4	25.0	0.0	Low	Important
Renner 2007 UK	Future problems with loss of urine or stool (N=32)	65.6	18.8	15.6	0.0	Low	Important

1 ## Economic evidence

2 ### Included studies

3 No economic evidence was identified for this review.

4 See the study selection flow chart in Supplement 2 (Health economics).

5 ### Excluded studies

6 No full-text copies of articles were requested for this review and so there is no
7 excluded studies list (see Supplement 2 (Health economics)).

8 ## Summary of studies included in the economic evidence review

9 No economic evidence was identified for this review (and so there are no economic
10 evidence tables in Supplement 2 (Health economics)).

11 ## Economic model

12 No economic modelling was undertaken for this review because the committee
13 agreed that other topics were higher priorities for economic evaluation (see
14 Supplement 2 (Health economics)).

Evidence statements

Women with previous caesarean section

Qualitative evidence for overarching category A – antenatal information provision in the healthcare setting for women with previous caesarean section

Theme 1 – antenatal information provision in the healthcare setting for women with previous caesarean section, 'Receiving information from supportive clinicians'

Moderate quality evidence from 1 qualitative study with women who experienced vaginal birth after caesarean section (VBAC) in Finland, the Netherlands and Sweden reported on antenatal information provision in the healthcare setting. Women wanted realistic information tailored to each woman's needs. They wanted to be well informed about what was going to happen. Women noted that information should not be idealised and should provide answers to their questions. They wanted a midwife or doctor during pregnancy who would listen, encourage and motivate them and support them to be confident. The support should take into account that some women may not have experienced a vaginal birth before.

Theme 2 – antenatal information provision in the healthcare setting for women with previous caesarean section, 'Letting go of the previous childbirth in preparation for the new birth'

Moderate quality evidence from 1 qualitative study with women who had experienced VBAC in Finland, the Netherlands and Sweden reported on antenatal information provision in the healthcare setting. Women wanted information and guidance that would help them to let go of the previous childbirth experience in preparation for the new birth. Information to better understand previous indications for caesarean section was considered helpful. If a woman had fears, then the midwife should try to understand the cause, and if needed, refer the woman to additional support or schedule extra visits. Women wanted antenatal classes for them and their partners where they could be with other women who were preparing for VBAC. Being able to visit the maternity ward was seen as being important, as was receiving advice on how to handle the situation should an emergency caesarean section be needed during the next birth.

Qualitative evidence for overarching category B – antenatal information provision about vaginal birth in water for women with previous caesarean section

Theme 3 – antenatal information provision in the healthcare setting about vaginal birth in water for women with previous caesarean section

Low quality evidence from 1 qualitative study with women who had a vaginal birth in water after a previous caesarean section in a Scottish midwife-led unit reported on information provision in the healthcare setting. All women had to ask for the option of water VBAC, as it was not offered antenatally by healthcare professionals. Not only did women have to ask about water VBAC, some women had to "push for" water VBAC after raising this option, and they had to prepare arguments in favour of their preference for water VBAC. All women said that to some extent they had to convince their midwife and consultant obstetrician to agree to water VBAC.

Theme 4 – women with previous caesarean section accessing information about vaginal birth in water outside the healthcare setting in the antenatal period

Low quality evidence from 1 qualitative study with women who had a vaginal birth in water after a previous caesarean section in a Scottish midwife-led unit reported on accessing information outside the healthcare setting. All women had accessed some information on the risks of water VBAC, however, this was mostly anecdotal due to a lack of empirical studies. All women looked for information online and some contacted women from other countries who had experienced a water VBAC. Accounts from other women were valued more highly than 'impersonal' academic research and obstetric recommendations. The women identified some incorrect information online about the baby drowning during water VBAC. They discounted this but had to manage family fears arising from such incorrect information.

Qualitative evidence for overarching category C – accessing information outside the healthcare setting in the antenatal period

Theme 5 – accessing information outside the healthcare setting in the antenatal period, 'information from experienced women'

Moderate quality evidence from 1 qualitative study with women who had experienced VBAC in Finland, the Netherlands and Sweden reported on accessing information outside the healthcare setting. Women mentioned the Internet and friends as significant sources of information. Moreover, they suggested that it would be very valuable to meet other women who had experienced VBAC and to hear about their experiences. They suggested organising information and support meetings and indicated that they would be prepared and motivated to share their experiences with women who were planning to have a VBAC.

Theme 6 – antenatal information provision for women with previous caesarean section with an online education programme

Low quality evidence from 1 qualitative study with women who attempted VBAC in a regional teaching hospital in Taiwan reported on their views and experiences about an online education programme on the practicalities of vaginal birth, which they followed during the antenatal period. The women found the programme useful for multiple reasons. Women reported that the programme allowed preparation for a vaginal birth, helped in giving birth to the baby without complications, possibly improved chances of avoiding a repeat caesarean section, and made women feel confident because they knew about the childbirth process.

Qualitative evidence for overarching category D – information provision during labour

Theme 7 – information provision during labour for women with previous caesarean section, 'Receiving professional support from a calm and confident midwife or obstetrician during childbirth'

Moderate quality evidence from 1 qualitative study with women who had experienced VBAC in Finland, the Netherlands and Sweden reported on information provision during labour for women with previous caesarean section. Women wanted to receive continuous and attentive guidance. They wanted to be directed through the birth process by a calm and confident professional. Women mentioned that when a woman feels afraid of giving birth vaginally, it helps to explain thoroughly what is going to happen. Women appreciated continuous care, preferably by the same professional. Some women described feeling left alone and being overcome by panic

when professionals left them. Women considered it to be acceptable if caregivers motivated them to hold on a little longer before performing an emergency caesarean section, but some women thought that they were pushed beyond their limit or did not receive an explanation for why it took so long before the caesarean section was performed. The women understood that in some circumstances the birth plan they had made earlier might not be realised, but some women's experience was that professionals did not always keep to agreements. This affected the relationship between the caregiver and the woman, and resulted in women feeling less confident during the birth. Some women perceived that sometimes doctors minimised their worries, and this made them feel they were no longer a partner in the childbearing process.

Theme 8 – information provision for women with previous caesarean section during labour, 'special competence' of professionals

Moderate quality evidence from 1 qualitative study with women who had experienced VBAC in Finland, the Netherlands and Sweden reported on information provision during labour for women with previous caesarean section. Most women were willing to follow the advice of professionals if it would benefit their baby's health and they recognised the special competence of professionals.

Quantitative evidence

<u>Outcomes for the woman</u>

Woman's experience of pregnancy, labour and birth

Low quality evidence from 1 survey conducted with women with previous caesarean section after a trial of labour in a large teaching hospital in the USA reported on the level of information received antenatally on specific topics. In relation to uterine rupture (N=34), 3% of women reported that this had not been addressed, 21% reported receiving too little information and 9% too much information. In relation to birth assisted with forceps or vacuum (N=34), 44% reported that this had not been addressed, 29% reported receiving too little information, and no woman reported too much information. In relation to recovery time from vaginal birth (N=34), 12% reported that this had not been addressed, 15% reported too little information and 6% too much information. In relation to bleeding with vaginal birth (N=32), 15% reported that this had not been addressed, 27% reported receiving too little information and 6% too much information. In relation to blood transfusion following vaginal birth, 41% reported that this had not been addressed, 34% reported receiving too little information, and no woman reported too much information. In relation to future problems with incontinence (loss of urine or stools; N=32), 66% reported that this had not been addressed, 19% reported receiving too little information and no woman reported too much information.

Women with breech presenting in labour

Qualitative evidence for theme 9 – information provision in the healthcare setting for women attempting a vaginal breech birth

Low quality evidence from 2 qualitative studies with women who attempted a vaginal breech birth reported on information provision in the healthcare setting. One study was conducted in 2 maternity hospitals in Australia; the other was an online survey with women from multiple countries. Women felt that there was a lack of information in the antenatal period about breech. Women encountered 'coercion and fear' and 'scare tactics' from care providers in relation to choice of mode of birth and this

continued into labour. When comprehensive information was provided in the antenatal period about management options, women were relieved to hear that a breech presentation did not mean that there was anything wrong with them.

Women with macrosomic babies

Qualitative evidence for theme 10 – antenatal and intrapartum information provision in the healthcare setting for women with macrosomic babies

Low quality evidence from 1 qualitative study with women who gave birth to a macrosomic baby in a Health and Social Care Trust in Northern Ireland reported on information provision in the healthcare setting. Negative interactions mostly related to 'not being listened to' were reported by 7 of the 11 women interviewed. Topics on which women reported not being listened to included prediction of macrosomia, planning mode of birth, perception of pain and being in labour.

Recommendations

J1. Follow the recommendations on communication in the NICE guideline on intrapartum care for healthy women and babies for women in labour with obstetric complications or no antenatal care.

J2. Recognise that women in labour with obstetric complications or no antenatal care:

- may be more anxious than other women in labour, **and**
- are likely to have a better experience of labour and birth if they receive information about the benefits and risks of options for their care and are fully involved in decision-making.

J3. Provide information about care in labour and mode of birth, which:

- is personalised to the woman's circumstances and needs
- uses local and national figures where possible
- expresses benefits and risks in a way that the woman can understand.

J4. Recognise that individual views about risk vary and support a woman's decision-making and choices.

J5. Involve the woman in planning her care by asking about her preferences and expectations for labour and birth. Take account of previous discussions, planning, decisions and choices, and keep the woman and her birth companion(s) fully informed.

Rationale and impact

Why the committee made the recommendations

Evidence was limited but the committee agreed that good quality information is important for women who are at increased risk of serious medical problems for themselves or their babies. These women are likely to be more anxious than other women in labour and need information that presents risk in way that they can understand. The information should be based on local and national data where possible to allow women to make informed choices. Healthcare professionals should recognise that individuals have their own views of risk and they should support women to make informed decisions about their care. The committee recognised that

the evidence base was limited but showed that women felt they may be given biased information and that some options were not offered or were actively opposed. Women described having to search out information themselves. The evidence also suggested that there may be inequalities between women when it comes to making an informed decision and being in control of their care. Women who were not able to seek information could be disadvantaged in making informed choices. The committee noted that these themes were reflected by their own experiences and agreed that it is very important that information about all options is offered to women.

Impact of the recommendations on practice

The committee noted that there was variability in current practice relating to care of women in labour who have a higher chance of serious medical problems. The recommendations may result in a change in practice in some areas, with a change in focus from a risk-based approach to supporting informed decision-making for all women.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

For sub-objective 1, outcomes were not applicable because only qualitative studies were eligible for inclusion. Therefore, themes were identified from these studies, as opposed to extracting data on specific outcomes. For sub-objective 2, quantitative studies were eligible for inclusion, and so outcomes of interest were specified in the review protocol.

The committee rated a woman's satisfaction with involvement in decision-making as a critical outcome because this is the main reason for information giving. The committee agreed that informed decision-making would enable the woman to maximise her physical and emotional wellbeing. The committee also noted that this outcome was particularly pertinent after the 2015 Montgomery versus Lanarkshire Health Board Judgment of the UK Supreme Court, which drew increased attention to informed consent. The committee agreed that women should be supported to make informed decisions about their care, and recognised that the woman's choice may not always coincide with the course of action recommended by their healthcare professionals.

The committee considered maternal mortality as a critical outcome because information provided can influence the woman's decisions or choice of intervention; this might subsequently have an impact on mortality.

The committee considered major morbidity in the baby as a critical outcome because information provided can influence the woman's decisions or choice of intervention and engagement with the healthcare team; this might subsequently have an important impact on the baby's morbidity.

The committee rated a woman's experience of pregnancy, labour and birth, including experience of her birth companion(s), as an important outcome because they valued a woman's experience as an indicator of the quality of healthcare services. Women and their families' birth experiences can impact positively or negatively on their well-being as a family unit.

The committee considered major maternal morbidity (both physical morbidity and any antenatal, intrapartum and postnatal psychological outcomes, including post-traumatic stress disorder, postnatal depression and anxiety) as an important outcome because information provided can influence a woman's decisions or choice of intervention; this might subsequently have an impact on morbidity. The committee emphasised the importance of psychological outcomes for this question.

The committee rated mode of birth as an important outcome because information shared can influence a woman's decisions regarding mode of birth.

The quality of the evidence

The overall confidence in the review findings arising from the 6 qualitative studies ranged from low to moderate.

- Concerns about methodological limitations were assessed using the Critical Appraisal Skills Programme (CASP) checklist and ranged from none or very minor to serious. As each review finding came from only 1 study, serious concerns corresponded to a very low quality rating for the relevant study, and none or very minor concerns corresponded to a high quality rating for the study.
- Concerns about relevance for the context and population of interest in this guideline ranged from moderate to serious. For some studies there were concerns about the lack of diversity in the study population, either in relation to ethnic, socio-economic or educational backgrounds or in relation to the marital or cohabiting status of participants in the study. Some studies provided limited data on demographic characteristics of participants.
- Concerns about coherence ranged from none or very minor to moderate; for the majority of review findings concerns were none or very minor, as there were no data that contradicted findings and there were no ambiguous data.
- Concerns about adequacy ranged from moderate to serious; each review finding came from 1 study. For most findings there were moderate concerns about adequacy as the findings came from 1 study that offered moderately rich data. In a few cases the concerns were serious because the review findings came from 1 study that offered 'thin' data.

The quality of the findings from the quantitative study was rated as low with the Newcastle-Ottawa Scale adapted for cross-sectional studies, as there was high risk of selection bias.

Many studies were excluded because they focused on information related to interventions or comparisons excluded from the guideline scope. For example, multiple studies considered information provision for decision-making between planned vaginal birth and elective caesarean section in women with a previous caesarean section, which is within the remit of the NICE guideline on caesarean section (CG132) rather than this guideline. Similarly, several studies about induction of labour were excluded as this topic is covered by the NICE guideline on inducing labour (CG70). Moreover, qualitative studies in which it was unclear if quotations came from women with obstetric complications included in the scope of this guideline, or women with no antenatal care, or quantitative studies with no subgroup analysis for women with relevant obstetric complications or no antenatal care, were excluded. Studies in which women were interviewed only when pregnant and not after experiencing labour were excluded. These exclusions limited the comprehensiveness of the evidence base, but ensured direct relevance to the guideline scope for all included studies.

1 ***Benefits and harms***

2 The committee recognised that the evidence base was limited. There was some
3 evidence about women with previous caesarean section, women with breech
4 presenting in labour, and women with macrosomic babies, however there was no
5 evidence for other obstetric complications included in the guideline scope, nor for
6 women with no antenatal care. The quality of the included evidence ranged from low
7 to moderate. It showed that women felt they might be given biased information and
8 that some choices were not offered or were actively opposed. Women described
9 having to search out information themselves. The evidence also suggested that there
10 may be inequalities between women when it comes to making an informed decision
11 and being in control of their care. Although the committee was aware of the
12 limitations of the evidence, they noted that these themes were reflected in their own
13 experiences. The committee agreed that it is very important that all relevant options
14 are offered to women. The committee noted that women are not always able to
15 access information and choices equally, and women who are not able to seek
16 information might be disadvantaged in making informed choices. Therefore, the
17 committee developed recommendations on information provision to ensure that all
18 women are supported to make informed decisions and have their choices respected
19 and supported, including women who may be initially less informed or less confident
20 to ask for more information or to ask for specific care options.

21 The committee agreed that good quality information is important for women who are
22 at increased risk of serious medical problems for themselves or their babies. These
23 women need information relevant to their specific situation and related care options.
24 Therefore, when communicating with these women, it is particularly important for
25 healthcare professionals to practise the principles of informed decision-making.
26 These principles are embodied by the recommendations on communication in the
27 NICE guideline on intrapartum care for healthy women and babies (CG190), for
28 example, the recommendations to treat all women in labour with respect, to ensure
29 that the woman is in control of and involved in what is happening to her, and to ask
30 her about her wants and expectations in labour. The committee recommended,
31 therefore, that the recommendations on communication in the NICE guideline on
32 intrapartum care for healthy women and babies (CG190) be followed.

33 The committee noted that women with obstetric complications or no antenatal care
34 may be more anxious than other women in labour, and are likely to have a better
35 experience of labour and birth if they receive information about the benefits and risks
36 of options for their care and are fully involved in decision-making. The committee
37 recognised that sometimes healthcare professionals might assume that women
38 would be overwhelmed with too much information, however, they considered that
39 women are often able to process more information than might be assumed.

40 The committee noted that preferences and expectations about labour and birth vary
41 between women. Therefore, it is important to provide personalised information that is
42 relevant to the woman's individual circumstances and needs. The committee also
43 noted that information for women should be based on the best available evidence.
44 Wherever possible this should include both local and national figures (data). Local
45 figures may provide a better representation of the benefits and risks of an
46 intervention in the specific context in which the woman receives care. However,
47 national figures should be provided to ensure that women are offered all relevant
48 care options rather than only the options that represent standard care in a particular
49 unit. This information might also enable women to understand how their local service
50 differs from services elsewhere. When healthcare professionals refer to evidence
51 about benefits and risks, it is helpful to clarify the quality and source of the evidence,

or whether the information provided is merely anecdotal, as this can help the woman to assess the reliability of the information.

The committee noted that women in labour with obstetric complications or no antenatal care may be anxious (perhaps more so that other women in labour); this might have a negative impact on the woman's understanding of information provided. Healthcare professionals should adapt their way of communicating to ensure benefits and risks are expressed in terms the woman can understand, for example, using terms familiar to the woman, and checking for understanding during the conversation. The committee noted that the Royal College of Obstetricians and Gynaecologists (RCOG) patient information leaflet on Understanding how risk is discussed in healthcare provides clear guidance on how healthcare professionals should explain risk.

The committee noted that healthcare professionals should reflect on how their own values and beliefs inform their attitudes to risk and to what extent their own perceptions of risk are based on evidence. Some healthcare professionals might focus exclusively on the goal of safety and they might underestimate the positive impact on the woman of her being in control of the decision-making process (the impact being felt in the woman's overall physical and emotional wellbeing). For women, the whole experience of their perinatal journey is very important. Safety is of paramount importance to women; they also need to be well emotionally and psychologically during and after their experience of labour and birth. The committee noted that most women listen to advice from healthcare professionals, however, if healthcare professionals do not listen to the woman's concerns and preferences the relationship might break down and the opportunity to engage in productive communication might be lost. In light of all these considerations, the committee recommended that healthcare professionals should recognise that individual views about risk vary and they should support a woman's decision-making and choices.

The committee noted that preferences and expectations for labour and birth vary between women. Therefore, it is important to explore these preferences and expectations when involving the woman in planning her care, and it is important to take account of previous discussions, planning, decisions and choices, and to keep the woman and her birth companion(s) fully informed.

Cost effectiveness and resource use

The committee noted that providing information for women about all relevant and available options and supporting women in making informed decisions takes time, therefore sufficient human resources are needed. However, the committee agreed that supporting informed decision-making could save costs in the long term. Women are likely to be more satisfied with their care and experience of labour and birth, and to experience better mental health in the postnatal period, when their decisions are supported.

Other factors the committee took into account

The committee discussed the importance of informed decision-making for all women, and that this could vary for women who did not speak English as a first language, or had physical disabilities or learning difficulties. These women may need additional time and expertise (for example, interpreters or advocates) when making decisions about their labour and birth in the context of an increased chance of complications. The committee did not make a specific recommendation regarding these considerations because NICE's existing recommendations on woman-centred care

1 are explicit in ensuring that communication with women acknowledges the
2 importance of factors making communication difficult.

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1 # Appendices

2 ## Appendix A – Review protocol

3 ### Information provision (women at high risk of adverse outcomes for
4 themselves and/or their babies because of obstetric complications or
5 other reasons)

Item	Details	Working notes
Area in the scope	Women at high risk of adverse outcomes for themselves and/or their baby because of obstetric complications or other reasons – information provision	
Review question in the scope	What are the information needs of women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period?	
Review question for the guideline	What are the information needs of women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period?	
Objective	The overarching aim of this review is to determine what information makes a positive difference to women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period, and what information makes a positive difference to their babies. There are two sub-objectives: 1. to explore the areas of information that would make a positive difference to women and their birth companions 2. to evaluate the effectiveness of various information strategies or packages. Areas of information, and information strategies or packages, to be included in the review will be relevant to quality of care in the intrapartum period (although they may be discussed or implemented in the antenatal, intrapartum or postnatal period). The review will consider women's reports of what information they would have liked to have received, and what information would have been helpful for their families	
Population and directness	Women at high risk of adverse outcomes in labour due to obstetric complications covered by the scope that arise: • before the intrapartum period • during the intrapartum period. Relevant obstetric complications include: • pyrexia • sepsis (suspected or diagnosed) • intrapartum haemorrhage (that is, haemorrhage occurring during the course of labour and birth) • breech presenting in labour • small-for-gestational age • large-for-gestational age • previous caesarean section • labour after 42 weeks of pregnancy.	

Item	Details	Working notes
	Women who present in labour having had no antenatal care will also be included. Studies in which up to 34% of the women have multiple pregnancy will be included. Evidence in which any of the women have multiple pregnancy should be downgraded for indirectness.	

Phenomenon of interest (for sub-objective 1) or intervention (for sub-objective 2)	For sub-objective 1
	Phenomenon of interest:
	• information about obstetric complications covered by the scope that arise before or during the intrapartum period, associated risk of adverse outcomes, and management of complications during labour and birth.
	
	Themes will be identified from the available literature, but expected themes are:
	• antenatal provision of information about the likelihood of obstetric intrapartum complications by type of complication
	• antenatal provision of information about the risks for the woman and the baby associated with obstetric complications, including the likelihood of admission to ITU/NICU
	• antenatal, intrapartum and postnatal discussions about the management of obstetric complications with the woman and her birth companion
	• different ways to deliver information, for example:
	  ○ different formats such as oral, written, video, online, audio, multiple languages
	  ○ use of social media, apps and technology.
	• ongoing opportunities to talk about the risk of obstetric complications and their management
	• opportunities to tour the ITU and neonatal unit
	• checklists to remind women and healthcare professionals about information that should be discussed
	• optimal timing of information including the effectiveness of postnatal debriefing
	• impact of complications on choice of infant feeding
	• involvement in decision making (informed decision making that is non-biased, and shared decision making)
	• engagement with and trust in the healthcare team
	• continuity of contact with healthcare professionals.
	
	For sub-objective 2
	Intervention:
	• any intervention or package of care designed to provide specific or additional information about labour and birth for women at high risk of adverse outcomes in labour due to obstetric complications that arise before or during the intrapartum period	

Item	Details	Working notes
Comparison	For sub-objective 1 • N/A For sub-objective 2 • Absence of information • Usual information provision • Different interventions or packages of care	

Outcomes	For sub-objective 1
	• N/A
	
	For sub-objective 2
	Critical outcomes:
	• for the woman:
	  ○ woman's satisfaction with involvement in decision making (informed decision making that is unbiased, and shared decision making)
	  ○ mortality
	• for the baby:
	  ○ major morbidity
	
	Important outcomes:
	• for the woman:
	  ○ woman's experience of pregnancy, labour and birth, including experience of the birth companion
	  ○ major morbidity – physical morbidity and antenatal, intrapartum and postnatal psychological outcomes (any, including post-traumatic stress disorder, depression and anxiety)
	  ○ mode of birth
	
	Outcomes of limited importance:
	• for the baby:
	  ○ mortality	

Importance of outcomes	For sub-objective 1 • N/A For sub-objective 2 Preliminary classification of the outcomes for decision making: • critical (up to 3 outcomes) • important but not critical (up to 3 outcomes) • of limited importance (1 outcome)	
Context or setting	For sub-objectives 1 and 2 All settings	
Stratified, subgroup and adjusted analyses	For sub-objectives 1 and 2 • Groups that will be reviewed and analysed separately: ○ for complication-specific information, women with different obstetric complications will be analysed separately	

Item	Details	Working notes
	○ if information is specific to experiencing complications before or during labour, evidence will be analysed separately based on when the participants experienced complications. For sub-objective 2 only In the presence of heterogeneity, the following subgroups will be considered for sensitivity analysis: ○ different complications experienced by women ○ different interventions implemented in the light of complications ○ socioeconomic background ○ substance abuse. • Potential confounders: ○ accessibility of information given to women ○ age ○ parity ○ level of education ○ socioeconomic background ○ cultural and religious background ○ access to services ○ role, seniority and continuity of contact with the person giving the information	
Language	English	
Study design	For sub-objective 1 • Published full-text papers only • Qualitative studies (for example, studies that use interviews, focus groups, or observations) • Surveys that include qualitative data) • Exclusions: ○ purely quantitative studies (including surveys reporting only quantitative data) ○ studies may be excluded based on data saturation if more comprehensive evidence is available from other studies ○ conference abstracts will not be considered. For sub-objective 2 • Published full-text papers only • Systematic reviews • RCTs • Only if RCTs unavailable or there is limited data to inform decision making: ○ prospective or retrospective comparative observational studies (including cohort and case-control studies) ○ before-and-after studies if the difference in outcomes is selectively due to differences in the information given, not due to changes in the entire system	

Item	Details	Working notes
	○ surveys (only for woman's satisfaction with involvement in decision making, woman's and birth companion's experience and psychological outcomes) • Prospective study designs will be prioritised over retrospective study designs • Conference abstracts will not be considered	
Search strategy	Sources to be searched: Medline, Medline In-Process, CCTR, CDSR, DARE, HTA, Embase, PsycInfo and MIDIRS. Limits (e.g. date, study design): qualitative, systematic review, RCT, cohort and before-and-after study filters applied. Apply standard animal/non-English language filters. No date limit. Supplementary search techniques: No supplementary search techniques were used. See Appendix B – Literature search strategies for full strategies	
Review strategy	For sub-objective 1 • Appraisal of methodological quality: ○ the methodological quality of each study will be assessed using a qualitative study quality checklist (CASP) as set out in the NICE guidelines manual 2014 ○ the quality of the evidence for each review finding (that is, across studies) will be assessed using the GRADE-CERQual approach. • Synthesis of data: ○ thematic analysis of the data will be conducted and findings presented. For sub-objective 2 • Appraisal of methodological quality: ○ the methodological quality of each study will be assessed using checklists recommended in the NICE guidelines manual 2014 (for example, AMSTAR or ROBIS for systematic reviews, and Cochrane RoB tool for RCTs) and the quality of the evidence for each outcome (that is, across studies) will be assessed using GRADE ○ if studies report only p-values, this information will be recorded in GRADE tables without an assessment of imprecision • Synthesis of data: ○ meta-analysis will be conducted where appropriate ○ default MIDs will be used; 0.8 and 1.25 for dichotomous outcomes; 0.5 times the SD of the measurement in the control arm (or median score across control arms if multiple studies are included) for continuous outcomes ○ for continuous data, change scores will be used in preference to final scores for data from non-RCT studies; final and change scores will not be pooled; if any study reports both, the method used in the majority of studies will be adopted	Review questions selected as high priorities for health economic analysis (and those selected as medium priorities and where health economic analysis could influence recommendations) will be subject to dual weeding and study selection; any discrepancies will be resolved through discussion between the first and second reviewers or by reference to a third person. This review question was not prioritised for health economic analysis and so no formal dual weeding, study selection (inclusion/exclusion) or data extraction into evidence tables will be undertaken. However, internal (NGA) quality assurance processes will include consideration of the outcomes of weeding, study selection and data extraction and the committee will review the results of study

Item	Details	Working notes
		selection and data extraction
Equalities	Equalities considerations will be considered systematically in relation to the available evidence and draft recommendations. The guideline scope includes women with cognitive or physical disability as populations for whom there may be equalities issues. Recommendations about information provision should take into account patient inequalities such as those caused by vision, auditory and cognitive difficulties. Women who have received no antenatal care will be considered as a subgroup for all systematic reviews performed within the medical conditions work stream and a specific question has been included in the obstetric complications work stream for this population	
Notes/additional information	Care Quality Commission. 2015 survey of women's experiences of maternity care: statistical release. December 2015 (http://www.cqc.org.uk/sites/default/files/20151215b_mat15_statistical_release.pdf) NICE guideline on preterm labour and birth (https://www.nice.org.uk/guidance/ng25/resources/preterm-labour-and-birth-pdf-1837333576645) NICE guideline on antenatal care for uncomplicated pregnancies (https://www.nice.org.uk/guidance/cg62/resources/antenatal-care-for-uncomplicated-pregnancies-pdf-975564597445)	
Key papers	None identified by the committee	

1 *AMSTAR: Assessing the Methodological Quality of Systematic Reviews; CDSR: Cochrane Database of*
2 *Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; DARE: Database of*
3 *Abstracts of Reviews of Effects; GRADE: Grading of Recommendations Assessment, Development and*
4 *Evaluation; HTA: Health Technology Assessment; ITU: intensive therapy unit; MID: minimally important*
5 *difference; N/A: not applicable; NGA: National Guideline Alliance; NICE: National Institute for Health and*
6 *Care Excellence; NICU: neonatal intensive care unit; RCT: randomised controlled trial; RoB: risk of bias;*
7 *SD: standard deviation; ROBIS: Risk of Bias in Systematic Reviews*

1 # Appendix B – Literature search strategies

2 ## Information provision (women at high risk of adverse outcomes for themselves
3 and/or their babies because of obstetric complications or other reasons)

4 **Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process & Other Non-**
5 **Indexed Citations**

#	Searches
1	interview$.mp.
2	experience$.mp.
3	qualitative$.tw.
4	or/1-3
5	META-ANALYSIS/
6	META-ANALYSIS AS TOPIC/
7	(meta analy* or metanaly* or metaanaly*).ti,ab.
8	((systematic* or evidence*) adj2 (review* or overview*)).ti,ab.
9	(reference list* or bibliograph* or hand search* or manual search* or relevant journals).ab.
10	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
11	(search* adj4 literature).ab.
12	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
13	cochrane.jw.
14	or/5-13
15	randomized controlled trial.pt.
16	controlled clinical trial.pt.
17	pragmatic clinical trial.pt.
18	randomi#ed.ab.
19	placebo.ab.
20	randomly.ab.
21	CLINICAL TRIALS AS TOPIC/
22	trial.ti.
23	or/15-22
24	COHORT STUDIES/
25	(cohort adj3 (study or studies)).ti,ab.
26	(Cohort adj3 analy$).ti,ab.
27	FOLLOW-UP STUDIES/
28	(Follow$ up adj3 (study or studies)).ti,ab.
29	LONGITUDINAL STUDIES/
30	(longitudinal$ adj3 (study or studies)).ti,ab.
31	PROSPECTIVE STUDIES/
32	(prospective$ adj3 (study or studies)).ti,ab.

#	Searches
33	RETROSPECTIVE STUDIES/
34	(retrospective$ adj3 (study or studies)).ti,ab.
35	OBSERVATIONAL STUDY/
36	(observational adj3 (study or studies)).ti,ab.
37	CASE-CONTROL STUDIES/
38	(case adj3 (comparison? or control?) adj3 (study or studies)).ti,ab.
39	or/24-38
40	CONTROLLED BEFORE-AFTER STUDIES/
41	(before$ adj3 after$ adj3 (study or studies)).ti,ab.
42	or/40-41
43	"SURVEYS AND QUESTIONNAIRES"/
44	survey?.ti,ab.
45	or/43-44
46	PERIPARTUM PERIOD/
47	PARTURITION/
48	exp LABOR, OBSTETRIC/
49	OBSTETRIC LABOR, PREMATURE/
50	DELIVERY, OBSTETRIC/
51	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).ti,ab.
52	((during or giving or give) adj3 birth?).ti,ab.
53	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).ti,ab.
54	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).ti,ab.
55	or/46-54
56	exp FEVER/
57	(fever$ or pyrexi$ or hyperthermi$).ti,ab.
58	((elevat$ or high$) adj3 temperature?).ti,ab.
59	or/56-58
60	exp SEPSIS/
61	sepsis.ti,ab.
62	BLOOD-BORNE PATHOGENS/
63	(blood$ adj3 (pathogen$ or poison$)).ti,ab.
64	exp SYSTEMIC INFLAMMATORY RESPONSE SYNDROME/
65	"systemic inflammatory response syndrome".ti,ab.
66	SIRS.ti,ab.
67	septic?emi$.ti,ab.
68	((septic or endotoxic or toxic) adj3 shock).ti,ab.
69	(py?emi$ or pyohemi$).ti,ab.
70	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).ti,ab.
71	or/60-70

#	Searches
72	FETAL MACROSOMIA/
73	macrosomia?.ti,ab.
74	(large adj3 gestational adj3 age?).ab,ti.
75	(large adj3 date?).ab,ti.
76	or/72-75
77	BREECH PRESENTATION/
78	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).ab,ti.
79	or/77-78
80	PREGNANCY, PROLONGED/
81	(pregnan$ adj3 prolong$).ab,ti.
82	(pregnan$ adj1 late).ab,ti.
83	(postterm$ or post-term$).ab,ti.
84	(postdate$ or post-date$).ab,ti.
85	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
86	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
87	or/80-86
88	CESAREAN SECTION, REPEAT/
89	CESAREAN SECTION/ and (repeat$ or previous$).ti.
90	CESAREAN SECTION/ and (repeat$ or previous$).ab. /freq=2
91	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).ti,ab.
92	VAGINAL BIRTH AFTER CESAREAN/
93	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
94	VBAC.ti,ab.
95	TRIAL OF LABOR/ and CESAREAN SECTION/
96	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
97	TOLAC.ti,ab.
98	or/88-97
99	INFANT, SMALL FOR GESTATIONAL AGE/
100	GESTATIONAL AGE/ and small.ti.
101	GESTATIONAL AGE/ and small.ab. /freq=2
102	(small adj3 gestational age?).ab,ti.
103	SGA.ti,ab.
104	FETAL GROWTH RETARDATION/

#	Searches
105	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).ti,ab.
106	IUGR.ti,ab.
107	INFANT, LOW BIRTH WEIGHT/
108	exp INFANT, VERY LOW BIRTH WEIGHT/
109	(low birthweight? or low birth weight?).ti,ab.
110	LBW.ti,ab.
111	or/99-110
112	*HEALTH SERVICES ACCESSIBILITY/
113	HEALTHCARE DISPARITIES/
114	HEALTH SERVICES MISUSE/
115	NO-SHOW PATIENTS/
116	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).ab,ti.
117	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).ti,ab.
118	(unbook$ or un-book$ or (late adj3 book$)).ti,ab.
119	walk$ in?.ti,ab.
120	((no or non) adj3 engag$).ti,ab.
121	no show.ti,ab.
122	or/112-121
123	PREGNANCY, UNPLANNED/
124	PREGNANCY, UNWANTED/
125	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).ti,ab.
126	or/123-125
127	PERIPARTUM PERIOD/

#	Searches
128	PARTURITION/
129	LABOR, OBSTETRIC/
130	UTERINE CONTRACTION/
131	LABOR ONSET/
132	LABOR STAGE, FIRST/
133	LABOR STAGE, SECOND/
134	OBSTETRIC LABOR, PREMATURE/
135	DELIVERY, OBSTETRIC/
136	(labo?r or childbirth or partur$ or intra?part$ or peri?part$).ti,ab.
137	((during or giving) adj3 birth?).ti,ab.
138	or/127-137
139	HEMORRHAGE/
140	SHOCK, HEMORRHAGIC/
141	UTERINE HEMORRHAGE/
142	or/139-141
143	138 and 142
144	((labo?r or birth? or childbirth? or partur$ or intra?part$ or peri?part$) adj3 (h?emorrhag$ or bleed$)).ti,ab.
145	or/143-144
146	*PREGNANCY, HIGH-RISK/
147	(pregnan$ adj2 high$ adj2 risk$).ab,ti.
148	or/146-147
149	55 and (59 or 71 or 76 or 79 or 87 or 98 or 111 or 122 or 126 or 148)
150	145 or 149

#	Searches
151	HEALTH EDUCATION/
152	exp CONSUMER HEALTH INFORMATION/
153	PATIENT EDUCATION AS TOPIC/
154	exp PARENTS/ed [education]
155	INFORMATION SEEKING BEHAVIOR/
156	POSTERS AS TOPIC/
157	PUBLICATIONS/
158	GOVERNMENT PUBLICATIONS AS TOPIC/
159	PAMPHLETS/
160	INTERNET/
161	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ti.
162	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ab. /freq=2
163	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ti,ab.
164	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media) adj5 (informat$ or educat$)).ti,ab.
165	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media)).ti,ab.
166	(informat$ adj3 (model? or program$ or strateg$ or package? or checklist? or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).ti,ab.
167	(informat$ adj3 provid$).ti.
168	(informat$ adj3 provid$).ab.
169	informat$.ab. /freq=2
170	168 and 169
171	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).ti,ab.

#	Searches
172	(informat$ adj3 (type? or content? or method? or quality)).ti,ab.
173	((additional or extra or added or further) adj3 informat$).ti,ab.
174	((time? or timing or when or prompt$) adj3 informat$).ti,ab.
175	((give? or giving or gave) adj3 informat$).ti,ab.
176	(informat$ adj3 (hospital? or unit? or department? or service? or resource? or red flag? or emergency care or contact?)).ti,ab.
177	patient education handout.pt.
178	151 or 152 or 153 or 154 or 155 or 156 or 157 or 158 or 159 or 160 or 161 or 162 or 163 or 164 or 165 or 166 or 167 or 170 or 171 or 172 or 173 or 174 or 175 or 176 or 177
179	PATIENT CARE PLANNING/
180	CRITICAL PATHWAY/
181	CLINICAL PROTOCOLS/
182	or/179-181
183	informat$.ti,ab.
184	182 and 183
185	(informat$ adj3 (care plan$ or pathway? or protocol?)).ti,ab.
186	or/184-185
187	COMMUNICATION BARRIERS/
188	((communicat$ or language?) adj3 (barrier? or facilitat$)).ti,ab.
189	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).ti,ab.
190	(communicat$ adj3 (time? or timing? or initiat$)).ti,ab.
191	TRANSLATING/
192	(translat$ adj7 (communicat$ or language? or informat$)).ti,ab.
193	or/187-192
194	178 or 186 or 193

#	Searches
195	150 and 194
196	PRENATAL EDUCATION/
197	*PRENATAL CARE/
198	PERINATAL CARE/
199	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).ti,ab.
200	or/196-199
201	informat$.ti.
202	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ab.
203	or/201-202
204	200 and 203
205	195 or 204
206	limit 205 to english language
207	LETTER/
208	EDITORIAL/
209	NEWS/
210	exp HISTORICAL ARTICLE/
211	ANECDOTES AS TOPIC/
212	COMMENT/
213	CASE REPORT/
214	(letter or comment*).ti.
215	or/207-214
216	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
217	215 not 216

#	Searches
218	ANIMALS/ not HUMANS/
219	exp ANIMALS, LABORATORY/
220	exp ANIMAL EXPERIMENTATION/
221	exp MODELS, ANIMAL/
222	exp RODENTIA/
223	(rat or rats or mouse or mice).ti.
224	or/217-223
225	206 not 224
226	4 and 225
227	14 and 225
228	23 and 225
229	39 and 225
230	42 and 225
231	45 and 225
232	or/226-231

Database: Cochrane Central Register of Controlled Trials

#	Searches
1	PERIPARTUM PERIOD/
2	PARTURITION/
3	exp LABOR, OBSTETRIC/
4	OBSTETRIC LABOR, PREMATURE/
5	DELIVERY, OBSTETRIC/
6	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).ti,ab,kw.
7	((during or giving or give) adj3 birth?).ti,ab.
8	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).ti,ab.
9	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).ti,ab.
10	or/1-9

#	Searches
11	exp FEVER/
12	(fever$ or pyrexi$ or hyperthermi$).ti,ab,kw.
13	((elevat$ or high$) adj3 temperature?).ti,ab.
14	or/11-13
15	exp SEPSIS/
16	sepsis.ti,ab,kw.
17	BLOOD-BORNE PATHOGENS/
18	(blood$ adj3 (pathogen$ or poison$)).ti,ab.
19	exp SYSTEMIC INFLAMMATORY RESPONSE SYNDROME/
20	"systemic inflammatory response syndrome".ti,ab.
21	SIRS.ti,ab.
22	septic?emi$.ti,ab,kw.
23	((septic or endotoxic or toxic) adj3 shock).ti,ab.
24	(py?emi$ or pyohemi$).ti,ab,kw.
25	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).ti,ab,kw.
26	or/15-25
27	FETAL MACROSOMIA/
28	macrosomia?.ti,ab,kw.
29	(large adj3 gestational adj3 age?).ab,ti.
30	(large adj3 date?).ab,ti.
31	or/27-30
32	BREECH PRESENTATION/
33	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).ab,ti.
34	or/32-33
35	PREGNANCY, PROLONGED/
36	(pregnan$ adj3 prolong$).ab,ti.
37	(pregnan$ adj1 late).ab,ti.
38	(postterm$ or post-term$).ab,ti.
39	(postdate$ or post-date$).ab,ti.
40	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
41	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
42	or/35-41
43	CESAREAN SECTION, REPEAT/
44	CESAREAN SECTION/ and (repeat$ or previous$).ti.
45	CESAREAN SECTION/ and (repeat$ or previous$).ab. /freq=2
46	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).ti,ab.
47	VAGINAL BIRTH AFTER CESAREAN/
48	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.

#	Searches
49	VBAC.ti,ab.
50	TRIAL OF LABOR/ and CESAREAN SECTION/
51	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
52	TOLAC.ti,ab.
53	or/43-52
54	INFANT, SMALL FOR GESTATIONAL AGE/
55	GESTATIONAL AGE/ and small.ti.
56	GESTATIONAL AGE/ and small.ab. /freq=2
57	(small adj3 gestational age?).ab,ti.
58	SGA.ti,ab.
59	FETAL GROWTH RETARDATION/
60	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).ti,ab.
61	IUGR.ti,ab.
62	INFANT, LOW BIRTH WEIGHT/
63	exp INFANT, VERY LOW BIRTH WEIGHT/
64	(low birthweight? or low birth weight?).ti,ab,kw.
65	LBW.ti,ab.
66	or/54-65
67	*HEALTH SERVICES ACCESSIBILITY/
68	HEALTHCARE DISPARITIES/
69	HEALTH SERVICES MISUSE/
70	NO-SHOW PATIENTS/
71	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).ab,ti.
72	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).ti,ab.
73	(unbook$ or un-book$ or (late adj3 book$)).ti,ab.
74	walk$ in?.ti,ab.
75	((no or non) adj3 engag$).ti,ab.
76	((no or non) adj3 show$).ti,ab.
77	or/67-76
78	PREGNANCY, UNPLANNED/
79	PREGNANCY, UNWANTED/
80	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).ti,ab.
81	or/78-80
82	PERIPARTUM PERIOD/
83	PARTURITION/
84	LABOR, OBSTETRIC/
85	UTERINE CONTRACTION/
86	LABOR ONSET/

#	Searches
87	LABOR STAGE, FIRST/
88	LABOR STAGE, SECOND/
89	OBSTETRIC LABOR, PREMATURE/
90	DELIVERY, OBSTETRIC/
91	(labo?r or childbirth or partur$ or intra?part$ or peri?part$).ti,ab,kw.
92	((during or giving) adj3 birth?).ti,ab.
93	or/82-92
94	HEMORRHAGE/
95	SHOCK, HEMORRHAGIC/
96	UTERINE HEMORRHAGE/
97	or/94-96
98	93 and 97
99	((labo?r or birth? or childbirth? or partur$ or intra?part$ or peri?part$) adj3 (h?emorrhag$ or bleed$)).ti,ab.
100	or/98-99
101	*PREGNANCY, HIGH-RISK/
102	(pregnan$ adj2 high$ adj2 risk$).ab,ti.
103	or/101-102
104	10 and (14 or 26 or 31 or 34 or 42 or 53 or 66 or 77 or 81 or 103)
105	100 or 104
106	HEALTH EDUCATION/
107	exp CONSUMER HEALTH INFORMATION/
108	PATIENT EDUCATION AS TOPIC/
109	exp PARENTS/ed [education]
110	INFORMATION SEEKING BEHAVIOR/
111	POSTERS AS TOPIC/
112	PUBLICATIONS/
113	GOVERNMENT PUBLICATIONS AS TOPIC/
114	PAMPHLETS/

#	Searches
115	INTERNET/
116	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ti.
117	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ab. /freq=2
118	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ti,ab.
119	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media) adj5 (informat$ or educat$)).ti,ab.
120	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media)).ti,ab.
121	(informat$ adj3 (model? or program$ or strateg$ or package? or checklist? or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).ti,ab.
122	(informat$ adj3 provid$).ti.
123	(informat$ adj3 provid$).ab.
124	informat$.ab. /freq=2
125	123 and 124
126	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).ti,ab.
127	(informat$ adj3 (type? or content? or method? or quality)).ti,ab.
128	((additional or extra or added or further) adj3 informat$).ti,ab.
129	((time? or timing or when or prompt$) adj3 informat$).ti,ab.
130	((give? or giving or gave) adj3 informat$).ti,ab.
131	(informat$ adj3 (hospital? or unit? or department? or service? or resource? or red flag? or emergency care or contact?)).ti,ab.
132	patient education handout.pt.
133	106 or 107 or 108 or 109 or 110 or 111 or 112 or 113 or 114 or 115 or 116 or 117 or 118 or 119 or 120 or 121 or 122 or 125 or 126 or 127 or 128 or 129 or 130 or 131 or 132
134	PATIENT CARE PLANNING/
135	CRITICAL PATHWAY/

#	Searches
136	CLINICAL PROTOCOLS/
137	or/134-136
138	informat$.ti,ab.
139	137 and 138
140	(informat$ adj3 (care plan$ or pathway? or protocol?)).ti,ab.
141	or/139-140
142	COMMUNICATION BARRIERS/
143	((communicat$ or language?) adj3 (barrier? or facilitat$)).ti,ab.
144	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).ti,ab.
145	(communicat$ adj3 (time? or timing? or initiat$)).ti,ab.
146	TRANSLATING/
147	(translat$ adj7 (communicat$ or language? or informat$)).ti,ab.
148	or/142-147
149	133 or 141 or 148
150	105 and 149
151	PRENATAL EDUCATION/
152	PRENATAL CARE/
153	PERINATAL CARE/
154	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).ti,ab.
155	or/151-154
156	informat$.ti.
157	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ab.
158	or/156-157

#	Searches
159	155 and 158
160	150 or 159

Database: Cochrane Database of Systematic Reviews

#	Searches
1	PERIPARTUM PERIOD.kw.
2	PARTURITION.kw.
3	LABOR, OBSTETRIC.kw.
4	OBSTETRIC LABOR, PREMATURE.kw.
5	DELIVERY, OBSTETRIC.kw.
6	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).ti,ab.
7	((during or giving or give) adj3 birth?).ti,ab.
8	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).ti,ab.
9	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).ti,ab.
10	or/1-9
11	FEVER.kw.
12	(fever$ or pyrexi$ or hyperthermi$).ti,ab.
13	((elevat$ or high$) adj3 temperature?).ti,ab.
14	or/11-13
15	SEPSIS.kw.
16	sepsis.ti,ab.
17	BLOOD-BORNE PATHOGENS.kw.
18	(blood$ adj3 (pathogen$ or poison$)).ti,ab.
19	SYSTEMIC INFLAMMATORY RESPONSE SYNDROME.kw.
20	"systemic inflammatory response syndrome".ti,ab.
21	SIRS.ti,ab.
22	septic?emi$.ti,ab.
23	((septic or endotoxic or toxic) adj3 shock).ti,ab.
24	(py?emi$ or pyohemi$).ti,ab.
25	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).ti,ab.
26	or/15-25
27	FETAL MACROSOMIA.kw.
28	macrosomia?.ti,ab.
29	(large adj3 gestational adj3 age?).ab,ti.
30	(large adj3 date?).ab,ti.
31	or/27-30
32	BREECH PRESENTATION.kw.

#	Searches
33	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).ab,ti.
34	or/32-33
35	PREGNANCY, PROLONGED.kw.
36	(pregnan$ adj3 prolong$).ab,ti.
37	(pregnan$ adj1 late).ab,ti.
38	(postterm$ or post-term$).ab,ti.
39	(postdate$ or post-date$).ab,ti.
40	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
41	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
42	or/35-41
43	CESAREAN SECTION, REPEAT.kw.
44	CESAREAN SECTION.kw. and (repeat$ or previous$).ti.
45	CESAREAN SECTION.kw. and (repeat$ or previous$).ab.
46	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).ti,ab.
47	VAGINAL BIRTH AFTER CESAREAN.kw.
48	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
49	VBAC.ti,ab.
50	(TRIAL OF LABOR and CESAREAN SECTION).kw.
51	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
52	TOLAC.ti,ab.
53	or/43-52
54	INFANT, SMALL FOR GESTATIONAL AGE.kw.
55	GESTATIONAL AGE.kw. and small.ti.
56	GESTATIONAL AGE.kw. and small.ab.
57	(small adj3 gestational age?).ab,ti.
58	SGA.ti,ab.
59	FETAL GROWTH RETARDATION.kw.
60	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).ti,ab.
61	IUGR.ti,ab.
62	INFANT, LOW BIRTH WEIGHT.kw.
63	INFANT, VERY LOW BIRTH WEIGHT.kw.
64	(low birthweight? or low birth weight?).ti,ab.
65	LBW.ti,ab.
66	or/54-65
67	HEALTH SERVICES ACCESSIBILITY.kw.
68	HEALTHCARE DISPARITIES.kw.
69	HEALTH SERVICES MISUSE.kw.
70	NO-SHOW PATIENTS.kw.

#	Searches
71	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).ab,ti.
72	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).ti,ab.
73	(unbook$ or un-book$ or (late adj3 book$)).ti,ab.
74	walk$ in?.ti,ab.
75	((no or non) adj3 engag$).ti,ab.
76	((no or non) adj3 show$).ti,ab.
77	or/67-76
78	PREGNANCY, UNPLANNED.kw.
79	PREGNANCY, UNWANTED.kw.
80	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).ti,ab.
81	or/78-80
82	PERIPARTUM PERIOD.kw.
83	PARTURITION.kw.
84	LABOR, OBSTETRIC.kw.
85	UTERINE CONTRACTION.kw.
86	LABOR ONSET.kw.
87	LABOR STAGE, FIRST.kw.
88	LABOR STAGE, SECOND.kw.
89	OBSTETRIC LABOR, PREMATURE.kw.
90	DELIVERY, OBSTETRIC.kw.
91	(labo?r or childbirth or partur$ or intra?part$ or peri?part$).ti,ab.
92	((during or giving) adj3 birth?).ti,ab.
93	or/82-92
94	HEMORRHAGE.kw.
95	SHOCK, HEMORRHAGIC.kw.
96	UTERINE HEMORRHAGE.kw.
97	or/94-96
98	93 and 97
99	((labo?r or birth? or childbirth? or partur$ or intra?part$ or peri?part$) adj3 (h?emorrhag$ or bleed$)).ti,ab.
100	or/98-99
101	PREGNANCY, HIGH-RISK.kw.
102	(pregnan$ adj2 high$ adj2 risk$).ab,ti.
103	or/101-102
104	10 and (14 or 26 or 31 or 34 or 42 or 53 or 66 or 77 or 81 or 103)

#	Searches
105	100 or 104
106	HEALTH EDUCATION.kw.
107	CONSUMER HEALTH INFORMATION.kw.
108	PATIENT EDUCATION AS TOPIC.kw.
109	INFORMATION SEEKING BEHAVIOR.kw.
110	POSTERS AS TOPIC.kw.
111	PUBLICATIONS.kw.
112	GOVERNMENT PUBLICATIONS AS TOPIC.kw.
113	PAMPHLETS.kw.
114	INTERNET.kw.
115	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ti.
116	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ab.
117	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ti,ab.
118	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media) adj5 (informat$ or educat$)).ti,ab.
119	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media)).ti,ab.
120	(informat$ adj3 (model? or program$ or strateg$ or package? or checklist? or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).ti,ab.
121	(informat$ adj3 provid$).ti.
122	(informat$ adj3 provid$).ab.
123	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).ti,ab.
124	(informat$ adj3 (type? or content? or method? or quality)).ti,ab.
125	((additional or extra or added or further) adj3 informat$).ti,ab.

#	Searches
126	((time? or timing or when or prompt$) adj3 informat$).ti,ab.
127	((give? or giving or gave) adj3 informat$).ti,ab.
128	(informat$ adj3 (hospital? or unit? or department? or service? or resource? or red flag? or emergency care or contact?)).ti,ab.
129	or/106-128
130	PATIENT CARE PLANNING.kw.
131	CRITICAL PATHWAY.kw.
132	CLINICAL PROTOCOLS.kw.
133	or/130-132
134	informat$.ti,ab.
135	133 and 134
136	(informat$ adj3 (care plan$ or pathway? or protocol?)).ti,ab.
137	or/135-136
138	COMMUNICATION BARRIERS.kw.
139	((communicat$ or language?) adj3 (barrier? or facilitat$)).ti,ab.
140	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).ti,ab.
141	(communicat$ adj3 (time? or timing? or initiat$)).ti,ab.
142	TRANSLATING.kw.
143	(translat$ adj7 (communicat$ or language? or informat$)).ti,ab.
144	or/138-143
145	129 or 137 or 144
146	105 and 145
147	PRENATAL EDUCATION.kw.
148	PRENATAL CARE.kw.

#	Searches
149	PERINATAL CARE.kw.
150	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).ti,ab.
151	or/147-150
152	informat$.ti.
153	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ab.
154	or/152-153
155	151 and 154
156	146 or 155

Database: Database of Abstracts of Reviews of Effects

#	Searches
1	PERIPARTUM PERIOD.kw.
2	PARTURITION.kw.
3	LABOR, OBSTETRIC.kw.
4	OBSTETRIC LABOR, PREMATURE.kw.
5	DELIVERY, OBSTETRIC.kw.
6	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).tw,tx.
7	((during or giving or give) adj3 birth?).tw,tx.
8	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).tw,tx.
9	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).tw,tx.
10	or/1-9
11	FEVER.kw.
12	(fever$ or pyrexi$ or hyperthermi$).tw,tx.
13	((elevat$ or high$) adj3 temperature?).tw,tx.
14	or/11-13
15	SEPSIS.kw.
16	sepsis.tw,tx.
17	BLOOD-BORNE PATHOGENS.kw.
18	(blood$ adj3 (pathogen$ or poison$)).tw,tx.
19	SYSTEMIC INFLAMMATORY RESPONSE SYNDROME.kw.
20	"systemic inflammatory response syndrome".tw,tx.
21	SIRS.tw,tx.
22	septic?emi$.tw,tx.
23	((septic or endotoxic or toxic) adj3 shock).tw,tx.

#	Searches
24	(py?emi$ or pyohemi$).tw,tx.
25	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).tw,tx.
26	or/15-25
27	FETAL MACROSOMIA.kw.
28	macrosomia?.tw,tx.
29	(large adj3 gestational adj3 age?).tw,tx.
30	(large adj3 date?).tw,tx.
31	or/27-30
32	BREECH PRESENTATION.kw.
33	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).tw,tx.
34	or/32-33
35	PREGNANCY, PROLONGED.kw.
36	(pregnan$ adj3 prolong$).tw,tx.
37	(pregnan$ adj1 late).tw,tx.
38	(postterm$ or post-term$).tw,tx.
39	(postdate$ or post-date$).tw,tx.
40	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).tw,tx.
41	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).tw,tx.
42	or/35-41
43	CESAREAN SECTION, REPEAT.kw.
44	CESAREAN SECTION.kw. and (repeat$ or previous$).tw,tx.
45	CESAREAN SECTION.kw. and (repeat$ or previous$).tw,tx.
46	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).tw,tx.
47	VAGINAL BIRTH AFTER CESAREAN.kw.
48	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).tw,tx.
49	VBAC.tw,tx.
50	(TRIAL OF LABOR and CESAREAN SECTION).kw.
51	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).tw,tx.
52	TOLAC.tw,tx.
53	or/43-52
54	INFANT, SMALL FOR GESTATIONAL AGE.kw.
55	GESTATIONAL AGE.kw. and small.tw,tx.
56	GESTATIONAL AGE.kw. and small.tw,tx.
57	(small adj3 gestational age?).tw,tx.
58	SGA.tw,tx.
59	FETAL GROWTH RETARDATION.kw.
60	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).tw,tx.

#	Searches
61	IUGR.tw,tx.
62	INFANT, LOW BIRTH WEIGHT.kw.
63	INFANT, VERY LOW BIRTH WEIGHT.kw.
64	(low birthweight? or low birth weight?).tw,tx.
65	LBW.tw,tx.
66	or/54-65
67	HEALTH SERVICES ACCESSIBILITY.kw.
68	HEALTHCARE DISPARITIES.kw.
69	HEALTH SERVICES MISUSE.kw.
70	NO-SHOW PATIENTS.kw.
71	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).tw,tx.
72	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).tw,tx.
73	(unbook$ or un-book$ or (late adj3 book$)).tw,tx.
74	walk$ in?.tw,tx.
75	((no or non) adj3 engag$).tw,tx.
76	((no or non) adj3 show$).tw,tx.
77	or/67-76
78	PREGNANCY, UNPLANNED.kw.
79	PREGNANCY, UNWANTED.kw.
80	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).tw,tx.
81	or/78-80
82	PERIPARTUM PERIOD.kw.
83	PARTURITION.kw.
84	LABOR, OBSTETRIC.kw.
85	UTERINE CONTRACTION.kw.
86	LABOR ONSET.kw.
87	LABOR STAGE, FIRST.kw.
88	LABOR STAGE, SECOND.kw.
89	OBSTETRIC LABOR, PREMATURE.kw.
90	DELIVERY, OBSTETRIC.kw.
91	(labo?r or childbirth or partur$ or intra?part$ or peri?part$).tw,tx.
92	((during or giving) adj3 birth?).tw,tx.
93	or/82-92
94	HEMORRHAGE.kw.
95	SHOCK, HEMORRHAGIC.kw.
96	UTERINE HEMORRHAGE.kw.
97	or/94-96
98	93 and 97

#	Searches
99	((labo?r or birth? or childbirth? or partur$ or intra?part$ or peri?part$) adj3 (h?emorrhag$ or bleed$)).tw,tx.
100	or/98-99
101	PREGNANCY, HIGH-RISK.kw.
102	(pregnan$ adj2 high$ adj2 risk$).tw,tx.
103	or/101-102
104	10 and (14 or 26 or 31 or 34 or 42 or 53 or 66 or 77 or 81 or 103)
105	100 or 104
106	HEALTH EDUCATION.kw.
107	CONSUMER HEALTH INFORMATION.kw.
108	PATIENT EDUCATION AS TOPIC.kw.
109	INFORMATION SEEKING BEHAVIOR.kw.
110	POSTERS AS TOPIC.kw.
111	PUBLICATIONS.kw.
112	GOVERNMENT PUBLICATIONS AS TOPIC.kw.
113	PAMPHLETS.kw.
114	INTERNET.kw.
115	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).tw,tx.
116	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).tw,tx.
117	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).tw,tx.
118	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media) adj5 (informat$ or educat$)).tw,tx.
119	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media)).tw,tx.

#	Searches
120	(informat$ adj3 (model? or program$ or strateg$ or package? or checklist? or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).tw,tx.
121	(informat$ adj3 provid$).tw,tx.
122	(informat$ adj3 provid$).tw,tx.
123	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).tw,tx.
124	(informat$ adj3 (type? or content? or method? or quality)).tw,tx.
125	((additional or extra or added or further) adj3 informat$).ti.
126	((time? or timing or when or prompt$) adj3 informat$).tw,tx.
127	((give? or giving or gave) adj3 informat$).tw,tx.
128	(informat$ adj3 (hospital? or unit? or department? or service? or resource? or red flag? or emergency care or contact?)).tw,tx.
129	or/106-128
130	PATIENT CARE PLANNING.kw.
131	CRITICAL PATHWAY.kw.
132	CLINICAL PROTOCOLS.kw.
133	or/130-132
134	informat$.tw,tx.
135	133 and 134
136	(informat$ adj3 (care plan$ or pathway? or protocol?)).tw,tx.
137	or/135-136
138	COMMUNICATION BARRIERS.kw.
139	((communicat$ or language?) adj3 (barrier? or facilitat$)).tw,tx.
140	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).tw,tx.
141	(communicat$ adj3 (time? or timing? or initiat$)).tw,tx.
142	TRANSLATING.kw.

#	Searches
143	(translat$ adj7 (communicat$ or language? or informat$)).tw,tx.
144	or/138-143
145	129 or 137 or 144
146	105 and 145
147	PRENATAL EDUCATION.kw.
148	PRENATAL CARE.kw.
149	PERINATAL CARE.kw.
150	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).tw,tx.
151	or/147-150
152	informat$.ti.
153	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).tw,tx.
154	or/152-153
155	151 and 154
156	146 or 155

Database: Health Technology Assessment

#	Searches
1	PERIPARTUM PERIOD/
2	PARTURITION/
3	exp LABOR, OBSTETRIC/
4	OBSTETRIC LABOR, PREMATURE/
5	DELIVERY, OBSTETRIC/
6	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).tw.
7	((during or giving or give) adj3 birth?).tw.
8	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).tw.
9	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).tw.
10	or/1-9
11	exp FEVER/
12	(fever$ or pyrexi$ or hyperthermi$).tw.

#	Searches
13	((elevat$ or high$) adj3 temperature?).tw.
14	or/11-13
15	exp SEPSIS/
16	sepsis.tw.
17	BLOOD-BORNE PATHOGENS/
18	(blood$ adj3 (pathogen$ or poison$)).tw.
19	exp SYSTEMIC INFLAMMATORY RESPONSE SYNDROME/
20	"systemic inflammatory response syndrome".tw.
21	SIRS.tw.
22	septic?emi$.tw.
23	((septic or endotoxic or toxic) adj3 shock).tw.
24	(py?emi$ or pyohemi$).tw.
25	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).tw.
26	or/15-25
27	FETAL MACROSOMIA/
28	macrosomia?.tw.
29	(large adj3 gestational adj3 age?).tw.
30	(large adj3 date?).tw.
31	or/27-30
32	BREECH PRESENTATION/
33	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).tw.
34	or/32-33
35	PREGNANCY, PROLONGED/
36	(pregnan$ adj3 prolong$).tw.
37	(pregnan$ adj1 late).tw.
38	(postterm$ or post-term$).tw.
39	(postdate$ or post-date$).tw.
40	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).tw.
41	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).tw.
42	or/35-41
43	CESAREAN SECTION, REPEAT/
44	CESAREAN SECTION/ and (repeat$ or previous$).tw.
45	CESAREAN SECTION/ and (repeat$ or previous$).tw.
46	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).tw.
47	VAGINAL BIRTH AFTER CESAREAN/
48	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).tw.
49	VBAC.tw.
50	TRIAL OF LABOR/ and CESAREAN SECTION/

#	Searches
51	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).tw.
52	TOLAC.tw.
53	or/43-52
54	INFANT, SMALL FOR GESTATIONAL AGE/
55	GESTATIONAL AGE/ and small.tw.
56	GESTATIONAL AGE/ and small.tw.
57	(small adj3 gestational age?).tw.
58	SGA.tw.
59	FETAL GROWTH RETARDATION/
60	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).tw.
61	IUGR.tw.
62	INFANT, LOW BIRTH WEIGHT/
63	exp INFANT, VERY LOW BIRTH WEIGHT/
64	(low birthweight? or low birth weight?).tw.
65	LBW.tw.
66	or/54-65
67	*HEALTH SERVICES ACCESSIBILITY/
68	HEALTHCARE DISPARITIES/
69	HEALTH SERVICES MISUSE/
70	NO-SHOW PATIENTS/
71	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).tw.
72	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).tw.
73	(unbook$ or un-book$ or (late adj3 book$)).tw.
74	walk$ in?.tw.
75	((no or non) adj3 engag$).tw.
76	no show.tw.
77	or/67-76
78	PREGNANCY, UNPLANNED/
79	PREGNANCY, UNWANTED/
80	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).tw.
81	or/78-80
82	PERIPARTUM PERIOD/
83	PARTURITION/
84	LABOR, OBSTETRIC/
85	UTERINE CONTRACTION/
86	LABOR ONSET/
87	LABOR STAGE, FIRST/
88	LABOR STAGE, SECOND/

#	Searches
89	OBSTETRIC LABOR, PREMATURE/
90	DELIVERY, OBSTETRIC/
91	(labo?r or childbirth or partur$ or intra?part$ or peri?part$).tw.
92	((during or giving) adj3 birth?).tw.
93	or/82-92
94	HEMORRHAGE/
95	SHOCK, HEMORRHAGIC/
96	UTERINE HEMORRHAGE/
97	or/94-96
98	93 and 97
99	((labo?r or birth? or childbirth? or partur$ or intra?part$ or peri?part$) adj3 (h?emorrhag$ or bleed$)).tw.
100	or/98-99
101	*PREGNANCY, HIGH-RISK/
102	(pregnan$ adj2 high$ adj2 risk$).tw.
103	or/101-102
104	10 and (14 or 26 or 31 or 34 or 42 or 53 or 66 or 77 or 81 or 103)
105	100 or 104
106	HEALTH EDUCATION/
107	PATIENT EDUCATION AS TOPIC/
108	exp PARENTS/ed [education]
109	INFORMATION SEEKING BEHAVIOR/
110	POSTERS AS TOPIC/
111	PUBLICATIONS/
112	GOVERNMENT PUBLICATIONS AS TOPIC/
113	PAMPHLETS/
114	INTERNET/
115	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).tw.

#	Searches
116	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).tw.
117	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media) adj5 (informat$ or educat$)).tw.
118	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media)).tw.
119	(informat$ adj3 (model? or program$ or strateg$ or package? or checklist? or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).tw.
120	(informat$ adj3 provid$).tw.
121	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).tw.
122	(informat$ adj3 (type? or content? or method? or quality)).tw.
123	((additional or extra or added or further) adj3 informat$).tw.
124	((time? or timing or when or prompt$) adj3 informat$).tw.
125	((give? or giving or gave) adj3 informat$).tw.
126	(informat$ adj3 (hospital? or unit? or department? or service? or resource? or red flag? or emergency care or contact?)).tw.
127	patient education handout.pt.
128	or/106-127
129	PATIENT CARE PLANNING/
130	CRITICAL PATHWAY/
131	CLINICAL PROTOCOLS/
132	or/129-131
133	informat$.tw.
134	132 and 133
135	(informat$ adj3 (care plan$ or pathway? or protocol?)).tw.
136	or/134-135

#	Searches
137	COMMUNICATION BARRIERS/
138	((communicat$ or language?) adj3 (barrier? or facilitat$)).tw.
139	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).tw.
140	(communicat$ adj3 (time? or timing? or initiat$)).tw.
141	TRANSLATING/
142	(translat$ adj7 (communicat$ or language? or informat$)).tw.
143	or/137-142
144	128 or 136 or 143
145	105 and 144
146	PRENATAL EDUCATION/
147	PRENATAL CARE/
148	PERINATAL CARE/
149	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).tw.
150	or/146-149
151	informat$.ti.
152	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).tw.
153	or/151-152
154	150 and 153
155	145 or 154

Database: Embase

#	Searches
1	interview:.tw.
2	exp HEALTH CARE ORGANIZATION/
3	experiences.tw.
4	or/1-3
5	SYSTEMATIC REVIEW/

#	Searches
6	META-ANALYSIS/
7	(meta analy$ or metanaly$ or metaanaly$).ti,ab.
8	((systematic or evidence) adj2 (review$ or overview$)).ti,ab.
9	(reference list$ or bibliograph$ or hand search$ or manual search$ or relevant journals).ab.
10	(search strategy or search criteria or systematic search or study selection or data extraction).ab.
11	(search$ adj4 literature).ab.
12	(medline or pubmed or cochrane or embase or psychlit or psyclit or psychinfo or psycinfo or cinahl or science citation index or bids or cancerlit).ab.
13	((pool$ or combined) adj2 (data or trials or studies or results)).ab.
14	cochrane.jw.
15	or/5-14
16	random$.ti,ab.
17	factorial$.ti,ab.
18	(crossover$ or cross over$).ti,ab.
19	((doubl$ or singl$) adj blind$).ti,ab.
20	(assign$ or allocat$ or volunteer$ or placebo$).ti,ab.
21	CROSSOVER PROCEDURE/
22	SINGLE BLIND PROCEDURE/
23	RANDOMIZED CONTROLLED TRIAL/
24	DOUBLE BLIND PROCEDURE/
25	or/16-24
26	COHORT ANALYSIS/
27	(cohort adj3 (study or studies)).ti,ab.
28	(Cohort adj3 analy$).ti,ab.
29	FOLLOW UP/
30	(Follow$ up adj3 (study or studies)).ti,ab.

#	Searches
31	LONGITUDINAL STUDY/
32	(longitudinal$ adj3 (study or studies)).ti,ab.
33	PROSPECTIVE STUDY/
34	(prospective$ adj3 (study or studies)).ti,ab.
35	RETROSPECTIVE STUDY/
36	(retrospective$ adj3 (study or studies)).ti,ab.
37	OBSERVATIONAL STUDY/
38	(observational adj3 (study or studies)).ti,ab.
39	CASE CONTROL STUDY/
40	(case adj3 (comparison? or control?) adj3 (study or studies)).ti,ab.
41	or/26-40
42	(before$ adj3 after$ adj3 (study or studies)).ti,ab.
43	QUESTIONNAIRE/
44	survey?.ti,ab.
45	or/43-44
46	*PERINATAL PERIOD/
47	exp *BIRTH/
48	exp *LABOR/
49	*PREMATURE LABOR/
50	*OBSTETRIC DELIVERY/
51	*INTRAPARTUM CARE/
52	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).ti,ab.
53	((during or giving or give) adj3 birth?).ti,ab.

#	Searches
54	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).ti,ab.
55	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).ti,ab.
56	or/46-55
57	*FEVER/
58	(fever$ or pyrexi$ or hyperthermi$).ti,ab.
59	((elevat$ or high$) adj3 temperature?).ti,ab.
60	or/57-59
61	exp *SEPSIS/
62	sepsis.ti,ab.
63	*BLOODBORNE BACTERIUM/
64	(blood$ adj3 (pathogen$ or poison$)).ti,ab.
65	*SYSTEMIC INFLAMMATORY RESPONSE SYNDROME/
66	"systemic inflammatory response syndrome".ti,ab.
67	SIRS.ti,ab.
68	septic?emi$.ti,ab.
69	((septic or endotoxic or toxic) adj3 shock).ti,ab.
70	(py?emi$ or pyohemi$).ti,ab.
71	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).ti,ab.
72	or/61-71
73	*MACROSOMIA/
74	macrosomia?.ti,ab.
75	(large adj3 gestational adj3 age?).ab,ti.
76	(large adj3 date?).ab,ti.

#	Searches
77	or/73-76
78	*BREECH PRESENTATION/
79	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).ab,ti.
80	or/78-79
81	*PROLONGED PREGNANCY/
82	(pregnan$ adj3 prolong$).ab,ti.
83	(pregnan$ adj1 late).ab,ti.
84	(postterm$ or post-term$).ab,ti.
85	(postdate$ or post-date$).ab,ti.
86	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
87	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
88	or/81-87
89	*REPEAT CESAREAN SECTION/
90	*CESAREAN SECTION/ and (repeat$ or previous$).ti.
91	*CESAREAN SECTION/ and (repeat$ or previous$).ab. /freq=2
92	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).ti,ab.
93	*VAGINAL BIRTH AFTER CESAREAN/
94	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
95	VBAC.ti,ab.
96	*"TRIAL OF LABOR"/ and *CESAREAN SECTION/
97	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
98	TOLAC.ti,ab.
99	or/89-98

#	Searches
100	*SMALL FOR DATE INFANT/
101	*GESTATIONAL AGE/ and small.ti.
102	*GESTATIONAL AGE/ and small.ab. /freq=2
103	(small adj3 gestational age?).ab,ti.
104	SGA.ti,ab.
105	*INTRAUTERINE GROWTH RETARDATION/
106	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).ti,ab.
107	IUGR.ti,ab.
108	*LOW BIRTH WEIGHT/
109	exp *VERY LOW BIRTH WEIGHT/
110	(low birthweight? or low birth weight?).ti,ab.
111	LBW.ti,ab.
112	or/100-111
113	*HEALTH CARE DISPARITY/
114	*PATIENT ATTENDANCE/
115	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).ab,ti.

#	Searches
116	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).ti,ab.
117	(unbook$ or un-book$ or (late adj3 book$)).ti,ab.
118	walk$ in?.ti,ab.
119	((no or non) adj3 engag$).ti,ab.
120	no show.ti,ab.
121	or/113-120
122	*UNPLANNED PREGNANCY/
123	*UNWANTED PREGNANCY/
124	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).ti,ab.
125	or/122-124
126	*PERINATAL PERIOD/
127	*BIRTH/
128	*LABOR/
129	*UTERUS CONTRACTION/
130	*LABOR ONSET/
131	*LABOR STAGE 1/

#	Searches
132	*LABOR STAGE 2/
133	*PREMATURE LABOR/
134	*OBSTETRIC DELIVERY/
135	*INTRAPARTUM CARE/
136	(labo?r or childbirth or partur$ or intra?part$ or peri?part$).ti,ab.
137	((during or giving) adj3 birth?).ti,ab.
138	or/126-137
139	*BLEEDING/
140	*OBSTETRIC HEMORRHAGE/
141	*INTRAPARTUM HEMORRHAGE/
142	*HEMORRHAGIC SHOCK/
143	*UTERUS BLEEDING/
144	or/139-143
145	138 and 144
146	((labo?r or birth? or childbirth? or partur$ or intra?part$ or peri?part$) adj3 (h?emorrhag$ or bleed$)).ti,ab.
147	or/145-146

#	Searches
148	*HIGH RISK PREGNANCY/
149	(pregnan$ adj2 high$ adj2 risk$).ab,ti.
150	or/148-149
151	56 and (60 or 72 or 77 or 80 or 88 or 99 or 112 or 121 or 125 or 150)
152	147 or 151
153	*INFORMATION/
154	*CONSUMER HEALTH INFORMATION/
155	*INFORMATION DISSEMINATION/
156	*INFORMATION SEEKING/
157	*PATIENT EDUCATION/
158	*MEDICAL INFORMATION/
159	*PUBLICATION/
160	*INTERNET/
161	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ti.
162	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ab. /freq=2
163	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ti,ab.

#	Searches
164	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application?) adj5 (informat$ or educat$)).ti,ab.
165	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application?)).ti,ab.
166	(informat$ adj3 (model? or program$ or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).ti,ab.
167	(informat$ adj3 provid$).ti.
168	(informat$ adj3 provid$).ab.
169	informat$.ab. /freq=2
170	168 and 169
171	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).ti,ab.
172	(informat$ adj3 (type? or content? or method? or quality)).ti,ab.
173	((additional or extra or added or further) adj3 informat$).ti,ab.
174	((time? or timing or when or prompt$) adj3 informat$).ti,ab.
175	((give? or giving or gave) adj3 informat$).ti,ab.
176	(informat$ adj3 (hospital? or service? or resource? or red flag? or emergency care or contact?)).ti,ab.
177	153 or 154 or 155 or 156 or 157 or 158 or 159 or 160 or 161 or 162 or 163 or 164 or 165 or 166 or 167 or 170 or 171 or 172 or 173 or 174 or 175 or 176
178	*PATIENT CARE PLANNING/
179	*CLINICAL PATHWAY/

#	Searches
180	*CLINICAL PROTOCOLS/
181	or/178-180
182	informat$.ti,ab.
183	181 and 182
184	(informat$ adj3 (care plan$ or pathway? or protocol?)).ti,ab.
185	or/183-184
186	((communicat$ or language?) adj3 (barrier? or facilitat$)).ti,ab.
187	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).ti,ab.
188	(communicat$ adj3 (time? or timing? or initiat$)).ti,ab.
189	"TRANSLATING (LANGUAGE)"/
190	(translat$ adj7 (communicat$ or language? or informat$)).ti,ab.
191	or/186-190
192	177 or 185 or 191
193	152 and 192
194	CHILDBIRTH EDUCATION/
195	*PRENATAL CARE/

#	Searches
196	*PERINATAL CARE/
197	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).ti,ab.
198	or/194-197
199	informat$.ti.
200	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ab.
201	or/199-200
202	198 and 201
203	193 or 202
204	limit 203 to english language
205	letter.pt. or LETTER/
206	note.pt.
207	editorial.pt.
208	CASE REPORT/ or CASE STUDY/
209	(letter or comment*).ti.
210	or/205-209
211	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.

#	Searches
212	210 not 211
213	ANIMAL/ not HUMAN/
214	NONHUMAN/
215	exp ANIMAL EXPERIMENT/
216	exp EXPERIMENTAL ANIMAL/
217	ANIMAL MODEL/
218	exp RODENT/
219	(rat or rats or mouse or mice).ti.
220	or/212-219
221	204 not 220
222	4 and 221
223	15 and 221
224	25 and 221
225	41 and 221
226	42 and 221
227	45 and 221

#	Searches
228	or/222-227

Database: PsycInfo

#	Searches
1	BIRTH/
2	"LABOR (CHILDBIRTH)"/
3	INTRAPARTUM PERIOD/
4	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).ti,ab.
5	((during or giving or give) adj3 birth?).ti,ab.
6	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).ti,ab.
7	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).ti,ab.
8	or/1-7
9	HYPERTHERMIA/
10	(fever$ or pyrexi$ or hyperthermi$).ti,ab.
11	((elevat$ or high$) adj3 temperature?).ti,ab.
12	or/9-11
13	sepsis.ti,ab.
14	(blood$ adj3 (pathogen$ or poison$)).ti,ab.
15	"systemic inflammatory response syndrome".ti,ab.
16	SIRS.ti,ab.
17	septic?emi$.ti,ab.
18	((septic or endotoxic or toxic) adj3 shock).ti,ab.
19	(py?emi$ or pyohemi$).ti,ab.
20	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).ti,ab.
21	or/13-20
22	macrosomia?.ti,ab.
23	(large adj3 gestational adj3 age?).ab,ti.

#	Searches
24	(large adj3 date?).ab,ti.
25	or/22-24
26	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).ab,ti.
27	(pregnan$ adj3 prolong$).ab,ti.
28	(pregnan$ adj1 late).ab,ti.
29	(postterm$ or post-term$).ab,ti.
30	(postdate$ or post-date$).ab,ti.
31	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
32	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
33	or/27-32
34	CESAREAN SECTION/ and (repeat$ or previous$).ab,ti.
35	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).ti,ab.
36	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
37	VBAC.ti,ab.
38	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
39	TOLAC.ti,ab.
40	or/34-39
41	(small adj3 gestational age?).ab,ti.
42	SGA.ti,ab.
43	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).ti,ab.
44	IUGR.ti,ab.
45	BIRTH WEIGHT/
46	(low birthweight? or low birth weight?).ti,ab.

#	Searches
47	LBW.ti,ab.
48	or/41-47
49	HEALTH DISPARITIES/
50	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).ab,ti.
51	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).ti,ab.
52	(unbook$ or un-book$ or (late adj3 book$)).ti,ab.
53	walk$ in?.ti,ab.
54	((no or non) adj3 engag$).ti,ab.
55	no show.ti,ab.
56	or/49-55
57	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).ti,ab.
58	HEMORRHAGE/
59	(h?emorrhag$ or bleed$).ti,ab.
60	or/58-59
61	(pregnan$ adj2 high$ adj2 risk$).ab,ti.
62	12 or 21 or 25 or 26 or 33 or 40 or 48 or 56 or 57 or 60 or 61
63	8 and 62
64	HEALTH EDUCATION/
65	CLIENT EDUCATION/
66	INFORMATION SEEKING/
67	INTERNET/
68	SOCIAL MEDIA/
69	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ti.

#	Searches
70	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ab. /freq=2
71	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ti,ab.
72	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media) adj5 (informat$ or educat$)).ti,ab.
73	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application? or social media)).ti,ab.
74	(informat$ adj3 (model? or program$ or strateg$ or package? or checklist? or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).ti,ab.
75	(informat$ adj3 provid$).ti.
76	(informat$ adj3 provid$).ab.
77	informat$.ab. /freq=2
78	76 and 77
79	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).ti,ab.
80	(informat$ adj3 (type? or content? or method? or quality)).ti,ab.
81	((additional or extra or added or further) adj3 informat$).ti,ab.
82	((time? or timing or when or prompt$) adj3 informat$).ti,ab.
83	((give? or giving or gave) adj3 informat$).ti,ab.
84	(informat$ adj3 (hospital? or unit? or department? or service? or resource? or red flag? or emergency care or contact?)).ti,ab.
85	64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 78 or 79 or 80 or 81 or 82 or 83 or 84
86	TREATMENT PLANNING/
87	TREATMENT GUIDELINES/
88	or/86-87
89	informat$.ti,ab.
90	88 and 89
91	(informat$ adj3 (care plan$ or pathway? or protocol?)).ti,ab.

#	Searches
92	or/90-91
93	COMMUNICATION BARRIERS/
94	((communicat$ or language?) adj3 (barrier? or facilitat$)).ti,ab.
95	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).ti,ab.
96	(communicat$ adj3 (time? or timing? or initiat$)).ti,ab.
97	FOREIGN LANGUAGE TRANSLATION/
98	INTERPRETERS/
99	(translat$ adj7 (communicat$ or language? or informat$)).ti,ab.
100	or/93-99
101	85 or 92 or 100
102	63 and 101
103	PRENATAL CARE/
104	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).ti,ab.
105	or/103-104
106	informat$.ti.
107	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ab.
108	or/106-107
109	105 and 108

#	Searches
110	102 or 109
111	limit 110 to english language
112	limit 111 to ("0100 journal" or "0110 peer-reviewed journal" or "0120 non-peer-reviewed journal")

Database: Maternity and Infant Care Database

#	Searches
1	LABOUR.de.
2	DELIVERY.de.
3	(labo?r or childbirth or partu$ or intra?part$ or peri?part$).ti,ab.
4	((during or giving or give) adj3 birth?).ti,ab.
5	((Postpartum? or Post-partum? or Postnatal$ or Post-natal$ or Puerperium? or Puerperal?) adj3 period adj3 immediat$).ti,ab.
6	((twenty four hour? or twentyfour hour? or 24 hour? or 24 h? or 24h?) adj3 (birth$ or childbirth$ or parturition?)).ti,ab.
7	or/1-6
8	FEVER.de.
9	(fever$ or pyrexi$ or hyperthermi$).ti,ab.
10	((elevat$ or high$) adj3 temperature?).ti,ab.
11	or/8-10
12	SEPSIS.de.
13	sepsis.ti,ab.
14	(blood$ adj3 (pathogen$ or poison$)).ti,ab.
15	"systemic inflammatory response syndrome".ti,ab.
16	SIRS.ti,ab.
17	septic?emi$.ti,ab.
18	((septic or endotoxic or toxic) adj3 shock).ti,ab.
19	(py?emi$ or pyohemi$).ti,ab.
20	(bacter?emi$ or fung?emi$ or parasit?emi$ or vir?emi$ or endotox?emi$ or candid?emi$).ti,ab.
21	or/12-20
22	FETAL MACROSOMIA.de.
23	macrosomia.ab,ti.
24	(large adj3 gestational adj3 age?).ab,ti.
25	(large adj3 date?).ab,ti.
26	or/22-25
27	BREECH PRESENTATION.de.
28	(breech$ adj3 (present$ or complet$ or incomplet$ or frank$)).ab,ti.

#	Searches
29	or/27-28
30	PREGNANCY - PROLONGED.de.
31	(pregnan$ adj3 prolong$).ab,ti.
32	(pregnan$ adj1 late).ab,ti.
33	(postterm$ or post-term$).ab,ti.
34	(postdate$ or post-date$).ab,ti.
35	(overdue? adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
36	((42 week? or fourty two week? or fourty second week?) adj5 (pregnan$ or birth? or childbirth? or labo?r$)).ab,ti.
37	or/30-36
38	CESAREAN SECTION.de. and (repeat$ or previous$).ab,ti.
39	((c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$)) adj3 (repeat$ or previous$)).ti,ab.
40	(vagina$ adj1 (birth$ or born or deliver$) adj2 after$ adj2 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
41	VBAC.ti,ab.
42	(trial adj2 labo?r adj3 after$ adj3 (c?esar#an$ or c section$ or csection$ or (deliver$ adj3 abdom$))).ti,ab.
43	TOLAC.ti,ab.
44	or/38-43
45	INFANT - SMALL FOR GESTATIONAL AGE.de.
46	GESTATIONAL AGE.de. and small.ti,ab.
47	(small adj3 gestational age?).ab,ti.
48	SGA.ti,ab.
49	FETAL GROWTH RETARDATION.de.
50	((fetal$ or fetus$ or intrauterine) adj3 grow$ adj3 (restrict$ or retard$)).ti,ab.
51	IUGR.ti,ab.
52	LOW BIRTH WEIGHT.de.
53	(low birthweight? or low birth weight?).ti,ab.
54	LBW.ti,ab.
55	or/45-54
56	HEALTH SERVICES ACCESSIBILITY.de.
57	((no or late or delay$ or lack$ or without) adj5 (antenatal$ or prenatal$ or pre-natal$) adj3 care).ab,ti.
58	((no or unable or retsrict$ or limit$) adj3 access$ adj3 (care or healthcare or service?)).ti,ab.
59	(unbook$ or un-book$ or (late adj3 book$)).ti,ab.
60	walk$ in?.ti,ab.
61	((no or non) adj3 engag$).ti,ab.
62	no show.ti,ab.
63	or/56-62
64	PREGNANCY - UNPLANNED.de.
65	PREGNANCY - UNWANTED.de.

#	Searches
66	((conceal$ or hide? or hidden or hiding or unexpected or un-expected or unintended or un-intended or unsuspect$ or un-suspect$ or unaware or un-aware or unplanned or un-planned or unwanted or un-wanted) adj3 pregnan$).ti,ab.
67	or/64-66
68	(h?emorrhag$ or bleed$).ti,ab.
69	PREGNANCY - HIGH RISK.de.
70	(pregnan$ adj3 high$ adj3 risk$).ab,ti.
71	or/69-70
72	11 or 21 or 26 or 29 or 37 or 44 or 55 or 63 or 67 or 68 or 71
73	7 and 72
74	INTRAPARTUM CARE.de.
75	73 or 74
76	INFORMATION.de.
77	PATIENT EDUCATION.de.
78	HEALTH EDUCATION.de.
79	PARENTS - EDUCATION.de.
80	INFORMATION SOURCES.de.
81	POSTERS.de.
82	PUBLICATIONS.de.
83	INTERNET.de.
84	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ti.
85	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 educat$).ab. /freq=2
86	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ti,ab.
87	((pamphlet? or leaflet? or booklet? or manual$ or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application?) adj5 (informat$ or educat$)).ti,ab.
88	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj5 (pamphlet? or leaflet? or booklet? or manual? or brochure? or publication? or handout? or written or website? or web site? or web page? or webpage? or web based or video? or dvd? or online? or internet? or app? or application?)).ti,ab.
89	(informat$ adj3 (model? or program$ or need? or requir$ or seek$ or access$ or dissem$ or shar$ or provision)).ti,ab.
90	(informat$ adj3 provid$).ti.
91	(informat$ adj3 provid$).ab.
92	informat$.ab. /freq=2
93	91 and 92
94	(informat$ adj3 (help$ or support$ or benefi$ or hinder$ or hindran$ or barrier? or facilitat$ or practical$ or clear$ or accurat$)).ti,ab.
95	(informat$ adj3 (type? or content? or method? or quality)).ti,ab.
96	((additional or extra or added or further) adj3 informat$).ti,ab.
97	((time? or timing or when or prompt$) adj3 informat$).ti,ab.

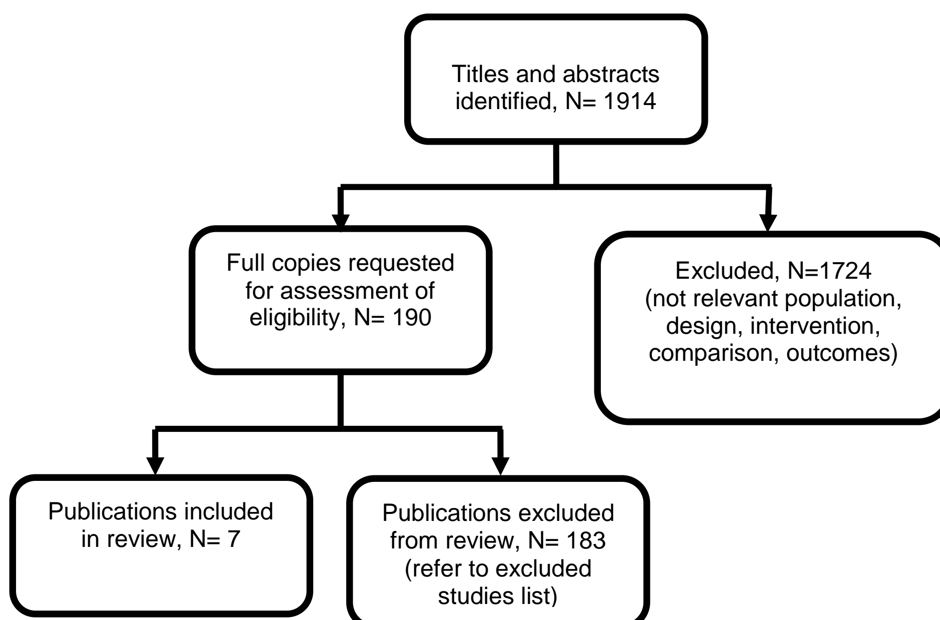
#	Searches
98	((give? or giving or gave) adj3 informat$).ti,ab.
99	(informat$ adj3 (hospital? or service? or resource? or red flag? or emergency care or contact?)).ti,ab.
100	76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 or 85 or 86 or 87 or 88 or 89 or 90 or 93 or 94 or 95 or 96 or 97 or 98 or 99
101	PATIENT CARE PLANNING.de.
102	CRITICAL PATHWAYS.de.
103	CLINICAL PROTOCOLS.de.
104	or/101-103
105	informat$.ti,ab.
106	104 and 105
107	(informat$ adj3 (care plan$ or pathway? or protocol?)).ti,ab.
108	or/106-107
109	((communicat$ or language?) adj3 (barrier? or facilitat$)).ti,ab.
110	(communicat$ adj3 (help$ or unhelp$ or un-help$ or encourag$ or prevent$ or good or bad$ or effect$ or ineffect$ or in-effect$ or poor$ or difficult$)).ti,ab.
111	(communicat$ adj3 (time? or timing? or initiat$)).ti,ab.
112	INTERPRETING.de.
113	(translat$ adj7 (communicat$ or language? or informat$)).ti,ab.
114	or/109-113
115	100 or 108 or 114
116	75 and 115
117	PRENATAL CARE.de.
118	PERINATAL CARE.de.
119	((antenatal$ or prenatal$ or pre-natal$ or perinatal$) adj1 care).ti,ab.
120	or/117-119
121	informat$.ti.

#	Searches
122	((patient? or user? or famil$ or parent$ or father? or husband? or partner? or mother? or carer? or caregiver?) adj3 informat$).ab.
123	or/121-122
124	120 and 123
125	116 or 124
126	limit 125 to (case control study or cohort study or consensus statement or consumer information or consumer survey or government publication or guidelines or information pack or interview or "literature review" or longitudinal study or meta analysis or meta-analysis or observational study or personal experience or position paper or position statement or prospective study or protocol or protocols or qualitative research or qualitative study or questionnaire or randomised controlled trial or retrospective study or "systematic review")

Appendix C – Clinical evidence study selection

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

Figure 2: Flow diagram of clinical article selection for information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)



1 # Appendix D – Excluded studies

2 ## Information provision (women at high risk of adverse outcomes for themselves
3 ## and/or their babies because of obstetric complications or other reasons)

4 ### Clinical studies

Study	Reason for exclusion
About induction of labour - information for pregnant women, their partners and their families, London: National Institute for Clinical Excellence	NICE booklet about induction of labour (information for pregnant women, their partners and their families)
"Going longer", Our Newsletter: Centre for Loss in Multiple Birth, 1-7, 1996	Newsletter on 'going longer' after intrauterine death of one or more babies
Heartbreak pregnancies: unfulfilled promises, Minneapolis, Minnesota: Abbott Northwestern Hospital	A full-text copy of the article could not be obtained
Abed Saeedi, Z., Ghazi Tabatabaie, M., Moudi, Z., Vedadhir, A. A., Navidian, A., Childbirth at home: a qualitative study exploring perceptions of risk and risk management among Baloch women in Iran, Midwifery, 29, 44-52, 2013	Not relevant population. Three women with previous caesarean section, however, unclear which quotations refer to these women
Abera, M., Gebremariam, A., Belachew, T., Predictors of safe delivery service utilization in arsi zone, South-East ethiopia, Ethiopian Journal of Health Sciences, 21, 95-106, 2011	No phenomenon of interest; attitudes towards utilisation of safe services for labour and birth. No subgroup analysis for women with relevant complications
Aborigo, R. A., Moyer, C. A., Gupta, M., Adongo, P. B., Williams, J., Hodgson, A., Allote, P., Engmann, C. M., Obstetric danger signs and factors affecting health seeking behaviour among the Kassena-Nankani of Northern Ghana: a qualitative study, African Journal of Reproductive Health, 18, 78-86, 2014	Focuses on information provision and education on obstetric danger signs for all pregnant women in the community rather than on information specific to women with relevant complications
Adler, C. L., Zarchin, Y. R., The "virtual focus group": using the Internet to reach pregnant women on home bed rest, JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 31, 418-27, 2002	Not the obstetric complication of interest - pregnant women with a diagnosis of preterm labour and a prescribed treatment of bed rest at home
Afsana,K., Rashid,S.F., The challenges of meeting rural Bangladeshi women's needs in delivery care, Reproductive Health Matters, 9, 79-89, 2001	A survey about birth in a health centre or at home and women's experience. Unclear whether quotations refer to relevant complications
Akhund, S., Avan, B. I., Development and pretesting of an information, education and communication (IEC) focused antenatal care handbook in Pakistan, BMC Research Notes, 4, 91, 2011	Describes the development of an antenatal care handbook. Pregnant women and health care providers were asked to give their feedback on the handbook
Alder, J., Stadlmayr, W., Tschudin, S., Bitzer, J., Post-traumatic symptoms after childbirth: what should we offer?, Journal of Psychosomatic Obstetrics & Gynecology, 27, 107-12, 2006	Non-systematic literature review

Study	Reason for exclusion
Alkazaleh, F., Thomas, M., Grebenyuk, J., Glaude, L., Savage, D., Johannesen, J., Caetano, M., Windrim, R., What women want: women's preferences of caregiver behavior when prenatal sonography findings are abnormal, Ultrasound in Obstetrics & Gynecology, 23, 56-62, 2004	Not the question of interest. It is about women's experiences in receiving abnormal antenatal sonography findings. No subgroup analysis for relevant population
Al-Qutob, R., Mawajdeh, S., Assessment of the quality of prenatal care: the transmission of information to pregnant women in maternal and child health centers in jordan, International Quarterly of Community Health Education, 13, 47-62, 1992	Pregnant women; no information about whether women were at high risk of adverse outcomes during labour
American College of, Obstetricians, Gynecologists,, Shoulder dystocia, International Journal of Gynecology and Obstetrics, 80, 87-92, 2003	Clinical considerations and recommendations regarding shoulder dystocia
American College of, Obstetricians, Gynecologists,, Psychosocial risk factors: perinatal screening and intervention, Obstetrics and Gynecology, 108, 469-477, 2006	A full-text copy of the article could not be obtained
Andajani-Sutjahjo, S., Manderson, L., Stillbirth, neonatal death and reproductive rights in Indonesia, Reproductive Health Matters, 12, 181-188, 2004	Some women had complications not relevant for the guideline review. Two women had very low birthweight babies, however, the article did not clarify which quotations were from these women
Anonymous,, Health information technology for the perinatal setting, Nursing for Women's Health, 15, 346-348, 2011	Descriptive article about hospital- and institution-wide health information technology systems
Anya,S.E., Hydara,A., Jaiteh,L.E., Antenatal care in The Gambia: missed opportunity for information, education and communication, BMC Pregnancy and Childbirth, 8, 9-, 2008	Not the question of interest. It is a survey about pregnant women's experiences with antenatal information, education and communication which was collected using antenatal client exit interviews and WHO antenatal record review questionnaires
Arsenijevic, J., Pavlova, M., Groot, W., Shortcomings of maternity care in Serbia, Birth, 41, 14-25, 2014	Not relevant study population. Respondents to online questionnaire were women who accessed the website of an initiative to improve conditions in Serbian maternity wards. The percentage of women with relevant complications is unclear
Artieta-Pinedo, I., Paz-Pascual, C., Grandes, G., Remiro-Fernandezdegamboa, G., Odriozola-Hermosilla, I., Bacigalupe, A., Payo, J., The benefits of antenatal education for the childbirth process in Spain, Nursing Research, 59, 194-202, 2010	Not relevant intervention. Intervention is not just information provision, it also involves 'body work', which includes physical exercise, breathing exercises, relaxation techniques, and pushing practices. Not relevant population. No subgroup analysis for women with relevant complications
Assarag, B., Dujardin, B., Delamou, A., Meski, F. Z., De Brouwere, V., Determinants of maternal near-miss in Morocco: too late, too far, too sloppy?, PLoS ONE [Electronic Resource], 10, e0116675, 2015	Quantitative evidence: not relevant comparison. Outcomes in women with near misses compared to controls. Qualitative evidence: although the study population included some women with

Study	Reason for exclusion
	relevant complications (such sepsis) it is not clear whether quotations are from these women
Assarag, B., Dujardin, B., Essolbi, A., Cherkaoui, I., De Brouwere, V., Consequences of severe obstetric complications on women's health in Morocco: Please, listen to me!, Tropical Medicine and International Health, no pagination, 2015	Quantitative evidence: not relevant comparison. Outcomes in women with complicated births compared to women with uncomplicated births. Qualitative evidence: not clear whether quotations refer to women with relevant complications
Astbury, J., The crisis of childbirth: can information and childbirth education help?, Journal of Psychosomatic Research, 24, 9-13, 1980	Not the question of interest. The study explores anxiety levels in women in the last trimester of pregnancy, during labour and in the postpartum hospital stay
Ayiasi, M. R., Van Royen, K., Verstraeten, R., Atuyambe, L., Criel, B., Garimoi, C. O., Kolsteren, P., Exploring the focus of prenatal information offered to pregnant mothers regarding newborn care in rural Uganda, BMC Pregnancy & Childbirth, 13, 176, 2013	Explores women's experiences with antenatal and postnatal care in Uganda
Beck, C. T., Benefits of participating in internet interviews: women helping women, Qualitative Health Research, 15, 411-22, 2005	Not the question of interest. The study explores the benefits of participation in qualitative e-mail interviews for women with birth trauma
Beck, C. T., Watson, S., Subsequent childbirth after a previous traumatic birth, Nursing Research, 59, 241-9, 2010	Unclear whether any quotation is from a woman who had a relevant complication
Benn, C., Budge, R. C., White, G. E., Women planning and experiencing pregnancy and childbirth: information needs and sources, Nursing praxis in New Zealand inc, 14, 4-15, 1999	Not the population of interest, that is, not women at high risk of adverse outcomes in labour
Berger, B., Schwarz, C., Heusser, P., Watchful waiting or induction of labour - a matter of informed choice: Identification, analysis and critical appraisal of decision aids and patient information regarding care options for women with uncomplicated singleton late and post term pregnancies: A review, BMC Complementary and Alternative Medicine, 15, no pagination, 2015	Induction of labour in prolonged pregnancies is outside the scope of this guideline
Bhardwaj, N., Hasan, S. B., Yunus, M., Zaheer, M., High risk pregnancy and its relation with maternal care receptivity (MCR)--a rural study from India, Journal of the Royal Society of Health, 111, 43-6, 1991	Not the question of interest. The article explores the concept of maternal care receptivity and its relation to high risk pregnancy
Bililign, N., Mulatu, T., Knowledge of obstetric danger signs and associated factors among reproductive age women in Raya Kobo district of Ethiopia: A community based cross-sectional study, BMC Pregnancy and Childbirth, 17, no pagination, 2017	Not the question of interest. The article examines awareness of obstetric complications during pregnancy, birth and the postpartum period in women who had given birth within the 12 months preceding data collection
Biro, M. A., Waldenstrom, U., Brown, S., et al.,, Satisfaction with team midwifery care for low-	Not the question of interest. The article examines whether a team midwifery model was

Study	Reason for exclusion
and high-risk women: a randomized controlled trial, Birth, 30, 1-10, 2003	associated with greater satisfaction for women than the standard model of maternity care
Bray, Martha L., Edwards, Linda H., A primary health care approach using Hispanic outreach workers as nurse extenders, Public Health Nursing, 11, 7-11, 1994	Not the question of interest. The article describes the evaluation of the Hispanic outreach worker programme
Brazier, E., Fiorentino, R., Barry, S., Kasse, Y., Millimono, S., Rethinking how to promote maternity care-seeking: factors associated with institutional delivery in Guinea, Health Care for Women International, 35, 878-95, 2014	Not the question of interest. The article explores factors associated with women's knowledge and practices related to birth preparedness and their use of health facilities during childbirth
Brixval, C. S., Axelsen, S. F., Thygesen, L. C., Due, P., Koushede, V., Antenatal education in small classes may increase childbirth self-efficacy: Results from a Danish randomised trial, Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives, 10, 32-34, 2016	Not the question of interest. The article explores the effect of a structured antenatal education programme in small classes versus auditorium-based lectures on childbirth self-efficacy. Women in the study had not given birth yet
Bryant, A., Mukasa, P., Nakabembe, E., Murthy, A., Tejani, N., Kabakyenga, J., Strategies for improving intrapartum care: Identification of women who should be targeted for hospital delivery, International Journal of Gynecology and Obstetrics, 107, S136, 2009	Conference abstract
Burcher, P., Cheyney, M. J., Li, K. N., Hushmendy, S., Kiley, K. C., Cesarean Birth Regret and Dissatisfaction: A Qualitative Approach, Birth, 43, 346-352, 2016	No quotations are identifiable as being from a relevant population
Care Quality Commission, 2015 survey of women's experiences of maternity care: statistical release, NHS, 2015	No subgroup analysis for relevant complications
Care Quality Commission, CQC's response to the 2015 survey of women's experiences of maternity care, NHS, 2016	No subgroup analysis for relevant complications
Centre for Reviews and Dissemination, Non-clinical interventions that increase the uptake and success of vaginal birth after caesarean section: a systematic review (Provisional abstract), Database of Abstracts of Reviews of Effects, 2015	A systematic review of quantitative studies evaluating non-clinical interventions for increasing the uptake or success of vaginal birth after caesarean section. Individual studies were assessed separately for inclusion
Centre for Reviews and Dissemination, Feasibility and effects of decision aids (Structured abstract), Database of Abstracts of Reviews of Effects, 2015	A systematic review on the feasibility of using decision aids and their effects on decision making and patient outcomes. Individual studies were assessed separately for inclusion. One study in the published review included pregnant women but the decision aid was related to a circumcision of a newborn boy
Centre for Reviews and Dissemination, Trial of labor or repeated Cesarean section: the woman's choice (Structured abstract), Database of Abstracts of Reviews of Effects, 2015	A systematic review about preferred birth method for pregnant women who underwent previous caesarean section and with no

Study	Reason for exclusion
	contraindications to labour. Individual studies were assessed separately for inclusion
Centre for Reviews and Dissemination, Management of prolonged pregnancy (Structured abstract), Database of Abstracts of Reviews of Effects, 2015	Not the question of interest. The article explores benefits and risks of different strategies for the management of prolonged pregnancy
Centre for Reviews and Dissemination, The effectiveness of preterm-birth prevention educational programs for high-risk women: a meta-analysis (Structured abstract), Database of Abstracts of Reviews of Effects, 2015	A systematic review of studies evaluating the effectiveness of preterm-birth prevention educational programmes. Individual studies assessed separately for inclusion
Centre for Reviews and Dissemination, Home visits during pregnancy: consequences on pregnancy outcome, use of health services, and women's situations (Structured abstract), Database of Abstracts of Reviews of Effects, 2015	Explores the effect of home visits on preterm birth and hospital admission rates during pregnancy
Chigbu,C.O., Enwereji,J.O., Ikeme,A.C., Women's experiences following failed vaginal birth after cesarean delivery, International Journal of Gynaecology and Obstetrics, 99, 113-116, 2007	Does not focus on information and although the study authors reported that "most of respondents reported receiving inadequate information on vaginal birth after caesarean section", they did not provide further details
Chinkam, S., Ewan, J., Koeniger-Donohue, R., Hawkins, J. W., Shorten, A., The Effect of Evidence-Based Scripted Midwifery Counseling on Women's Choices About Mode of Birth After a Previous Cesarean, Journal of Midwifery and Women's Health, 61, 613-620, 2016	No relevant intervention; scripted counselling intervention about trial of labour after caesarean section (TOLAC) versus elective repeat caesarean birth (ERCB)
Coffman, S., Ray, M. A., African American women describe support processes during high-risk pregnancy and postpartum, JOGNN: Journal of Obstetric, Gynecologic and Neonatal Nursing, 31, 536-544, 2002	Not relevant population. In-depth stories of 4 women with 4 different complications not relevant for this review: gestational diabetes, drug rehabilitation, severe congenital abnormalities, and HIV
Coffman, Sherrilyn, Ray, Marilyn A., Mutual intentionality: A theory of support processes in pregnant African American women, Qualitative Health Research, 9, 479-492, 1999	Describes processes by which women and their significant others give and receive support
Collins,C., The discrepancy between the information pregnant women expect and receive in Ireland and the lost oppurtunity for health promotion and education, International Journal of Health Promotion and Education, 45, 61-66, 2007	Not the question of interest. The article examines the discrepancy between antenatal information women expect and receive. Not a qualitative study
Cote-Arsenault, Denise, Schwartz, Katharine, Krowchuk, Heidi, McCoy, Thomas P., Akkerman, Armstrong Bergner Cote-Arsenault Cote-Arsenault Cote-Arsenault Cote-Arsenault Cote-Arsenault Cote-Arsenault Cote-Arsenault Cote-Arsenault Fitzmaurice Gaudet Glover Grote Hughes Huizink Huizink Hutti Kitzman O'Connor O'Leary O'Leary Olds Smyth Swanson	Population was healthy women; also, it is not stated what information was provided in the pregnancy information booklets

Study	Reason for exclusion
Swanson Swanson Van den Bergh Wampler Wurmser, Evidence-based intervention with women pregnant after perinatal loss, Special Issue: Perinatal and pediatric bereavement, 39, 177-186, 2014	
Dadiz,R., Weinschreider,J., Schriefer,J., Arnold,C., Greves,C.D., Crosby,E.C., Wang,H., Pressman,E.K., Guillet,R., Interdisciplinary simulation-based training to improve delivery room communication, Simulation in Healthcare: The Journal of The Society for Medical Simulation, 8, 279-291, 2013	Not the question of interest. The study evaluates the effectiveness of an interdisciplinary simulation-based training programme to improve communication (specific types of information that should be communicated during high risk birth) between obstetric and paediatric teams. No women were involved in the communication
Dahl, K., Kesmodel, U., Hvidman, L., Olesen, F., Informed consent: providing information about prenatal examinations, Acta Obstetricia et Gynecologica Scandinavica, 85, 1420-5, 2006	A review about information provided regarding Down syndrome and screening tests and, different ways of expressing the risk; not relevant to guideline scope
Dahlen, H. G., Homer, C. S., 'Motherbirth or childbirth'? A prospective analysis of vaginal birth after caesarean blogs, Midwifery, 29, 167-73, 2013	Not the question of interest. The study explores how women discuss the option of vaginal birth after caesarean section in blog sites and what factors influence their decision making
Defino, T., A healthy start, HMO, 36, 44-51, 1995	A full-text copy of the article could not be obtained
Department of Health, Social Services, Public, Safety, A strategy for maternity care in Northern Ireland 2012-2018, Belfast: DHSSPSNI, 2012	A document about the strategic direction for maternity care in Northern Ireland and not a peer-reviewed clinical study
Department of Human, Services, Having a baby, Adelaide Australia: Department of Human Services, 2001	Not a clinical research artcle. Online information for women
Doyle, Patricia A., Bird, Barbara C., Appel, Steve, Parisi, Donna, Rogers, Perdietha, Glaros, Roberta, Brandt, Nancy, Barber, Virginia, Salmon, Christine A., Birkhead, Guthrie, Stoto,, Developing an effective communications campaign to reach pregnant women at high risk of late or no prenatal care, Social Marketing Quarterly, 12, 35-50, 2006	The winning messages and images (based on focus groups and numerical dial metres) encouraged women to access antenatal care but were not directly related to quality of care in the intrapartum period. Quantitative evaluation of communications campaign did not focus on outcomes relevant to this review
Dugas, M., Shorten, A., Dube, E., Wassef, M., Bujold, E., Chaillet, N., Decision aid tools to support women's decision making in pregnancy and birth: a systematic review and meta-analysis, Social Science & Medicine, 74, 1968-78, 2012	Included studies were assessed for inclusion and were not relevant to the guideline review
Eden, K. B., Perrin, N. A., Vesco, K. K., Guise, J. M., A randomized comparative trial of two decision tools for pregnant women with prior cesareans, Journal of obstetric, gynecologic, and neonatal nursing : JOGNN / NAACOG, 43, 568-579, 2014	Decision aid and brochures about decision making between planned vaginal birth versus elective caesarean section in women with a previous caesarean section. Not relevant to this guideline (relevant to NICE caesarean section guideline scope)
Eden,K.B., Hashima,J.N., Osterweil,P., Nygren,P., Guise,J.M., Childbirth preferences	A literature review about preferences for mode of birth among women with a previous caesarean section

Study	Reason for exclusion
after cesarean birth: A review of the evidence, Birth, 31, 49-60, 2004	
Elcioglu,O., Kirimlioglu,N., Yildiz,Z., How do the accounts of the patients on pregnancy and birth process enlighten medical team in terms of narrative ethics?, Patient Education and Counseling, 61, 253-261, 2006	Describes women's experiences during labour and birth. Not stated whether women were at high risk of adverse outcomes in labour. Not stated what information was given to women
Elder, J. S., Wilkens, J., Audit of management of women with one previous Caesarean section at the Royal Infirmary of Edinburgh, Archives of Disease in Childhood: Fetal and Neonatal Edition, 95, Fa77, 2010	Conference abstract
Elmir, R., Schmied, V., A meta-ethnographic synthesis of fathers' experiences of complicated births that are potentially traumatic, Midwifery, 32, 66-74, 2016	Included studies were assessed for inclusion but were excluded from the guideline review
Emmett, C. L., Shaw, A. R., Montgomery, A. A., Murphy, D. J., Di, Amond study group, Women's experience of decision making about mode of delivery after a previous caesarean section: the role of health professionals and information about health risks, BJOG: An International Journal of Obstetrics & Gynaecology, 113, 1438-45, 2006	No relevant phenomenon of interest. This study aimed to explore women's experiences of decision making between planned vaginal birth and elective caesarean section in women with a previous caesarean section (relevant to NICE guideline on caesarean section scope)
Emmett, Clare L., Murphy, Deirdre J., Patel, Roshni R., Fahey, Tom, Jones, Claire, Ricketts, Ian W., Gregor, Peter, Macleod, Maureen, Montgomery, Alan A., Di, Amond Study Group, Anderson, Bekker Campbell Charles Chuang Dowie Eden Edwards Elwyn Elwyn Emmett Fraser Hamilton Kamal Lavender Mankuta Minkoff Montgomery Montgomery Nassar O'Connor O'Connor Paling Paterson-Brown Roberts Roberts Shorten Shorten Shy Stewart Walker Wills York, Decision-making about mode of delivery after previous caesarean section: Development and piloting of two computer-based decision aids, Health Expectations: An International Journal of Public Participation in Health Care & Health Policy, 10, 161-172, 2007	No relevant intervention; the main focus of the decision aids was to help women with decision-making between planned vaginal birth and elective caesarean section after a previous caesarean section (relevant to NICE caesarean section guideline scope)
Engle, P. L., Scrimshaw, S. C., Zambrana, R. E., Dunkel-Schetter, C., Prenatal and postnatal anxiety in Mexican women giving birth in Los Angeles, Health Psychology, 9, 285-99, 1990	Not relevant population. Women with no major medical complication of pregnancy. No subgroup analysis for women with relevant obstetric complications
Engstrom, A., Lindberg, I., Mothers' experiences of a stay in an ICU after a complicated childbirth, Nursing in Critical Care, 17, 64-70, 2012	Unclear whether any quotation is from a woman with a relevant complication
Eri,T.S., Blystad,A., Gjengedal,E., Blaaka,G., 'Stay home for as long as possible': midwives' priorities and strategies in communicating with first-time mothers in early labour, Midwifery, 27, e286-e292, 2011	Explores how midwives talk with and care for first-time mothers by telephone and during check-ups. Mixed population, that is, low and high risk women

Study	Reason for exclusion
Fair, C., Crawford, A., Latham, V., "After having a waterbirth, i feel like it's the only way people should deliver babies": The decision making process of women who plan waterbirth, Journal of Women's Health, 26, A18-A19, 2017	Conference abstract
Fard, M. K., Mirghafourvand, M., Mohammad alizade charandabi, S., Khodabandeh, F., Jafarabadi, M. A., Mansoori, A., Effect of lifestyle educational package on prevention of postpartum health problems in nulliparous mothers: A randomized clinical trial. [Persian], Journal of Mazandaran University of Medical Sciences, 25, 33-48, 2016	Not in English language
Farnworth, A., Pearson, P. H., Choosing mode of delivery after previous caesarean birth, British Journal of Midwifery, 15, 188, 190, 192-194, 2007	The article explores the decision making experience of women with previous caesarean section. No relevant quotations were identified
Farrell, T. J., Homer, C. S. E., Davis, G. K., et al.,, The risk associated pregnancy team: an Australian approach to collaborative care, In: International Confederation of Midwives, 2002	A full-text copy of the article could not be obtained
Fawcett, J., Burritt, J., An exploratory study of antenatal preparation for cesarean birth, JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 14, 224-30, 1985	It is not stated whether women were at high risk of adverse outcomes in labour; they were all primiparous. The information on caesarean section was rather general and not specifically aimed at women with obstetric complications such as previous caesarean section
Freda, M. C., Andersen, H. F., Damus, K., Merkatz, I. R., Are there differences in information given to private and public prenatal patients?, American Journal of Obstetrics & Gynecology, 169, 155-60, 1993	Not the population of interest. Women were questioned during pregnancy - they had not experienced labour
Friedman, A. M., Srinivas, S. K., Is documentation of TOLAC counseling a good measure of quality of care?, Journal of Maternal-Fetal & Neonatal Medicine, 29, 1710-4, 2016	Explores whether counselling is associated with improved knowledge of trial of labour after previous caesarean section
Friedman, Alexander Michael, Srinivas, Sindhu K., Is documentation of TOLAC counseling a good measure of quality of care?, The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians, 29, 1710-4, 2016	Focuses on counselling relating to benefits and harms of trial of labour after caesarean versus planned repeat caesarean section. Women completed questionnaires in the antenatal period only. There was no data collection after women experienced a trial of labour
Frost,J., Shaw,A., Montgomery,A., Murphy,D.J., Women's views on the use of decision aids for decision making about the method of delivery following a previous caesarean section: qualitative interview study, BJOG: An International Journal of Obstetrics and Gynaecology, 116, 896-905, 2009	Not phenomenon of interest. This study aimed to explore women's views on decision aids described in Emmett 2007, which has been excluded from this review because decision aids focused on the choice between vaginal birth after caesarean section (VBAC) and elective repeat caesarean section (CS)

Study	Reason for exclusion
Fullerton, G., Forrest, J., Humphrey, T., Previous caesarean section clinic, BJOG: An International Journal of Obstetrics and Gynaecology, 122, 8-9, 2015	Conference abstract
Gamble, J. A., Creedy, D. K., Women's preference for a cesarean section: incidence and associated factors, Birth, 28, 101-10, 2001	Explores the incidence of pregnant women's preference for a caesarean section among the general birthing population
Gamble, Jenny, Creedy, Debra K., McCourt, Chris, Weaver, Jane, Beake, Sarah, Buckley, Behague Chong Creedy Declercq Donati Edwards Gamble Gamble Ghetti Hildingsson Hirst Hodnett Hopkins Johanson King Klein Lapeyre Laws Lee Lin Marx McCourt McCourt Murray Murray Paterson-Brown Potter Tatar Waldenstrom Walker Young, A critique of the literature on women's request for Cesarean section, Birth: Issues in Perinatal Care, 34, 331-340, 2007	Not phenomenon of interest and no relevant population. This review focuses on decision making between planned vaginal birth and elective caesarean section in the general population of women that were pregnant or had experienced labour
Gao, L. L., Larsson, M., Luo, S. Y., Internet use by Chinese women seeking pregnancy-related information, Midwifery, 29, 730-5, 2013	Women had not had labour yet when they responded to the questionnaire
Gibbins,J., Thomson,A.M., Women's expectations and experiences of childbirth, Midwifery, 17, 302-313, 2001	Unclear whether any of the quotations refer to someone with a complication relevant for this review. One woman had a post-term labour. Three women had ventouse births due to fetal distress, one woman had an emergency CS due to fetal distress. However cause of fetal distress was unclear. Inclusion criteria included cephalic presentation
Glaso, A. H., Sandstad, I. M., Vanky, E., Breech delivery--what influences on the mother's choice?, Acta Obstetricia et Gynecologica Scandinavica, 92, 1057-62, 2013	The article does not specify what information was given to women
Goulet, Celine, Polomeno, Viola, Harel, Francois, Canadian cross-cultural comparison of the high-risk pregnancy stress scale, Stress Medicine, 12, 145-154, 1996	The article presents validation results for an instrument to measure antenatal stress in high-risk pregnant women. No definition of high-risk pregnancy
Gourounti, K., Kouklaki, E., Lykeridou, K., Validation of the Childbirth Attitudes Questionnaire in Greek and psychosocial characteristics of pregnant women with fear of childbirth, Women and Birth, 28, e44-e51, 2015	The article presents the results of a validation of a fear of childbirth instrument in Greece. Participating pregnant women had a low-risk pregnancy
Greenhalgh, R., Slade, P., Spiby, H., Fathers' coping style, antenatal preparation, and experiences of labor and the postpartum, Birth, 27, 177-84, 2000	The article explores whether fathers' attendance at antenatal classes influenced their experience of attending childbirth. Not stated whether the fathers' partners were at high risk of obstetric complications during labour
Gregg, Robin, "Choice" as a double-edged sword: Information, guilt and mother-blaming in a high-tech age, Women & Health, 20, 53-73, 1993	A narrative article about choices that pregnant women face to select a doctor, whether to have antenatal tests etc. No relevant quotations were reported

Study	Reason for exclusion
Griffin,T., Kavanaugh,K., Soto,C.F., White,M., Parental evaluation of a tour of the neonatal intensive care unit during a high-risk pregnancy, JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing, 26, 59-65, 1997	The article addresses parents' evaluation of a tour of the neonatal intensive care unit (NICU) during a high-risk pregnancy. The high-risk pregnancies considered were not due to relevant obstetric complications as defined in the guideline review protocol
Grimes, H. A., Forster, D. A., Newton, M. S., Sources of information used by women during pregnancy to meet their information needs, Midwifery, 30, e26-e33, 2014	No subgroup analysis for women with relevant complications
Grimes, H., Newton, M., Forster, D., Sources of information used by women during pregnancy to meet their information needs related to pregnancy, birth and early parenting: A cross-sectional study, Journal of Paediatrics and Child Health, 49, 26, 2013	Conference abstract
Gummi,F.B., Hassan,M., Shehu,D., Audu,L., Community education to encourage use of emergency obstetric services, Kebbi State, Nigeria. The Sokoto PMM Team, International Journal of Gynaecology and Obstetrics, 59 Suppl 2, S191-S200, 1997	Evaluates community education activities by assessing changes in community awareness about obstetric complications and utilisation of obstetric services. There is no subgroup analysis for women who had experienced relevant complications
Hall,R., A prospective study into women ' s understanding of emergency procedures during labour, Journal of Obstetrics and Gynaecology, 33, 923-, 2013	Conference abstract
Harvey, M. E., Pattison, H. M., Being there: a qualitative interview study with fathers present during the resuscitation of their baby at delivery, Archives of Disease in Childhood Fetal & Neonatal Edition, 97, F439-43, 2012	Unclear whether quotations refer to birth experiences associated with relevant complications. Fathers of 2 babies born via breech vaginal birth were included, but unclear which quotations were theirs
Heath, S., Summers, K., Rainbow babies, Journal of Paediatrics and Child Health, 53, 42, 2017	Conference abstract
Hinton, L., Locock, L., Knight, M., Partner experiences of "near-miss" events in pregnancy and childbirth in the UK: a qualitative study.[Erratum appears in PLoS One. 2014;9(9):e108803], PLoS ONE [Electronic Resource], 9, e91735, 2014	Some quotations are about complications not relevant to this review. For some quotations it is unclear whether the woman had a relevant complication. Some quotations are about women with haemorrhage but it is unclear whether this refers to intrapartum haemorrhage
Hodnett, E. D., Fredericks, S., Support during pregnancy for women at increased risk of low birthweight babies, Cochrane Database of Systematic Reviews, CD000198, 2003	The review assesses the effects of programmes offering additional social support for pregnant women who are believed to be at risk for having preterm or growth restricted babies, or both. Included studies assessed separately for inclusion but no data on information about relevant obstetric complications reported
Hodnett,E.D., Osborn,R.W., A randomized trial of the effects of monitrice support during labor: mothers' views two to four weeks postpartum, Birth, 16, 177-183, 1989	Describes obstetric outcomes of women randomised to receive professional intrapartum support or routine nursing care 2-4 weeks

Study	Reason for exclusion
	postpartum. No relevant quotations were reported
Hollins Martin, C. J., Robb, Y., Women's views about the importance of education in preparation for childbirth, Nurse Education in Practice, 13, 512-518, 2013	The article reports on women's perceptions of birth satisfaction or dissatisfaction in relation to their recent experience of birth. Only women with an uncomplicated pregnancy were included in the study
Horey, D., Kealy, M., Davey, M. A., et al.,, Interventions for supporting pregnant women's decision-making about mode of birth after a caesarean (Cochrane Review). (Date of most recent substantive update: 22 July 2013), The Cochrane Database of Systematic Reviews, 2013	Included studies were assessed for inclusion in the guideline review and were not relevant because they focused on decision making between planned VBAC and elective repeat CS
Hueston,W.J., Knox,M.A., Eilers,G., Pauwels,J., Lonsdorf,D., The effectiveness of preterm-birth prevention educational programs for high-risk women: a meta-analysis, Obstetrics and Gynecology, 86, 705-712, 1995	The review presents the results of a meta-analysis on the effectiveness of preterm-birth prevention educational programmes, which is not relevant to the guideline review
Ip, W. Y., Tang, C. S., Goggins, W. B., An educational intervention to improve women's ability to cope with childbirth, Journal of Clinical Nursing, 18, 2125-35, 2009	Women in the study were expected to have a vaginal birth without complications; no subgroup analysis for women with obstetric complications
Johansson, M., Hildingsson, I., Fenwick, J., Important factors working to mediate Swedish fathers' experiences of a caesarean section, Midwifery, 29, 1041-9, 2013	Most fathers' partners had elective caesarean sections (not relevant to this review). A few had emergency caesarean sections for dystocia and/or asphyxia, however it was unclear whether these were due to relevant complications
Johansson, M., Rubertsson, C., Radestad, I., Hildingsson, I., The Internet: One important source for pregnancy and childbirth information among prospective fathers, Journal of Men's Health, 7, 249-258, 2010	A full-text copy of the article could not be obtained
Khunpradit,S., Tavender,E., Lumbiganon,P., Laopaiboon,M., Wasiak,J., Gruen,R.L., Non-clinical interventions for reducing unnecessary caesarean section, Cochrane Database of Systematic Reviews, CD005528-, 2011	Included studies were assessed for inclusion in the guideline review and were not relevant
Kim, M. S., Song, I. G., An, A. R., Kim, K. H., Sohn, J. H., Yang, S. W., Healthcare access challenges facing six African refugee mothers in South Korea: a qualitative multiple-case study, Korean Journal of Pediatrics, 60, 138-144, 2017	No relevant population. This article was checked to see whether there was data relating to labour after no antenatal care, however at least some of the women in the paper received antenatal care and the topic of interest was not explored
Kim, T. H., Lee, H. H., Chung, S. H., The attitude of South Korean people regarding usage of the internet perinatal consultation, International Journal of Fertility and Sterility, 8, 299-302, 2014	No subgroup analysis for women with relevant complications
King, T. L., Can a vaginal birth after cesarean delivery be a normal labor and birth? Lessons	Non-systematic literature review

Study	Reason for exclusion
from midwifery applied to trial of labor after a previous cesarean delivery, Clinics in Perinatology, 38, 247-63, 2011	
Kiran, T. S. U., Jayawickrama, N. S., Who is responsible for the rising caesarean section rate?, Journal of Obstetrics and Gynaecology, 22, 363-365, 2002	Describes the results of a survey to assess the opinions of clinicians regarding the rising incidence of caesarean sections
Klerman,L.V., Ramey,S.L., Goldenberg,R.L., Marbury,S., Hou,J., Cliver,S.P., A randomized trial of augmented prenatal care for multiple-risk, Medicaid-eligible African American women, American Journal of Public Health, 91, 105-111, 2001	No subgroup analysis for women with relevant complications. Intervention (augmented care) did not only include additional information provision but also other components such as reminders and transportation vouchers
Kok,M., Gravendeel,L., Opmeer,B.C., van der Post,J.A., Mol,B.W., Expectant parents' preferences for mode of delivery and trade-offs of outcomes for breech presentation, Patient Education and Counseling, 72, 305-310, 2008	Examines preferences of expectant parents with an at-term fetus in breech position for either planned vaginal birth or planned caesarean section
Konheim-Kalkstein, Yasmine L., Whyte, Rosemarie, Miron-Shatz, Talya, Stellmack, Mark A., Barger, Bernhardt Bernstein Biermann Cox Dahlen Declercq Declercq Dekker Eden Emmett Ferguson Galinsky Guise Klemm Konheim-Kalkstein Lagan Lagan Lundgren Madara Martin Romano Soet Waldenstrom, What are VBAC women seeking and sharing? A content analysis of online discussion boards, Birth: Issues in Perinatal Care, 42, 277-282, 2015	Quantitative evidence: there was no subgroup analysis for women who experienced VBAC. Qualitative evidence: none of the quotations from women who experienced VBAC related to information
Kumbani, L. C., McLnerney, P., Primigravidae's knowledge about obstetric complications in an urban health centre in Malawi, Curationis, 29, 41-9, 2006	Focuses more on the knowledge of pregnant women regarding obstetric complications than providing information. Not reported whether women were at high risk of adverse outcomes in labour due to obstetric complications or whether they had already experienced labour
Kumbani, L., Mc Inerney, P., The knowledge of obstetric complications among primigravidae in a rural health centre in the district of Blantyre, Malawi, Curationis, 25, 43-54, 2002	Focuses more on knowledge of pregnant women regarding obstetric complications than providing information. Not reported whether women were at high risk of adverse outcomes in labour due to obstetric complications or whether they had already experienced labour
Langer,A., Farnot,U., Garcia,C., Barros,F., Victora,C., Belizan,J.M., Villar,J., The Latin American trial of psychosocial support during pregnancy: effects on mother's wellbeing and satisfaction. Latin American Network For Perinatal and Reproductive Research (LANPER), Social Science and Medicine, 42, 1589-1597, 1996	Evaluates a psychosocial support intervention during pregnancy aimed at improving perinatal health and womens' psychosocial conditions. No results regarding information provision were reported
Larsson, M., A descriptive study of the use of the Internet by women seeking pregnancy-related information, Midwifery, 25, 14-20, 2009	No clear description of participants is given so it is unclear whether any of the participating women were at high risk of adverse outcomes in labour due to obstetric complications; not clear

Study	Reason for exclusion
	whether any of them had already experienced labour
Lee, S., Holden, D., Ayers, S., How women with high risk pregnancies use lay information when considering place of birth: A qualitative study, Women & Birth: Journal of the Australian College of Midwives, 29, e13-7, 2016	Women were pregnant and had not experienced labour when they were interviewed
Lerman, Sheera F., Shahar, Golan, Czarkowski, Kathryn A., Kurshan, Naamit, Magriples, Urania, Mayes, Linda C., Epperson, C. Neill, Aiken, Appleby Attkisson Attkisson Clarke Cohen Cohen Di Blasi Dunsis Galassi Harrison Hrasky Kurki Maruish Orr Phillips Phillips Roter Stewart, Predictors of satisfaction with obstetric care in high-risk pregnancy: The importance of patient-provider relationship, Journal of Clinical Psychology in Medical Settings, 14, 330-334, 2007	The study population was women with high-risk pregnancies, including "women presenting with a history of recurrent losses, previous second or third trimester pregnancy loss, fetal demise, previous or present fetal genetic abnormality, advanced maternal age and/or other obstetric or medical complications of pregnancy". No subgroup analysis for women with relevant complications
Lewis, C., Blott, M. J., Whitten, S. M., Which mode of delivery? A mixed-method investigation into decision-making by women with one previous caesarean section, Archives of Disease in Childhood: Fetal and Neonatal Edition, 96, Fa94, 2011	Conference abstract
Lindberg, I., Engstrom, A., A qualitative study of new fathers' experiences of care in relation to complicated childbirth, Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives, 4, 147-52, 2013	Unclear whether quotations refer to relevant complications. One woman had emergency caesarean section due to placental abruption; quotations from "Father 8" refer to bleeding but not to information provision
Lowe,P., Powell,J., Griffiths,F., Thorogood,M., Locock,L., Making it all normal: the role of the internet in problematic pregnancy, Qualitative Health Research, 19, 1476-1484, 2009	Explores the role of the Internet as an information source in relation to antenatal screening. Not phenomenon of interest and not women with relevant complications
Lucas,A., Information for women after CS: are they getting enough?, RCM Midwives, 7, 472-475, 2004	Not phenomenon of interest; study aimed to examine women's decision making between VBAC and repeat elective CS
Lundgren, I., Begley, C., Gross, M. M., Bondas, T., 'Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section), BMC Pregnancy & Childbirth, 12, 85, 2012	Individual studies were assessed separately for inclusion in the guideline review and were not relevant
Maimburg, R. D., Vaeth, M., Hvidman, L., Durr, J., Olsen, J., Women's worries in first pregnancy: results from a randomised controlled trial, Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives, 4, 129-31, 2013	Compares the extent of worry during pregnancy in women attending an antenatal educational programme with those receiving routine care. It is not reported whether women were at high risk of adverse outcomes in labour due to obstetric complications
Maitra,K., Singh,K.K., Sekhar,C.C., Saxena,B.N., A multicentre collaborative study of the care of mothers and infants with a comprehensive MCH care package utilizing high	Not the intervention of interest. The article describes different intervention strategies such as training and re-training of medical officers, paramedics, community education, development

Study	Reason for exclusion
risk approach strategy at primary health centres: summary, conclusions and recommendations, Indian Pediatrics, 32, 67-72, 1995	of improved data record forms or cards, and development of referral systems
Malhotra, Geeta, The role of information and communication technologies in addressing safe motherhood in south Asia, Marriage & Family Review, 44, 357-363, 2008	Descriptive article about health care, information and communication technologies
Malouf, Reem, McLeish, Jenny, Ryan, Sara, Gray, Ron, Redshaw, Maggie, 'We both just wanted to be normal parents': a qualitative study of the experience of maternity care for women with learning disability, BMJ open, 7, e015526, 2017	No relevant complications. The study mentions only that 3 out of 9 participants also had a long-term health condition or physical disability and 1 had a serious mental health disorder
Manley, A. J., Lavender, T., Smith, D. M., Processing fluency effects: Can the content and presentation of participant information sheets influence recruitment and participation for an antenatal intervention?, Patient Education and Counseling, 98, 391-394, 2015	No description of the population; not clear whether pregnant women were at risk of adverse outcomes in labour due to obstetric complications
Markovic,M., Manderson,L., Schaper,H., Brennecke,S., Maternal identity change as a consequence of antenatal hospitalization, Health Care for Women International, 27, 762-776, 2006	Study population was pregnant women hospitalised for common serious disorders of pregnancy but none of them was relevant to this review
McArdle, A., Flenady, V., Toohill, J., Gamble, J., Creedy, D., How pregnant women learn about foetal movements: sources and preferences for information, Women & Birth: Journal of the Australian College of Midwives, 28, 54-9, 2015	Not clear whether any of the women was at high risk of adverse outcomes in labour due to obstetric complications
McCarthy, K. J., Blanc, A. K., Warren, C. E., Kimani, J., Mdawida, B., Ndwidga, C., Can surveys of women accurately track indicators of maternal and newborn care? A validity and reliability study in Kenya, Journal of Global Health, 6, 020502, 2016	Not the question of interest. The study assesses how accurately women report on the coverage of maternal and newborn health interventions received during the intrapartum and immediate postnatal period through surveys conducted at initial discharge following the birth and 13-15 months after the birth
McCartney, Patricia R., Travis,, Sidelines--Supporting mothers on bed rest, MCN: The American Journal of Maternal/Child Nursing, 29, 405, 2004	Descriptive article about a website
McKinley, J., Abramson, R., Hernandez, W., Tapping powerful resources: Community-based doula programs, Breastfeeding Medicine, 8, S7-S8, 2013	Conference abstract
McLennan,M.T., Melick,C.F., Alten,B., Young,J., Hoehn,M.R., Patients' knowledge of potential pelvic floor changes associated with pregnancy and delivery, International Urogynecology Journal, 17, 22-26, 2006	No subgroup analysis for women with previous caesarean section reported

Study	Reason for exclusion
Meddings,F., Phipps,F.M., Haith-Cooper,M., Haigh,J., Vaginal birth after caesarean section (VBAC): exploring women's perceptions, Journal of Clinical Nursing, 16, 160-167, 2007	Not phenomenon of interest. The study focuses on informed choice between VBAC and elective repeat CS
Midhet, F., Becker, S., Impact of community-based interventions on maternal and neonatal health indicators: Results from a community randomized trial in rural Balochistan, Pakistan, Reproductive Health, 7, no pagination, 2010	Describes results of a community-based operations research project to reduce maternal and neonatal mortality in Pakistan
Midirs,, N. H. S. Centre for Reviews, Dissemination,, Informed choice information pack, Bristol: MIDIRS, 1997	A full-text copy of the article could not be obtained
Moffat,M.A., Bell,J.S., Porter,M.A., Lawton,S., Hundley,V., Danielian,P., Bhattacharya,S., Decision making about mode of delivery among pregnant women who have previously had a caesarean section: A qualitative study, BJOG: An International Journal of Obstetrics and Gynaecology, 114, 86-93, 2007	Not phenomenon of interest. The article focuses on decision making in relation to planned vaginal birth versus elective caesarean section
Montgomery, A. A., Emmett, C. L., Fahey, T., Jones, C., Ricketts, I., Patel, R. R., Peters, T. J., Murphy, D. J., Di, Amond Study Group, Two decision aids for mode of delivery among women with previous caesarean section: randomised controlled trial, BMJ, 334, 1305, 2007	No relevant intervention. The article reports that the interventions are described in detail in the Emmett 2007, which was excluded from the guideline review because the main focus of the decision aids was to help women with decision-making between VBAC and elective repeat CS
Morey,J.A., Gregory,K., Nurse-led education mitigates maternal stress and enhances knowledge in the NICU, MCN, American Journal of Maternal Child Nursing, 37, 182-191, 2012	Not the obstetric complications of interest
Mrisho, M., Obrist, B., Schellenberg, J. A., Haws, R. A., Mushi, A. K., Mshinda, H., Tanner, M., Schellenberg, D., The use of antenatal and postnatal care: Perspectives and experiences of women and health care providers in rural southern Tanzania, BMC Pregnancy and Childbirth, 9, no pagination, 2009	Describes women's experiences with antenatal and postnatal care. Quotations do not refer to relevant complications
Murphy, D. J., Pope, C., Frost, J., et al.,, Women's views on the impact of operative delivery in the second stage of labour: qualitative interview study, BMJ, 327, 1132-1135, 2003	Describes women's experiences of instrumental birth. It is unclear whether quotations are from women with relevant complications. One woman mentioned 'He was quite big, he had a big head' as the indication for her instrumental birth however no other quotations are reported for the same woman
Naghizadeh, S., Azari, S., Mohammady, F., Ebrahimpour Mirza Rezaei, M., Sehhati, F., Maternal satisfaction about prenatal and postnatal cares in vaginal and cesarean section delivery at teaching and non- teaching hospitals of Tabriz/Iran, International Journal of Women's Health and Reproduction Sciences, 2, 146-154, 2014	Not the question of interest. The article compares physical, informational, ethical and emotional aspects of satisfaction of care between teaching and non-teaching hospitals. Not reported whether women were at risk of adverse outcomes

Study	Reason for exclusion
Nassar, N., Roberts, C. L., Raynes-Greenow, C. H., Barratt, A., Peat, B., Decision Aid for Breech Presentation Trial, Collaborators, Evaluation of a decision aid for women with breech presentation at term: a randomised controlled trial [ISRCTN14570598], BJOG: An International Journal of Obstetrics & Gynaecology, 114, 325-33, 2007	Exclusion criteria included contraindications to external cephalic version (ECV) such as women presenting with breech in labour
Nassar,N., Roberts,C.L., Raynes-Greenow,C.H., Barratt,A., Development and pilot-testing of a decision aid for women with a breech-presenting baby, Midwifery, 23, 38-47, 2007	Decision aid on trying ECV versus planning a caesarean section: not relevant for this guideline, which covers women presenting with breech in labour - for these women ECV is not possible
Nicholls, K., Ayers, S., Childbirth-related post-traumatic stress disorder in couples: a qualitative study, British Journal of Health Psychology, 12, 491-509, 2007	Unclear whether quotations refer to relevant complications
Nikiema, B., Beninguisse, G., Haggerty, J. L., Providing information on pregnancy complications during antenatal visits: unmet educational needs in sub-Saharan Africa, Health Policy & Planning, 24, 367-76, 2009	Explores whether women were advised about pregnancy complications during antenatal care. Not reported what proportion of participating women were at high risk of adverse outcomes in labour due to obstetric complications
Nilsson, C., Lundgren, I., Smith, V., Vehvilainen-Julkunen, K., Nicoletti, J., Devane, D., Bernloehr, A., van Limbeek, E., Lalor, J., Begley, C., Women-centred interventions to increase vaginal birth after caesarean section (VBAC): A systematic review, Midwifery, 31, 657-663, 2015	Studies included in this review were assessed separately for inclusion
Owusu-Addo, S. B., Owusu-Addo, E., Morhe, E. S., Health information-seeking behaviours among pregnant teenagers in Ejisu-Juaben Municipality, Ghana, Midwifery, 41, 110-117, 2016	The study population is teenage girls who have not had experienced labour
Perreira, K. M., Bailey, P. E., de Bocaletti, E., Hurtado, E., Recinos de Villagran, S., Matute, J., Increasing awareness of danger signs in pregnancy through community- and clinic-based education in Guatemala, Maternal & Child Health Journal, 6, 19-28, 2002	The evaluation of the intervention was focused on the changing percentages of women who were aware of obstetric complications. However, there was no subgroup analysis for women who actually experienced the complications
Petrovska, Karolina, Sheehan, Athena, Homer, Caroline S. E., The fact and the fiction: A prospective study of internet forum discussions on vaginal breech birth, Women and birth : journal of the Australian College of Midwives, 30, e96-e102, 2017	Focuses on antenatal decision-making relating to elective caesarean section or planned vaginal birth
Petrovska, Karolina, Watts, Nicole P., Catling, Christine, Bisits, Andrew, Homer, Caroline S. E., Supporting Women Planning a Vaginal Breech Birth: An International Survey, Birth (Berkeley, Calif.), 43, 353-357, 2016	Focuses on antenatal decision-making relating to elective caesarean section or planned vaginal birth

Study	Reason for exclusion
Pozzo, M. L., Brusati, V., Cetin, I., Clinical relationship and psychological experience of hospitalization in "high-risk" pregnancy, European Journal of Obstetrics, Gynecology, & Reproductive Biology, 149, 136-42, 2010	Not the population of interest. Participating pregnant women were at high-risk due to complications other than those listed in the review protocol. Not clear from the article what information was given to women
Priddis, H. S., Schmied, V., Kettle, C., Sneddon, A., Dahlen, H. G., "A patchwork of services"--caring for women who sustain severe perineal trauma in New South Wales--from the perspective of women and midwives, BMC Pregnancy & Childbirth, 14, 236, 2014	Unclear whether any quotation is from a woman with a relevant complication
Raynes-Greenow,C.H., Roberts,C.L., Barratt,A., Brodrick,B., Peat,B., Pregnant women's preferences and knowledge of term breech management, in an Australian setting, Midwifery, 20, 181-187, 2004	Not relevant population. Pregnant women were asked to imagine that their current pregnancy was breech
Redshaw, M., Malouf, R., Gao, H., Gray, R., Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period, BMC Pregnancy & Childbirth, 13, 174, 2013	No subgroup analysis for women with relevant complications
Rodger, D., Skuse, A., Wilmore, M., Humphreys, S., Dalton, J., Flabouris, M., Clifton, V. L., Pregnant women's use of information and communications technologies to access pregnancy-related health information in South Australia, Australian Journal of Primary Health, 19, 308-12, 2013	Interviews were conducted when women were still pregnant
Rosman, A. N., Vlemmix, F., Fleuren, M. A., Rijnders, M. E., Beuckens, A., Opmeer, B. C., Mol, B. W., van Zwieten, M. C., Kok, M., Patients' and professionals' barriers and facilitators to external cephalic version for breech presentation at term, a qualitative analysis in the Netherlands, Midwifery, 30, 324-30, 2014	The article describes facilitators of and barriers to the implementation of external cephalic version of breech presentation at term. No relevant quotations were reported
Ruiz,R.L., Shah,M.K., Lewis,M.L., Theall,K.P., Perceived access to health services and provider information and adverse birth outcomes: Findings from LaPRAMS, 2007-2008, Southern Medical Journal, 107, 137-143, 2014	Not the question of interest. The article examines perceived access to healthcare services across different races
Saaka, M., Aryee, P., kuganab-lem, R., Ali, M., Masahudu, A. R., The effect of social behavior change communication package on maternal knowledge in obstetric danger signs among mothers in East Mamprusi District of Ghana, Globalization and Health, 13, no pagination, 2017	Describes women's knowledge of obstetric danger signs and not information provision
Shorten, A., Shorten, B., Kennedy, H. P., Complexities of choice after prior cesarean: a narrative analysis, Birth (Berkeley, Calif.), 41, 178-184, 2014	No phenomenon of interest; the study explores values and expectations that guide women during decision making between VBAC and elective repeat CS

Study	Reason for exclusion
Shorten,A., Chamberlain,M., Shorten,B., Kariminia,A., Making choices for childbirth: development and testing of a decision-aid for women who have experienced previous caesarean, Patient Education and Counseling, 52, 307-313, 2004	Focuses on a decision-aid for decision making between VBAC and elective repeat CS
Shorten,A., Shorten,B., Keogh,J., West,S., Morris,J., Making choices for childbirth: a randomized controlled trial of a decision-aid for informed birth after cesarean, Birth, 32, 252-261, 2005	No relevant intervention; decision-aid booklet about risks and benefits of trial of labour versus elective repeat CS
Sikder, S. S., Labrique, A. B., Ullah, B., et al.,, Accounts of severe acute obstetric complications in Rural Bangladesh, BMC Pregnancy and Childbirth, 11, 13, 2011	Not relevant. A study about the health care decision-making process during severe acute obstetric complications among women and their families in rural Bangladesh. Some quotations are from women with complications not relevant to the guideline review, such as eclampsia, termination of pregnancy, puerperal sepsis and postpartum haemorrhage. For other quotations it is unclear whether the woman had a relevant complication
Sisk, P. M., Lovelady, C. A., Dillard, R. G., Gruber, K. J., O'Shea, T. M., Maternal and infant characteristics associated with human milk feeding in very low birth weight infants, Journal of Human Lactation, 25, 412-9, 2009	The same lactation counselling intervention was received by all women in the study, therefore there was no control group to assess the effectiveness of the intervention
Skinner, E., Dietz, H. P., Psychological consequences of traumatic vaginal birth, Neurourology and Urodynamics, 34, S170-S171, 2015	Conference abstract
Slager-Earnest, S. E., Hoffman, S. J., Beckmann, C. J., Effects of a specialized prenatal adolescent program on maternal and infant outcomes, JOGNN - Journal of Obstetric, Gynecologic, & Neonatal Nursing, 16, 422-9, 1987	No subgroup analysis for women with relevant complications
Tam,W.H., Lee,D.T., Chiu,H.F., Ma,K.C., Lee,A., Chung,T.K., A randomised controlled trial of educational counselling on the management of women who have suffered suboptimal outcomes in pregnancy, BJOG: An International Journal of Obstetrics and Gynaecology, 110, 853-859, 2003	Not relevant population. No subgroup analysis for women with relevant complications
Trinh, L. T., Dibley, M. J., Byles, J., Antenatal care procedures and information reported by women in three rural areas of Vietnam, Southeast Asian Journal of Tropical Medicine & Public Health, 38, 927-35, 2007	Not about obstetric complications. Not reported whether women at high risk of complications during were included
Tschudin, S., Huang, D., Mor-Gultekin, H., Alder, J., Bitzer, J., Tercanli, S., Prenatal counseling--implications of the cultural background of pregnant women on information	A full-text copy of the article could not be obtained

Study	Reason for exclusion
processing, emotional response and acceptance, Ultraschall in der Medizin (Stuttgart, Germany : 1980), 32 Suppl 2, E100-107, 2011	
Tuncalp, O., Hindin, M. J., Adu-Bonsaffoh, K., Adanu, R., Listening to women's voices: the quality of care of women experiencing severe maternal morbidity, in Accra, Ghana, PLoS ONE [Electronic Resource], 7, e44536, 2012	Unclear whether any quotation reported is from a woman with a relevant complication
Turnbull,D.A., Wilkinson,C., Yaser,A., Carty,V., Svigos,J.M., Robinson,J.S., Women's role and satisfaction in the decision to have a caesarean section, Medical Journal of Australia, 170, 580-583, 1999	Not the question of interest. The article explores women's involvement in decision to have a caesarean section
Umoiyoho,A.J., Abasiattai,A.M., Etuk,S.J., Perceptions among the Annang women of South-South Nigeria regarding antenatal healthcare information, International Journal of Gynaecology and Obstetrics, 108, 77-78, 2010	Not the question of interest. The article explores the perceptions of antenatal health education among pregnant women in South Nigeria
Vallely, A., Hughes, L., Wise, M., Women's satisfaction with a primary caesarean section and preference for subsequent births-an early postnatal review of attitudes, Australian and New Zealand Journal of Obstetrics and Gynaecology, 56, 62, 2016	Poster
Villar,J., Farnot,U., Barros,F., Victora,C., Langer,A., Belizan,J.M., A randomized trial of psychosocial support during high-risk pregnancies. The Latin American Network for Perinatal and Reproductive Research, New England Journal of Medicine, 327, 1266-1271, 1992	Not relevant population. Women with a risk factor for giving birth to a low-birthweight baby. No subgroup analysis for relevant complications
Vlemmix, F., Rosman, A. N., Rijnders, M. E., Beuckens, A., Opmeer, B. C., Mol, B. W., Kok, M., Fleuren, M. A., Implementation of client versus care-provider strategies to improve external cephalic version rates: a cluster randomized controlled trial, Acta Obstetricia et Gynecologica Scandinavica, 94, 518-26, 2015	Explores the efficacy of 2 different counselling strategies relating to external cephalic version
Waldenstrom, U., McLachlan, H., Forster, D., Brennecke, S., Brown, S., Team midwife care: maternal and infant outcomes, Australian & New Zealand Journal of Obstetrics & Gynaecology, 41, 257-64, 2001	Not the comparison of interest. The article compares team midwifery care versus standard antenatal care
Walker, R., Turnbull, D., Pratt, N., Wilkinson, C., The development and process evaluation of an information-based intervention for pregnant women aimed at addressing rates of caesarean section, BJOG : an international journal of obstetrics and gynaecology, 112, 1605-1614, 2005	Not phenomenon of interest. The study focuses on decision making between elective CS and planned vaginal birth

Study	Reason for exclusion
Walker,M.G., Windrim,C., Ellul,K.N., Kingdom,J.C., Web-based education for placental complications of pregnancy, Journal of Obstetrics and Gynaecology Canada: JOGC, 35, 334-339, 2013	Not relevant population: pregnant women had not yet experienced labour when web-based education strategy was evaluated
White, G., You cope by breaking down in private: fathers and PTSD following childbirth, British Journal of Midwifery, 15, 39-45, 2007	Unclear whether quotations refer to relevant complications
Wyrzykowska, W., Donnelly, J., Burke, N., Daly, D., Burke, G., Breatnach, F., McAuliffe, F., Morrison, J., Turner, M., Dornan, S., Higgins, J., Cotter, A., Geary, M., Daly, S., McParland, P., Dicker, P., Tully, E., Malone, F., Women's perceptions of labour and delivery: Results from the Multicenter Genesis Study, BJOG: An International Journal of Obstetrics and Gynaecology, 123, 94, 2016	Conference abstract
Yelland, J., Riggs, E., Small, R., Brown, S., Maternity services are not meeting the needs of immigrant women of non-English speaking background: Results of two consecutive Australian population based studies, Midwifery, 31, 664-70, 2015	Not relevant population. No subgroup analysis for women with relevant complications
Yeoh, P. L., Hornetz, K., Dahlui, M., Antenatal Care Utilisation and Content between Low-Risk and High-Risk Pregnant Women, PLoS ONE [Electronic Resource], 11, e0152167, 2016	Explores antenatal care utilisation, associated factors, and antenatal care content adequacy among pregnant women with a different risk level of pregnancy in Malaysia
Yokote, Naomi, Fathers' feelings and thoughts when their partners require an emergency cesarean section: Impact of the need for surgery, Japan Journal of Nursing Science, 4, 103-110, 2007	No quotations related to relevant complications. The father of a baby born via emergency caesarean section after breech presentation was included but no quotations from this father were reported
Youash, S., Campbell, M. K., Avison, W., Peneva, D., Xie, B., Examining the pathways of pre- and postnatal health information, Canadian Journal of Public Health. Revue Canadienne de Sante Publique, 103, e314-9, 2012	No subgroup analysis for women with relevant complications

1 Economic studies

2 See Supplement 2 (Health economics) for details of economic evidence reviews and health
3 economic modelling.

1
Appendix E – Clinical evidence tables

2
Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric
3 complications or other reasons)

4

Study details	Participants	Methods	Findings	Comments
Full citation Homer, C. S., Watts, N. P., Petrovska, K., Sjostedt, C. M., Bisits, A., Women's experiences of planning a vaginal breech birth in Australia, BMC Pregnancy & Childbirth, 15, 89, 2015 **Ref Id** 630653 **Study type** Qualitative **Aim of the study** To explore experiences of women who had planned a	**Sample size** N=22 **Characteristics** All women were Caucasian, 73% were primiparous, all women chose to attempt a VBB when the baby remained breech after an attempted external cephalic version; 55% achieved a VBB, 45% had a caesarean section after labour had started **Inclusion criteria** Women who planned a VBB for a singleton pregnancy in the past 7 years regardless of the eventual mode of birth,	**Setting** Two maternity hospitals in Australia that supported VBB **Sample selection** Women who planned a VBB were chosen from the hospitals' database; 32 women were invited to participate and 22 (69%) accepted the invitation **Data collection** Two members (experienced healthcare providers) of the research team conducted the interviews. Interviews were usually conducted in the woman's home and recorded using a digital voice recorder. Interviews were guided by a series of trigger questions and lasted about 1 hour **Data analysis**	**Themes/categories** **Lack of information** 'Women felt there was a lack of information about their options' (p.4): "I didn't really have any understanding of breech at that point [at diagnosis]. I don't remember it being covered in antenatal classes. And I hadn't read much about it in the books. It was a shock" (12; CS) (p.4) "I don't feel that I was given anything [about breech]. I felt like I was sort of expecting to go and find out about breech" (5; CS) (p.4) **Individualised, reliable information and support** 'Women were relieved to hear that a breech presentation did not mean there was something wrong with them' (p.5). "The doctor just took the time to answer all my questions. It was,	**Limitations** Limitations were assessed using the CASP qualitative checklist. **Aims:** Aim of the study was clearly reported, research design was appropriate for answering the research question. **Sample selection:** Sample selection was clearly reported. **Data collection:** Data collection relied on interviews. Not reported what type of interviews were used, although the study authors reported that the trigger questions were used during the interviews. Saturation of data was not discussed. **Data analysis:** The analytical process was described and the use of predefined methods from the literature was mentioned. The method to identify "themes" was predefined from the literature and described by the study authors. Counterexamples or negative

Study details	Participants	Methods	Findings	Comments
vaginal breech birth (VBB) **Country/ies where the study was carried out** Australia **Study dates** March - December 2013 **Source of funding** The study was supported by a scholarship grant from the Australian College of Midwives, New South Wales branch	and who could read and speak English **Exclusion criteria** Not reported	A process of inductive thematic analysis was used to identify and describe themes. The research team identified initial codes and potential themes, after which the themes were reviewed in relation to the codes and the data set as a whole. The themes were checked against the interview narratives, considering counterexamples or negative cases from each theme. Themes were named using the women's exact words	so relieving to hear that my body is capable of giving birth. That nothing was wrong with me. …I went out of that and, suddenly everything's opened up again. But it felt really good, to have all these options" (12; CS) (p.5) **Quantitative results** Not applicable	cases from each theme were checked against the interview narrative to ensure that the similarity and diversity of experiences were captured. The study authors discussed the role and potential influences of the interviewers (who were health professionals, and the women were aware of this) as they reported that it was possible that interviewers' own experiences influenced the way women responded. However, the interviewers did not work at the hospital where the participants were booked and they did not provide any aspect of their health care. The study authors also reported that they employed researcher reflectivity to maintain credibility of the findings and to ensure a consistent approach. **Findings/results:** Results were reported clearly with the generous use of quotations where appropriate (quotations and the researchers' own input were clearly distinguished). In relation to consistency and credibility of the findings, the study authors reported that the interviewers took notes for personal reflection when they were reviewing audio recordings after the interviews

Study details	Participants	Methods	Findings	Comments
				and they had an ongoing reflection with the wider research team. The study authors discussed transferability of the findings to other populations as they reported that all women were Caucasian, the majority were educated to tertiary level and none of them wanted an elective caesarean section; therefore it is unlikely that the participants in this study were representative of the wider population of women having a vaginal breech birth. Those who were less concerned about achieving a vaginal birth may have been less likely to agree to participate in the study. However, the study authors reported that this was the largest qualitative study on the topic. The study authors provided adequate discussion of the findings. **Overall quality:** Moderate **Other information** The study obtained formal ethics committee approval
Full citation McKenna, J. A., Symon, A. G., Water	**Sample size** N=8 women	**Setting** Scottish MLU next to an obstetric unit	**Themes/categories** **Provision of information from healthcare professionals on water VBAC as an option**	**Limitations** Limitations were assessed using the CASP qualitative checklist. **Aims:**

Study details	Participants	Methods	Findings	Comments
VBAC: exploring a new frontier for women's autonomy, Midwifery, 30, e20-e25, 2014 **Ref Id** 630797 **Study type** Qualitative **Aim of the study** To explore women's reasons for requesting vaginal birth after caesarean section (VBAC) in water and women's experience of the process **Country/ies where the study was carried out** UK **Study dates** Interviews were conducted between March and April 2012	**Characteristics** Women with a water VBAC; other characteristics not reported **Inclusion criteria** Women with a water VBAC between 2008 and 2011 in a Scottish maternity-led unit (MLU) who consented to be contacted for future research **Exclusion criteria** Did not give consent to participate within the timeframe available for data collection	**Sample selection** All women who had a water VBAC in the Scottish MLU between 2008 and 2011 consented to be contacted for future research and all were contacted with an initial letter with a participant information sheet; 8 out of 10 women accepted the invitation to participate in the timeframe available for data collection **Data collection** Semi-structured interviews. The interviews were recorded and played back to each participant at the end. No revisions were requested, and the interviews were transcribed verbatim **Data analysis** The study used an interpretative phenomenological analysis approach (Smith 2003). Major themes were identified using the constant comparative method (Barbour 2008). Exceptions, inconsistencies and contradictions to the themes were examined thoroughly to ensure analytical rigour and to allow more sophisticated themes to be extracted. Medical records of women were not	All women had to ask for the option of water VBAC, as they were not offered this antenatally. All interviewees stated that GPs and midwives caring for them in the early stages of pregnancy did not mention water VBAC as an option. "I'd heard about Water Birth for women who had C-Sections and thank goodness because the midwife certainly wasn't about to tell me about it! So I had to bring it up myself, which is a bit ridiculous". (R2, p. e23) All women interviewed emphasised that information on water VBAC should be made available to all pregnant women, and that this birth option should be "an actual choice" (R2, p. e23) rather than "a secret you have to actively go after" (R7, p. e23) **Shared decision making after VBAC was raised as an option** Not only did women have to ask about VBAC, some women had to "push for" water VBAC after raising this option. Three women were "pre-warned" (R4, p. e23) that water VBAC would not be an option. "You'd definitely need to be someone who isn't afraid to	Aim of the study was clearly reported, research design was appropriate for answering the research question. **Sample selection:** Sample selection was clearly reported. Unclear why 2 women did not consent to participate within the timeframe available for data collection. **Data collection:** Data collection relied on semi-structured interviews. Unclear whether topic guide was used. Saturation of data was not discussed but the study authors acknowledged that the sample size was small. **Data analysis:** The analytical process was described and the use of predefined methods from the literature was mentioned. The method to identify "themes" was predefined from the literature. Exceptions, inconsistencies and contradictions were examined to modify the identified themes into more sophisticated themes. Researchers critically reviewed their own roles and potential influences in the process, because they reported that 1 of the researchers works in the MLU where women had their water

Study details	Participants	Methods	Findings	Comments
Source of funding The study was funded by the Florence Nightingale Foundation through a research scholarship awarded by the Band Trust		accessed. All information originates from the women's own accounts	speak their mind … [and] doesn't shy away from confrontation … it's probably only the pushy middle class who get their [VBAC] Water Birth!" (R6), p. e23 Five women only realised at their initial booking visit that they were "high risk", therefore had their "arguments ready" (R1, p. e23) in favour of water VBAC after this first appointment. One woman showed her consultant obstetrician "an essay with references and footnotes and everything" (R3, p. e23) to support her reasons for preferring water VBAC. All women said that to some extent they had to convince their midwife and consultant obstetrician to agree to water VBAC. Two women stated themselves ready to "threaten a home birth" (R6, p. e23) in order to "be given the compromise of the MLU" (R1, p. e23), even if home birth is not what they wanted. Only 2 women reported their midwives as being supportive of a water VBAC request from the very beginning, and they had to arrange additional appointments with the consultant obstetrician to	VBAC, and participants may have been influenced by this even if guarantees about confidentiality were provided. **Findings/results:** Results were presented clearly with the generous use of quotations where appropriate (quotations and the researchers' own input were clearly distinguished). In relation to the credibility of their findings, researchers mentioned that respondent validation was limited to playing back the interview to each participant. The researchers discussed transferrability of the findings to other populations; the study authors reported that findings were unlikely to be representative of the wider population of women with water VBAC, particularly because the study only included women who had successfully achieved a water VBAC. Those who attempted this birth method unsuccessfully may have very different views. Moreover, the study authors reported that future research should be based on a larger sample and on a wider range of socio-economic and ethnic backgrounds (although they did not report baseline characteristics

Study details	Participants	Methods	Findings	Comments
			discuss this option further. One midwife referred 2 of the women to a different obstetric consultant because he was "more midwife-friendly" (R4, p. e23) **Online information, personal accounts and academic research** All women had accessed some information on the risks of water VBAC, however, this was mostly anecdotal due to the lack of empirical studies. All women looked for information online and some contacted women from other countries who had had a water VBAC. These "personal" (R8, p. e23) accounts were valued more highly than "impersonal" (R2, p. e23) academic research and "obstetric recommendations". **Online incorrect information** The only negative outcome that some women had heard of was "the baby drowning" (R2). However, the 4 women who mentioned this commented on it as "rubbish" (R2, p. e23), "highly unlikely" (R4, p. e23), "scare tactics" (R5, p. e23), and an "urban myth"(R6, p. e23). **Online incorrect information and family experience**	of participants in their study). The study authors provided an adequate discussion of the findings. **Overall quality:** Moderate **Other information** The study obtained formal ethics committee approval

Study details	Participants	Methods	Findings	Comments
			"Horror stories about babies drowning" (R4) influenced the women's families, and interviewees had to manage family fears relating to this **Quantitative results** Not applicable	
Full citation Nilsson, Christina, van Limbeek, Evelien, Vehvilainen-Julkunen, Katri, Lundgren, Ingela, Vaginal Birth After Cesarean: Views of Women From Countries With High VBAC Rates, Qualitative Health Research, 27, 325-340, 2017 **Ref Id** 760045 **Study type** Qualitative **Aim of the study**	**Sample size** N=22 women **Characteristics** All women were of fertile age and had experienced VBAC **Inclusion criteria** Women who had experienced VBAC **Exclusion criteria** Not reported	**Setting** The interviews took place in Finland, the Netherlands, and Sweden (these countries have VBAC rates between 45% and 55%; EURO-PERISTAT 2008). In Finland, in gestational weeks 36 to 37, pregnant women with a previous caesarean section (CS) visit the hospital clinic to prepare a plan for the birth. At this visit, they can discuss issues about mode of birth with an obstetrician. In Sweden, where there are no national guidelines for VBAC, only local protocols, if a woman had a previous CS with no contraindications to a vaginal birth in the next pregnancy, VBAC would be recommended with regular visits to a midwife during pregnancy. Only if problems or issues arose would the midwife consult an obstetrician. However, a woman expressing an	**Themes/categories** **'Receiving information from supportive clinicians' (p.329)** This theme included the following sub-themes. **'Having realistic information tailored to women's needs' (p.329)** The study authors reported that women considered that information from clinicians should be tailored to the woman's needs and that it was easier for the woman to go through VBAC when she was well informed and knew what was going to happen. The women noted that information should contain both facts and experiences and they explained that the information the woman received should be straightforward and realistic and provide answers to their	**Limitations** Limitations were assessed using the CASP qualitative checklist. **Aims:** Aim of the study was clearly reported, the research design was appropriate for answering the research question. The study authors justified the methods used by reporting that a conventional content analysis 'is useful when little is known about the topic of research'. Moreover, they reported that they 'used a conventional content analysis approach because the research purpose was to gain a richer understanding. This approach implies creating categories from data during the data analysis, in contrast to directed and summative approaches where the researcher uses existing theory to develop initial codes for the analysis (Hsieh & Shannon,

Study details	Participants	Methods	Findings	Comments
To investigate women's views about factors that are important in improving the rate of vaginal birth after caesarean section (VBAC) among women in countries with high rates of VBAC **Country/ies where the study was carried out** Finland, the Netherlands, and Sweden **Study dates** Individual interviews or focus groups were conducted during 2012-2013. Finland: women had had VBAC during 2010 and 2011 and were interviewed during February to April 2013. The Netherlands: women had had VBAC during 2010-		intense fear of or strong preference for CS would be referred by her midwife to the 'fear clinic' (see below) or to an obstetrician. Women in Finland and Sweden can seek help for fear of childbirth in a "fear clinics" (Ryding 2003). In the clinic, women can discuss their fears related to the upcoming or previous birth, as also the mode of birth, in a face-to-face meeting with a specially trained midwife. In the Netherlands, women with a previous CS birth receive antenatal care from a primary care midwife until 36 weeks of gestation. In this period, the midwife would prepare the women for VBAC., recommending to women with a previous CS that they make an appointment with the obstetrician to talk about the upcoming birth. The appointment with the obstetrician would allow the woman to discuss matters they are uncertain of or scared about and to discuss a birth plan. In cases of planned CS, support should include preparation for the CS. At about 36 weeks of gestation, all women with a previous CS would be referred to the obstetrician for continuation of care. Both urban and rural maternity unit settings were included in the study.	questions. The information should not be idealised; it should contain what is painful and difficult. "You need very clear information, no glorification" (SE). However, the study authors acknowledged that the need for information differs among women and so their caregivers must adjust the information and counselling to the needs of the individual. **'Having a midwife or doctor during pregnancy who listens, encourages, and motivates' (p.329)** The study authors reported that women described the midwife or doctor at the antenatal clinic as the central person in supporting the woman to 'dare' to give birth vaginally: "She really listened to me, which was of great importance to me, as I felt that I had confidence in her" (SE) (p.329). The study authors reported that women identified a flexible visit schedule, allowing for additional visits, as helpful, and that midwives should be aware that after a previous CS a woman may feel unsure about vaginal birth if she has never	2005)'. The study authors reported that the choice of content analysis was based on its suitability for use with data from both focus groups and individual interviews. They explained that the original study plan had been to conduct focus groups but due to time constraints focus groups could not be conducted in all settings; individual interviews were used to make it easier to recruit women working full time and living in different parts of the country. **Sample selection:** There was detailed reporting of sample selection. **Data collection:** There is a clear description of the individual interviews and focus groups. The study authors discussed data saturation and reported that they believed that the sample size was sufficient for data saturation on the basis of rich data quality. **Data analysis:** The analytical process was described and the use of predefined methods from the literature was reported. There was a detailed description of how categories were identified. However, there was no discussion of contradictory data. The study authors did not discuss the

Study details	Participants	Methods	Findings	Comments
2012 and were interviewed in November and December 2012. Sweden: women had had VBAC during 2010 and 2011 and were interviewed during 2012 and 2013 **Source of funding** The study was part of the 4-year OptiBIRTH project, which was funded by the European Commission under the European Union's Seventh Framework Programme (FP7/200-2013)		Finland: one birth setting located in a university hospital in a medium-size city; VBAC rates in the hospital were among the highest in the country (56.8% in 2011). The Netherlands: as all women who experience VBAC are cared for by a primary care midwife during the antenatal period (see above), 2 midwifery practices, one rural and one urban, and both with approximately 300 women registered, were asked to identify women who had experienced VBAC during 2010–2012. These women gave birth in different hospitals, where VBAC rates were about 54%. Sweden: 2 maternity settings, 1 within a university hospital in a large city and the other within a hospital in a smaller city; VBAC rates in both hospitals were about 55% in 2013 **Sample selection** In Finland and Sweden, women were identified via hospital registers. The women were contacted by post, with a letter containing information about the study. Women interested in participating filled in and returned a response letter. Thereafter, they were contacted by telephone by the	experienced it before and she will benefit from extra attention. For example, one woman said, "You feel after CS that you are a primipara, but you are not treated like that although in a sense you are primiparous" (FI) (p.330). The study authors reported that women described clinicians' and partners' support, encouragement, and understanding as crucial when their self-confidence was lacking. Women explained that it was vital that they felt confident. "That it would take that long again, that was my fear. She [the obstetrician] said, "I guarantee you that it will not happen again. We will intervene in time; if necessary, we will do a CS if it's really taking too long"" (NL) (p.330) Confidence was reported by the women as something a caregiver could contribute to by establishing a personal relationship in which the woman felt safe; confidence would, in turn, allow the woman to rely on the caregiver's expertise. Thorough information and good preparation were identified factors enabling women to feel	potential influences of the researchers. **Findings:** Results were presented clearly with the generous use of quotations where appropriate (quotations and the researchers' own input were clearly distinguished). In relation to the credibility of the findings, during the process of the analysis the researchers used Skype meetings to discuss findings. They also validated the data on several occasions in each country via email, using the Track Changes tool in MS Word. Finally, all researchers validated the final results. The study authors discussed transferability and explained that to facilitate transferability they had reported the studied contexts carefully. They provided adequate discussion of the findings and identified areas where future research was needed. **Overall quality:** Moderate **Other information** Ethical approval was obtained. Women signed a consent form

Study details	Participants	Methods	Findings	Comments
		researcher and provided with additional information. In the Netherlands, women were contacted by telephone and informed about the study by their former midwife **Data collection** Data were derived from 8 individual interviews (Finland), 1 group interview with 6 participants and 3 individual interviews (the Netherlands), and 1 group interview with 3 participants and 2 individual interviews (Sweden). The individual interviews were semi-structured, using an interview or topic guide with the same 5 questions appearing in the same order as in the focus group interviews. In Finland, all 8 individual interviews were performed in a location chosen by the women. Each interview lasted about 15-20 minutes. In the Netherlands, the focus group interview was held at the midwifery practice and lasted 75 minutes. The individual interviews took place at either the midwifery practice or another location chosen by the women and lasted 20-30 minutes. In Sweden, the focus group interview took place in a conference room at a university and lasted for 90 minutes. The individual interviews took place at	confident and trust their caregiver. Women wanted a caregiver who would respect them and take them seriously, although sometimes caregivers acts in a way that limits the woman's trust. **'Receiving Professional Support From a Calm and Confident Midwife or Obstetrician During Childbirth' (p.330)** This theme included the following sub-themes. **Providing 'continuous attentive guidance' (p.330)** The study authors reported that women appreciate continuous care, preferably from the same professional. Some women described feeling left alone and being overcome by panic when professionals left them. The women in the Netherlands, were particularly vocal about this; sometimes they experienced the obstetrician as running in and out of the birthing room. "[The obstetrician] was taking care of four or five labouring women at the same time. She went from them to me and from me to them again . . . so then I told her that someone had to	

Study details	Participants	Methods	Findings	Comments
		the hospital in a private room normally used for meetings or in a meeting room at the university and they lasted about 30 minutes **Data analysis** This qualitative descriptive study used conventional content analysis of the data (Hsieh 2005; Polit 2012). The focus group and individual interviews were transcribed verbatim in the participants' native language. Open coding was used to create subcategories. Following the formation of subcategories, the text was translated into English and shared with the main study authors who grouped subcategories according to their similarities and differences and further abstracted findings into overall main categories and subcategories	stay with me. She asked the midwife and she sat with me the whole time" (NL) (p.330). The study authors reported that women wanted to be directed through the birth process by a calm and confident professional. They would appreciate midwives or obstetricians who told them what to do during labour. Clear instructions helped them reduce fear and gain confidence in their own efficacy. The women observed that, particularly for a woman who fears childbirth, it is important to receive support from a midwife who is calm and confident, who motivates the woman, and tells the woman what to do during the birth. The study authors reported that women mentioned that when a woman feels afraid of giving birth vaginally, it helps to explain thoroughly what is going to happen. The woman will want to know how the baby moves through the birth canal and also they will appreciate indications of how and when to push and what happens in utero. The study authors reported that a central factor of importance to women was good support from a midwife or doctor	

Study details	Participants	Methods	Findings	Comments
			during childbirth. 'Women in this study [...] strongly appreciate continuity of care. They believed that a woman's previous CS birth should not make the midwife anxious; moreover, the midwife fully understanding it is the woman's first vaginal birth helps to keep the woman feeling safe' (p.330). "The midwife's attitudes are key to how the birth succeeds" (FI) (p.330). **'Making necessary interventions in time' (p.331)** The study authors reported that women considered it to be acceptable if caregivers motivated them to hold on a little longer, but some women thought they were pushed to or beyond their limit. "I understand that if a woman says she cannot go on any longer, her obstetrician motivates her by saying, "You have to try longer; you can do it!" But he has to do it at the beginning. Not toward the end, when she has been in labor for a very, very long time" (NL) (p.331) The study authors reported that women who had a negative experience during the first birth	

Study details	Participants	Methods	Findings	Comments
			and many interventions (failed assisted vaginal birth) before CS was chosen would particularly emphasise that obstetricians should not hesitate to intervene in this situation. "Why did I have to suffer for 26 hours before they took the baby out, just because the baby was in good condition? . . . I had been screaming for hours that I didn't want to do this" (SE) (p.331). The same woman stated that she received no explanation for why it took so long before the CS was performed, and viewed her suffering as something that could have been avoided, or at least stopped earlier (no direct quotation reported). **'Taking agreements seriously' (p.331)** The study authors reported that women stated that any previous agreements about the birth should be made known to the midwife or obstetrician assisting with the birth. The women understood that in some circumstances the birth plan they had made may not be realised, but some women's experience was that	

Study details	Participants	Methods	Findings	Comments
			professionals did not always keep agreements. "They just have to listen to you and keep the agreements! They of course can promise you anything . . . we will do this and that, but if in the end it didn't happen, because it was a little hectic on the ward, then you think, why did I have this appointment [at 30 weeks]"? (NL) (p.331) The study authors reported that when agreements that could have been kept were not followed, the women believed they were not taken seriously. Failure to keep an agreement was highly damaging to the relationship between the caregiver and the woman, and resulted in women feeling less confident during the birth. Moreover, some women thought that doctors had a tendency to stretch agreements that had been made previously. Some of the women in the Netherlands stated that they sometimes perceived that doctors minimised their worries, and this made them feel they were no longer a partner in the childbearing process. Women stated that they should feel	

Study details	Participants	Methods	Findings	Comments
			heard by their midwife or obstetrician if they were to play an active part in the process of childbirth. **'Receiving information from experienced women' (p.332)** The study authors reported that women stated that they would search for and retrieve information from a range of sources. The women mentioned the Internet and friends as significant sources of information. Moreover, they suggested that it would be very valuable to meet other women who had experienced VBAC and to hear about their experiences. The women considered that meeting other women was more productive than just reading about VBAC, or listening to doctors. For example, they mentioned that it would have been helpful if they had been given an opportunity to contact women who had experienced VBAC. They suggested organising information and support meetings and indicated that they would be prepared and motivated to share their experiences with women who were planning to have VBAC.	

Study details	Participants	Methods	Findings	Comments
			"Your midwife did not experience VBAC herself, and I believe it would be very helpful to hear from women who experienced it and recognize your fears. I believe that would be the most effective way to reassure women" (NL) (p.332). Women thought that the suggested support groups could provide support and help women to prepare themselves by listening to other women's stories; they could also use this forum to describe their experiences. Such groups involve working through the previous childbirth experience together, talking about the experience and sharing feelings, which might, for example, include anger. **'Letting go of the previous childbirth in preparation for the new birth' (p.332)** This theme included the following sub-themes. **'Having information and guidance from clinicians' (p.332)** The study authors reported that women considered that the midwife or doctor should help the woman to let go of the previous childbirth and put it	

Study details	Participants	Methods	Findings	Comments
			aside so that she could focus on the approaching birth. “The physician made me [feel] sure that the vaginal birth will be a success and it is going to be a very nice delivery” (FI) (p.332). The study authors reported that information about what happened during the previous birth was particularly important as understanding previous indications for CS could help the woman to feel more confident about a successful VBAC. One woman explained how she believed the role of the midwife to be essential, helping the woman to separate her childbirth experiences and clarifying that the next childbirth did not have to be similar to the previous one: "She encouraged me to believe that the second childbirth had nothing to do with the first one. . . . To let go [of the first birth] was difficult because I had a hard time imagining that things could be different" (p.332). (SE) The study authors reported that women stated that the midwife could guide them to a new way of thinking, supporting and strengthening them. If a woman had fears, then the midwife should try to understand the	

Study details	Participants	Methods	Findings	Comments
			cause and, if needed, refer her to a "fear clinic" or a psychologist, or schedule extra visits if the woman wanted them. The study authors reported that, for some, being the only couple among a group of new parents to experience a CS birth was difficult. "I couldn't feel their happiness. I missed coming to a group with others who had the same experiences" (SE) (p.333). The study authors reported that specialised parenthood classes at antenatal centres had been proposed for women and their partners who had experienced a previous CS. The women suggested that such classes should include education on vaginal childbirth. **'Alleviating fear of childbirth and processing negative birth experiences' (p.333)** The study authors reported that, for women, fear was one of the main factors that could hinder VBAC. "I told other people [not professionals] all the time that I was afraid. I asked them, what could I expect, how does it start, what do contractions feel like,	

Study details	Participants	Methods	Findings	Comments
			what do I have to do?" (NL) (p.333). The study authors reported that, for Swedish and Finnish women with fear of childbirth, support from midwives at a "fear clinic" had given them the opportunity to talk through both their previous and the impending childbirths and to record a personal birth plan. "After the first delivery, I had a lot of fears. I went to discuss the issue in the 'fear clinic,' as I wanted to experience vaginal birth" (FI), (p.333). The study authors also reported that it was considered positive that the woman's partner could describe his experience of the previous birth. "... [The midwife] asked both me and my husband what we wanted to happen. . . . We had to write it down and then go through what we had written, and then we went through the technical details" (SE) (p.333). The study authors reported that being able to visit the maternity ward was seen as being important, as was receiving advice on how to handle the situation should an	

Study details	Participants	Methods	Findings	Comments
			emergency CS be needed during the next birth. One woman described an extremely rapid VBAC, something that she was unprepared for and which resulted in a negative childbirth experience: "Even though I'd already given birth to a child, I needed them to understand that this was my first vaginal childbirth because this was a completely new situation" (SE). The study authors reported that the woman's contractions were intense and made it difficult for her to understand what was happening; she was stressed and anxious and she felt exposed, experiencing the midwife as being insecure and unaware that it was her first vaginal birth. This woman stated she had no postpartum conversation with the midwife, which she would have found helpful. **Recognising that the decision about caesarean section must be taken by professionals with special competence (p.333)** The study authors reported that most women were willing to follow the advice of	

Study details	Participants	Methods	Findings	Comments
			professionals if it would benefit their baby's health. "I just really wanted to give birth naturally, even though it was a breech. But when the obstetrician tells you, I don't think it is responsible to try any further, who am I to say that I want to proceed?" (NL) (p.334) Note: themes and quotations specific to decision-making between planned vaginal birth and elective CS were not extracted for the guideline review **Quantitative results** Not applicable	
Full citation Petrovska, Karolina, Watts, Nicole P., Catling, Christine, Bisits, Andrew, Homer, Caroline Se, 'Stress, anger, fear and injustice': An international qualitative survey of women's experiences planning a vaginal breech birth,	**Sample size** N=204 **Characteristics** Age ranged from 18 to >41 years. Number of children ranged from 1 to 5. Mode of birth: vaginal n=104; emergency CS n=60; did not disclose mode of birth n=40.	**Setting** Multiple countries (online survey). The settings relating to each country were not reported. However, the study authors reported that a large proportion of respondents were from the USA where access to vaginal breech birth is limited in many states **Sample selection** A link to the survey was distributed via closed membership Facebook groups	**Themes/categories** **'Encountering coercion and fear' (p.43)** The study authors reported that respondents wanted to be able to choose their birth options and when expressing the desire to do this they felt further disempowered if they were subjected to 'scare tactics' by and judgmental attitudes from care providers. Women felt this was a direct cause of stress they experienced in the final weeks of	**Limitations** Limitations were assessed using the CASP qualitative checklist. **Aims:** Aim of the study was clearly reported, research design was appropriate for answering the research question. The study authors justified the methods they used by reporting that 'Thematic analysis was used as it has been cited as a process that identifies patterns that uncover true meanings in the data (Boyatzis,

Study details	Participants	Methods	Findings	Comments
Midwifery, 44, 41-47, 2017 **Ref Id** 760051 **Study type** Online survey with both closed and open-ended questions. This article focused only on qualitative evidence gained from the study **Aim of the study** To examine the experiences of women seeking a vaginal breech birth to increase understanding of how to care for such women **Country/ies where the study was carried out** Multiple countries (online survey)	University education: 76.3% 11.9% of participants were from the UK **Inclusion criteria** Women who planned a vaginal breech birth at or near full term in the previous 7 years, regardless of whether the final outcome was a vaginal breech birth or a caesarean section **Exclusion criteria** Not reported	from the USA, United Kingdom and Australia. The Facebook groups had a focus on vaginal breech birth and membership of the groups was not limited to women from the countries hosting the groups. Women who were involved in previous research on women's experiences in planning vaginal breech birth (Homer 2015) were invited by email to complete the survey anonymously. The extended period of data collection was implemented to maximise the sample size of respondents, given that planned vaginal breech birth is a relatively rare event. During the data collection period, one researcher was responsible for providing 2 reminders to ensure that as many women as possible viewed the link to the survey **Data collection** The survey was uploaded on SurveyMonkey®. It took approximately 30 minutes to complete **Data analysis** Two members of the research team used inductive thematic analysis to analyse and code the data (Liamputtong 2005).	pregnancy. The presence of supportive partners and clinicians did not stop women experiencing negative feelings and threats if other staff who were not supportive of vaginal breech birth were present. The study authors reported that 1 woman stated: "I was not happy with the threats and bullying which continued into labour - in the complete absence of any medical problems whatsoever I should add, it was a textbook breech/vertex twin birth. [They said]'You have to get on the bed for a VE (vaginal examination)- you don't have a choice, your babies are going to die, you are going to die, why did you come here if you don't want us to help you, your kids will be left without a mother…". (Participant 23) (p. 43) Note: themes and quotations specific to decision making between planned vaginal birth and elective caesarean section were not extracted for the guideline review **Quantitative results**	1998; Grbich, 2007; Betts et al., 2014)'. **Sample selection:** Sample selection was reported clearly. **Data collection:** There was a clear description of the open-ended questions in the survey. The study authors did not discuss data saturation. **Data analysis:** The analytical process was described and the use of predefined methods from the literature was reported. There was a detailed description of how categories were identified. However, there was no discussion of contradictory data. The study authors did not discuss the potential influences of the researchers. **Findings:** Results were reported clearly with the generous use of quotations where appropriate (quotations and the researchers' own input were clearly distinguished). In relation to the credibility of the findings, themes and subthemes were discussed between 2 researchers, and a third and fourth researcher then critiqued the findings and themes. With regard to transferability, the study authors reported that responses were not identified or analysed by country, and

Study details	Participants	Methods	Findings	Comments
Study dates The survey was posted from April 2014 to January 2015 **Source of funding** Not reported		The qualitative components of the survey were read and re-read by 2 members of the research team to gain familiarity with the text. Following this, an initial identification of codes and potential themes was undertaken using manual colour coding of transcripts. The accuracy with which codes with similar content were sorted into sub-themes was confirmed in discussions between the 2 researchers. Major themes were generated from the sub-themes and then compared with the entire data set to confirm authenticity and to ensure the respondents' experiences were captured (Taylor 2006). Where opinions differed, the data was re-examined, themes were revisited and refinements or changes were made (Dahlen 2011). A third and fourth researcher then critiqued the findings and themes, allowing for further refinement of the results	None relevant to the guideline review	differences in the provision of maternity care and training and the skill of clinicians might have influenced the findings. The study authors provided adequate discussion of the findings. **Overall quality:** Moderate **Other information** None
Full citation Reid, E. W., McNeill, J. A., Holmes, V. A., Alderdice, F. A., Women's perceptions and experiences of fetal macrosomia, Midwifery, 30, 456-463, 2014	**Sample size** N=11 **Characteristics** All the women interviewed were white, married or cohabiting, and were of UK or Northern Irish origin	**Setting** One Health and Social Care Trust in Northern Ireland **Sample selection** Participants were recruited from a larger cohort of women which took part in a prospective study on the impact of	**Themes/categories** **Providing adequate information in response to women's worries** Negative interactions, mostly related to "not being listened to", were reported by 7 out of the 11 women interviewed. Topics on which women reported not being	**Limitations** Limitations were assessed using the CASP qualitative checklist. **Aims:** Aim of the study was clearly reported, research design was appropriate for answering the research question. **Sample selection:**

Study details	Participants	Methods	Findings	Comments
Ref Id 630920 **Study type** Qualitative **Aim of the study** To explore women's perceptions and experiences of pregnancy and childbirth following birth of a macrosomic baby (a baby weighing ≥ 4000 g) **Country/ies where the study was carried out** UK **Study dates** The study was conducted between January and September 2010 **Source of funding**	Age, range: 23 to 36 years Parity, range: 0 to 2 Type of birth: "Normal" (unassisted) vaginal birth n=5; emergency CS: n=4; Barnes Neville forceps n=1; elective CS n=1 Infant birthweight, range: 4180 to 4840 g Infant birthweight from previous birth, range: 3450 to 5000 g **Inclusion criteria** Women who gave birth to a macrosomic baby (a baby weighing ≥ 4000 g) **Exclusion criteria** Not reported	physical activity and nutrition on macrosomia. Women who gave birth to babies ≥ 4000 g were selected for interview based on type of childbirth and complications, to ensure that different experiences were reflected in the sample. Women were contacted by telephone at 3 months post partum. If a woman agreed to be interviewed, an appointment was arranged. Recruitment stopped when data saturation had been reached. One woman approached during recruitment declined the invitation to participate **Data collection** A researcher called each woman at home at 13-19 weeks postpartum. The women were reassured about confidentiality. An interview schedule was used so that all aspects of the women's experiences were included in relation to the antenatal, intrapartum and postpartum periods. The interview schedule changed over time as new interviewees introduced new themes. Interviews were tape recorded and later transcribed. A copy of their transcript was sent to each interviewee for verification before analysis was undertaken and no changes to transcripts were requested	listened to included prediction of macrosomia, planning mode of birth, perception of pain and being in labour. Women who reported not being listened to included those with a professional background who according to the study authors "were clearly articulate and confident". Women reacted in different ways to the perception of not being listened to and some were more assertive than others. A woman who had a "normal" (unassisted) vaginal birth said she was not listened to and was not given adequate information relating to prediction of macrosomia: "I felt who am I to tell a specialist in his field that you're wrong and I'm right. This baby is bigger than the first. But I was kept convinced no it wasn't so I just went along with it but I myself felt that there was no way it was under 9[pounds]; I was expecting it to be over 9 [pounds]. So it turned out [Baby2] was not as good an experience as [Baby1] and she turned out to be 10 pounds 12½ [ounces]" (056/011) (p. 460) Some women reported that they looked for confirmation from	Sample selection was clearly reported. **Data collection:** Data collection relied on interviews. An interview schedule was used. Interviews were conducted at least 3 months postpartum to prevent responses being influenced by having just given birth to a healthy baby. **Data analysis:** The analytical process was described and the use of predefined methods from the literature was mentioned. The method to identify "themes" was predefined from the literature. Exceptions, inconsistencies and contradictions were examined to modify the identified themes into more sophisticated themes. Researchers critically reviewed their own roles and potential influences in the process, because they reported a concern relating to the interviewer being a registered midwife and health visitor; they considered whether interviewees may not give open responses because of the interviewer's profession, however overall the study authors reasoned that the professional status gave the interviewer more credibility rather than being a

Study details	Participants	Methods	Findings	Comments
The project was funded by the Department of Employment and Learning with additional funding from the Research and Development Office in Northern Ireland for equipment		**Data analysis** Interviews were analysed using content analysis (Hsieh 2005). Transcripts were read and reread, coded and recurring themes identified. A tree diagram was prepared outlining relationships between themes and sub-themes. For internal validity, other members of the research team discussed codes and themes based on a sample interview. Themes were then integrated "moving to a higher level of analysis by discovering common threads or themes" (Mayan 2001). The data analysis process was cyclical until final conclusions were reached	health professionals that their baby was macrosomic; others reported uncertainty about predicted birthweight and consequently felt unable to prepare for birth. Another woman who had a "normal" (unassisted) vaginal birth said: "Nobody had explained to me, I had asked when I was pregnant with [Baby 2] a number of times antenatally is this going to be big baby, I think this is going to be a big baby and people kept saying to me well what weight was your last one and I kept saying 9 pounds 2 [ounces] and they kept saying oh well it will be about the same, it will be about the same, but I knew I was bigger than I was with the first one because I was enormous and the baby just felt enormous" (025/008) (p. 458) **Quantitative results** Not applicable	barrier to honest responses. Recruitment stopped when data saturation was reached **Findings/results:** Results were presented clearly with the generous use of quotation where appropriate (quotations and the researchers' own input were clearly distinguished). In relation to the credibility of their findings and respondent validation, a copy of their transcript was sent to each interviewee for verification before the analysis was conducted and no changes to transcripts were requested. For internal validity, other members of the research team discussed codes and themes based on a sample interview. The researchers discussed transferrability of the findings to other populations; the study authors reported that the study population was white, English speaking in Northern Ireland and therefore findings "may not be transferable to larger culturally diverse populations". The study authors provided adequate discussion of the findings. **Overall quality:** High

Study details	Participants	Methods	Findings	Comments
				Other information None
Full citation Renner,R.M., Eden,K.B., Osterweil,P., Chan,B.K., Guise,J.M., Informational factors influencing patient's childbirth preferences after prior cesarean, American Journal of Obstetrics & Gynecology, 196, e14-e16, 2007 **Ref Id** 52147 **Study type** Cross-sectional survey **Aim of the study** To examine how information that women with previous	**Sample size** N=37 women (the study authors conducted analysis for 66 women but 29 had scheduled caesarean sections therefore data on these women were not relevant for the guideline review) **Characteristics** The mean age was 28 years, 29 (44%) had a scheduled caesarean section, 19 (28.8%) had a vaginal birth after caesarean section and 18 (27.1%) had a caesarean section following an attempted vaginal birth after caesarean section.* *Numbers estimated by NGA technical team based on percentages and total N (=66) reported in the article	**Setting** A large US teaching hospital **Sample selection** Research assistants, who were unaffiliated with obstetric providers, approached women on the postpartum unit 1-2 times per week on random days; 15% of women approached declined to participate in the survey **Data collection** Questionnaires were completed 1-4 days postpartum. Participating women answered questions about the amount of information they received with regard to benefits and risks of repeat cesarean sections and vaginal birth after a previous caesarean section, their satisfaction with the information provided, involvement in decision making and their selected and eventual mode of birth	**Themes/categories** Uterine rupture, forceps or vacuum birth, recovery time following vaginal birth, bleeding with vaginal birth, blood transfusion following vaginal birth, future problems with loss of urine or stools **Quantitative results** Results reported only for those women who had chosen a trial of labour. Level of information received: Uterine rupture (n=34): not addressed = 2.9%; too little = 20.6%; just right = 67.6%; too much = 8.8% Forceps or vacuum birth (n=34): not addressed = 44.1%; too little = 29.4%; just right = 26.5%; too much = 0% Recovery time following vaginal birth (n=34): not addressed = 11.8%; too little = 14.7%; just right = 67.6%; too much = 5.9%	**Limitations** **Limitations were assessed using the Newcastle-Ottawa Scale adapted for cross-sectional studies** Selection: (Maximum 5 stars) 1) Representativeness of the sample: no description of the sampling strategy. 2) Sample size: not justified. 3) Non-respondents: no description of the response rate or the characteristics of the responders and non-responders. 4) Ascertainment of the exposure (risk factor): non-validated measurement tool, but the tool is available or described.* Comparability: (Maximum 2 stars) The subjects in different outcome groups are comparable, based on the study design or analysis. Confounding factors are controlled. 1) Comparison between the two groups is not relevant here as data for only 1 group are relevant for the review question; study

Study details	Participants	Methods	Findings	Comments
caesarean section received about vaginal birth after caesarean section and repeat caesarean section affected their preferences and satisfaction **Country/ies where the study was carried out** USA **Study dates** November 2002 - August 2004 **Source of funding** Not reported	**Inclusion criteria** Postpartum women who had a previous caesarean section, giving birth vaginally after caesarean section or having a repeat caesarean section, and who spoke English or Spanish, had a prior caesarean section and were eligible for a trial of labour **Exclusion criteria** Women with a vertical uterine incision, multiple pregnancy, congenital anomalies, intrauterine fetal death or planned adoption	**Data analysis** Data were analysed using SPSS 12.0 by means of frequency and distribution of the study variables, Chi-squared or Fisher's exact test	Bleeding with vaginal birth (n=34): not addressed = 14.7%; too little = 26.5%; just right = 52.9%; too much = 5.9% Blood transfusion following vaginal birth (n=32): not addressed = 40.6%; too little = 34.4%; just right = 25%; too much = 0% Future problems with loss of uine or stools (n=32): not addressed = 65.6%; too little = 18.8%; just right = 15.6%; too much = 0%	reports only the % so no adjustment for confounders. Outcome: (Maximum 3 stars) 1) Assessment of the outcome: self report.* 2) Statistical test: the statistical test used to analyse the data was described clearly and appropriate. (Half star) **Overall quality = 2.5 stars out of 10 = low quality** **Other information** The study obtained formal ethics committee approval
Full citation Wang, H. H., Chung, U. L., Sung, M. S., Wu, S. M., Development of a Web-based childbirth	**Sample size** N=10 **Characteristics** Average age was 30.5 years, 40% of women had	**Setting** Obstetrics and gynaecology department of a regional teaching hospital **Sample selection**	**Themes/categories** **Provision of information on practicalities of 'natural' (unassisted) birth (p.5)** “My previous pregnancy didn’t go very smoothly compared with my current pregnant because I	**Limitations** Limitations were assessed using the CASP qualitative checklist. Overall this was a poorly reported study. **Aims:**

Study details	Participants	Methods	Findings	Comments
education program for vaginal birth after C-section (VBAC) mothers, Journal of Nursing Research, 14, 1-8, 2006 **Ref Id** 631069 **Study type** Evaluation research (before-and-after study); the article includes relevant qualitative evidence (quotations) **Aim of the study** To develop a web-based childbirth education programme for women considering vaginal birth after caesarean section (VBAC), and to compare knowledge about and attitudes towards VBAC before and after participating in the education programme	a college or higher education background, average gestational age was 34.8 weeks, 40% reported prolonged labour as the reason for their previous caesarean section **Inclusion criteria** Pregnant women at over 32 weeks of gestation without complications, with previous caesarean section and who participated in the online educational programme for at least 60 minutes. Nine women attempted VBAC and 8 achieved a vaginal birth **Exclusion criteria** Not reported	Not reported; it is only reported that announcements on the website, bulletin board system and hospital publicity were used to recruit participants **Data collection** An online survey. Date were collected on the following. 1) Knowledge and attitudes towards vaginal birth after caesarean section. The aim was to understand the difference in knowledge and attitudes regarding vaginal birth after caesarean section before and after attending the programme. N=5 pregnant women with previous caesarean section and N=5 experts confirmed the content validity of the survey [this evidence was reported quantitatively and is not relevant for the guideline review]. 2) Interview guidelines for content evaluation that were confirmed by experts. Telephone interviews lasted 10-20 minutes and included questions about the programme. The researchers followed-up by telephone to ask whether participating women had had a vaginal birth after caesarean section and how successful it was. The questions were: how did the web-based programme affect the participants in their current experience	hadn't taken this program. After taking this program including such things as the Lamaze method, exercise, nutrition and control of body weight, I knew how to prepare for a natural birth. This program covers many labor skills and methods I need and I can well prepare. So my chances of a successful child birth may be higher." (Case A) (p.5) "I took this course this time. This program was useful and practical. This helped me so much it resolved my troublesome." (Case E) (p.6) "This time my husband participated this program and he also often studied this internet course and we had the same concepts after discussion. My husband taught me how to breathe during child birth and it's very practical for me." (Case I) (p.6) "It's very practical such as the selection of the hospital, the preparation for child birth and the Lamaze method. They were all useful when I was giving birth and helped me so much to deliver the baby smoothly." (Case J) (p.6)	Aim of the study was clearly reported, research design was appropriate for answering the research question. **Sample selection:** Sample selection was not clearly reported. **Data collection:** Data collection relied on interviews. Not reported what type of interviews. Unclear whether topic guide was used. Saturation of data was not discussed but the study authors acknowledged that the sample size was small. **Data analysis:** The analytical process was described and the use of a predefined method from the literature was reported. The study authors did not report the methods used to identify "themes". There were no clearly defined themes or sub-themes. The researchers did not critically review their own roles and potential influences in the process. **Findings/results:** Results were poorly presented. The study authors cited some quotations without identifying clear themes. The study authors neither discussed and described the credibility of their findings nor

Study details	Participants	Methods	Findings	Comments
Country/ies where the study was carried out Taiwan **Study dates** November - December 2002 (as part of the implementation and evaluation stage of the research) **Source of funding** Not reported		of labour and birth; which parts of the programme were most helpful or not helpful; and what else should be included in the programme **Data analysis** SPSS 11.0 was used to produce descriptive statistics and to perform the paired t-test. Qualitative data were analysed according to the method of phenomenology (Colaizzi 1978)	"I knew more about natural birth after watching the movie in the courses. I felt confident about my child birth because I knew the next step of child birth." (Case J) (p.6) **Quantitative results** Not applicable	the transferability of the findings to other populations. The study authors provided a poor discussion of the findings. **Overall quality:** Very low **Other information** Whether the study obtained formal ethics committee approval was not reported

1

Appendix F – Forest plots

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

No meta-analysis was undertaken for this review and so there are no forest plots.

1 # Appendix G – GRADE-CERQual tables

2 ## Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric
3 ## complications or other reasons)

4 ### Women with previous caesarean section (qualitative evidence)

5 #### Overarching category A – antenatal information provision in the healthcare setting for women with previous caesarean section

6 **Table 4: Qualitative evidence profile for theme 1 – antenatal information provision in the healthcare setting for women with previous**
7 **caesarean section, 'Receiving information from supportive clinicians'**

Study information		Description of review finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Sub-theme 1 – 'Having realistic information tailored to women's needs' (p 329 of Nilsson 2017)					
1 (Nilsson 2017; Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that women considered that information from clinicians should be tailored to woman's needs and that it was easier for the woman to go through VBAC when she was well informed and knew what was going to happen. The women noted that information should contain both facts and experiences and they explained that the information the woman received should be straightforward and realistic and provide answers to their questions. The information should not be idealised; it should contain what is painful and difficult. "*You need very clear information, no glorification*" (SE) (p 329). However, the study authors acknowledged that the need for information differed among women and so their caregivers must adjust the information and counselling to the needs of the individual	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	
Sub-theme 2 – 'Having a midwife or doctor during pregnancy who listens, encourages, and motivates' (p 329 of Nilsson 2017)					

Study information		**Description of review finding**	**CERQual assessment of the evidence**		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
1 (Nilsson 2017; Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that women described the midwife or physician at the antenatal clinic as the central person in supporting women to 'dare' to give birth vaginally: "*She really listened to me, which was of great importance to me, as I felt that I had confidence in her*" (SE) (p.329). The study authors reported that women identified a flexible visit schedule, allowing for additional visits, as helpful, and that midwives should be aware that after a previous CS a woman may feel unsure about vaginal birth as she has never experienced it before and she will benefit from extra attention. For example, one woman said: "*You feel after CS that you are a primipara, but you are not treated like that although in a sense you are primiparous*" (FI) (p 330). The study authors reported that women described clinicians' and partners' support, encouragement, and understanding as crucial when their self-confidence was lacking. Women explained that it was vital that they felt confident. '*That it would take that long again, that was my fear. She [the obstetrician] said, "I guarantee you that it will not happen again. We will intervene in time; if necessary, we will do a CS if it's really taking too long.*" (NL) (p 330) Confidence was reported by the women as something a caregiver could contribute to by establishing a personal relationship in which the women felt safe; confidence would, in turn, allow the woman to rely on the caregiver's expertise. Thorough information and good preparation were identified factors enabling women to feel confident and trust their caregiver. Women wanted a caregiver who would respect them and	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
		take them seriously, although sometimes caregivers act in a way that limits the woman's trust			

1 *CASP: Critical Appraisal Skills Programme; CS: caesarean section; FI: Finland; NL: the Netherlands; SE: Sweden; VBAC: vaginal birth after caesarean section*
2 *1. One study with moderate rating based on CASP qualitative checklist*
3 *2. Interviews took place in Finland, the Netherlands, and Sweden. Demographic characteristic of participants not reported*
4 *3. No data that contradict the review finding; no ambiguous data*
5 *4. One study that offered moderately rich data*

6 **Table 5: Qualitative evidence profile for theme 2 – antenatal information provision in the healthcare setting for women with previous**
7 **caesarean section, 'Letting go of the previous childbirth in preparation for the new birth'**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Sub-theme 1 – 'Having information and guidance from clinicians' (p 332 of Nilsson 2017)					
1 (Nilsson 2017; Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that women considered that the midwife or doctor should help the woman to let go of the previous birth and put it aside so that she could focus on the approaching birth. "*The physician made me [feel] sure that the vaginal birth will be a success and it is going to be a very nice delivery*" (FI) (p332). The study authors reported that information about what happened during the previous birth was particularly important as understanding previous indications for CS could help the woman to feel more confident about a successful VBAC.	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
		One woman explained how she believed the role of the midwife to be essential, helping the woman to separate her childbirth experiences and clarifying that the next childbirth did not have to be similar to the previous one: "*She encouraged me to believe that the second childbirth had nothing to do with the first one. . . . To let go [of the first birth] was difficult because I had a hard time imagining that things could be different*". (SE) (p 332) The study authors reported that women stated that the midwife could guide them to a new way of thinking, supporting and strengthening them. If a woman had fears, then the midwife should try to understand the cause, and if needed, refer her to a "fear clinic" or a psychologist, or schedule extra visits if the woman wanted them. The study authors reported that, for some, being the only couple among a group of new parents to experience a CS birth was difficult' (p 333). "*I couldn't feel their happiness. I missed coming to a group with others who had the same experiences*" (SE) (p 333). The study authors reported that specialised parenthood classes at antenatal centres had been proposed for women and their partners who had experienced a previous CS. The women suggested that such classes should include education on vaginal childbirth			
Sub-theme 2 – 'Alleviating fear of childbirth and processing negative birth experiences' (p 333 of Nilsson 2017)					
1 (Nilsson 2017;	Qualitative study using individual	The study authors reported that, for women, fear was one of the main factors that could hinder VBAC.	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	and group interviews	"*I told other people [not professionals] all the time that I was afraid. I asked them, what could I expect, how does it start, what do contractions feel like, what do I have to do?*" (NL) (p 333). The study authors reported that, for Swedish and Finnish women with fear of childbirth, support from midwives at a "fear clinic" had given them the opportunity to talk through both their previous and the impending childbirths and to record a personal birth plan. "*After the first delivery, I had a lot of fears. I went to discuss the issue in the 'fear clinic,' as I wanted to experience vaginal birth*" (FI) (p 333). The study authors also reported that it was considered positive that the woman's partner could describe his experience of the previous birth. "*. . . [The midwife] asked both me and my husband what we wanted to happen. . . . We had to write it down and then go through what we had written, and then we went through the technical details*" (SE) (p 333). The study authors reported that being able to visit the maternity ward was seen as being important, as was receiving advice on how to handle the situation should an emergency CS be needed during the next birth. One woman described an extremely rapid VBAC, something that she was unprepared for and which resulted in a negative childbirth experience: "*Even though I'd already given birth to a child, I needed them to understand that this was my first vaginal childbirth because this was a*	Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
		completely new situation" (SE). The study authors reported that the woman's contractions were intense and made it difficult for her to understand what was happening; she was stressed and anxious and she felt exposed, experiencing the midwife as being insecure and unaware that it was her first vaginal birth. This woman stated she had no postpartum conversation with the midwife, which she would have found helpful			

1 *CASP: Critical Appraisal Skills Programme; CS: caesarean section; FI: Finland; NL: the Netherlands; SE: Sweden; VBAC: vaginal birth after caesarean section*
2 *1. One study with moderate rating based on CASP qualitative checklist*
3 *2. Interviews took place in Finland, the Netherlands, and Sweden. Demographic characteristic of participants not reported*
4 *3. No data that contradict the review finding; no ambiguous data*
5 *4. One study that offered moderately rich data*

6 **Overarching category B – antenatal information provision about vaginal birth in water for women with previous caesarean section**

7 **Table 6: Qualitative evidence profile for theme 3 – antenatal information provision in the healthcare setting about vaginal birth in water**
8 **for women with previous caesarean section**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
Sub-theme 1 – raising water VBAC as an option in the antenatal period					
1 (McKenna	Qualitative study using	All women had to ask for the option of water VBAC, as they were not offered this antenatally by healthcare professionals.	Methodological limitations	Minor concerns[1]	Low

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
2014; qualitative study; UK; N=8 women; all women had a water VBAC)	semi-structured interviews	All interviewees stated that GPs and midwives who cared for them in the early stages of pregnancy did not mention water VBAC as an option. "*I'd heard about Water Birth for women who had C-Sections and thank goodness because the midwife certainly wasn't about to tell me about it! So I had to bring it up myself, which is a bit ridiculous*". (R2, p e23) All women interviewed emphasised that information on water VBAC should be made available to all pregnant women, and that this birth option should be "*an actual choice*" (R2, p e23) rather than "*a secret you have to actively go after*" (R7, p e23)	Relevance	Serious concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	
Sub-theme 2 – shared decision making in antenatal discussions after water VBAC was raised as an option					
1 (McKenna 2014; qualitative study; UK; N=8 women; all women had a water VBAC)	Qualitative study using semi-structured interviews	Not only did women have to ask about water VBAC, some women had to "*push for*" water VBAC after raising this option. Three women were "*pre-warned*" (R4, p e23) that water VBAC would not be an option. "*You'd definitely need to be someone who isn't afraid to speak their mind … [and] doesn't shy away from confrontation … it's probably only the pushy middle class who get their [VBAC] Water Birth!*" (R6, p e23) Five women only realised at their initial booking visit that they were "*high risk*", therefore had their "*arguments ready*" (R1, p e23) in favour of water VBAC after this first appointment. One woman showed her consultant obstetrician "*an essay with references and footnotes and everything*" (R3, p e23) to support her reasons for preferring water VBAC. All women said that to some extent they had to convince their midwife and consultant obstetrician to agree to water VBAC. Two women stated themselves ready to "*threaten a home birth*" (R6, p e23) in order to "*be given the compromise of the MLU*" (R1, p e23), even if home	Methodological limitations	Minor concerns[1]	Low
			Relevance	Serious concerns[2]	
			Coherence	Moderate concerns[5]	
			Adequacy	Moderate concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
		birth was not what they wanted. Only 2 women reported their midwives as being supportive of a water VBAC request from the very beginning, and they had to arrange additional appointments with the consultant obstetrician to discuss this option further. One midwife referred 2 of the women to a different obstetric consultant because he was "*more midwife-friendly*" (R4, p e23)			

1 *CASP: Critical Appraisal Skills Programme; CS: caesarean section; GP: general practitioner; VBAC: vaginal birth after caesarean section*
2 *1. One study with moderate rating based on CASP qualitative checklist*
3 *2. One study in a Scottish midwife-led unit. Women gave birth in a midwifery unit, but according to the NICE guideline CG190, women with previous CS should give birth in an*
4 *obstetric unit because previous CS is among the 'medical conditions or situations in which there is increased risk for the woman or baby during or shortly after labour, where*
5 *care in an obstetric unit would be expected to reduce this risk'. All women interviewed had successfully achieved water VBAC. Baseline characteristics not reported but the*
6 *study authors reported that future research should be based on a wider range of socio-economic and ethnic backgrounds*
7 *3. No data that contradict the review finding; no ambiguous data*
8 *4. One study that offered moderately rich data*
9 *5. Study authors report that all women had to some extent convince their midwife and consultant obstetrician to agree to water VBAC, however they also reported that 2 women*
10 *reported their midwives as supporting of water VBAC request from the very beginning*
11

12 **Table 7: Qualitative evidence profile for theme 4 – women with previous caesarean section accessing information about vaginal birth in**
13 **water outside the healthcare setting in the antenatal period**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
Sub-theme 1 – online information accessed in the antenatal period, personal accounts and academic research					

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
1 (McKenna 2014; UK; N=8 women; all women had a water VBAC)	Qualitative study using semi-structured interviews	All women had accessed some information on the risks of water VBAC, however, this was mostly anecdotal due to the lack of empirical studies. All women looked for information online and some contacted women from other countries who had had a water VBAC. These "*personal*" (R8, p e23) accounts were valued more highly than "*impersonal*"(R2, p e23) academic research and "*obstetric recommendations*"	Methodological limitations	Minor concerns[1]	Low
			Relevance	Serious concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Serious concerns[4]	
Sub-theme 2 – online incorrect information on water VBAC identified in the antenatal period and women's experience					
1 (McKenna 2014; UK; N=8 women; all women had a water VBAC)	Qualitative study using semi-structured interviews	The only negative outcome that some women had heard of was "*the baby drowning*" (R2, p e23). However, the 4 women who mentioned this commented on it as "*rubbish*" (R2, p e23), "*highly unlikely*" (R4, p e23), "*scare tactics*" (R5, p e23), and "*urban myth*"(R6, p e23)	Methodological limitations	Minor concerns[1]	Low
			Relevance	Serious concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[5]	
Sub-theme 3 – online incorrect information on water VBAC identified in the antenatal period and family experience					
1 (McKenna 2014; UK;	Qualitative study using semi-	"*Horror stories about babies drowning*" (R4, p e23) influenced the women's families, and interviewees had to manage family fears relating to this	Methodological limitations	Minor concerns[1]	Low
			Relevance	Serious concerns[2]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
N=8 women; all women had a water VBAC)	structured interviews		Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[5]	

CASP: Critical Appraisal Skills Programme; CS: caesarean section; VBAC: vaginal birth after caesarean section

1. *One study with moderate rating based on CASP qualitative checklist*
2. *One study in a Scottish midwife-led unit. Women gave birth in a midwifery unit, but according to the NICE guideline CG190, women with previous CS should give birth in an obstetric unit because previous CS is among the 'medical conditions or situations in which there is increased risk for the woman or baby during or shortly after labour, where care in an obstetric unit would be expected to reduce this risk'. All women interviewed had successfully achieved water VBAC. Baseline characteristics not reported but the study authors reported that future research should be based on a wider range of socio-economic and ethnic backgrounds*
3. *No data that contradict the review finding; no ambiguous data*
4. *One study that offered 'thin' data*
5. *One study that offered moderately rich data*

1 **Overarching category C – accessing information outside the healthcare setting in the antenatal period**

2 **Table 8: Qualitative evidence profile for theme 5 – accessing information outside the healthcare setting in the antenatal period,**
3 **'information from experienced women'**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
1 (Nilsson 2017; Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that women stated that they would search for and retrieve information from a range of sources. The women mentioned the Internet and friends as significant sources of information. Moreover, they suggested that it would be very valuable to meet other women who had experienced VBAC and to hear about their experiences. The women considered that meeting other women was more productive than just reading about VBAC, or listening to doctors. For example, they mentioned that it would have been helpful if they had been given an opportunity to contact women who had experienced VBAC. They suggested organising information and support meetings and indicated that they would be prepared and motivated to share their experiences with women who were planning to have a VBAC. "*Your midwife did not experience VBAC herself, and I believe it would be very helpful to hear from women who experienced it and recognize your fears. I believe that would be the most effective way to reassure women*" (NL) (p 332). Women thought that the suggested support groups could provide support and help women to prepare themselves by listening to other women's stories; they could also use this forum to describe their experiences. Such groups involve working through the previous childbirth experience together, talking about the experience and sharing feelings, which might, for example, include anger	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

4 *CASP: Critical Appraisal Skills Programme; CS: caesarean section; FI: Finland; NL: the Netherlands; SE: Sweden; VBAC: vaginal birth after caesarean section*
5 *1. One study with moderate rating based on CASP qualitative checklist*

1 2. *Interviews took place in Finland, the Netherlands, and Sweden. Demographic characteristic of participants not reported*
2 3. *No data that contradict the review finding; no ambiguous data*
3 4. *One study that offered moderately rich data*

4 **Table 9: Qualitative evidence profile for theme 6 – antenatal information provision for women with previous caesarean section with an**
5 **online education programme**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Sub-theme 1 – provision of information in the antenatal period with a web-based education programme on practicalities of 'natural' (unassisted) birth (p 5 of Wang 2006)					
1 (Wang 2006; Taiwan; N=10 women with previous CS who participated in an online educational programme when pregnant; N=9 attempted VBAC)	Evaluation research (before-and-after study; the article includes relevant qualitative quotations)	Women found the education programme useful for multiple reasons: "*My previous pregnancy didn't go very smoothly compared with my current pregnant because I hadn't taken this program. After taking this program including such things as the Lamaze method, exercise, nutrition and control of body weight, I knew how to prepare for a natural birth. This program covers many labor skills and methods I need and I can well prepare. So my chances of a successful child birth may be higher.*" (Case A), p 5 "*I took this course this time. This program was useful and practical. This helped me so much it resolved my troublesome.*" (Case E), p 6 "*This time my husband participated this program and he also often studied this internet course and we had the same concepts after discussion. My husband taught me how to breathe during child birth and it's very practical for me.*" (Case I), p 6 "*It's very practical such as the selection of the hospital, the preparation for child birth and the Lamaze method. They were all useful when I was giving birth and helped me so much to deliver the baby smoothly.*" (Case J), p 6	Methodological limitations	Serious concerns[1]	Low
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
		"I knew more about natural birth after watching the movie in the courses. I felt confident about my child birth because I knew the next step of child birth." (Case J), p 6			

1 *CASP: Critical Appraisal Skills Programme; CS: caesarean section; VBAC: vaginal birth after caesarean section*
2 *1. One study with very low rating based on CASP qualitative checklist*
3 *2. One study in a regional teaching hospital in Taiwan with women who had participated for at least 60 minutes in the online educational programme*
4 *3. No data that contradict the review finding; no ambiguous data*
5 *4. One study that offered moderately rich data*

6 Overarching category D – information provision during labour

7 **Table 10: Qualitative evidence profile for theme 7 – information provision during labour for women with previous caesarean section,**
8 **'Receiving professional support from a calm and confident midwife or obstetrician during childbirth'**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
Sub-theme 1 – providing 'continuous attentive guidance' (p 330 of Nilsson 2017)					
1 (Nilsson 2017;	Qualitative study using individual	The study authors reported that women wanted to be directed through the birth process by a calm and confident professional. They would appreciate midwives or obstetricians who told them what to do during labour. Clear instructions helped them reduce fear and gain confidence	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	and group interviews	in their own efficacy. The women observed that, particularly for a woman who fears childbirth, it is important to receive support from a midwife who is calm and confident, who motivates the woman, and tells the woman what to do during the birth. The study authors reported that women mentioned that when a woman feels afraid of giving birth vaginally, it helps to explain thoroughly what is going to happen. The woman will want to know how the baby moves through the birth canal and also they will appreciate indications of how and when to push and what happens in utero. The study authors reported that a central factor of importance to women was good support from a midwife or doctor during childbirth. 'Women in this study […] strongly appreciate continuity of care. They believed that a woman's previous CS birth should not make the midwife anxious; moreover, the midwife fully understanding it is the woman's first vaginal birth helps to keep the woman feeling safe' (p 330). "*The midwife's attitudes are key to how the birth succeeds*" (FI) (p 330). The study authors reported that women appreciate continuous care, preferably from the same professional. Some women described feeling left alone and being overcome by panic when professionals left them. The women in the Netherlands were particularly vocal about this; sometimes they experienced the obstetrician as running in and out of the birthing room.	Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
		"[*The obstetrician] was taking care of four or five labouring women at the same time. She went from them to me and from me to them again . . . so then I told her that someone had to stay with me. She asked the midwife and she sat with me the whole time*'. (NL) (p 330)			
Sub-theme 2 – 'Making necessary interventions in time' (p 331 of Nilsson 2017)					
1 (Nilsson 2017 Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that women considered it to be acceptable if caregivers motivated them to hold on a little longer, but some women thought that they were pushed beyond their limit. *"I understand that if a woman says she cannot go on any longer, her obstetrician motivates her by saying, "You have to try longer; you can do it!" But he has to do it at the beginning. Not toward the end, when she has been in labor for a very, very long time"* (NL) (p331) The study authors reported that women who had a negative experience during the first birth and many interventions (failed assisted vaginal birth) before CS was chosen would particularly emphasise that obstetricians should not hesitate to intervene in this situation. Some women considered that they were pushed to the limit' (p331). "*Why did I have to suffer for 26 hours before they took the baby out, just because the baby was in good condition? . . . I had been screaming for hours that I didn't want to do this*" (SE) (p331). The same woman stated that she received no explanation for why it took so long before the CS was performed, and viewed her suffering as something that could have been avoided, or at least stopped earlier' (no direct quotation reported)	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	
Sub-theme 3 – 'Taking agreements seriously' (p 331 of Nilsson 2017)					

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
1 (Nilsson 2017; Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that women stated that any previous agreements about the birth should be made known to the midwife or obstetrician assisting with the birth. The women understood that in some circumstances the birth plan they had made may not be realised, but some women's experience was that professionals did not always keep agreements. *"They just have to listen to you and keep the agreements! They of course can promise you anything . . . we will do this and that, but if in the end it didn't happen, because it was a little hectic on the ward, then you think, why did I have this appointment [at 30 weeks]*"? (NL) (p 331) The study authors reported that when agreements that could have been kept were not followed, the women believed they were not taken seriously. Failure to keep an agreement was also highly damaging to the relationship between the caregiver and the woman, and resulted in women feeling less confident during the birth. Moreover, some women thought that doctors had a tendency to stretch agreements that had been made previously. Some of the women in the Netherlands stated that they sometimes perceived that doctors minimised their worries, and this made them feel they were no longer a partner in the childbearing process. Women stated that they should feel heard by their midwife or obstetrician if they were to play an active part in the process of childbirth	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

CASP: Critical Appraisal Skills Programme; CS: caesarean section; FI: Finland; NL: the Netherlands; SE: Sweden; VBAC: vaginal birth after caesarean section

1. *One study with moderate rating based on CASP qualitative checklist*
2. *Interviews took place in Finland, the Netherlands, and Sweden. Demographic characteristic of participants not reported*
3. *No data that contradict the review finding; no ambiguous data*
4. *One study that offered moderately rich data*

1 **Table 11: Qualitative evidence profile for theme 8 – information provision for women with previous caesarean section during labour,**
2 **'special competence' of professionals**

Study information		**Description of review finding**	**CERQual assessment of the evidence**		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
1 (Nilsson 2017; Finland, the Netherlands and Sweden; N=22 women who had experienced VBAC)	Qualitative study using individual and group interviews	The study authors reported that most women were willing to follow the advice of professionals if it would benefit their baby's health. '*I just really wanted to give birth naturally, even though it was a breech. But when the obstetrician tells you, I don't think it is responsible to try any further, who am I to say that I want to proceed?*' (NL) (p 334)	Methodological limitations	Minor concerns[1]	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Moderate concerns[4]	

3 *CASP: Critical Appraisal Skills Programme; CS: caesarean section; FI: Finland; NL: the Netherlands; SE: Sweden; VBAC: vaginal birth after caesarean section*
4 1. *One study with moderate rating based on CASP qualitative checklist*
5 2. *Interviews took place in Finland, the Netherlands, and Sweden. Demographic characteristic of participants not reported*
6 3. *No data that contradict the review finding; no ambiguous data*
7 4. *One study that offered moderately rich data*

1 **Women with breech presenting in labour**

2 **Table 12: Qualitative evidence profile for theme 9 – information provision in the healthcare setting for women attempting a vaginal**
3 **breech birth**

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Sub-theme 1 – lack of information provided in the antenatal period					
1 (Homer 2015; Australia; N=22 women; all attempted a vaginal breech birth when the baby remained breech after an attempted external cephalic version)	Qualitative study using interviews	'Women felt there was a lack of information [in the antenatal period] about their options' (p 4): "*I didn't really have any understanding of breech at that point [at diagnosis]. I don't remember it being covered in antenatal classes. And I hadn't read much about it in the books. It was a shock*" (12; respondent had had emergency CS after labour had commenced) (p 4) "*I don't feel that I was given anything [about breech]. I felt like I was sort of expecting to go and find out about breech* (5; respondent had had emergency CS after labour had commenced)" (p 4)	Methodological limitations	Minor concerns[1]	Low
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Serious concerns[4]	
Sub-theme 2 – individualised and comprehensive information provided in the antenatal period					
1 (Homer 2015; Australia; N=22 women; all attempted a vaginal breech birth when the	Qualitative study using interviews	'Women were relieved to hear that a breech presentation did not mean there was something wrong with them' (p 5). One woman said "*The doctor just took the time to answer all my questions. It was, so relieving to hear that my body is capable of giving birth. That nothing was wrong with me. …I went out of that and, suddenly everything's opened up again. But it felt really good, to have all these options* (12:	Methodological limitations	Minor concerns[1]	Low
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
baby remained breech after an attempted external cephalic version)		respondent had had emergency CS after labour had commenced)" (p 5)	Adequacy	Serious concerns[4]	
Sub-theme 3 – 'Encountering coercion and fear' (p 43 of Petrovska 2017)					
1 (Petrovska 2017; multiple countries; N=204 women who sought a vaginal breech birth; mode of birth vaginal, n=104; emergency CS, n=60; did not disclose mode of birth, n=40)	Qualitative analysis of responses to open questions in an online survey	Respondents felt 'disempowered when they experienced 'scare tactics' and judgmental attitudes from care providers' in relation to choice of mode of birth. 'The presence of supportive partners and clinicians did not preclude them from experiencing negative sentiments and threats from other staff present who were not supportive of VBB' (p 43). "*I was not happy with the threats and bullying which continued into labour - in the complete absence of any medical problems whatsoever I should add, it was a textbook breech/vertex twin birth. [They said]'You have to get on the bed for a VE (vaginal examination)-you don't have a choice, your babies are going to die, you are going to die, why did you come here if you don't want us to help you, your kids will be left without a mother….* " (Participant 23) (p 43)	Methodological limitations	Minor concerns[1]	Low
			Relevance	Moderate concerns[5]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Serious concerns[4]	

CASP: Critical Appraisal Skills Programme; CS: caesarean section

1. *One study with moderate rating based on CASP qualitative checklist*
2. *One study in 2 maternity hospitals in Australia; all women were Caucasian, the majority were educated to tertiary level and none of them wanted an elective CS*
3. *No data that contradict the review finding; no ambiguous data*
4. *One study that offered 'thin' data*
5. *Respondents to online survey lived in different countries; 12% were from the UK; 76% had a university education; ethnicity not reported*

1 **Women with macrosomic babies**

2 **Table 13: Qualitative evidence profile for theme 10 – antenatal and intrapartum information provision in the healthcare setting for women**
3 **with macrosomic babies**

Study information		**Description of review finding**	**CERQual assessment of the evidence**		
No of studies	**Design**		**Criteria**	**Level of concern**	**Overall assessment of confidence (overall quality)**
Sub-theme 1 – providing adequate information in response to women's worries in the antenatal and intrapartum period					
1 (Reid 2014; UK; N=11 women with a macrosomic baby)	1 qualitative study	Negative interactions mostly related to "*not being listened to*" were reported by 7 out of the 11 women interviewed. Topics on which women reported not being listened to included prediction of macrosomia, planning mode of birth, perception of pain and being in labour. Women who reported not being listened to included those with a professional background who according to the study authors "were clearly articulate and confident". Women reacted in different ways to the perception of not being listened to and some were more assertive than others. A woman who had a "normal" vaginal birth said she was not listened to and was not provided adequate information relating to prediction of macrosomia: "*I felt who am I to tell a specialist in his field that you're wrong and I'm right. This baby is bigger than the first. But I was kept convinced no it wasn't so I just went along with it but I myself felt that there was no way it was under 9[pounds]; I was expecting it to be over 9 [pounds]. So it turned out [Baby2] was not as good an experience as [Baby1] and she turned out to be 10 pounds 12½ [ounces]*" (056/011) (p 460) Some women reported that they looked for confirmation from health professionals that their baby was macrosomic; others reported uncertainty about predicted birthweight and consequently felt unable to prepare for birth.	Methodological limitations	No or very minor concerns[1]	Low
			Relevance	Moderate concerns[2]	
			Coherence	No or very minor concerns[3]	
			Adequacy	Serious concerns[4]	

Study information		Description of review finding	CERQual assessment of the evidence		
No of studies	Design		Criteria	Level of concern	Overall assessment of confidence (overall quality)
		Another woman who had a "normal" vaginal birth said: "*Nobody had explained to me, I had asked when I was pregnant with [Baby 2] a number of times antenatally is this going to be big baby, I think this is going to be a big baby and people kept saying to me well what weight was your last one and I kept saying 9 pounds 2 [ounces] and they kept saying oh well it will be about the same, it will be about the same, but I knew I was bigger than I was with the first one because I was enormous and the baby just felt enormous*" (025/008) (p 458)			

1 *CASP: Critical Appraisal Skills Programme; CS: caesarean section*
2 *1. One study with high rating based on CASP qualitative checklist*
3 *2. Although women were selected for interview based on type of childbirth and complications (to ensure that different experiences were captured in the sample) and*
4 *recruitment stopped when data saturation was reached, the study population was white, married or cohabiting, English-speaking in 1 Health and Social Care Trust in Northern*
5 *Ireland*
6 *3. No data that contradict the review finding; no ambiguous data*
7 *4. One study that offered moderately rich data on prediction of macrosomia, and 'thin' data on feelings of not being listened to or receiving adequate information provision*
8 *during labour*

9

Appendix H – Economic evidence study selection

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

See Supplement 2 (Health economics) for details of economic evidence reviews and health economic modelling.

Appendix I – Economic evidence tables

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

See Supplement 2 (Health economics) for details of economic evidence reviews and health economic modelling.

Appendix J – Health economic evidence profiles

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

See Supplement 2 (Health economics) for details of economic evidence reviews and health economic modelling.

Appendix K – Health economic analysis

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

See Supplement 2 (Health economics) for details of economic evidence reviews and health economic modelling.

Appendix L – Research recommendations

Information provision (women at high risk of adverse outcomes for themselves and/or their babies because of obstetric complications or other reasons)

No research recommendations were made for this review.