



# A mixed-methods study of women's birthplace preferences and decisions in England

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## ABSTRACT

**Problem:** Choice has been a key aspect of maternity care policy in England since 1993, however a gap remains between the birthplaces women want and where they actually give birth.

**Background:** The latest maternity care policy in England acknowledges that women are not being given 'real choice' in their care and often being told what to do. This is problematic since unfulfilled preferences have been linked to negative childbirth experiences.

**Aim:** To understand the factors affecting women's birthplace preferences and decisions, and why these might differ.

**Methods:** A sequential mixed-methods study consisting of an online questionnaire (n=49) and follow-up interviews (n=14) with women who were either currently pregnant or had recently given birth in a metropolitan region in England.

**Findings:** Most women in this study said that they would prefer to give birth in an alongside maternity unit because it offered a compromise between the risk of poor outcomes and risk of unnecessary medicalisation. However, the majority of women's preferences were medicalised at the point of decision-making as the minimisation of clinical risk was ultimately prioritised.

**Discussion:** Women's preference for the alongside maternity unit demonstrates the growing popularity for this less medicalised, 'alternative' birthplace option. However pre-existing conditions, reproductive histories and experiential knowledge influence women's decision to give birth in the labour ward and suggests that minimising clinical risk is women's key priority.

**Conclusion:** Women navigate complex and competing discourses when forming childbirth preferences and making decisions, selectively considering different risks and knowledges to make the decisions right for them.

### Statement of Significance

#### Problem

Despite policies to improve women's choice in maternity care in England, women are not being given 'real choice' and often being told what to do.

#### What is already known?

Women's birthplace preferences and decisions are shaped by complex social, historical and medical discourses of childbirth, and experiential knowledge.

#### What this paper adds?

This paper adds nuance to our understanding of women's childbirth choices by differentiating between birthplace preferences (personal favouring) and decisions (birth plan). It also contributes to a gap in knowledge regarding women's preferences for giving

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birth in an alongside maternity unit. Childbirth discourses, experiential knowledge, knowledge of maternity services and pre-existing conditions are key factors.

## Introduction

In England, under the National Health Service (NHS), women have free access to maternity care, with four main birthplace options to choose from: labour ward, alongside maternity unit (AMU), freestanding midwifery unit (FMU) and home birth (see Table 1). These birthplaces sit along a spectrum of medicalisation with different interventions and options available in each setting. The labour ward sits at the medicalised end and home birth at the demedicalised end.

‘Choice’ has been a key concept in NHS England’s maternity care service since the publication of the *Changing Childbirth* policy in 1993, produced in response to concerns about the NHS’s increasingly (bio) medical approach to birth [1]. The policy’s key message was summed up with the ‘three C’s’ of childbirth – choice, continuity, and control. However without the resources to support implementation, the *Changing Childbirth* policy is largely considered to have had a profound effect on the rhetoric of birth, but little impact on practice [2].

In 2007, the policy imperative for choice was reiterated in NHS England’s next maternity care policy, *Maternity Matters*, in which it was promised that by 2009 all women would have four national choice guarantees: (i) choice of how to access maternity care, (ii) choice of type of antenatal care, (iii) choice of place of birth, (iv) choice of place of postnatal care [3]. However an investigation by a UK charity, the National Childbirth Trust, found that by 2009 only 4.2% of women were given the full range of choices about where to give birth; and just 51% of women felt that they had enough information to make these choices [4].

In NHS England’s next and most recent maternity care policy, *Better Births* (2016), it was stated that “many women are not being offered real choice in the services they can access, and are too often being told what to do, rather than being given information to make their own decisions” [p.3] [5]. The importance of choice and control for women has been further reiterated in the NHS’ 2019 Long Term Plan and 2021 Personalised Care and Support Planning Guidance for local maternity systems [6,7]. The latter of these documents sets out the role of ‘personalised care and support plans’ as a tool to facilitate conversations about childbirth choices between women and maternity care professionals throughout the maternity journey, as well as documenting women’s personal preferences, values, circumstances and experiences [6]. This process might be started during the first maternity

**Table 1**  
NHS Birthplace settings.

NHS birthplace setting	Description
Labour ward (obstetric unit/delivery suite):	Located in a hospital with medical facilities and all forms of pharmacological pain relief available. Staffed by NHS midwives, obstetricians and other specialists.
Alongside Maternity Unit (AMU):	A birth centre/maternity unit located on the same site as a labour ward (and thus hospital). Led by NHS midwives with limited access to pharmacological pain relief. The focus is on birth without medical intervention.
Freestanding Midwifery Unit (FMU):	A birth centre/maternity unit on a community site separate to a labour ward and/or hospital. Led by NHS midwives with limited access to pharmacological pain relief. The focus is on birth without medical intervention.
Home birth:	Women are supported by an NHS midwife to give birth in their own home. For pain relief, gas and air can be brought by the midwife or Tens (transcutaneous electrical nerve stimulation) machines are commonly used.

appointment, which usually takes place with a midwife.

Place of birth is a key choice for women because *where* a woman gives birth will likely affect *how* she gives birth. As Table 1 shows, each birthplace offers something different so it is important that women choose a birthplace setting which caters to both their preferences and medical needs. Furthermore, actively taking part in this decision-making process and having control over the childbirth experience has been found to improve satisfaction, reduce negative effects on postpartum mental health, influence maternal bonding and shape future reproductive decisions [8–10].

The data in *Better Births* showed that 49% of women preferred to give birth in an AMU but only 9% actually did so, and whilst only 25% of women would choose to give birth in a labour ward, 87% of women did so [5]. This highlights a gap between the birthplaces women prefer/choose and where they actually give birth. Whilst there is little explanation in *Better Births* as to why the gap exists, it is acknowledged that women often lack choice in maternity care and that birth is becoming increasingly complex as more women give birth later in life and conditions such as diabetes, which can increase the risk of complications arising, become more common [5,11].

Women’s birthplace preferences are often shaped by a number of factors. They might be based in social, cultural, historical and medical discourses which are disseminated through friends, family, antenatal classes and the media, which can normalise some birthplace options whilst making others seem ‘risky’ or ‘alternative’ [12–19]. In addition, the moral and complicated nature of ‘good’ motherhood discourses can influence women’s choices as they strive to make the ‘right’ decisions for both themselves and the fetus, whilst simultaneously avoiding blame and guilt [8,15,16,20,21]. Information from healthcare professionals can also affect women’s childbirth choices, as they themselves may be influenced by different ideologies and knowledges of birth, workplace environments and perceptions of risk [22–24].

Experiential knowledge of birth has also been found to be an important factor since women who have a positive experience in their first birth often wish to repeat the same choice, whilst those who have a negative first experience typically desire something different next time [25,26]. This pattern seems to be the case for those who previously gave birth in labour wards [18], FMUs [27] and home births [28]. However, a meta-synthesis by Coxon et al. (2017) concluded that more research was needed on women’s reasons for preferring the AMU [15]. Research on birth centres generally (AMUs and FMUs) suggests that the woman-midwife relationship, personal sense of agency, belief in the body’s ability to give birth and unique environment were all key drivers for birth centres [29–31].

This paper aims to explore women’s birthplace preferences and decisions in England following the renewed commitment to choice made in the *Better Births* [5] policy. It contributes to the call for more research on women’s preference for the AMU and adds nuance to understandings of how birthplace preferences and decisions might differ.

## Participants, ethics and methods

In this paper, women’s antenatal birthplace choices are split into two stages: *preferences* (a woman’s personal favouring) and *decisions* (the birth plan made with a maternity care professional). Exploring choice in this way highlights the nuance and complexity of the decision-making process and enables the participation of pregnant women who were still in the midst of this process, as well as postnatal women who could reflect on their experience.

A mixed-methods sequential design was chosen for the study consisting of an online questionnaire and follow-up interviews. Ethical approval was granted by the National Health Service (NHS) Research Ethics Committee and Health Research Authority (18/WM/0149) in July 2018. Data collection occurred August 2018–February 2019. Throughout the research process, the research team reflected on their situated knowledges and positionalities at regular meetings.

### Online questionnaires

The purpose of the online questionnaire was to ask pregnant and postnatal women about their birthplace choices as a trajectory throughout their maternity journey, ascertain their knowledge of the *Better Births* policy, and collect demographic data. The questionnaire was originally designed around the four birthplace options in [Table 1](#) however, after piloting caesarean (the birthplace being ‘theatre’) was also included. Example questions from the online questionnaire are provided in [Box 1](#) (it is worth noting that these questions were for the postnatal participants and the wording was tweaked for pregnant participants).

Women who were currently pregnant or postnatal (given birth within the last 6 months) were recruited across a large and ethnically diverse metropolitan area in England. Recruitment leaflets containing study information and a link to the online questionnaire were distributed by an NHS midwife as well as via private maternity/parenting groups and networks. Posters were put up in community centres and an advert was placed on a local parenting website.

SPSS was used to calculate descriptive statistics and Microsoft Excel was used to explore patterns of medicalisation or de-medicalisation in women’s maternity choices.

### Follow-up interviews

At the end of the questionnaire, participants were asked to supply their contact details if they were interested in taking part in a follow up face-to-face interview to explore their choices and experiences in more depth. Interviews were audio recorded and transcribed with identifiers removed and pseudonyms assigned. Those who took part in an interview received a £10 shopping voucher in appreciation of their time and contribution.

The interview transcripts were imported into Nvivo11 and Braun and Clarke’s [\[32\]](#) six-phase approach to thematic analysis adopted: (i) becoming familiar with the data (by reading and rereading transcripts), (ii) generating initial codes, (iii) searching for themes, (iv) reviewing themes, (v) defining themes, (vi) writing up findings. To begin with codes were largely descriptive and themes were developed by identifying concepts that cut across codes. This process was facilitated by regular discussion, review and refinement during team meetings. The themes included here were frequently coded in the dataset. Rather than being a linear process, data analysis (influenced by a feminist methodology [\[33\]](#)) was an iterative process in which previous understandings of the topic (specifically around choice, power and risk) were drawn on to advance the analysis. Where possible the quantitative and qualitative data was analysed together to tell a story of individual women’s maternity journeys.

### Findings

This paper draws on quantitative data of women’s birthplace *preferences* (personal favouring) and *decisions* (birth plan made with a maternity care professional), in addition to qualitative data exploring the reasons behind these preferences, as well as how and why women’s birthplace decisions might differ from their preferences.

### Sample characteristics

Forty-nine women who were currently pregnant (n=38) or postnatal (n=11) participated in the online questionnaire about their birthplace choices. The participants who took part in the online questionnaire represented the ethnic diversity of study area (see [Table 2](#)).

From the online questionnaire sample, 33 women volunteered to take part in a follow-up interview which resulted in 14 semi-structured interviews taking place (pregnant n=4, postnatal n=10). Five women were first time mothers and nine were second time mothers. The

**Table 2**  
Participant demographic characteristics.

		Questionnaire		Interview	
		No. of ppts	%	No. of ppts	%
Age	20–24	3	6.1	0	0
	25–29	12	24.5	4	28.6
	30–34	19	38.8	5	35.7
	35–39	13	26.5	5	35.7
	40–44	2	4.1	0	0
Ethnicity	Asian	9	18.4	0	0
	Black	3	6.1	0	0
	Mixed/Multiple Ethnic Group	1	2.0	1	7.1
	White	35	71.4	12	85.7
Disability	Other	1	2.0	1	7.1
	Yes	2	4.1	1	7.1
Highest educational attainment	No	47	95.9	13	92.9
	No formal schooling completed	0	0	0	0
Highest educational attainment	Secondary education e.g. GCSEs (General Certificate of Secondary Education)	8	16.3	1	7.1
	Further education e.g. A-levels (Advanced level qualifications)	5	10.2	0	0
	Vocational training	3	6.1	0	0
	Undergraduate degree (e.g. BA/BSc)	18	36.7	7	50.0
	Postgraduate degree (e.g. MA/MSc, PhD, MD etc.)	15	30.6	6	42.8
	Total	49	100	14	100

#### Box 1

Example questions included in the online questionnaire.

#### Postnatal women

1. What date did you give birth? [DD/MM/YYYY]
2. Where did you give birth? [NHS Site A, B, C, D, Home Birth, Other]
3. What type of birth did you have? [Caesarean, Labour Ward (with doctors and midwives), Birth Centre (midwife-led), Home Birth (with NHS midwife), Home Birth (with private midwife/doula), Other]
4. Was the location and type of birth you had the same as the birth you would have chosen? [Y / N]
  - a. If the location was different, where would you have preferred to give birth? [NHS Site A, B, C, D, Home Birth, Other, N/A]
  - b. If the type of birth was different, what type of birth would you have preferred? [Caesarean, Labour Ward (with doctors and midwives), Birth Centre (midwife-led), Home Birth (with NHS midwife), Home Birth (with private midwife/ doula), Other, N/A]

interviews lasted on average 51 minutes. Unfortunately, the diversity of the online questionnaire sample did not translate to the follow-up interview. A smaller number of women from ethnically diverse backgrounds volunteered for a follow-up interview, and this decreased further in the number of actual interviews which took place (White English/Welsh/Scottish/Northern Irish  $n=12$ , Mixed/Multiple Ethnic Group  $n=1$ , Other Ethnic Group  $n=1$ ) (Table 2).

### Preference for the AMU

The data showed that 49% of women in the sample wanted to give birth in an AMU (a midwife-led unit attached to a hospital), making it the most popular birthplace preference in this dataset (Table 3). We developed two main narratives through our analysis which explain women's preferences for the AMU. The first is the 'just in case' narrative, where women are trying to balance choice with medical risk, and the second is the AMU as a 'holistic' experience, where women focussed on satisfaction and personalisation through choice.

#### The AMU 'just in case'

Many of the participants in this narrative focussed on managing uncertainty in birth and they framed their preference (and sometimes decision) for the AMU as a precautionary approach 'just in case' something went wrong.

[...] the fact that if anything's happening you can switch very quickly because they [AMU at NHS Site B] are very close to hospital, they're pretty much in the same place, so if anything happens, if there's an emergency they can take you straight up [...] so yeh the equipment they have as well means they're really prepared. – Minnie, 37, pregnant woman, second child

I'm also very lucky to live very much within a catchment area of [NHS Site B] so the thought of, do I go to [NHS Site E] for example where there's a lovely midwife-led birthing centre or [NHS Site B], didn't really cross my mind because I could literally walk in labour to [NHS Site B] had I chosen to \*laughter\*. Um and I knew that they'd have all of the specialist care there had something gone wrong with him. – Natasha, 34, postnatal woman, second child

These women, like others interviewed, spoke about the AMU as giving them access to specialist care and singled out NHS Site B (a hospital with a labour ward and AMU) in particular. As such, women attempted to reduce the uncertainty of birth by increasing their proximity to the labour ward. This provided them with reassurance and may also help them maintain their 'good' motherhood as their decision did not stray too far from the commonly held belief that the labour ward is the safest place to give birth, should they need to justify their decision for the AMU (an 'alternative' birthplace) to others. This was illustrated by the language used by some women. For example, Natasha's birthplace preference and decision was the AMU, suggesting that her pregnancy was considered medically uncomplicated and safe to take place there. Despite this medical assurance, she focusses on potential risk to "him" (assigning personhood to the fetus), but not herself, suggesting an internalisation of discourses which present childbirth as risky and a self-sacrificing display of 'good' motherhood which prioritises the perceived

**Table 3**  
Women's birthplace preferences and decisions.

Birthplace	Preference	Decision
AMU	49%	29%
FMU	2%	2%
Labour ward	20%	45%
Theatre (caesarean)	14%	10%
Home birth	12%	4%
Other	2%	-
Undecided	-	10%

needs of the fetus [19]. This illustrates how women can view the state of their pregnancy and/or labour as separate from the health of the fetus/baby with its own needs, separate to those of the mother.

The data here highlights how women do not just assess their preferred place of birth in isolation but consider it as part of the wider maternity system in which they are based and their knowledge of how services and birthplace options work together (i.e. ease of transfer from one birthplace setting to another). This complex process illustrates the unique nature of choice in maternity care where women are making decisions for themselves and their baby, intensifying the sense of personal responsibility.

#### The AMU as a holistic experience

The women quoted in this section, though conscious of safety, typically considered childbirth to be a normal physiological event, rather than a medical one. This difference in emphasis to those above meant that they described their preference for the AMU in a more 'holistic' manner, identifying various features of the AMU – in contrast of other birthplace settings – that were perceived as advantageous to maternal satisfaction as well as safety.

I was like really keen to avoid any medical intervention this time because I had a lot of medical stuff and like things following the birth last time. So that probably influenced my wish to be on the birth centre [AMU] rather than labour ward because I didn't want kind of ongoing medical things happening to my body. – Jane, 33, postnatal woman, second child

A difficult previous birth experience can affect women's approaches to subsequent births in different ways. In the previous section, Minnie's difficult first birth meant that she was reassured by the AMU's proximity to the labour ward and the medical equipment on hand. However Jane, quoted here, found reminders of the interventions she experienced in her first birth distressing and described the experience as "traumatic". Thus for her second birth she wanted to be in an AMU because she believed that the approach typically adopted in these units would reduce the risk of unwanted interventions and enable her to retain more control and bodily autonomy compared to a labour ward.

Other women also valued the AMU as distinct from the medical model of birth typically associated with labour wards and obstetric-led care:

I know midwives are very, very good at their jobs and I don't need a doctor to do it really. [...] I wanted it to be very much a home-from-home experience but equally have the... if anything was to go wrong I could be whisked around the corner to the delivery suite rather than being at home and having to get an ambulance and going into hospital that way. [...] I'm hoping for a water birth [...] they offer things like aromatherapy, massage and some of the midwives are also trained in reflexology. I came out feeling like I was going to have a spa experience not give birth! – Jessie, 27, pregnant woman, first child

Later on in the interview, when explaining why she had disregarded a home birth, Jessie said, "I would feel incredibly guilty if anything should happen, that I'm in the right place". Evidently, she was concerned about being accountable if complications arose, especially if she had decided to give birth in an 'alternative' birthplace setting, such as at home. Thus, Jessie's account highlights how the two narratives proposed here are not mutually exclusive. Indeed, for many of the women interviewed the AMU offered a place of compromise where women felt safe from both the (bio)medical risks of childbirth as well as the risk of unnecessary medical interventions.

#### Deciding on the labour ward

Table 3 shows that 49% of women preferred to give birth in the AMU, but that just 29% of women decided on this birthplace option. In



contrast, only 20% of women said that they would *prefer* to give birth in a labour ward, and yet 45% of women *decided* to give birth there. This section considers decision-making power when exploring the accounts of women whose birthplace *preference* was the AMU, but whose *decision* was the labour ward.

[...] because first child had a stroke straight after she was born [...] I'm considering caesarean this time. [...] if everything goes well, you know if I dilate properly and everything's fine I'll just do it naturally because it's better for the mother, it's better for the baby, it makes more sense to do it naturally. But obviously if things go wrong then we'll just go to the ward [...] The problem with birth plans is that you make them [...] and they never go according to the plan. – Minnie, 37, pregnant woman, second child

Here, Minnie (also quoted in the previous section) is torn between different childbirth options of varying degrees of medicalisation as a result her previous childbirth experience and personal preferences. In her desire to do what is 'right' for her baby she is prepared to have a medicalised birth in the form of a caesarean, but also references moralising discourses which associate 'natural' birth as 'good'. This demonstrates how fluid women's preferences and priorities can be depending on the circumstances they are faced with at the time. Indeed, it seems that Minnie's main approach to managing uncertainty in birth is to remain open to all possible options.

Zoe also associated 'natural' (by which she meant vaginal) with a 'good' and authentic childbirth experience:

[...] because my [first] son was born via emergency caesarean, I never actually got the chance to give birth and I sort of feel like I missed out. [...] I still went through the VBAC [vaginal birth after caesarean] pathway and had someone to talk to about um giving birth natural but no [...] I thought, oh I'd like to have water birth, that looks quite relaxing but she [midwife] said because I had the emergency caesarean before they needed to monitor the baby and they needed to monitor my scar as well. So she said no. She said it was a normal labour or nothing really. – Zoe, 36, postnatal woman, second child

When speaking about her previous caesarean Zoe said, "I felt like I'd let my son down." This demonstrated how women's birth experiences can shape their identities (as 'good' or 'bad' mothers), childbirth ideologies and future childbirth decisions as Zoe sought to correct the failings she perceived in her first birth, with her second birth. Experiential knowledge of previous births emerged as an important factor for all the women who said that they would prefer to give birth in an AMU but decided to give birth in a labour ward. For example, Magda reflected on how her birthplace preferences prior to giving birth had been altered by the experience of labour:

I'm quite a high risk, so I'm a Type I diabetic and um, so I had to have my labour induced [...] I was never going to be able to access any of these, sort of, you know, spa-like birth centres and things like that [...] prior to the birth I had been to see the then consultant um, midwife or chief midwife, um to talk about whether there was any way we could facilitate a water birth because that's something I'd always wanted, you know thinking ahead to when I might have children. But it just wasn't feasible in terms of the other things that I needed. [...] Having said that, I've been through birth twice now, I've had an epidural twice so, \*laughter\* whether I would have stayed in a birth centre or whether I would have gone somewhere else to have sort of better pain relief, I don't know. – Magda, 38, postnatal woman, second child

Although Magda and Zoe reference conversations with midwives about their birthplace preferences it is not clear if they had the "real choice" promised in *Better Births* as it seems that they perceived that their midwives ultimately held the decision-making power [5]. In contrast another women, Charlotte (27, pregnant woman, second child),

who had preeclampsia was advised by her doctor to give birth in the labour ward although her own preference was to give birth at home due to a particularly bad needle-phobia. In the end, they compromised on the AMU, "it will be kind of a halfway house really, so if we can't have the home birth that's the next best thing" in a display of shared decision-making. Of course, Magda and Zoe may not have felt that pursuing their preference for water births in the AMU was worth the potential clinical risks.

The women in this section all referenced the features and childbirth ideology of the AMU when explaining why this was their birthplace preference, drawing on 'The AMU as a holistic experience' narrative described above. Whilst only Magda explicitly referred to her 'high-risk' status, we may deduce that all three women in this section would be categorised as such because of their previous birth experiences or pre-existing health conditions, as well as their age, steering them towards obstetric-led care in a labour ward.

## Discussion

When measuring women's choices around birth, typically two points in the maternity experience are recorded and compared: what a woman wanted antenatally, and where she actually gave birth. However since it is acknowledged in the *Better Births* policy that women are "often being told what to do", [p.3] [5] the focus of this paper was to understand how women's personal preferences might differ to the decisions (i.e. birth plans) they make with maternity care professionals. This is important because research has shown that unfulfilled birth preferences can lead to lower maternal satisfaction and even trauma [34–36].

The quantitative data collected in this study (and in *Better Births* [5]) showed that the majority of women *preferred* to give birth in the AMU. Qualitative data illuminated that the popularity of the AMU was as a result of its ability to offer women a compromise between low-intervention care and close proximity to specialist care if needed. Indeed, the unique positionality of the AMU helps to mitigate women's concerns that something might go wrong in birth, their sense of responsibility to minimise risk and desire to avoid blame or guilt. As Lupton notes, "guilt is an emotion intimately linked to morality: having 'done wrong' in some way, or flouted a social convention" [p648-9] [21] such as choosing a 'risky' or 'alternative' birthplace. This chimes with previous research that AMUs offer 'the best of both worlds' [31,37], and suggests that the AMU is becoming a more mainstream, less 'alternative', birthplace [18].

One reason for the change in women's birthplace preferences might be the revision of guidelines from the National Institute for Health and Care Excellence in England in 2014. This revision required healthcare professionals to inform low-risk women that giving birth in a midwifery-led birth centre (AMU or FMU) or at-home was associated with a lower rate of intervention and comparable outcomes for the baby as in a labour ward (in 2023 this guideline was amended to highlight that for nulliparous women home birth presented a small increased risk for the baby) [38]. As such, these birthplace options started actively being offered to eligible women, perhaps increasing knowledge and awareness, as well as normalising them as viable birthplace options.

In understanding women's preference for the AMU, their previous birth experiences, reproductive histories and knowledge of maternity services (for example the ability to transfer between birthplace settings) were key factors. However as women tried to balance the risk of complications and poor outcomes with the risk of medicalisation, it appeared to be their experiential knowledge of birth which was the determining factor [25,26]. This highlights the importance of maternity care professionals understanding the reasons behind women's birthplace preferences and decisions in order to support choice and personalised care.

Despite the growing popularity of the AMU as a birthplace preference, the data showed that the majority of women decided to give birth in the labour ward. This was in line with a wider pattern of

medicalisation in the data as women progressed from birthplace preferences to decisions. When making sense of this change, between preferences and decisions, some women reframed their perspective as being open to all potential options, an approach which might help to avoid disappointment if birth preferences are ultimately unmet [10].

Previous research by Coxon et al. (2014) stated that discourses of risk, blame and responsibility had situated the labour ward so firmly as the dominant choice for women in England that change was “unlikely to be rapid or even to occur within a generation” [p.65] [16]. Indeed as the qualitative data here show, even those who had uncomplicated pregnancies suitable for the AMU had internalised discourses of risky childbirth and ‘good’ motherhood which meant that they struggled to imagine that their births would be uncomplicated until they were over. Research has found that midwives also struggle with an “ever-narrowing window of normality” in childbirth, [p.207] [23] begging the question if one party influences the other, or whether this precautionary approach to birth has simply become commonplace in England. When considering this latter point, it is worth noting the wider context of maternity care in England which has, in recent years, seen numerous high-profile maternity care scandals resulting in Government inquiries [39,40] into the running of maternity services at various sites across the country. In this context, where worst case scenarios are at the fore, it is perhaps not surprising that women and professionals would adopt a precautionary approach to the risks involved in pregnancy and birth.

When it came to deciding on the labour ward, women continued to draw on the narratives characterising women’s preference for the AMU. They privileged ‘natural’ approaches to birth and favoured the features of the AMU, such as water birth, but were concerned about the possibility of poor outcomes. For these women, experiential knowledge of birth was important but ultimately it was pre-existing medical conditions or complications from previous pregnancies (and perhaps by extension their ‘risk-status’) which became the deciding factor. This is in line with ‘good’ motherhood discourses which often focus on the minimisation of risk over personal preferences [20,21]. Nevertheless, for those whose birthplace decisions or actual births differ from their preferences, it is worth considering if the “real choice” and personalised care described in the *Better Births* policy has been provided in practice.

### Strengths and limitations

Although a small sample size is not automatically a limitation in qualitative research, and indeed the data provided valuable insights, caution may be applied when generalising these findings to the wider maternity care system and population, even though the richness could be transferable. Whilst the questionnaire sample was ethnically diverse, a limitation is that this diversity did not carry through to the interview sample which consisted of predominantly white, middle-class women. Research has suggested that barriers to achieving diverse samples can include language barriers, sociocultural factors, a negative attitude towards research/researchers, as well as practical issues for both the researcher and the participant (e.g. costs of travelling or hiring interpreters) [41]. It was hoped that an online questionnaire would help to mitigate some of these factors as participants could complete the questionnaire in their own time and were not required to travel or interact with anyone. Indeed it is a positive that the online questionnaire facilitated some degree of inclusion, which may have not been the case if only interviews had been used. Although the parity of interview participants was collected, this was not the case in the questionnaire and a limitation of this study is that the quantitative data cannot be analysed in relation to this.

During the interviews, a few participants asked the lead researcher (GC) if she had given birth herself or was medically trained. The answer to both of these questions was no, although another member of the research team had given birth. It could be considered a strength of the research that participants responded by adding more explanation to their answers rather than assuming prior knowledge. This also

highlights how researcher characteristics can affect the research process [42].

### Conclusion

This study found that the majority of women sampled here would prefer to give birth in an AMU, but when it came to making decisions in the form of a birth plan the majority settled on a labour ward birth. This lack of congruence could have implications for women’s childbirth satisfaction and as such it is important that maternity care professionals understand women’s birthplace preferences and the reasons behind them and work with women to try and achieve this as safely as possible. This might include if or how elements of the AMU could be incorporated into women’s labour ward births in order to personalise care and facilitate the kind of birth experience they had hoped for.

This paper shows that throughout the formation of birthplace preferences and decisions women are constantly trying to navigate complex and sometimes competing discourses: childbirth as a medical event and as a normal physiological event; the potential for complications and poor outcomes; the possibility of unwanted or unnecessary interventions; women’s personal preferences; the needs of the fetus; the association of ‘natural’ birth with ‘good’ motherhood, and medically mediated birth as ‘safe’. However, the women interviewed here did not simply accept or reject these complex and often competing discourses of birth but rather selectively considered risks most pertinent to them. This research found that women’s birthplace preferences were fluid and could be reconciled in unique and complex ways, drawing on a range of knowledges to respond to the situation they were in.

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### Ethical Statement

Ethics committee: National Health Service (NHS) Solihull Research Ethics Committee and Health Research Authority.

Approval number: 18/WM/0149.

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### CRediT authorship contribution statement

**Georgia Clancy:** Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Project administration, Funding acquisition. **Felicity Boardman:** Supervision, Formal analysis, Writing – review & editing. **Sophie Rees:** Supervision, Formal analysis, Writing – review & editing.

### Declaration of Competing Interest

We confirm that there are no conflicts of interest, the work is original and has not been published elsewhere, nor is it currently under consideration for publication elsewhere.

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