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Abstract

Introduction Women consider factors including safety and the psychological impact of their chosen location when deciding whether to give birth in hospital or at home. The same is true for women with high risk pregnancies who may plan homebirths against medical advice. This study investigated women's decision making during high risk pregnancies. Half the participants were planning hospital births and half were planning homebirths.

Methods: A qualitative study using semi-structured interviews set in a hospital maternity department in the United Kingdom. Twenty-six participants with high risk pregnancies, at least 32 weeks pregnant. Results were analysed using systematic thematic analysis.

Results: Three themes emerged: perceptions of birth at home and hospital; beliefs about how birth should be; and the decision process. Both groups were concerned about safety but they expressed different concerns. Women drew psychological comfort from their chosen birth location. Women planning homebirths displayed faith in the natural birth process and stressed the quality of the birth experience. Women planning hospital births believed the access to medical care outweighed their misgivings about the physical environment.

Discussion: Although women from both groups expressed similar concerns about safety they reached different decisions about how these should be addressed regarding birth location. These differences may be related to beliefs about the birth process. Commitment to their decisions may have helped reduce cognitive stress.

Introduction

Where to give birth is one of the key decisions women face in pregnancy. Women planning vaginal births must weigh up their options and choose between birth at home, in a hospital obstetric unit, or, where available, at alongside or freestanding midwifery units. They will usually discuss this decision with the healthcare professionals responsible for their care. How women reach the decision on where to give birth is therefore of interest to any professionals working with pregnant women and those who plan and commission maternity services.

Perceived safety of the chosen location is a major factor when deciding on place of birth [1]. Not all women believe hospital is the safest birth environment. Higher rates of intervention in hospital can be perceived as increasing risk in uncomplicated pregnancy, and this holds even when the pregnancy is already complicated by medical or obstetric factors [2]. Conversely, other women may perceive hospital as the safer option in case of complications in the birth process requiring medical intervention [3]. Thus perceptions of risk and safety vary in pregnancy and there is evidence that healthcare professionals and pregnant women assess risk differently [4].

Individuals construct their perceptions of risk from meanings and impressions formed over the course of time [5] but the definition and assessment of risk also functions at a societal level. Pregnancy has typically been viewed in Western society as conferring a special but vulnerable status upon women so that they require additional monitoring and intervention [6]. However, in a contemporary context, characterised by increased levels of individualisation, the concept of risk has become linked with that of blame; individuals may have more freedom to define their roles and behaviours than in previous times, but they are also held more responsible for the consequences of doing so [6]. Thus pregnant women who

are considered to have contributed to their own degree of risk, for example by choosing to give birth in a location which is not medically sanctioned, are considered to be stepping outside societal norms and therefore worthy of censure [7].

Women also consider the psychological impact of their birth location. For some women, the perceived safety of a hospital setting increases security [3]. However women who plan homebirths cite the enhanced feeling of control this provides as a major factor in their decision [8]. How women experience giving birth is influenced by their individual expectations and beliefs about birth [9]. It is therefore likely women will want different things from the experience reflecting these various ideas. Unsatisfying birth experiences are associated with postpartum depression [10].

The concept of sharing decisions regarding care between patients and professionals is now central to most spheres of healthcare [11]. However, Cheyney (2008) questions whether women's input into decisions about birth is truly respected by professionals [12]. She suggests women who choose homebirths are constructing a new woman-centred narrative of childbirth which moves away from the traditional medical definition of birth as risky and in need of medical management.

The aim of this paper is to examine decisions regarding place of birth among a group of women with high-risk pregnancies, half planning to give birth in a hospital obstetric unit and half at home, despite medical advice to the contrary. The intention was to consider differences and similarities between the groups in the factors they considered and emphases they placed on these when deciding on place of birth.

Methods

This paper forms part of a qualitative study using semi-structured interviews to examine risk perception and decision making processes in women with high risk pregnancies

booked to give birth at home or in a hospital obstetric unit. This paper reports the analysis and results of the factors women took into account when deciding where to give birth. Findings on women's risk perception including the degree of risk they believed they faced, the psychological impact this had during the pregnancy, and the coping strategies they employed, are reported elsewhere [13]. Ethics approval for the study was obtained from the North Tyneside II Research Ethics Committee.

The study was conducted in the United Kingdom. Women were recruited via the maternity department of a National Health Service hospital. The department is broadly supportive of homebirths and the area has a homebirth rate higher than the national average. The local area does not have an alongside or freestanding midwifery unit; the nearest (freestanding) is approximately 25 miles away. Women were eligible to participate if they were pregnant and had a medical or obstetric condition which meant their pregnancy was at higher risk. Conditions defined as high risk included any that could potentially have an impact on the pregnancy and required referral to an obstetrician. Written consent to participate was obtained from all women.

Purposive sampling was used to recruit women planning to give birth at home. All potential participants were initially told about the study by their obstetrician or midwife when discussing their birth choices. Permission was requested to pass their details to the first author who then contacted them directly. Women planning to give birth in hospital, who were part of a larger population, were recruited randomly during antenatal clinics and were approached directly by the first author. Seventeen women planning hospital births were approached to participate in the study and 14 women planning homebirths. Thirteen women from each group agreed to participate. Details of participants' medical and obstetric conditions and demographic data are reported in Table 1. Women's conditions varied across the groups but all meant women fell within clinical categories advised to give birth in

hospital. Maternity care at the time of the study was provided in accordance with NICE guidelines [14]

The interviews took place between April 2012 and November 2013. They were carried out in a location of participants' choosing; usually their homes but also local cafes or private areas at the hospital or their workplace. Interviews were conducted from 32 weeks of pregnancy onwards. They lasted between 20 minutes and 1 hour forty minutes and were digitally recorded. The researcher made notes after the interviews regarding her impressions of the process and as an aid to reflexivity. The interview schedule consisted of open-ended questions to explore (i) how women perceived their chosen place of birth and (ii) how they perceived the other location and whether they had considered this as a possible birth location (Table 2). The interviewer had the freedom to follow lines of enquiry introduced by women. Data collection ended when no new information or themes seemed to be arising from a number of consecutive interviews (i.e. perceived data saturation was achieved).

The interviews were carried out by the first author, an experienced midwife, under the supervision of the second author, a psychologist with extensive experience of peripartum research. The study team was aware the interviewer's status as a midwife could influence the research and a process of reflexivity was undertaken to mitigate this [15]. This involved reflection on the part of the interviewer before and after the interviews and regular discussion within the team on the potential impact of her values, perceptions and identity as a midwife on the interview process. Women were aware the interviewer was a midwife connected with the hospital but she was not involved with any participant's healthcare. Participants were reassured about confidentiality and encouraged to be open regarding their thoughts and feelings about their healthcare. There was also a possibility that by asking questions about risk in pregnancy, the interviewer could potentially increase participants' anxiety regarding the subject or have made them think about their pregnancies in terms of increased risk [16].

Participants were all aware they had medical or obstetric conditions which could affect their pregnancies. This was ascertained at the beginning of the interviews.

Inductive thematic analysis was used to analyse the transcripts [17]. This is a systematic approach to identifying, describing and analysing themes and patterns within data. Thematic analysis is useful for developing rich and vivid descriptions of participants' experiences [18] which ensure their views remain at the centre of the study. An inductive, i.e. data-driven, approach was chosen as it facilitates an intricate understanding of the data and is highly sensitive to the context in which the data occurs. By remaining focussed on the data, it also reduces the likelihood of the introduction of contaminating factors via intermediaries [19].

The interviews were transcribed by the researcher and anonymised. Transcripts were read several times to ensure familiarity with the data. Initial codes arising from the data were identified. These were refined and organised into potential themes. Initial codes included beliefs about the physical surrounding of each location and their potential psychological impact, the perceived implication for care at each location, and safety considerations. These eventually became the theme 'perception of birth at home and in hospital'. The codes concerning ideas about and plans for birth became the theme 'beliefs about how birth should be'. Codes related to decision making, weighing up the risks and benefits of locations and the possibility of considering giving birth in an alternative location were amalgamated into the theme 'the decision process'. The themes were reviewed in relation to the codes and the original data to ensure theoretical connectedness [18] and finally were named and defined. The study team discussed each stage of the process to ensure there was a consensus regarding the themes and their supporting data. NVivo 10 was used to organise the data.

Findings

Three similar themes arose in both groups of women concerning the choice of place of birth. These were: perceptions of birth at home and hospital; beliefs about how birth should be; and the decision process. Similarities or differences between the groups are discussed within each theme. Direct quotes supporting the themes are provided, coded (Home1-13 and Hospital1-13) to maintain confidentiality.

Perceptions of birth at home and hospital

Safety was the major consideration for all women when thinking about birth at home or in hospital. This was conceptualised in various ways: rapid access to medical care versus iatrogenic risk; emotional safety; and perception of the care they would receive in each location.

Those planning to give birth in hospital perceived this as the safest place in case of problems during the birth. This concern took precedence over all others: *"my decision making will one hundred per cent come down to the safety aspect"* (Hospital7). The ready availability of medical support in the hospital was cited as a source of safety: *"having the medical team around me, if anything was to go wrong then they're there at hand to help"* (Hospital1). Women planning homebirths were also concerned about safety but interpreted it in more diverse ways. Planning a homebirth was seen as a safer option because there was an increased likelihood of labour progressing smoothly and less risk of medical intervention. There was general agreement that if serious problems occurred at home the women would agree to be transferred to hospital. While it was acknowledged this transfer could cause a delay in treatment, other factors were felt to mitigate this: *"with the care of having a one to one midwife at home… it's probably more likely to be picked up early and have time to go to the hospital"* (Home11).

Both groups also spoke about the psychological impact of their birth locations and how the locations could facilitate feelings of emotional safety. Women spoke in positive terms about their choices: *"I think you just have everything you need that's familiar around you. I think that really helps with the whole birthing process… for things to happen in a natural way"* (Home6); *"I think I sit more into the hospital part because I'd worry. And I'd rather feel relaxed to give birth"* (Hospital13). Thus being in one's preferred location was seen a source of comfort and reassurance and important for the labour process, whichever location was chosen. Women planning homebirths frequently mentioned feeling more in control at home. They believed being in their own surroundings gave them more confidence to take an active role in their care: *"I think I feel more in control actually… it's your space so it feels like it's your choice"* (Home6).

Women believed their chosen location would have an impact on the care they received. Women planning homebirths perceived hospital care to be more routine and policy driven: *"there's a clock ticking and there's a time frame and the protocols are a little bit more rigid"* (Home3). They also believed the care had safety implications: *"I sort of feel you're on your own quite a lot cos obviously the midwife is looking after lots of other people"* (Home2). Women planning hospital births described their belief that hospital care could improve safety: *"you've got more support at the hospital with a midwife there and I know at home you don't have midwife there until much later"* (Hospital13).

Other factors discussed in reference to the choice of birth location included the perception of the physical surroundings of home and hospital. Women across the groups described the hospital environment in negative terms. It was regarded as clinical and lacking privacy. They believed it was dirty and presented an infection risk: *"The infection rates are higher than being at home"* (Hospital8). In addition, women planning homebirths valued the familiarity of their home surroundings: *"You can't really take your duvet and all the food*

that you like… you can't necessarily bundle all of that into hospital" (Home12). Women planning hospital births agreed home surroundings could offer more physical comforts but expressed concerns about the mess created by a homebirth and worried about their neighbours overhearing them during labour: *"I live in a flat and the acoustic separation isn't brilliant"* (Hospital5); *"I'd kind of like to do my nesting, leave it all clean and tidy and come away and do the messy bit elsewhere and then go back to it"* (Hospital7). Women planning to give birth at home mentioned these issues but were less concerned by them: *"Even in my tiny terraced house where I gave birth to my two children, the neighbours didn't hear anything at all"* (Home5); *"[My partner] was the one who was having to [tidy up afterwards] himself, which he wasn't too happy about but it was like it's ours, no one else is gonna do it"* (Home8).

Beliefs about how birth should be

This theme refers to women's beliefs about the nature of childbirth and what they hoped for from their own births. There were differences between the groups in both areas.

Women who were planning homebirths frequently described a philosophy of childbirth as a natural event. They displayed confidence in their bodies to be able to give birth without medical intervention: *"My body's been designed to do this, and if I work with my body… it should be able to happen"* (Home4). Giving birth at home was regarded as part of this philosophy: *"This is something that women have been doing for many hundreds, thousands of years. Hospitals are a relatively new thing in the whole scheme of human history"* (Home12). Women planning hospital births made less reference to a particular philosophy of childbirth and displayed more varied attitudes towards birth. These ranged from the belief that birth is a natural process albeit one in which complications may develop, to the view that *"the whole thing is terrifying"* (Hospital10).

For their own births, the women planning homebirths emphasised the importance of feeling in control and take an active role in decision-making. This was considered more likely to occur at home: *"being able to feel like I can make my own decisions… I feel like at home I've got more of a chance"* (Home7). The quality of the birth experience was highlighted beyond physical health of mother and baby: *"it feels important that it's a really positive experience, not just for [my partner] and I, but also for the baby"* (Home4).

Women planning hospital births also spoke about wanting to be consulted about decisions about their care but this was of secondary importance to the physical health of their babies: *"A baby, a healthy baby, that's the top and bottom of it"* (Hospital7). They hoped for positive experiences of the birth but this was not the primary consideration: *"I'd love to have a great experience… but the ultimate thing is just a healthy baby"* (Hospital12). They accepted these hopes might not be fulfilled: *"I'd like to try for a natural birth and I'd be proud of myself if I did achieve that, but if I didn't, it's not the end of the world"* (Hospital11).

The decision process

Women planning both home and hospital births described their decision about birth location as straightforward. Generally, they had always been certain about where they wanted to give birth: *"it was a given, I kind of always just knew I would"* (Home4), *"from the beginning I knew [hospital birth] was the course of events"* (Hospital2). This certainty meant the decision process was not protracted: *"we didn't even have to discuss it, it was just the obvious choice"* (Home11), *"it's probably the one part of my birthplan preferences that I didn't put an enormous amount of thought into"* (Hospital5).

When it came to choosing a birth location, for women planning hospital births, the precedence of concerns about safety and the belief these were best served in the hospital

environment outweighed other considerations: *"I can see the benefits of a lovely homebirth in your own environment but I would personally prioritise the medical support part"* (Hospital4). Other considerations were of secondary importance: *"The actual experience itself wasn't so much a factor in my decisions"* (Hospital2).

Women planning homebirths expressed concern for their babies' health but did not see achieving this as incompatible with a positive birth experience. They reported considering more factors when deciding where to give birth: *"Obviously you go for the health and safety, but there are more things to add to that. They're not on the same level but they are as important I think"* (Home11). The health of the baby was prioritised but they also considered their own needs and how these related to their birth location: *"If mentally I'm going to feel more secure, stable, happy here then that for me is the best decision."* (Home7).

There were also differences between the groups in attitudes towards the idea of birth in the non-preferred location. Women planning homebirths rarely described contemplating hospital when deciding on their birth location. However, women planning hospital births displayed a range of reactions to the idea of homebirth. For most it was out of the question, often due to concerns about the perceived inherent riskiness of childbirth: *"I wouldn't want to have one at home because I would think it was terrifying"* (Hospital1). Others recognised homebirth could be a positive experience but found this outweighed by safety concerns: *"it would be great if you knew it would all go smoothly… but for me the apprehension would probably override that"* (Hospital13).

Discussion

The aim of this study was to examine decisions regarding place of birth among a group of women with high-risk pregnancies. It provides new insight into how women with known pregnancy complications make decisions about place of birth. The study identified

three themes: perceptions of birth at home and hospital; beliefs about how birth should be; and the decision process. The relationships between the themes add depth to this insight. Thus women planning homebirths described their choice of location in terms of safety. Their perceptions of safety as the reduction of iatrogenic risk reflected their beliefs that birth is a natural process which proceeds best with minimal intervention. Women planning to give birth in hospital described more anxieties about the birth process and so desired greater access to medical support. The degree of confidence women displayed in the birth process was also apparent in their decision making. Women planning homebirths focussed on this process and the quality of the experience whereas women planning hospital births expected less from the experience beyond that they and their babies would be physically safe. The women planning to give birth at each location displayed similarities and differences in the factors they considered and emphases they placed on these when making this decision.

Safety was the key factor for all the women, although they defined safety in different ways. Women from both groups believed their chosen birth locations represented psychological safety by allowing them to feel secure and reassured. When they referred to issues regarding safety, they cited different concerns but both used the same label. Women planning to give birth in hospital prioritised physical safety defined in biomedical terms and believed these were best met by the ready availability of medical back up. Women planning to give birth at home expressed concerns about the effects of medical intervention and iatrogenic risk and described safety in terms of the reduction of the likelihood of these possibilities. Thus both groups described the same concerns but arrived at different conclusions as to how they would meet them. Decisions on birth location were based on definitions of safety, backed up by beliefs about the birth process in general and differing hopes and expectations for personal birth experiences.

Previous work on women's risk perception regarding place of birth has found women do want information about risks [20] and are aware of the risks associated with their birth choices [21]. Women will not take what they perceive as unnecessary or reckless risks with their own or their babies' health, rather they make choices they believe to be in their best interests [22]. They are aware their choices will not be without an element of risk and employ practical and emotional coping strategies to manage these [21]. In discussions about place of birth, women prefer to focus on, and use language which reflects, concepts of safety rather than risk [20]. This study establishes women with high risk pregnancies also make decisions regarding place of birth with safety as their primary consideration. It adds to the understanding of decision making in this group by relating their decisions to their wider beliefs about the birth process.

This study confirms earlier work on women's perceptions of childbirth: Catling-Paul et al (2011) found women who choose homebirths were more likely to display confidence in the natural birth process and perceive less need for potential medical intervention [20]. Regan and McElroy (2013) used the results from an interview study to categorise women according to the ideas they held about birth [23]. Women who regarded birth as a natural process and demonstrated belief in their ability to give birth were labelled matricentric; women who had less faith in the birth process without medical support and regarded hospital care as a source of security, as gynocentric [23]. Matricentric women regarded the experience of childbirth as important to them but gynocentric women were willing to tolerate a poor experience if they were certain of its safety. The women in this study planning homebirths echoed many of the qualities of matricentric women and it is of note that their belief in the natural birth process persisted despite medical advice that their medical conditions were posing some degree of risk to their pregnancies. Women planning hospital

births displayed more of the features of gynocentric women. Further research can investigate cognitive strategies women use to maintain their beliefs in the face of challenges to them.

Women who were planning homebirths referred to the quality of the birth experience as being of importance to them. The choice of homebirth may be related to a perceived improvement in the experience and a sense of achievement [8]. The sense of achievement may explain why attempting a homebirth is important for some women, even though they are aware they may require transfer to hospital at some point during the process. This difference in feelings and beliefs about the birth process and desire for a positive experience may explain why women made different decisions regarding place of birth when they both described safety, albeit conceived in different ways, as their primary concern. Further research is needed to establish if these different decisions are based on different philosophies regarding childbirth.

Women in this study emphasised the positive aspects of their chosen locations and also made reference to the negative aspects of rejected locations; thus women planning homebirths referred to the potential iatrogenic risks of the hospital and women planning hospital births described the lack of medical support at home as unsafe. Shepherd-McClain (1983) found similar results in a study of women's choices of maternity care [24]. Once women had chosen the type of care they wanted, Shepherd-McClain described how they undertook 'bolstering' activities to reinforce their choices. These included disparaging the benefits and exaggerating the risks of the rejected birth location, and playing up the advantages and discounting the risks of the chosen one. Whilst people's preferences influence their choices, choices have also been shown to influence preferences [25]. Thus once a decision has been made, the initial options may be re-evaluated and the chosen one viewed more positively so cementing commitment to the decision. This process may help reduce cognitive stress regarding the decision [24, 25]. Further research should investigate

the extent to which women use these cognitive strategies regarding place of birth and to what degree their opinions are already formed prior to consultation with healthcare professionals.

Both groups had negative perceptions of the physical surroundings of the hospital environment. This was a concern even for women choosing to give birth in hospital. Seibold et al (2010) found midwives were aware of their limited ability to manage the physical environment in hospital [26]. They recognised a lack of privacy, intrusive noise levels and limited resources can all negatively impacted on women's birth experiences, and that efforts to overcome these only have limited success. However research has also found midwives underestimate the importance of cleanliness of the environment to women, a concern mentioned frequently in this study [27].

This study provides new understanding of the factors women consider when deciding on place of birth. These include their thoughts and feelings about safety, the physical environment of location and their perceptions of its psychological influence on the birth process. Strengths of the study include rigorous use of established techniques for data collection and analysis: data coding was checked by an external rater; the research team discussed and agreed on each stage of the process. Themes can be traced back to the data through the use of quotes and are linked to existing research in the field. Limitations include the fact that participants all came for a single area and the majority had a similar sociodemographic background. Further research is therefore required to investigate how women from different backgrounds make decisions about where to give birth. The participants were aware the interviewer was connected with the hospital but were reassured about confidentiality. They had opportunities to ask questions about the study and also, during the interviews, to raise subjects they perceived as important to their decisions. Future research should also explore whether women with high risk pregnancies approach decision making differently to women with straightforward pregnancies.

Professionals working with women deciding where to give birth should be aware the decision draws on individual's beliefs and expectations for the birth process. If a professional does not agree with a woman's decision, this does not mean it is inherently wrong. If the decision-making process has been of high quality, i.e. it has been supported by knowledge, thought and feeling on the part of the decision maker, the outcome decision must also be regarded as high quality [11]. This can still be the case if the decision does not agree with available evidence but does represent an individual's values and beliefs [28]. Typically, decisions around risk have been categorised as rational and irrational according to the judgement of the rater, however Zinn (2008) argues most decisions fall along a spectrum between these two extremes, and intuition and emotion are trusted features of the majority of decisions [29]. Decisions are also more likely to be considered irrational when viewed by individuals not privy to the context in which they were taken [6] and women should not face censure from healthcare professionals if they made decisions professionals would not choose for themselves [30]. Shepherd-McClain (1983) suggests as women use bolstering strategies to reinforce their preferences and choices, it is likely healthcare professionals will do the same thing with theirs. Professionals should be aware of this tendency during discussions with women [24].

Women who choose to give birth at home, even when this contradicts professional advice, often do not reject all aspects of maternity care. They may regard antepartum care as part of their preparation for a safe homebirth and recognise the need for hospital care in case of emergencies [22]. This is not surprising as individuals may alternate between welcoming and challenging input from healthcare professionals depending on which stance they believe will best ensure their needs are met [31]. Professionals should therefore be respectful and sensitive in discussions with women regarding birth location in order not to alienate women

from seeking help when they do require it. They should also bear in mind the association between unsatisfying birth experiences and poor postpartum mental health.

This study clarifies and deepens knowledge of how women with high risk pregnancies decide on their birth location. It shows they can have deeply held beliefs about childbirth which may not be altered by discussions with healthcare professionals. It shows there are similarities and differences in feelings and beliefs between women who plan to give birth in hospital and those who plan homebirths. Professionals working with women with high risk pregnancies should consider these factors when interacting with these women.

Declaration of Interest statement

The authors report no conflicts of interest.

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Current knowledge on the subject

- Whether to give birth at home or in hospital is a key decision for pregnant women.
- Some women with high risk pregnancies choose to give birth at home against medical advice.
- Safety is a key factor for women deciding on their birth location.

What this study adds

- Women planning to give birth at home perceive risk and safety differently to women planning hospital births.
- They also display a greater degree of confidence in their ability to give birth naturally.
- They place greater emphasis on the quality of the birth experience.

Table 1. Women's obstetric and demographic details

Women's details	**Planning homebirth**	**Planning hospital birth**
	***n*=13 (%)**	***n*=13 (%)**
Medical/obstetric conditions		
Diabetes (inc Type 1 & gestational)	2 (15)	9
Previous caesarean section	7 (54)	6[a] (46)
Hypothyroidism	2 (15)	1[a] (8)
Von Willebrand's disease	1 (8)	-
Previous postpartum haemorrhage	1 (8)	-
Twin pregnancy	-	1 (8)
Osteoarthritis & hypermobility syndrome	-	1 (8)
Polycystic kidneys	-	1 (8)
Cardiac condition	-	1 (8)
Ethnicity		
White European	11 (84)	12 (92)
Hispanic	1 (8)	-
Mixed	1 (8)	1 (8)
Marital status		
Married/living with partner	13 (100)	12 (92)
Separated	-	1 (8)
Education		
None	1 (8)	-
GCSE	-	2 (15)
A level/Diploma/City & Guilds	3 (23)	3 (23)
Undergraduate	7 (54)	3 (23)
Postgraduate	2 (15)	5 (39)
Social class[b]		
Class I	-	3 (23)
Class II	11 (84)	8 (62)
Class III	1 (8)	2 (15)
Unemployed	1 (8)	-

[a]One woman had a previous caesarean and hypothyroidism

[b]Determined by occupation according to Office for National Statistics Socio-economic Classification

Table 2. Interview questions

Decision making
Place of birth Tell me about how you chose where you would like to give birth. What are the good points about giving birth there? Are there any drawbacks to giving birth there? Have you considered giving birth in Other Location? What are the drawbacks of giving birth there? Are there any good points to giving birth there? **Birth experience** What is important to you about your birth experience? How will giving birth in Chosen Location help you achieve this?