U.S. Nulliparas' Reasons for Expected Provider Type and Childbirth Setting

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ABSTRACT

The objective of this study was to describe nulliparas' reasons for the type of provider (i.e., midwife, physician) and childbirth setting (i.e., home, hospital, hospital-based birth center) that respondents expected for their births. Data were collected via a cross-sectional, descriptive, self-administered, Web-based survey including both close- and open-ended questions and were analyzed using conventional content analysis. Respondents were 220 nulliparous women aged 18–40 years, living in the United States, and pregnant at 20 or fewer weeks' gestation. Women's reasons were categorized broadly as relating to provider/setting attributes, relationship with provider/setting, normative choices, respondent attributes, and practical considerations. Respondents' reasons highlight misconceptions about childbirth care options, especially regarding midwifery and nonhospital settings, which may be addressed by childbirth education.

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In the United States, hospital childbirth with an obstetrician-gynecologist in attendance is the norm. Midwives—a category that includes certified nurse-midwives (CNMs), certified midwives, certified professional midwives (CPMs), and licensed midwives (LMs)—attended only 8.5% of all U.S. births in 2011 (Martin, Hamilton, Ventura, Osterman, & Mathews, 2013). Home births (planned and unplanned) represented only 0.84% of the nearly 4 million U.S. births in 2011 (Martin et al., 2013). Consequently, childbirth attended by midwives and/or at home in the United States can be described as nonnormative.

Promoting greater uptake of midwifery care and planned home birth requires first understanding the reasons behind women's care choices, whether normative or not. The findings presented here were

drawn from a parent study designed to describe nulliparas' childbirth preferences and to identify some predictors thereof, the quantitative results of which are reported elsewhere (Arcia, 2013). The purpose of the exploratory line of inquiry used in this article was to describe the breadth and character of nulliparas' reasons for the type of provider (i.e., midwife, physician) and childbirth setting (i.e., home, hospital, hospital-based birth center) that respondents expected for their births.

Promoting greater uptake of midwifery care and planned home birth requires first understanding the reasons behind women's care choices, whether normative or not.

An active role during childbirth, especially with respect to having control of decision making, repeatedly has been associated with midwifery care, either as an attribute of midwifery clients or as an explicit reason provided by women who chose to be attended by midwives (Arcia, 2013; Bylund, 2005; Callister, 1995; Chute, 1985; Galotti, Pierce, Reimer, & Luckner, 2000; Jimenez, Klein, Hivon, & Mason, 2010; Parry, 2008). The perception that childbirth is normal and natural, not fearful and risky, is more common among midwives' clients than among obstetricians' clients (Hall et al., 2009; Howell-White, 1997; Wilson & Sirois, 2010). In a qualitative study of eight Canadian women, Parry (2008) found that in addition to a natural approach to childbirth and a model of shared decision making, women gave six additional types of reasons for choosing midwives: continuity of care, woman-centered care, emotional care, professional ability, family-friendly practices, and personal control. In a population-based survey of 2,400 American women who had a singleton in hospital from mid-2011 to mid-2012 (known as *Listening to Mothers III*), participation in their insurance plan, a good match with their values, affiliation with a preferred hospital, and prior experience (well-woman care) were the top four reasons that women gave for selecting their maternity care provider (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013). However, respondents' reasons were related to the selection of an individual provider (as opposed to type of provider) and thus do not cover quite the same conceptual territory as those reported in other studies.

Because planned home births are attended almost exclusively by midwives, it is logical that women gave similar reasons for choosing this setting as they did for choosing midwifery care. Maternal desire for active involvement and control was a reason cited in multiple studies (Boucher, Bennett, McFarlin, & Freeze, 2009; Janssen, Henderson, & Veddam, 2009; Murray-Davis et al., 2012; Ng & Sinclair, 2002; van Haaren-ten et al., 2012; Viisainen, 2001), as was the belief that birth is a natural process and not an illness (Boucher et al., 2009; Jimenez et al., 2010; Neuhaus, Piroth, Kiencke, Göhring, & Mallman, 2002; Ng & Sinclair, 2002; Viisainen, 2001). Another commonly cited reason is that one's home is a familiar and familial environment that allows for comfort, intimacy, and privacy (Bashour & Abdulsalam, 2005; Boucher et al., 2009; Hildingsson, Waldenström, & Rådestad, 2003; Janssen et al., 2009; Murray-Davis et al., 2012; Ng & Sinclair, 2002;

van Haaren-ten et al., 2012). Some women elected home birth as a way of avoiding pain medication and other medical interventions (Boucher et al., 2009; Hildingsson et al., 2003; Janssen et al., 2009; Murray-Davis et al., 2012; Neuhaus et al., 2002) and/or in response to a previous negative hospital experience (Boucher et al., 2009; Viisainen, 2001). In the few studies in which women reported reasons for selecting the hospital setting, safety was a prime motivator, especially in the event of complications (Hildingsson et al., 2003; Miller & Shriver, 2012; van Haaren-ten et al., 2012). Interestingly, safety also was cited by some of the women who chose planned home birth, suggesting that they conceptualized risk and safety differently than did the women who believed hospitals to be safest (Boucher et al., 2009; Ng & Sinclair, 2002; van Haaren-ten et al., 2012).

Most of the aforementioned studies have been retrospective. The inherent difficulty of interpreting their results is that it is impossible in retrospective studies to disentangle cause from effect. Women may reflect as much on their impressions of the care they received as on the reasons for initially selecting the care option. In other words, recall of one's reasons for making a choice can be diminished or enhanced based on the experience of having made the choice. For instance, "women who want to be involved in decision making may be more likely to choose midwives, who in turn are more likely to offer involvement in decision making" (Bylund, 2005, p. 36). Although the results of the relevant retrospective studies (i.e., Hildingsson et al., 2003; Howell-White, 1997; van Haaren-ten et al., 2012) have been largely congruent with those of the few prospective studies, there still has been a need for a prospective study in a U.S. context in which reasons for normative and nonnormative choices are compared directly. This study fills that gap in the literature.

METHODS

Design

Data were collected via a cross-sectional, descriptive, self-administered, Web-based survey. Ethical approval was obtained from the institutional review board of the University of Miami. Nulliparous women aged 18–44 years, living in the United States, and pregnant at 20 or fewer weeks' gestation were eligible for the study. The ideal timing for the elicitation of the care preferences of nulliparas would be immediately after the discovery of pregnancy so that preferences could be identified prior to any

influence by prenatal care providers. An exclusion criterion of a gestational age greater than 20 weeks served as a proxy for the ideal time point, given the impracticality of the ideal. Substantial numbers of nulliparas may have had a spontaneous or induced abortion (Pazol et al., 2011) so these women were included. Women were excluded, however, if they had had any prior pregnancy beyond 13 weeks' gestation, to screen out those who may have had extended exposure to prenatal care. Eligibility was assessed by self-report. The survey was offered in English via the Internet from March 16, 2011 to July 22, 2011. To meet the statistical analysis requirements of the parent study, the target sample size was set at 200–250 completed surveys.

Advertisements on the social networking website Facebook were used to recruit respondents. Ads were targeted such that the Facebook algorithm automatically selected only the profiles of women residing in the United States and aged 18–44 years on which to display the ads. The ads were shown to 7.2 million unique users, of which 5,963 clicked through to the study site. A link at the end of the survey allowed for snowball sampling because respondents could use it to share the survey start page with friends via social networking websites or e-mail. The recruitment methods article associated with this study provides a detailed description of the recruitment procedures (Arcia, 2014).

The study survey was hosted by SurveyMonkey; all data were collected anonymously. Respondents who wished to participate consented by clicking on the “Agree” button at the end of the informed consent form. Respondents could not be identified by their Facebook accounts or e-mail addresses because the survey website was separate from all recruitment materials. Respondents who wished to register for the study incentive (a random drawing with 1-in-50 odds for a unisex infant gift) provided an e-mail address through a separate survey accessible only via the study survey. Separation of the surveys ensured respondent anonymity. All e-mail addresses were deleted after the incentives were distributed.

Survey Items

Respondents were asked to identify the type of provider they expected to attend their birth (obstetrician-gynecologist, CNM, CPM/LM, family physician, or unsure/don't know) and then were presented the free-response item “Why have you chosen the type of provider you just indicated?” Next, respondents

were asked to identify their expected childbirth setting (hospital, birth center inside a hospital, free-standing birth center, home, or unsure/don't know) followed by the free-response item “Why have you chosen the location you just indicated?” Items relating to demographics also were collected. The full survey is reproduced in Arcia (2011).

Data Analysis

Frequency distributions were calculated for the closed-ended responses using SPSS 17.0. Conventional content analysis was used to analyze free-text responses. Content analysis is a method whereby the researcher can make valid and replicable inferences from a source material to the context in which the material occurs (Krippendorff, 2004). The researcher engages in careful word-by-word reading and coding of the text (Hsieh & Shannon, 2005). In the conventional content analysis approach, codes and themes are allowed to emerge from the text without the use of predetermined categories. Sorting of the codes into categories aids the researcher in understanding the concepts found in the text and the relationships between them.

All responses were read several times before using the computer software NVivo Version 9 to assign codes to the responses based on subcategories that emerged from the data. Subcategories were then organized into broader categories that are reported in the “Results” section. Given the similarities in the types of responses offered for expected type of provider and setting, the categories and subcategories for the two questions were deliberately made parallel in structure. Open-ended responses from women who expected care from CNMs and CPMs were collapsed into one midwifery category because of small sample sizes. CNMs and CPMs have differing educational preparation and scope of practice and thus are not entirely comparable. The grouping together of CNMs and CPMs is admittedly imperfect but does allow for greater ease of comparison with physicians who practice obstetrics. A second researcher, a doctorally prepared nurse practitioner with experience in conventional content analysis, reviewed the principal investigator's audit trail to assess dependability, and concurred with the principal investigator's findings.

RESULTS

Sample

The mean age of the respondents ($N = 220$) was 21 years ($SD = 4.1$). More than half of the women were 18 or 19 years old; fewer than 14% were aged

25–40 years. Respondents' mean weeks' gestation was 12.1 ($SD = 5.7$). Eligible respondents represented 41 states, with the largest numbers coming from high-population states (e.g., California, Texas, New York).

Additional demographic data were collected at the end of the survey and therefore represent only those respondents who completed the survey (see Table 1). Dropout was evident throughout the 92-item survey and was attributed primarily to respondent fatigue. Respondents were predominantly non-Hispanic (88.9%, $n = 112$) and White (76.3%, $n = 90$). The largest group (37.0%, $n = 47$) was those living with a partner, followed by just over one third who reported being single, never married (34.6%, $n = 44$). Married women were 22.8% ($n = 29$) of those who reported marital status. The generally low educational attainment of the sample is partially a function of the young age of the respondents combined with the fact that 28.9% ($n = 35$) were reportedly students. Just under one third of the women (31.4%, $n = 38$) indicated they were not employed but seeking work, 16.5% ($n = 20$) worked full-time, and 14.9% ($n = 18$) worked part-time. More than half (52.7%, $n = 58$) of the women who reported household income indicated that it was less than \$15,000 per year.

Expected Provider Type and Childbirth Setting

Of the 201 women who responded to the item about expected provider type, 82.1% ($n = 165$) expected to be attended by an obstetrician-gynecologist, 6.0% ($n = 12$) by a CNM, 5.0% ($n = 10$) by a CPM or LM, and 3.0% ($n = 6$) by another type of provider (i.e., family physician; see Table 2). Of the 212 women who indicated an expected childbirth setting, 82.1% ($n = 167$) expected to birth in a hospital, 16.5% ($n = 35$) expected to use a hospital-based birth center, and 3.8% ($n = 8$) planned to birth at home. None of the respondents in this sample indicated an expectation to use a freestanding birth center.

Free-Response Items

There were 220 respondents who provided an answer to one or both of the free-response questions. Two hundred one responses were recorded regarding expected provider type and 212 regarding expected childbirth setting. Responses ranged from a single word (e.g., "better") to a few sentences; most were short phrases. Approximately 5% of the responses to each question expressed uncertainty (e.g., "I don't know") or simply reiterated preference (e.g., "personal preference") without providing a specific

TABLE 1
Participants' Age, Prenatal Care Attendance, Ethnicity, Race, Marital Status, Education, Employment Status, and Household Income

Characteristic	<i>n</i>	%
Age ($n = 220$)		
18	56	25.5
19	55	25.0
20	34	15.4
21	16	7.3
22–24	32	14.5
25–34	24	10.9
35–40	3	1.4
41–44	0	0.0
Number of prenatal care visits ($n = 216$)		
None	22	10.2
One or more	194	89.8
Hispanic ethnicity ($n = 126$)		
No	112	88.9
Yes	14	11.1
Race ^a ($n = 118$)		
American Indian/Alaska Native	8	6.8
Asian	5	4.2
Black/African American	25	21.2
White	90	76.3
Selected one race category	111	94.1
Selected two race categories	5	4.2
Selected three race categories	2	1.7
Marital status ($n = 127$)		
Single, never married	44	34.6
Living with partner	47	37.0
Married	29	22.8
Separated	2	1.6
Divorced	5	3.9
Education ($n = 127$)		
Some high school	21	16.5
High school diploma or GED	43	33.9
Some college but no degree	44	34.6
Associate's degree	7	5.5
Bachelor's degree	9	7.1
Graduate degree	3	2.4
Employment status ^a ($n = 121$)		
Work full-time	20	16.5
Work part-time	18	14.9
Self-employed	8	6.6
Not employed, looking for work	38	31.4
Not employed, not looking for work	13	10.7
Retired	2	1.7
Student	35	28.9
Homemaker	14	11.6
Annual household income ($n = 110$)		
less than \$15,000	58	52.7
\$15,000–\$24,999	16	14.5
\$25,000–\$34,999	11	10.0
\$35,000–\$49,999	9	8.2
\$50,000–\$74,999	8	7.3
\$75,000–\$99,999	4	3.6
\$100,000–\$124,999	2	1.8
\$125,000 or more	2	1.8

Note. GED = general education development.

^aPercentages sum to more than 100% because participants were able to select more than one response option.

TABLE 2
Expected Provider Type and Childbirth Setting

	<i>n</i>	%
Type of provider expected to attend birth (<i>n</i> = 201)		
Obstetrician-gynecologist	165	82.1
Certified nurse-midwife	12	6.0
Certified professional midwife/licensed midwife	10	5.0
Other (family physician/nurse practitioner)	6	3.0
Unsure/don't know	6	3.0
Prefer not to answer	2	1.0
Expected childbirth setting (<i>n</i> = 212)		
Hospital	167	78.8
Birth center inside a hospital	35	16.5
Home	8	3.8
Unsure/don't know	2	0.9
Freestanding birth center	0	0.0

reason. Responses are all reproduced verbatim. There is a great deal more data about the reasons behind the selection of physicians as care providers and hospitals as childbirth settings because of the large proportion of respondents expecting such care. As such, the data regarding physicians and hospitals are far richer than the data regarding respondents' expectation of midwifery care and nonhospital settings.

Reasons for Expected Provider Type

With respect to the choice of provider type, respondents' reasons were broadly categorized as relating to Provider Attributes, Relationship with Provider, Normative Choices, Respondent Attributes, and Practical Considerations. See Table 3 for the categories and subcategories relating to expected provider type along with responses that are representative of each. There are four subcategories of Provider Attributes. Reputation and Referral applies both to physicians' and midwives' clients and refers to the selection of a provider based on others' recommendations. The remaining subcategories within Provider Attributes apply only to women who expected physician care. For the subcategory Expertise, Education, and Professionalism, respondents indicated that they valued these three traits highly. For Perceived Superiority, respondents expressed the perception that physicians' care was inherently best. In the last subcategory of Provider Attributes, Safety, women indicated that the safety of their birth was enhanced by the choice of a physician.

There are five subcategories of Relationship with Provider. Prior Experience refers to the fact that for some respondents, a provider's attendance at

childbirth continues an existing relationship. The subcategory Comfort includes responses that speak to an ease of rapport between client and clinician. Some respondents expressed their selection as an appreciation for their provider's Practice Style. The responses of women who chose physicians also fell into the subcategories of Liking (an affinity for a particular provider) and Trust (faith and confidence in the provider).

The category Normative Choices is composed of the subcategory Family Tradition and includes only responses from women who expected physician care. Although conceptually similar to the Reputation and Referral subcategory, responses coded under Family Tradition speak to continuation over multiple generations and as such belie a deeper motivation than pursuing a recommendation that happens to come from a family member.

Some respondents—none of whom expected midwifery care—framed their choice of provider as a reflection of their needs as a patient. These responses were coded in the category/subcategory Respondent Attributes and included attributes such as nulliparity, risk profile, and age.

The final category, Practical Considerations, is composed of the subcategories Insurance, Setting Chosen First, Convenience, Lack of Choice, and Unfamiliar with Alternatives. Coverage afforded by Insurance meant that for some women, a physician was the only option, and for others, that a midwife was obligatory. For other women, the choice of provider was secondary to the choice of setting; their responses were coded to the subcategory Setting Chosen First. For a few women who expected care from a physician, that choice was one of Convenience, whereas for others it was because of Lack of Choice. Lastly, some women admitted that they were Unfamiliar with Alternatives.

Reasons for Expected Childbirth Setting

Respondents' reasons for choice of childbirth setting were broadly categorized as relating to Setting Attributes, Relationship with the Setting, Normative Choices, Respondent Attributes, and Practical Considerations. See Table 4 for the categories and subcategories relating to expected childbirth setting along with responses that are representative of each. The subcategories of Setting Attributes are Safety, Expert Assistance, Perceived Superiority, Cleanliness, Reputation and Referral, and Ambience and Features. Safety was a highly valued attribute regardless of the setting. It is noteworthy that for each setting,

TABLE 3

Representative Responses for Categories and Subcategories of Reasons for Selection of Expected Childbirth Care Provider

Categories/Subcategories	Physician	Midwife
Provider attributes		
Reputation and referral	<p>"Because I was recommended my OB/GYN by my other doctor"</p> <p>"My doctor came with excellent recommendations"</p>	<p>"I have heard from people that midwives are allot more nicer"</p> <p>"I chose the midwives because I had heard badly about all of the doctors in this area"</p>
Expertise, education, and professionalism	<p>"Specialty"</p> <p>"I would like a professional"</p> <p>"Because they know what they doing"</p> <p>"They have more expertize in this field where midwives don't"</p> <p>"Education. They know extensively what to do in any possible scenario"</p>	—
Perceived superiority	<p>"Best"</p> <p>"THEY SEEM WAY MUCH BETTER"</p> <p>"I strongly believe that a medical doctor who specializes in obstetrics is the best for helping with child birth"</p>	—
Safety	<p>"It feels safer to me"</p> <p>"I think it is the safest if there are any complications"</p> <p>"Because they know more of what they are doing and I want a safe delivery"</p>	—
Relationship with provider		
Prior experience	<p>"She is my regular obgyn"</p> <p>"She has been my doctor for many years"</p>	<p>"She also helped deliver my nephew and has been my doctor for years"</p>
Comfort	"I feel more comfortable with her"	"It's what I feel comfortable with"
Practice style	"Because my obgyn is a good doctor and explains everything step by step to me"	<p>"I feel that it's more personal and a better option"</p> <p>"She is more personal and warmer than the physician"</p>
Liking	"I really like my OB/GYN"	—
Trust	<p>"I trust this provider"</p> <p>"Believe that she will do what is best for me and my baby"</p> <p>"When I first met my OB/GYN I felt confident and secure"</p>	—
Normative choices		
Family tradition	<p>"Because he was who delivered me"</p> <p>"Because the doctor has been in the family and we trust him and want him to deliver the baby"</p>	—
Respondent attributes	<p>"Because I'm young"</p> <p>"For being my first"</p> <p>"Because I am high risk"</p> <p>"I'm a little young to understand what a midwife is"</p>	—
Practical considerations		
Insurance	<p>"My Medicaid covers it"</p> <p>"Because that is what my insurance requires"</p>	"State insurance covers it"
Setting chosen first	"I wanted to deliver at the hospital I want"	"Because she will do home births"
Convenience	"It's easier to arrange"	—
Lack of choice	"Because there is no midwives in the area"	—
Unfamiliar with alternatives	<p>"Haven't been introduced to other options"</p> <p>"Because I was unaware you could go to someone else!"</p>	—

Note. Responses are reproduced verbatim. Dashes (—) indicate there were no responses in a category for that type of provider.

OB/GYN = obstetrician and gynecologist

TABLE 4
Representative Responses of Categories and Subcategories of Reasons for Selection of Expected Childbirth Setting

Categories/Subcategories	Hospital	Hospital-Based Birth Center	Home
Setting attributes			
Safety	"The hospital is much safer"	"To me it is the safest place to give birth"	"Safer, less stress on me and baby"
Expert assistance	"Doctors and nurses" "Availability of resources" "Me and my unborn child will have all the support we need"	"Because they are specialized"	—
Perceived superiority	"A better setting" "Get the best health care"	"It's the best birthing hospital in [city, state]"	—
Cleanliness	"More sanitary"	"Germ free"	—
Reputation and referral	"They have a really good staff" "My doctor works in a very good hospital"	—	—
Ambience and features	—	"Serene and more quiet" "I would like a water birth"	"Familiar environment" "I want to have a water birth" "A comfortable place where I can be relaxed and know all people who are involved"
Relationship with setting			
Comfort	"I would feel more comfortable giving birth in a hospital"	"I feel comfortable there"	—
Liking	"I like it best"	—	—
Trust	"Trust it more"	—	—
Prior experience	"Hospitals are the primary form of health care I seek out" "Good previous experience with other health-related issues"	—	—
Normative choices			
The obvious option	"Logical" "Normal" "Common sense" "Where people usually give birth to babies" "It's the obvious option, do not think it seems safe to give birth somewhere besides a hospital"	—	—
Family tradition	"Tradition" "Because all my family and my soon-to-be husband's family all gave birth in a hospital"	—	—
Respondent attributes	"It is my first" "Because I am so young" "Because I am high risk"	"It's a lot safer, my pregnancy is a high risk pregnancy"	"I trust my body"

(Continued)

TABLE 4
Representative Responses of Categories and Subcategories of Reasons for Selection of Expected Childbirth Setting (Continued)

Categories/Subcategories	Hospital	Hospital-Based Birth Center	Home
Practical considerations			
Insurance	"The physician and hospital facility are covered by my health insurance plan"	"Medicaid"	—
Provider chosen first	"It's where my doctor does it"	"Where my CNM delivers"	—
Convenience	"It's easier"	"Cause it closer to me"	—
	"It is close to my home"		
Lack of choice	"No choice"	—	—
	"No other options are available in my area"		
Second choice	"I want to at home, but it will be held at a hospital most likely"	—	—
Unfamiliar with alternatives	"Not yet aware of other options"	—	—

Note. Except for one instance in which a location has been redacted, responses are reproduced verbatim. Dashes (—) indicate there were no responses in a subcategory for that type of setting. CNM = certified nurse-midwife.

there were women who characterized it as safer than the alternatives. Women planning childbirth within the hospital setting stressed the importance of the availability of Expert Assistance. The subcategories of Perceived Superiority and Cleanliness emerged from the responses of women planning to birth in a hospital or hospital-based birth center who felt that these settings were likeliest to provide the best care and be sanitary, respectively. A few women indicated they had chosen a hospital because of Reputation and Referral. Women who expected to birth at home or in a birth center mentioned criteria such as Ambience and Features that did not come up among women electing to use traditional hospital labor and delivery units.

The subcategories of Relationship with Setting are Comfort, Liking, Trust, and Prior Experience. Whether planning to birth in a hospital-based birth center or in a traditional hospital unit, multiple women expressed nearly identical sentiments about how that setting inspired feelings of comfort. Only women who expected to birth in a traditional hospital unit invoked the subcategories of Liking, Trust, and Prior Experience.

The category of Normative Choices only emerged for women expecting a hospital birth. Responses in the subcategory The Obvious Option exemplified the perspective that hospital birth is a given. As with the selection of a provider, for some women, the

choice of a hospital was a matter of a Family Tradition that spanned generations.

The category Respondent Attributes applies to statements that women made in reference to themselves. As with choice of provider, women planning hospital-based childbirth invoked age, nulliparity, and risk profile. Their statements stand in stark contrast to that of one woman who explained her choice of home birth as stemming from a trust in her body.

As with the selection of a provider, respondents planning hospital birth faced Practical Considerations: Insurance; Provider Chosen First; Convenience; Lack of Choice; Second Choice; and Unfamiliar with Alternatives. The responses of women planning to birth at home did not evoke any of these subcategories. Coverage by Insurance was the deciding factor for some respondents. Responses that indicated that the choice of setting was secondary to the choice of provider were coded in the subcategory Provider Chosen First. For some women, convenience was a consideration that allowed them to prioritize factors such as proximity to home. The responses of women who indicated a dearth of options were coded to the subcategory Lack of Choice. A few women indicated that the hospital was a Second Choice but did not specify the reason for compromise, whereas for others, a true choice was not possible because they were Unfamiliar with Alternatives.

DISCUSSION

The reasons respondents gave for their selection of expected provider type and childbirth setting collectively reveal the breadth and character of the considerations the women weighed in their decision-making processes. Within their normative context and the constraints of practical considerations such as insurance coverage, women took into account their individual needs (Respondent Attributes), the nature of their relationship with potential providers and settings, and the qualities of the services on offer (Provider/Setting Attributes). These findings are congruent with those of prior studies such as *Listening to Mothers III* (Declercq et al., 2013).

Respondent Attributes are an extension of the woman's self-perception. The Provider Attributes and by extension, the Setting Attributes that a woman values are an expression of her perception of the care provider's role. In other words, a woman will likely look for a provider and setting that meet her expectations of the role that she believes the provider and setting should play in childbirth. For example, if a woman believes that the provider's role is to use the latest health technologies, she may be likelier to seek out a provider from among those that have privileges at the most technologically advanced hospital in her area. Comfort, Liking, and Trust can come about when the provider and setting meet the woman's role expectations. For instance, a woman expecting technologically advanced care may be more apt to like, trust, and feel comfortable with a provider that makes frequent use of ultrasound imaging than one who relies more on manual palpation.

Normative choices are the backdrop against which the mother's expectations and decisions occur. For example, if the normative context in a woman's life is that the hospital is the only acceptable setting, that woman may be able to choose one hospital over another but may risk disapproval for choosing another setting. Women who flouted the norm and planned a home birth have been accused of being irresponsible (Cheyney, 2008) and have felt pressured by family and care providers to abandon their plans (Lavender & Chapple, 2005). Similarly, a woman may have reservations about choosing a midwife, or even a family physician, if the providers recommended by family and friends are all obstetricians.

Practical Considerations are the externally imposed boundaries of women's choices. For example, a woman might prefer childbirth in a freestanding

A woman will likely look for a provider and setting that meet her expectations of the role that she believes the provider and setting should play in childbirth.

birth center, but if none are reasonably close to her home, she will have to conform her preferences and choices to the settings that are available to her. For many women, insurance coverage restricts choice of both provider and setting because the financial burden of paying out-of-pocket for noncovered services is so great.

One of the strengths of this study is that it included the perspectives of women expecting various forms of care and thus allowed for questions that invited a direct comparison of childbirth settings and provider types. Most of the studies that have examined women's reasons for choosing midwives and/or home birth have not also included the perspectives of women making more normative choices, making direct comparisons impossible. The reasons that women in this study gave for their care choices are not especially new or surprising; they are the reasons that people who work with birthing women would say, "Everybody knows." However, this is one of the few studies—Miller and Shriver (2012) is another—in which the reasons for physician-attended hospital birth that "everyone knows" actually have been documented in the scientific literature.

LIMITATIONS

These findings come from descriptive items in a parent study (Arcia, 2013); the sampling was optimized to address the research questions of the larger study. Thus, the principal limitation is that relatively few women in the sample expected to be attended by a midwife or to birth at home, and none planned to use a freestanding birth center. The data are not as rich as they might have been had these women been purposively sampled, and low numbers precluded meaningful analyses and comparisons of the frequencies with which women cited each reason.

Another limitation is that the respondents were recruited primarily through Facebook. Although 84% of online U.S. adults aged 18–29 years and 79% of those aged 30–49 years are Facebook users, a probability sample was not possible with this method because U.S. childbearing women are not all online or social network users (Duggan & Smith, 2013). Recruitment via Facebook possibly was a factor in the

participants' low mean age (20.9 years vs. 25.4 years) compared to the larger population of U.S. mothers at first birth. In addition, respondents were much less likely to be Hispanic (11.1% vs. 23.6%) or married (23.2% vs. 59.1%) as compared to all U.S. childbearing women (Martin et al., 2013). Women's real-world access to and uptake of various forms of care is known to vary according to demographic factors (Martin et al., 2013), but it is unclear whether or how age, ethnicity, or marital status systematically affect women's reasons for their provider and setting selections beyond simple lack of access/choice. For example, there are as many studies in which age has been related to childbirth preferences (Angeja et al., 2006; Buyukbayrak et al., 2010; Fuglenes, Aas, Botten, Øian, & Kristiansen, 2011) as there are in which there was no such relationship (Bracken, Dryfhout, Goldenhar, & Pauls, 2008; Nieminen, Stephansson, & Ryding, 2009; Thurman, Zoller, & Swift, 2004). Facebook does not report demographic data about its users; the characteristics of nonrespondents could not be determined. Respondents' eligibility was based on self-report and could not be verified independently. In this respect, this survey was no different than a telephone or mail survey; respondents may not be who they claim to be. However, the very modest nature of the participation incentive and the deliberate targeting of ads to Facebook users who, *a priori*, met at least three of the eligibility criteria (women, aged 18–44 years, living in the United States) served to reduce the likelihood of the inclusion of ineligible respondents.

Not all women have a full suite of options with respect to childbirth care in their communities. Some respondents noted this limitation explicitly and their responses were captured primarily by the subcategory Lack of Choice. However, all the other responses may have been shaded by lack of choice and should be read with this limitation in mind.

PRACTICE AND POLICY IMPLICATIONS

The findings presented here are suggestive of the specific areas that are worth addressing in educational materials about midwifery care within the U.S.

Most respondents perceived physicians to be superior. Given that respondents were asked a question that invites comparison (“Why have you chosen the type of provider you just indicated?”), responses such as “because they are the best” imply that midwives are second-rate. Physicians were valued for their expertise, education, and professionalism, and there was a widespread belief that their care is safest. The indirect implication of respondents' choice of superlative words about physicians (e.g., “they have the best knowledge,” “safest if there are any complications”) is that midwives are somewhat lacking in the desired qualities. Essentially, midwifery has an image problem. Although it is true that physicians' training and scope of practice is more extensive than that of midwives, midwives' expertise, professionalism, and quality of care are valuable assets in our maternity care system. The most telling responses may be those in which women admitted to being unfamiliar with alternative care options. Previous research has shown the general U.S. public to be ill-informed about midwives' education and scope of practice (Johnson & Midwifery Research Project Group, 1998). Therefore, educational materials should include information about (a) the availability of midwifery care in most communities, (b) the educational and experiential requirements for midwifery certification and/or licensure, (c) midwives' areas of expertise and scope of practice, and (d) the positive outcomes associated with midwifery care. In a similar vein, the promotion of planned home birth would be facilitated by the presentation of factual, evidence-based information about the conditions (e.g., healthy, low-risk pregnancy; skilled birth attendant; adequate contingency plan) under which this choice of setting is associated with healthy and satisfying outcomes. Childbirth educators are well-positioned to provide all such information and to enhance it by tailoring the information to the context of the communities they serve. Given that many women turn to the Internet to learn about pregnancy and childbirth, it is important that childbirth educators be aware of and engage with online resources whenever possible (Arcia, 2013; Declercq et al., 2013; Romano, 2007).

It is important to note that even a well-designed educational intervention may meet with only modest success. The influence of women's normative context cannot be underestimated. The widespread cultural beliefs that, as one respondent put it, the hospital is “the normal place to have a baby” and

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that physicians, as another woman noted, “KNOW EVERYTHING [emphasis original]” are powerful ones that may take time and considerable effort to overcome.

The effort required to promote changes in attitudes about midwifery care and births in homes and freestanding birth centers is likely to be a wise investment given the changing landscape of health care in the United States. With the passage of the Patient Protection and Affordable Care Act of 2010, Medicaid reimbursement to nurse-midwives has increased from 65% to 100% of the rate physicians receive. Under the new law, the facility fee for freestanding birth centers also is covered under Medicaid. The intent of the reimbursement changes is improved availability of these services. As the nation confronts ever more burdensome health-care costs, these legal provisions are a clear signal that policymakers are giving increasing priority to these cost-effective forms of maternity care. Childbirth educators should prepare for these and future changes in health policy and should be ready to help women adapt to the changes that will affect their childbirth options.

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