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Deciding where to give birth in East London: An ethnography

Cassandra M. Yuill

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City, University of London

School of Health Sciences

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Abstract

Decisions about health and care are rarely uncomplicated, and in maternity, they are no less so. In England, choice is at the forefront of maternal health policy, which maintains that women with straightforward pregnancies should have a choice of place of birth. A growing body of evidence shows that midwifery-led settings, such as midwifery units and home birth, are as safe as obstetric units (OUs), and that women planning their births in these settings have better outcomes with reduced chances of medical interventions and caesarean sections. However, a majority of those eligible for midwifery-led care are still giving birth in OUs. Policymakers, clinicians and stakeholders are now focused on augmenting 'informed' choice about place of birth among parents as a means for improving services and uptake, zeroing in on decision-making as the crucial point in which it is initiated and formed. What delineates an informed choice, and how does decision-making during pregnancy engender such a choice? Creating decisions aids or rolling out models of 'shared decision-making' are popular solutions for augmenting informed choice, with the intention of easing the burden of decision-making for parents. Researchers commonly approach each from a disembodied standpoint, assuming rationality in complex, lived phenomena that are in actuality neither linear nor uniform.

This thesis, instead, explores decision-making and choice as a process, building an ethnographic account of parents' place of birth decision-making experiences in East London and investigating the feasibility of research related to decision aids and informed choice. To achieve this, I conducted two studies over nearly two years: a community-based study situated in the boroughs of Newham, Tower Hamlets and Waltham Forest; and a feasibility study based in Barts Health NHS Trust, which offers all four birthplace options for women with straightforward pregnancies. I argue, contrary to long-held decision theory, that decision-making about place of birth is an embodied practice, one that has corporeal, temporal and affective modalities and involves enskilment built up before, during and after pregnancy. Modern English maternity continues to be a nexus of biomedical and obstetric dominance, uncertainty in terms of risk and safety and notions of good motherhood, all of which are layered through women's decision-making and reified by the frameworks that shape it. My analysis illuminated that informed choice, in the context of place of birth decision-making, is a culmination of skilled practice, a phenomenological and embodied event. Its establishment, in maternity policy and care, is marked by silences concerning knowledge and services. Current conceptions of choice in English maternity are built on a market ideology, which places the onus of improvements to services on women and their families; however, in seeing parental decision-making and informed choice as embodied, we can begin to envision future policy and practice based on a platform of human rights.

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Abbreviations

AIMS	Association for Improvements in the Maternity Services
AMU	Alongside Midwifery Unit
BAME	Black, Asian or Minority Ethnic group
CQC	Care Quality Commission
DoH	Department of Health
DHSS	Department of Health and Social Security
FMU	Freestanding Midwifery Unit
GP	General Practitioner (family community doctor)
MH	Ministry of Health
MVP	Maternity Voices Partnership
NCCWCH	National Collaborating Centre for Women's and Children's Health
NCT	National Childbirth Trust
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute of Health Research
NPEU	National Perinatal Epidemiology Unit
OU	Obstetric Unit (consultant-led)
RCOG	Royal College of Obstetricians and Gynaecologists
WHO	World Health Organisation

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Introduction

Over and above our memories, the house we were born in is physically inscribed in us.

Pierre Bourdieu, 1964

This thesis is fundamentally about place and how we are intrinsically and corporeally connected to where we decide to place ourselves. These decisions, it turns out, are rarely as simple and straightforward as they appear. Where and how women give birth in the United Kingdom (UK) has evolved over the last 100 years. Before the mid-20th century, a majority of women gave birth at home, attended by local midwives or family members. However, facility-based births became increasingly common with the foundation of the National Health Service (NHS) in 1948, after which the country saw immense growth in the number of hospital births and wider medicalisation of maternity, while home birth rates dwindled and finally dropped below 5% in 1975, where they have remained. Given the steady decline in maternal and infant mortality after 1948, hospital-based birth is now synonymous with safety and proper care. Though care was ‘safer’, women’s choice and roles therein were limited or even non-existent. Since the early 1990s, increasing choice and expanding women’s roles in their care have come to the forefront of the public health policy agenda in virtually every area of maternity services. The commitment to facilitating ‘informed choice’ has become a fundamental aspect of NHS care provision (Department of Health, 1991; Entwistle, et al., 1998; NHS England, 2014). Recently, NHS England’s report, *Better Births*, reiterated the centrality of informed choice to maternity care, stating:

“Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information” (National Maternity Review, 2016)

Providing a service that offers and promotes a choice of place of birth was advantages along several lines, particularly for women. Those opting to give birth in non-obstetric unit (OU) settings (midwifery units and home) are more likely to have a spontaneous vaginal birth, have lower rates of medical interventions and caesarean sections and have shorter recovery times, thus reducing the costs associated

with these options (Chamberlain, et al., 1997; Nikodem, 2002; Schroeder, et al., 2012). Moreover, research has shown that births planned in these non-OU settings are *as safe* for women and their babies as those planned in OUs (Birthplace in England Collaborative Group, 2011; Hutton, et al., 2019). Essentially, midwifery units and home births are safe, beneficial and cost effective, yet most women who are eligible for these settings still plan their births in OUs across England. While there are indications that OU use is decreasing, with a 5.2% drop between 2012 and 2015 (NHS, 2015a; NHS, 2015b), and there have been increases in the number of midwifery units nationwide (NMPA Project Team, 2019), the fact remains that only 14% of births take place in midwifery units – though calculations show 36% of pregnant women could potentially receive midwifery-led care (Walsh, et al., 2018).

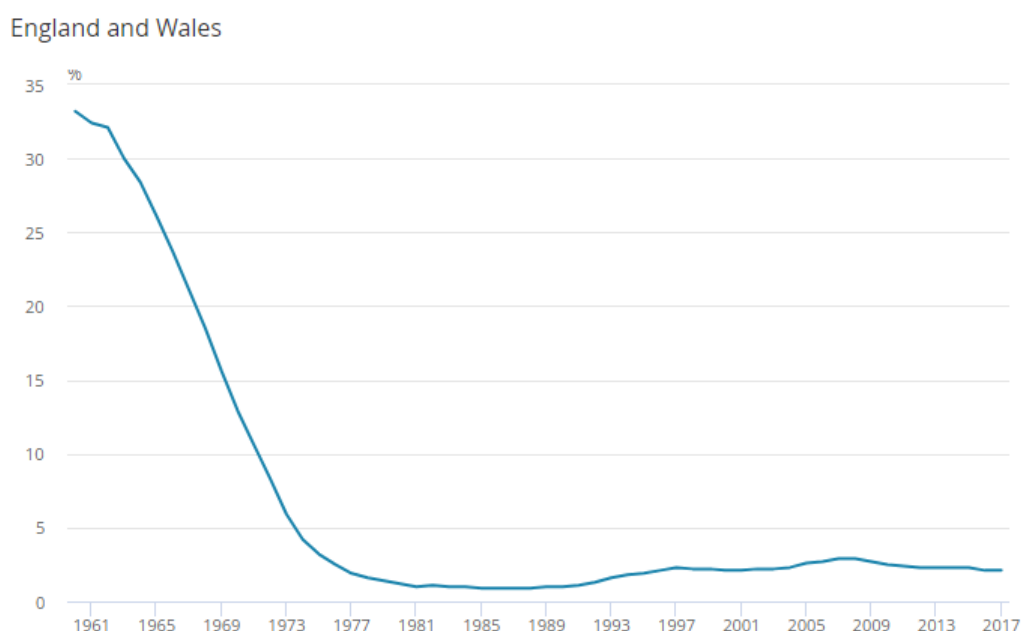


Figure 1. Percentage of women giving birth at home in England and Wales, 1960 to 2017.

Research and policy in England have aligned to promote choice of place of birth, personalised continuity of care and family-centred clinical models; however, it appears that aspects of these have been lost in translation to practice and service provision. Not only are home birth rates declining (Figure 1), midwifery-led care configuration is not consistent across England, uptake of midwifery units varies widely and closures of freestanding midwifery units (FMUs) and continuity of carer services are becoming increasingly common (Rayment, et al., 2019; NMPA Project Team, 2019). One in 10 pregnant women would prefer to have a

home birth, yet only 2.1% of births occur at home (ONS, 2017). Is this disjuncture coming from parents simply deciding to plan their births in other settings, enacting their informed choice, or a breakdown at the nexus of choice, information provision and service configuration?

Why study place of birth?

In the opening of *Bodies That Birth*, Chadwick tackles not only the ‘why’, the ‘where’ and the ‘how’ but also the ‘why now’, concerning her study of birth. As researchers, we often do not consider the timing of investigation, simply the apparent need for it. As she points out, birth politics continue to be contested, locally and globally, with a lingering “sense of crisis” attached to rising rates of medical interventions, dominance of risk discourse, high rates of unnecessary maternal deaths and increased visibility of birth trauma and obstetric violence:

We are currently witnessing a period of stagnation in relation to the feminist politics of birth, particularly in Northern settings, which has been argued to be currently characterized by conceptual impasses (see Walsh, 2010) and limited by narrow neoliberal valorizations of ‘choice’ (Beckett, 2005)...Continued essentialist understandings of birthing bodies and pervasive mind–body dualism have limited our ability to conceptualize and fully hear what women are saying when they tell stories about their births. Furthermore, narrow binary conceptualizations of biomedical versus natural models of birth, usually written from privileged geopolitical positions, has stymied our ability to think of birth in alternative, heterogeneous and intersectional ways. (Chadwick, 2018, p. 2)

For parents living in the ‘global North’, choice illusions and realities have created disjuncture between birth plans and lived experiences. “In a global sense, all is not well with birth” (Chadwick, 2018, p. 4). Despite positive policy shifts, promoting agency and experiences that are aligned with personal values can lead to complex trade-offs, as choices are based on more sophisticated, expanding services with less reliance on clinicians’ intuitive judgment (Woolf, et al., 2005). How and whether informed choice is actually achieved are less concrete, with some maintaining that it is “at best, illusory” (Jomeen, 2012; Jenkinson, et al., 2016). The issue remains that, while health care professionals (HCPs) believe they are offering service users a choice, in reality, women still have a limited role in decision-making and do not feel their care is presented

as a choice (Stapleton, et al., 2002; Lewin, et al., 2005; McCourt, 2005; Hinton, et al., 2018; Naylor Smith, et al., 2018).

With the push for the diversification of services and their uptake, researchers and policymakers often seek to untangle what influences parents' decisions, in order to shape maternity care and information provision. Such considerations throw the complexities related to informed choice into sharp relief, specifically how to achieve it, augment it and assess it. Definitions of informed choice rely on theoretical predispositions, and attempts to reconcile these assorted definitions result in a concept that does not reflect how individuals make decisions in practice (Bekker, et al., 1999). Assessing informed choice appears to be just as perplexing: a systematic review of informed decision-making about health revealed a "paucity" of high-quality research (Bekker, et al., 1999), and little has changed since then. The concept is most often explored through the development and evaluation of decision-making aids. A review of pregnancy and birth decision aids suggests that decision analysis tools (DATs), those that help individuals make decisions when there are several options, significantly influence final choice and final outcome (Dugas, et al., 2012); however, the research on modern decision aids is still underdeveloped. This signals a need to further investigate to what extent a decision aid can influence choice and empower women to put birthplace preferences into practice. Exploring the decision pathway to a specific place of birth and subsequent choice outcomes will be key, as will be the differences between the two.

Providing choice not only increases the rate of straightforward births and parents' satisfaction with their birth experience and outcome (NCT, 2009), but also, in theory, 'empowers' women. Even the act of making a birth plan can strengthen women's decision-making capacities by expanding knowledge and understanding of maternity care (Moore & Hopper, 1995). Place of birth choices are often situated within an individual's socio-economic (Davis-Floyd, 1990) and cultural context (Donner, 2003), meaning there is an additional layer of entanglement beyond the physical, emotional and experiential aspects of childbirth, and this demands a social science, specifically medical anthropological, perspective. Such an approach provides a prism through which the complexity of decision-making and informed choice can be better understood, as the exploration of such intricacies is central to the discipline. Using a medical anthropological perspective and an ethnographic approach, I conducted research in East London, where the local NHS trust provides all four birthplace options to women with straightforward pregnancies, to address the issues surrounding parents' decision-making and informed choice, place of birth information

and decision aids. While the primary aim of this research was to explore and elucidate decision-making and informed choice about place of birth using ethnography, it also focused on contributing to an evaluation of Which? Birth Choice, an online resource and birthplace decision aid, in order to generate recommendations and outcomes for future development and research.

Which? Birth Choice

Which? Birth Choiceⁱ (www.which.co.uk/birth-choice/) is an online birth information resource for women and their families. The website is part of the charitable arm (No. 296072) of Which?, the brand under which The Consumer's Association operates. It was designed and launched in 2014 in collaboration with BirthChoiceUK, a group of maternity data experts. The site aims to support women and their partners to make the best decisions for them about where to give birth. The advice is independent and evidence-based, and the site aims to provide comprehensive information about NHS facilities across the UK. Which? Birth Choice is "designed to promote informed discussions with health professionals" (www.which.co.uk/birth-choice/about-us) and helps women find which of their local services suit their preferences and circumstances.

A key aspect of the site is the Birth Choice tool, which is an interactive decision aid that encourages women to explore their birthplace options, by way of a short survey that provides users with their 'best fit' at the end. All of the recommendations, which are updated according to the national clinical guidance, from the tool are based on the NICE Clinical Guideline (NICE, 2014) and findings from the Birthplace in England study (Birthplace in England Collaborative Group, 2011). The results that the tool produces also take into account the woman's personal preferences and circumstances, such as age, parity, geographical location and views on pain relief, transfer and medical interventions. The tool and its updates are tested with pregnant women and assessed by the Which? Birth Choice Review Board, a multidisciplinary panel of experts, who ensure all generated scenarios are clinically appropriate. BirthChoiceUK also reviews its performance on an ad-hoc basis to support development that adheres to clinical standards while simultaneously acknowledging women's autonomy about their birth choices.

The site receives over 60,000 unique visits a month, and internal research appears to reveal that many use the site to confirm pre-existing views on birthplace, while others use it to aid in deciding where they want to give birth. It is unclear, since no independent research has been conducted on the site, in what ways Which? Birth Choice influences these decisions. Research on decision aids in maternity care is inconclusive and indicates that information use is complex, with some forms of information having little influence on choice. Because evidence-based maternal health information websites are still somewhat of a novelty, there is little understanding of how women and their birth partners engage with and use the content, particularly a feature like the Birth Choice tool, throughout pregnancy. This is why a section of this thesis is devoted to simply exploring the site's use, influence and interaction with other information sources, in an effort to expound on these queries.

Affiliation with Which?

This doctoral research was co-funded by the charity branch of Which? and functioned as an independent evaluation of the Which? Birth Choice. The Consumer's Association also uses the Which? brand for their company limited by guarantee (No. 5801128); however, this project was not affiliated with this arm of the organisation. Which? is the largest consumer association in Europe, with over 800,000 members. The organisation is a politically-unaffiliated social enterprise that is funded by their commercial ventures and does not receive government funding or public donations.

Organisation of the thesis

This thesis is composed of 10 chapters, which encompass the rationale, background, methodology, findings and conclusions of my research. For clarity, I will outline what each broadly covers and describes. Chapter 1 discusses the history of English public health policy from the 1950s to present day, and how it has been entwined with place of birth and affected service provisions over the years. It also highlights the convergence of birthplace and medicalisation, the academic and public challenges to the latter and the changing 'landscape' of maternity care in England. In Chapter 2, my focus moves to academic contributions to what we know about place of birth. This includes both qualitative and quantitative research from the UK

and relevant research from other countries. It also highlights three emerging or key areas among birthplace studies: research conducted with women's (birth) partners, research about the health outcomes associated with different birth settings and considerations of control and choice. Though choice features prominently in maternal health discourse, I was not able to identify any systemic reviews, outside of those focusing specifically on influences, looking at the wider evidence on decision-making and informed choice in pregnancy and birth care. Chapter 3 details the systematic review that I undertook with three collaborators, describing our meta-synthesis design and resulting conceptual framework of decision-making and informed choice. Rounding out the literature review, Chapter 4 discusses contributions to anthropology of reproduction and birth, in which this thesis is situated disciplinarily, and develops the theoretical lens of my own research into place of birth, which ultimately argues for decision-making as *embodied practice*, drawing from Bourdieu's notion of *habitus* and Merleau-Ponty's concept of the *lived body*.

Chapter 5 is primarily concerned with laying out the methodology, setting and design of my research. I conducted two studies in order to build an ethnography of place of birth decision-making and informed choice. The first was an exploratory study based in the East London community, and the second was a feasibility study through Bart Health NHS Trust. The chapter also lays out my analytical strategy and considerations when employing ethnography in contemporary, urban field sites. Studying phenomena in context and employing reflexivity are cornerstones of ethnographic research, so Chapter 6 builds a reflexive account and thick description of East London and Barts Health NHS Trust, drawing from historical and local documents, my field notes and my community-based study. Chapter 7 delves into the findings and outcomes of the NHS-based feasibility study, with the intention of identifying the feasibility of conducting a randomised controlled trial (RCT) and longitudinal study on informed choice to test the impact of Which? Birth Choice more formally. It also provides an evaluation of such a decision aid. In Chapter 8, I use several 'vignettes' from my interlocutors in the NHS-based study to illustrate the corporeal and temporal dimensions of deciding where to give birth and further develop my analysis of decision-making as embodied practice. This chapter leads to my discussion of the core themes and argument of the thesis in Chapter 9, in which I develop my ideas on embodied practice, which consider decision-making as a process that implicates the body, discuss the wider cultural attitudes to maternity in England and reconceptualise informed choice. Chapter 10 concludes with a description of the limitations and challenges of my research

and the recommendations for future decision aid and research development. Finally, I close with a consideration of the implications of this thesis for the field of anthropology of birth and for policy and practice.

Terminology and citations

Over the years, birthplace-related research has used a variety of terms to define different settings, which can lead to difficulties and confusion when discussing it. The following terms were adopted by the NPEU Birthplace in England Collaborative Group, so, for purposes of consistency, these are also used throughout my thesis:

- Planned home birth;
- Birth in a midwifery unit, either ‘freestanding’ (FMU), or ‘alongside’ (AMU), where care is led by midwives;
- Birth in an obstetric unit (OU), which is led by consultants.

The glossary (Appendix M) provides more detailed definitions of these, along with other potentially unfamiliar terms related to pregnancy and birth. Classifications of pregnancies as ‘low-risk’/straightforward or ‘high-risk’/complex are consistent with the advice in the NICE *Intrapartum Care Clinical Guideline* (2014). This thesis uses terms related to women’s risk status interchangeably, as it is still common in many health systems, especially in England, to designate women as either ‘low-risk’ or ‘high-risk’.

References in this thesis have been cited according to Harvard guidelines, using final publication dates. Several papers and sources were pre-published online in advance of their eventual publication date, presented at conferences beforehand or shared via personal communication. Some citations in the following chapters have very recent publication dates; where this occurs, the cited research has informed the conduct of this research, and was available in pre-publication format during the course of the study.

Chapter 1: Public health policy and place of birth

In England, shifts in patterns of birth setting uptake are inextricably linked to a history of medicalisation and our relationship to the medical system itself. The medicalisation of maternity can be traced to the late 19th century, as public health policy unfolded more prominently into social and political life, and the professionalisation of obstetrics and midwifery moved forward. The development of the NHS in 1948, while a watershed moment in British history, expedited the increasing trends of hospital birth. The focus of this chapter, therefore, will be to explore the linkages between public health policies, medicalisation and place of birth trends from the 1950s onwards. Overall, this was a period of expanded hospital-based care and obstetric practice, until pressure groups, such as the National Childbirth Trust (NCT), emerged during the 1970s and 1980s, demanding more respectful maternity care, less intervention in obstetric practices and the 'right to choose'. Policy responses to this pushback were often slow; the most significant shift in choice rhetoric occurred in only 1993 with the publication of *Changing Childbirth* (Department of Health, 1993). Since this report, the government has been committed to ensuring that women have access to a range of choices in maternity services (Department of Health, 2016), with National Institute for Health and Clinical Excellence (NICE) recommending that women with straightforward pregnancies should be offered a choice of home birth, midwife-led units or OUs, and emphasising that HCPs should be providing information and advice about all available settings in order to facilitate informed birthplace decisions. Given the prominence of *Changing Childbirth*, this chapter will also review the policy actions of the last quarter century and how they affect present-day research on place of birth.

Place of birth and medicalisation

Women did not always predominantly give birth in the hospital in the UK. Until the mid-20th century, birth primarily took place at home, with midwives in attendance. In the 1960s, women started giving birth more frequently in hospitals, meaning both midwives and recent generations of mothers are less likely to have memories, personal experience or family stories about birthing outside of this setting. Home birth has sprung back into the British pop cultural milieu with the popularity of the BBC television series, *Call the*

Midwife, which depicts midwifery care in the post-World War II East End of London. While the series brings non-facility-based birth back into the collective, social memory, it tells stories about maternity when care services and social infrastructure were very different. This, coupled with the popularity of another series, *One Born Every Minute*, which follows contemporary women giving birth primarily in OUs, presents a confusing media message about how birth ought to be and where it should take place. I submit these two series for scrutiny to illustrate how the depictions and conversations about birthplace matter. The content of these, among other factors, affects the discourse about it and the everyday practices of women in subtle ways, while also reflecting common social views about the nature of childbirth. They are very different; however, each series depicts birth as a drama, a life changing, albeit potentially dangerous, event.

These series, in a sense, provide a visual history of what British maternity care used to be and a reality television-stylised view of what it looks in the early 21st century. From the perspective of public health policy, this history and the current state of affairs are certainly less dramatically gripping, despite the fact that the documentation is infused with similar notions of safety and risk as they are related to hospital-based medical care. Several researchers have since pointed to this rhetoric of safety and risk as one of the driving forces of the medicalisation of childbirth (Tew, 1990; Coxon, et al., 2012; Clews, 2013). In this policy context, birth was pathologised (Flint, 1986) and reproduced as a process that requires technological management within an OU (Towler & Bramall, 1986). By 1959, the Royal College of Obstetricians and Gynaecologists (RCOG) supported hospital birth for all women to ensure “maximum safety” (Ministry of Health, 1959, p. 5); however, public health policy did not reflect this aim until 1970. The Peel report (DHSS, 1970) recommendation that *all* birth should take place in the hospital was unequivocally accepted and further promoted the notion that this setting equated safety, thus implying that community midwifery care was an inherently risky practice (Cahill, 2001). The transportation of childbirth from home to hospital, from midwife to doctor coincided with a period of decreasing maternal and infant mortality rates, which was erroneously used to strengthen and support medical claims of safety. The assumption was that correlation equalled causation, and unsubstantiated links were drawn between decreased mortality rates, biomedical knowledge and hospital-based birth that are still commonly referred to but have since been discredited (Campbell & Macfarlane, 1987; De Brouwere & Van Lerberghe, 2001). Essentially, when comprehensively reviewed, dropping mortality rates cannot be attributed to one, single intervention, as there were several aspects of health care concurrently improving, including governmental

commitment to public health, availability of high quality data, access to medical care and advances in obstetric practices (De Brouwere & Van Lerberghe, 2001).

There are several implications of policies companioning more medicalised, hospital-based births. Medicalisation squarely placed the privilege and power of care within obstetrics, which marginalised midwifery knowledge, as well women's own intuitive knowledge (Hewer, et al., 2009). This policy position contested the safety of non-hospital birth and midwifery care, using evidence that was either underdeveloped, uncertain or unsubstantiated and effectively delegitimising care that was not strictly obstetrics. The issue is not necessarily that the hospital is unsafe, but rather that it is problematic, in terms of the amount of interventions occurring in this setting, the extent to which they are necessary and the effect that they are having on health outcomes and birth experiences. Medical interventions and caesarean section rates continue to rise, while the rate of spontaneous vaginal birth declines. Induction at onset of labour has risen from 20% to 32% between 2007-08 and 2017-18, while spontaneous onset of labour has dropped from 69% to 52% (NHS, 2018). Research does indicate that birth interventions are associated with lower general health postpartum, and reported issues ranged from exhaustion, lack of sleep, bowel problems, sexual problems and perineal pain. (Lydon-Rochelle, et al., 2001; Thompson, et al., 2002). While postpartum morbidity is widespread and affects many women regardless of mode of birth, those who have had an assisted vaginal birth or caesarean section experience more short- and long-term morbidity than those who have had a spontaneous vaginal birth (Borders, 2006).

Caesarean rates have increased steadily over the past four decades, from 4% in 1970 to 12% in 1990, and then climbing further still to 28% in 2017-18, a growing proportion (12%) of which are elective (Dodson, 2001; Parliamentary Office of Science and Technology, 2002; NHS, 2018). Caesarean section is a life-saving procedure; however, with increased use, especially without medical indication, it is crucial to have a firm understanding of its effects on women and their children. Since 1985, the WHO has recommended that necessary caesarean section rates should not exceed 10-15%, and yet, figures from developed countries continue to climb well above this mark. Researchers, the British government and the WHO all take similar stances on the effectiveness of increased caesarean rates for producing better outcomes for mothers and babies (Johanson, et al., 2002; Parliamentary Office of Science and Technology, 2002; WHO, 2015), and there is also no association, at the population level, between caesarean section rates over 10-15% and a reduction in maternal and neonatal mortality. Sandall and colleagues (2018)

recently brought together and reviewed evidence concerning the effects of caesarean sections on the short- and long-term health outcomes for mothers and their children. They found that the prevalence of maternal mortality and maternal morbidity is higher after caesarean section than after spontaneous vaginal birth. The procedure is associated with increased risks of uterine rupture, abnormal placentation, ectopic pregnancy, stillbirth and premature birth, and there is emerging evidence that infants born by caesarean section have “different hormonal, physical, bacterial, and medical exposures” (Sandall, et al., 2018, p. 1349). Short-term risks for children include altered immune development, increased chance of allergy, atopy and asthma and reduced diversity in the gut microbiome. There is less research about the persistence of these into later life, but the research reviewed often reported an association between caesarean section and greater incidence of late childhood obesity and asthma.

Western societies appear, then, to have a warped view about how far the parameters of ‘safety’ stretch when it comes to maternal and infant health and well-being. Skirting immediate obstetric ‘dangers’ or sketchy birth uncertainties appears to trump short- and long-term livelihoods of families. It is important to emphasise that there is much that researchers do not know because “[t]he evidence regarding outcomes of [caesarean sections] for women, infants and children is complex, often of poor quality, and carries uncertainty in establishing causality over the longer term” (Sandall, et al., 2018, p. 1354). In light of this research, unpacking how the rhetoric of safety, medicalisation and misuse of evidence subsequently affected British women and their maternity care for over 50 years is crucial. In reviewing the policy history, it becomes more or less explicit where the tipping points were and how they spilled into women’s lives. For instance, the Peel report (DHSS, 1970) did not seek opinions from the public and left little room for women to make decisions about their care. This is indicative of the policy agenda of the time, in which there was no reference to women’s preferences, rather an allusion to increasing demand for hospital birth, while special interest groups campaigned for better access to maternity care for poorer women (Coxon, 2011). These oversights afforded a space for critique during the 1980s, as concerns about medicalisation and caesarean rates mounted. Work from academics and midwives paved the way to a multidisciplinary collaboration that questioned the capacity of hospitals to provide good quality maternity care (Oakley, 1980; Inch, 1982; Oakley, 1984; Tew, 1977; Campbell & Macfarlane, 1987). Despite the burgeoning evidence of their potentially pernicious effects, interventions during birth are still routinely performed and in increasing numbers, particularly among women who plan their births in OUs. According to the Birthplace

in England study (2011), 58% of low-risk mothers achieved a spontaneous vaginal, or 'straightforward', birth in the OU, whereas 88% achieved this during their planned home births. However, unlike previous decades, there is now a sense of convergence as evidence and policy point in the direction of midwifery units and home birth not only as ideal, providing a 'gold standard' of care, but also as protective of women's agency and bodies.

Cranbrook report (1959)

Though there was a growing inclination, among both HCPs and women, for facility-based birth before the 1950s, more notable steps were taken during the decade to solidify the move from home to hospital, resulting in rates reaching near-complete hospitalisation by 1975. The 1955 Guillebaud enquiry¹ into the cost of the NHS raised concerns about how maternity care was shared among three sectors, GP executive councils, hospitals and local authorities, and the regional variations in services, resulted in the recommendation of a review. The Cranbrook committee, led by the Earl of Cranbrook, was subsequently charged with this review, meeting 41 times over three years, consulting across professional boundaries and seeking testimonies from women's groups. Aforementioned, the RCOG already supported total "institutional confinement", and the College was against the distribution of maternity services, putting forward unification under obstetrics. The committee, on the other hand, did not find total hospitalisation in women's best interest, recommending "sufficient hospital maternity beds to provide for a national average of 70% of all confinements to take place in hospital", as this "should be adequate to meet the needs of all women in whose case the balance of advantage appears to favour confinement in hospital" (Ministry of Health, 1959, p. Appendix 1).

With a hospitalisation rate nearing 65%, 70% this was hardly a stretch, and the latter appears to more represent a compromise between the Guillebaud committee and the RCOG, rather than an intensification to hospital care provision. The recommendation of 70% attempted to provide hospital birth to women with known or foreseeable issues, particularly first-time and impoverished mothers, those over the age of 35 and women with more than three children. The Cranbrook report did acknowledge that 10-

¹ The Guillebaud committee proposed hospital provision for 50% of women giving birth.

20% of women preferred home birth, and that it had physical and psychological benefits, including reduced fear of labour and risk of infant infection, increased breastfeeding and continuity of care and improved mother-infant bonding. However, it argued that preventable deaths were happening at home mainly because women were not selected appropriately for them, even though it also attributed the growing hospital birth demand to 'inter-war propaganda' concerning maternal mortality, showing just how disparate the evidence, organisational stances and opinions were during this enquiry. In fact, the shift from home to hospital was born from inter-professional competition between community and hospital doctors, as well as the desire to wrestle the management of births from midwives' control (Chamberlain, et al., 1997), under the guise of promoting increased safety for mothers and better health care access for lower-income women.

Cranbrook sparked a yearlong debate in the *British Medical Journal (BMJ)* over the course of 1960, unpacking the report's claim that there was unmet hospital demand among the public. Several articles presented research from local surveys demonstrating that around 80% of women preferred home birth, and another added that, while 80% of women in their area preferred home birth, only 24% actually chose it. These were further challenged by Baird (1960), arguing that poorer women could be pressured by their social circumstances to choose home birth, as using a hospital meant leaving their children with husbands, relatives or strangers. For Baird, birthplace choice was perpetuating unequal access to hospital care, affording affluent women more flexibility in their choices. In rebuttal, Elias-Jones and Gordon agreed with the provision of hospital beds where justified; however, they should not be provided for those who "demand them for non-medical – and even frivolous – reasons" (Elias-Jones & Gordon, 1960, p. 1366). While each side makes an effort to reason demand and choice, there is a paternalistic concern for women's health and well-being. For Baird, offering choice also constrains choice; eliminating it all together levels the field for women's access to care, in that everyone accesses the same services, regardless of class. It mistakenly assumes the issue for poorer women is having choices, rather than systematic inequalities that affect their decisions and health. It also reflects, as Coxon (2011) points out, the patriarchal values espoused at the time and the gendered language used to communicate women's desires:

"The use of the term 'preference' appears important in this context, because it carries connotations of politeness and careful consideration; the act of preferring is feminine in the sense that it expresses wishes without conveying *insistence*...Women in the GP and Local Authority doctors' surveys were usually couched

as having preferences (feminine and accepting), but became problematic when they ‘frivolously insist upon’ and even ‘demand’ hospital care” (Coxon, 2011, p. 25)

Peel report (1970)

The RCOG’s stance was eventually actualised vis-à-vis total hospitalisation with the Peel report, which stated that “the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100% hospital delivery” (DHSS, 1970, p. paragraph 277). The committee cited the 25% hospital transfer rate for first-time mothers having a home birth and the higher perinatal mortality (three times the national average) as proof that the Cranbrook report’s guidance for home birth selection was not being implemented properly. The support of blanket hospital-based births essentially implied the withdrawal of policy support for home birth (Campbell & Macfarlane, 1990), though the authors claimed to “accept the view of the Royal College of Midwives and Chairman of Local Medical Committees that wishes for home confinement should be respected, provided, of course, that there are no medical or social contra-indications” (DHSS, 1970, p. paragraph 249). Despite citing the interest of women’s safety in the elimination of home birth, there was little substantial data provided by the report’s authors of increased safety in hospitals, which left a space for criticism in the prevailing decades.

In many ways, outside of hospitalisation rate recommendations, the Peel report differed from the Cranbrook report. Data was collected differently, in that the Peel committee took evidence only from professional bodies, without consulting the public, as the Cranbrook committee had done. They met 13 times, as opposed to 41, and the committee was chaired by Sir John Peel, who was a consultant obstetrician and then-president of the RCOG. Researchers and writers condemnatory of the Peel report criticised the lack of statistical expertise as leading to poor quality analysis, and cited the limited consultation of mothers’ actual views (Oakley, 1984; Campbell & Macfarlane, 1987; Tew, 1990) as interconnected with the intensification of medicalisation, even though women had long been advocating for increased access to pain relief and hospital beds for lower-income parents. Indeed, the Peel report consultation was constrained compared to Cranbrook’s, yet it is difficult to extricate if women’s opinions were sincerely appraised and not cherry-picked to support an ongoing power struggle between community and hospital

doctors, as well as between obstetricians and midwives (Chamberlain, et al., 1997). Women's views were perhaps used more to redress policy, rather than influence service provision, meaning that they were actually 'subservient' to several overarching organisations, used as subsidiaries to fuel professional agendas (Coxon, 2011).

The primary issue was *why* perinatal mortality had not dropped, even with the move towards greater hospitalisation. Obstetricians generally pointed to home birth uptake despite pregnancy risk, which meant criteria for complications warranting hospital birth were widened (Tew, 1990). Pregnancy effectively became a socially constructed period of risk (Edwards & Murphy-Lawless, 2006) – albeit risk that was preventable – for which only “[g]ood antenatal care and safe delivery in a hospital fully equipped and staffed to deal with any emergency can prevent family tragedies once thought to be unavoidable” (The Lancet, 1963). Class differences were also invoked during debates of safety, which implied that poorer women were subject to unsafe home birth due their inability to leave other children with reliable carers (Barid, 1960) or to understand GP explanations of hospital benefits because of lower education (Topliss, 1970). What is evident is that the argument of ‘hospital is the medically safest option’ was in the best of interest of hospital-based obstetrics, regardless of whether this was built on any tangible evidence of improved outcomes or considered evaluation of women's subjectivities in maternal experience.

Much of women's identities are associated with motherhood, and the notions of maternal responsibility are highly moralistic and driven by social sanctions. Using safety as a primary factor in choosing hospital birth, not only immediately places a sanction on choosing any setting outside of it but also ascribes either responsibility or irresponsibility to women's birthplace choices. Women were inundated with “admonitions that to give birth anywhere [other than hospital] was to endanger their own and their baby's life” leading women to “acquiesce” and concede that “doctor knows best” (Tew, 1990, p. 15). It is a powerful narrative to suggest that a woman's birth preferences could harm her baby and are, thus, a social irresponsibility, given that motherhood and nurturing are built heavily into femininity. Though women wanted greater access to hospital birth, the appropriate provision of which could have worked towards lessening maternal and infant health disparities, it is hard to disentangle to what extent they wanted this, and whether or not ‘demand’ was predicated on a gendered discourse that maligned women's choice in favour of profession-specific advancement and domination. It appears unbelievable that women could want *all* of these aspects to their maternity services, augmentation of hospital birth, continued

availability of home birth, ubiquitous safety, pain relief and continuity of carer – or that services could safely support such a multifaceted system – rather than a forced dichotomy of medicalised care versus midwifery services.

Challenging medicalisation

Because the Peel report used such tenuous evidence to justify total hospitalisation of birth, a barrage of literature was published challenging the assumption that this setting was the safest place to give birth. Tew (1977; 1985) produced two epidemiological studies of birthplace and perinatal mortality, and Inch published *Birthrights*, introducing and describing the concept of a “cascade of intervention” (Inch, 1982, p. 244). It would be remiss to leave out the crucial social science research from the US (Shaw, 1974; Arms, 1975; Jordan, 1978; Martin, 1987) that partially led to the escalating focus on maternity care. In *Immaculate Deception*, the namesake was the belief among obstetricians and parents alike that the hospital is the safest setting and that medical interventions can improve the birth process, while home birth is dangerous and midwives incompetent compared to doctors (Arms, 1975). At the time it was published, there was little public engagement over the American obstetric record, and much of the knowledge production about birth was dominated by obstetricians, rather than midwives and academics. Pushback in the 1970s was connected to the Women’s Liberation movement, part of which was concerned with empowerment through understanding basic information about female reproduction, asking questions about bodily functions and gaining control over one’s body. Kitzinger, who carried out research for the NCT about episiotomy use in the NHS, noted that her work:

[E]ncouraged many women to ask questions where they hadn’t dared question before...It’s not as if women are terribly brave about asking questions now or they may be told, you know, you don’t want to harm your baby, do you?...That’s why it’s to do with women’s liberation, with feminism...it’s a worldwide movement and a worldwide challenge as women everywhere, in developing societies too, learn how to take control of their bodies, not in the sense of gymnastic exercises and ordering their bodies to behave in certain ways, but trusting them, living through them, expressing themselves (Kitzinger, 2012).

During the mid-1980s, criticisms of hospital birth and maternity services' treatment of women took off, as concerns over rising caesarean section rates sparked debates in academic spheres, and the incompetence case against Wendy Savage became publicised. Savage was removed from her position at the London Hospital (now the Royal London Hospital), and a public enquiry followed, during which it was insinuated that her support of home birth at once challenged medical norms and isolated her in a "profession [that] still behaves on occasions like an Edwardian gentlemen's club, concerned to close ranks against anyone with non-conformist tendencies and taking on faith the integrity of "clubbable" individuals" (BMJ, 1986, p. 286). Though there may have been little public debate about place of birth, the plates had already started shifting and taking shape. Oakley published *Women Confined* (1980) and *The Captured Womb* (1984), critically exploring the treatment of women during pregnancy and birth. Campbell and Macfarlane (1986; 1987) co-authored reviews, synthesising birthplace evidence and continuing to challenge the Peel report's analysis.

Though there was a surge of policy-altering research produced during the 1980s, the activity was varied, with important contributions from Association for Improvement in the Maternity Services (AIMS), Association of Radical Midwives (ARM), NCT and Society for the Support of Home Deliveries (Campbell & Macfarlane, 1994). In 1987, the first International Conference on Homebirth was held, proving the flourishing alliance between HCPs, researchers and childbirth advocates, and the public critique of hospital-based maternity care was gaining traction. There is an overwhelming feeling, reviewing this period, that women were dissatisfied with and beginning to reject the dominant medicalised systems and culture, and that doctor-patient relationships and communication were fraught with contention and power imbalance (Topliss, 1970; Graham & Oakley, 1981). What emerges is a sense of "competing ideologies" (Graham & Oakley, 1981), between professional and maternal, medical and natural, a separation that persists today. How ubiquitous were these views? Many of the figures active in researching and challenging medicalisation were middle-class women, who placed "heavy emphasis on personal experience [that]...resulted in the emergence of a single critique which presumes to speak for all women" (Nelson, 1983, p. 285), obscuring the experiences and perspectives of lower-class women. Nelson (1983) and McIntosh (1989) found that working-class women were less opposed to medical interventions and HCP control over the management of their births. They were also less concerned with the 'natural birth' movement than middle-class women, which required time and money, two components that were less accessible to lower-income women

(Nelson, 1983; Reid, 1983). Further research suggested that even middle-class women accepted medicalised birth and procedures – termed the ‘technocratic model’ – which, to them, represented upholding the ideals of their society (Davis-Floyd, 1993). Nelson is careful, in making her distinctions between middle- and working-class women’s ‘models’ of birth to note that no one, in either group, was truly getting what they wanted; the issue was that social movements were not addressing the maternity concerns of the latter in a relevant or meaningful way (Nelson, 1983).

Notwithstanding these valid and necessary critiques, choice in care and control in maternity experience were relegated to obstetricians. Home births had dropped from 30% to 0.9% between 1964 and 1987, and community-based intrapartum care effectively ended, save in isolated GP units (previously called maternity homes), where most of the care was provided by midwives, unless in the event of a complication (Tew, 1990; Campbell & Macfarlane, 1994). In 1991, the ‘purchaser-provider split’ was introduced, proposed as a remedy for inefficiency in the NHS, based on free-market ideology, and maternity services were consolidated into ‘trusts’. Institutions fixated on efficiency meant that models and methods of care were adopted to maximise productivity and minimise time consumption (Oakley, 1984; Martin, 1987). Women’s bodies were constructed as machines, the baby its product, and because this machine was imperfect and prone to dysfunction, obstetric practice was the only and *best* way to keep the birth process efficient and safe, rendering their knowledge the authority on maternity, regardless of whether it was correct or in accordance with women’s wishes (Martin, 1987; Davis-Floyd, 1993). Unnecessary interventions, such as episiotomies, enemas and perineal shaving, and limiting women’s role to that of the ‘good patient’ were all part of routine birth care that supported and perpetuated this industrialised, medicalised system, even if some procedures had no effect on incidence of infection (Romney, 1980). With the building evidence of inappropriate use of obstetric interventions, the WHO began a campaign, supporting the suitable use of technology and stressing the risks associated with unnecessary procedures (WHO, 1985), and a number of UK policy changes were in the pipeline that would shape future discourse on women’s choice in maternity care.

Winterton report (1992) and *Changing Childbirth* (1993)

The Winterton report (House of Commons Health Committee, 1992) was released in 1992 and challenged the Peel report, and this policy shift was reflected the next year with the publication of *Changing Childbirth* (Department of Health, 1993), which recommended that women be offered a choice of birthplace along with the provision of information and opportunities to discuss their options with HCPs. The first report was a culmination of a review of maternity care, after consistent reports of poor care during pregnancy and birth, which was supported by professional and public consensus, clinical evidence and activism. In response to the Peel report's 100% hospital birth recommendation, it argued that "the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety" (House of Commons Health Committee, 1992). The Winterton report recommendations were rejected by the RCOG, but an expert group was formed, chaired by Baroness Cumberlege – a minister, not an obstetrician² – to investigate further. In a notable shift of power, the group included the NCT but no members from a Royal College, and drew heavily from *Where to be Born: the Debate and the Evidence* (Campbell & Macfarlane, 1987) to reach its conclusions, ultimately finding "no clear statistical evidence that having babies away from general hospital units is less safe for women with uncomplicated pregnancies" (Department of Health, 1993).

The Cumberlege report, known as *Changing Childbirth*, reconceptualised the notion of safety, cautioning against its use as "an excuse for unnecessary interventions and technological surveillance which detract from the experience of the mother" (Department of Health, 1993, pp. 9-10). A choice of place of birth should be provided to women, as well as better information about their options and opportunities to discuss their decision with HCPs. Information and greater capacity in decision-making was expected to lead to improved experiences and satisfaction with childbirth. The provision of choice meshed nicely with the Conservative government's neoliberal policies. "Neoliberalism proposes that individual well-being is best advanced by liberating entrepreneurial freedoms and skills within an institutional framework, characterised by strong private property rights, free markets and free trade" (Harvey, 2005; Strurgeon, 2014, pp. 408-9). Reducing profligates and allocating resources with coherence was seen to be achieved most efficiently

² Baroness Cumberlege is the daughter of a GP and had experience of GP-midwife home birth services as the norm.

through markets, and for the public sector services, this meant commodifying health care, creating new consumers, introducing individual choice and forging public accountability (Strurgeon, 2014). The purchaser-provider split did more than attempt to consolidate the health and social care; it also introduced internal markets into the NHS in an effort to augment services' quality and efficiency. Mothers, already mechanically commodified, were reproduced as consumers, whose empowerment was assembled from their participation in the health care market, though 'choosing' their care. *Changing Childbirth* is often cited as a watershed moment for maternity care in the UK; however, it was a propagation of the ideals of the time, which have since been the focus of much scrutiny. Sandall identified five themes from the report, including "consumer-led care responsive to local needs", "efficient and effective care" and "provides value for money" (1995, p. 202; emphasis my own). McCourt found, during this period, that a multifaceted report evaluating a midwifery service providing continuity of carer was reduced to a question of economics by health service managers (McCourt, 1998). Moreover, expanding choice and consumer capacities in health care was seen as a way to partially alleviate poverty (Sandall, 1995). There is only suggestive evidence of an equalising effect from increased choice in health, while a great deal more has been done on how structural inequalities shape health and care access, which has been used selectively or not at all in the development of British policies (Fotaki, 2010).

How *Changing Childbirth* was then translated into practice and service provision was underdeveloped, as it required organisationally complex changes. Though it championed continuity of carer and community-based models, at the time, there was little evidence to as to what these looked like in practice, for both midwives and women (Sandall, 1995). There was also little research to back up the claim that "a more holistic, empathic and egalitarian style of care" would actually ensure increased choice and control for women (Sandall, 1995, p. 206). The report was beneficial in breaking the obstetric hold on pregnancy and childbirth at the policy level, but it appears that women still had limited opportunities to exercise choice, proven by the subsequent wealth of research aiming to improve decision-making, including this thesis. Only marginal increases in home birth rates took place, far from the 10-15% estimate of Campbell and Macfarlane (1987). Women *felt* that they had a choice, which rose from 17% to 57% between 1995 and 2007 (Audit Commission, 1997; Health Care Commission, 2008), yet uptake of non-hospital services remained low, suggesting either an aggrandisement of home birth preference or persisting constraints on choice that were structural, rather than simply professional.

Maternity Matters (2007)

Since the mid-2000s, there has been a revitalised commitment to providing women with real choice in their maternity care, including place of birth options. *Maternity Matters* (Department of Health, 2007a) outlined the specific birthplace options that women, depending on their circumstances, could choose. Crucially, they included “birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre”, or midwifery units (Department of Health, 2007a, pp. 12-13), and a policy provision that women would have all of these choices by the end of 2009. Again, augmenting choice, now coupled with the promise of diverse birth services provision, was placed as the central component for the government’s initiatives to reduce unnecessary interventions and provide better care; however, “choice itself is a complex issue involving many facets” (Edwards, 2008, p. 772).

As the Edwards (2008) lays out, there were several strands that made up this complexity, particularly women’s relationships with practitioners, external influences that direct choices, contentious views among professionals, differential risk criteria and resources for quality provision of services. There were conflicting views within choice literature about whether or not women’s decisions were being blocked by HCPs (Jomeen, 2007), or if finding the amount of information required to make decisions was too overwhelming to manage (Levy, 1999). There were issues of systematic privilege and choice accessibility; those who were better educated and had higher incomes had better access to information and non-hospital options (Kirkham, et al., 2002), while those from ethnic minorities had less choice (McCourt & Pearce, 2000; Dartnall, et al., 2005). There was institutional disagreement over where the safest place of birth was located; the RCOG maintained the hospital, and the Royal College of Midwives (RCM) promoted non-hospital settings with proper assessments and resources. At this point there was little evidence indicating the safety of one birthplace over another, and the NICE *Intrapartum Care Clinical Guidelines* went so far as to state that:

Women should be informed that if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care. (NCCWCH, 2007, p. 62)

Risk and uncertainty are intertwined in many of the debates on safety of different places of birth, and without definitive research, there was only a trend that suggested that perinatal mortality *might* be higher with planned out of hospital births. Risk status, regardless of the organisational body it is generated from, is a powerful framework that shapes the choices open to women. The NICE *Intrapartum Care Clinical Guidelines* did provide a criterion for assessing risk status, relieving potential imbalances between HCP-defined risk and women's own perspectives of their status, yet it is still the professionals who dictate which category women are placed in, meaning evidence-based practice and choice may be discordant at times.

Despite the good intentions of *Maternity Matters*, resource management and limitations could be a reason that it was unrolled unevenly across England, and given the efficiency ideals that underpinned the purchaser-provider spilt – still firmly in place at this point – there was uncertainty whether opening smaller midwifery units was more costly than centralisation of services (Edwards, 2008). Several midwifery units were under threat of closure, whether it be for underuse or overcrowding (Savage, 2007). In their 2005 survey of nine trusts, Beake and colleagues (2007) found that only three had midwifery units, and though all supported home birth, the mean rate of uptake was 1.5%. This was a snapshot of English maternity care, but it shows that Trusts had varying levels of service provision, and without adequate funding for new staff and units, implementing policy and creating alternative birthplace settings was difficult. There was some successful implementation of the recommendations from *Changing Childbirth* and *Maternity Matters*, but the odds were stacked against wider midwifery unit development. The 'payment by results' tariff system, which was introduced in 2003, with the goal of bringing more transparency to NHS funding, meant that providers were paid more for assisted births and caesarean sections than spontaneous vaginal births, creating a disincentive in working to reduce them (Rocca-Ihenacho, 2017), and has been cited as a major impediment to midwifery unit expansion (McCourt, et al., 2014).

As with *Changing Childbirth*, there was a gap between policy rhetoric and institutional realities that kept the NHS from fully realising the recommendations of *Maternity Matters*. Moreover, the neoliberal principles of augmenting public accountability, efficiency and consumer choice were again prioritised without consideration for systematic inequalities or indeterminate research on women's decision-making, safety of settings, financial benefits or constraints, successful models of care and local capacities for diverse service provision. The goal of *Maternity Matters* was to improve the quality of care through choice, instead of supporting physiological birth; it was simply implicit that this would be achieved in non-hospital settings,

where intervention was less likely (Coxon, 2011). Even with the continued push for choice, the caesarean section rates in England continued to increase: 23% in 2004-2005 (NHS, 2006); 26.5% in 2014-2015 (NHS, 2015b). What was clearly needed was a more comprehensive mapping of childbirth services, a cohesive professional stance on place of birth, a genuine commitment to physiological birth and a realistic consideration of women's choice.

Better Births (2016)

In recent years, there has been a further sea change in maternal health care policy, which is gradually rippling out to service provision and care practices. The focus, it appears, is increased integration of personalised care and community-based services, with particular emphasis on facilitating informed choice, reducing interventions during birth and promoting physiological birth. More definitive evidence about the safety and health outcomes for low-risk women and their infants using different birthplace options was published, accompanied by an economic study suggesting that midwifery units and home birth were the most cost-effective settings for nulliparous and multiparous women, respectively (Birthplace in England Collaborative Group, 2011; Schroeder, et al., 2012). The policy repercussions of the study have been significant. Since the Birthplace in England study, the NICE Intrapartum Guidelines (2014) and the NICE Quality Standards (2015) have recommended service providers offer midwifery-led settings to women with uncomplicated pregnancies. The Birthplace in England group also provided wide scale mapping of maternity services, finding that, in 2007, 66% of trusts did not have midwifery units (MCourt & Redshaw, 2011). The number of units did increase 11% by 2010, but there was considerable variation in the strategies that NHS trusts employed, the capacity in units during labour and birth and the admission eligibility criteria (Redshaw, et al., 2011). Though some differences can be explained by population density, the authors stated that it was:

[U]nlikely that the care needs of mothers and babies vary to the extent that services do, particularly those at low risk of complications. The variation in all the aspects of maternity care service delivery and organisation reported goes beyond such differences and appears to reflect inequalities in provision...While the evidence and findings presented create a national picture, perhaps more significantly, the variations described can be used as drivers for change and quality improvement both locally and nationally. (Redshaw, et al., 2011, p. 13)

In essence, the study was meant not as a critique of weak policy implementation, rather it presented an opportunity to review and make changes to services, using a comprehensive evidence base.

Another step forward in beginning to realise policy recommendations was the reform of the ‘payments by results’ and the introduction of a pathway payment system that addressed the “inability of th[e former] payment system to act as a sufficient lever for quality improvement” (Commissioning Board, 2012, p. 4). Instead of episodic tariffs, maternity care payments were split into three pathways: antenatal, birth and postnatal, each with different tariff levels depending on a woman’s risk assessment. The goal was to encourage dynamic services with less costly interventions, which saves providers money, but there have been subsequent concerns that the new payment policy was “rushed” (Henderson, 2016, p. 6). Because the financial viability and efficiency of individual birthplace options have become so central to their provision and sustainability, it is crucial to track how these payment systems change and their consequent effects on maternity care. FMUs and continuity of care models are often perceived to be more expensive, despite the evidence from the Birthplace in England reports, and are often threatened with closure due to this (Rayment, et al., 2019).

Given the complexities of service variation and policy implementation, as well as the elaboration of birthplace evidence, a review of maternity in England was undertaken in order to shape the proceeding five year development of services (NHS England, 2015). The National Maternity Review (2016), or *Better Births*, appears to be a proactive policy rather than a responsive one, though it acknowledges the impetus for the review was multifaceted: increasing birth rates, high stillbirth rates compared to the rest of Europe, updated NICE guidelines about birthplace and high negligence claims costs. Most prominently, *Better Births* reiterated the centrality of informed choice to maternity care, stating, “Personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information” (National Maternity Review, 2016, p. 8). It was the first of their seven statements for re-envisioning maternity services across England. In the context of this thesis, three others are also relevant:

- Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman’s decisions.

- Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.
- A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice. (National Maternity Review, 2016, pp. 9-12)

One of the goals of *Better Births* is to shape a maternity service that is not only woman-centred but is also driven by her choices, both fiscally and in actuality. It recommends that costing for services follow a bottom-up approach, with adjustments that accurately reflect relative costs, potentially leading to differences between home, FMU, AMU and OU births (National Maternity Review, 2016). The report sets out to test a ‘personal maternity care budget’ system, which gives women control of the money used to commission their care. There is also a stronger commitment to providing continuity of *carer* – as opposed to fragmented care or only aiming for continuity of care – and the report was followed up by *Implementing Better Births*, which provides resources for Local Maternity Systems to “manage local transformation” (Maternity Transformation Programme, 2017a) and plan and administer continuity of carer models (Maternity Transformation Programme, 2017b).

The gift of hindsight is not yet established to fully survey the benefits and drawbacks of *Better Births*, as it is for *Maternity Matters* and *Changing Childbirth*, but maternity statistics so far have not been promising (Figure 2). The caesarean section rate is currently 28%, induction rates have risen from 20.4% to 32.6% since 2007, and only 52.2% of women achieved a spontaneous vaginal birth last year (NHS, 2018). Gleaning more detailed information about place of birth from maternity statistics can prove to be challenging. The Office of National Statistics (ONS) separates birthplace locations into four categories (NHS establishments, Non-NHS establishments, At home and Elsewhere), which does not delineate between OU, FMU and AMU. This means that 97.3% of live births take place at a NHS establishment and 2.1% at home, according to the ONS (2017), giving us an incomplete sketch of maternity service uptake across England, though there can be little doubt that home birth has significantly decreased. For England and Wales, the home birth rate in 1960 was 33.2% of live births. It dropped to 1.0% by 1981 and hovered between 0.9% and 1.1% until 1992, around the time major policy changes started taking shape, after which it began to

rise slowly. In the past 10 years, the rate of live births at home has only managed to increase to 2.9% in 2007 and 2008 before it slightly dipped again (ONS, 2017).

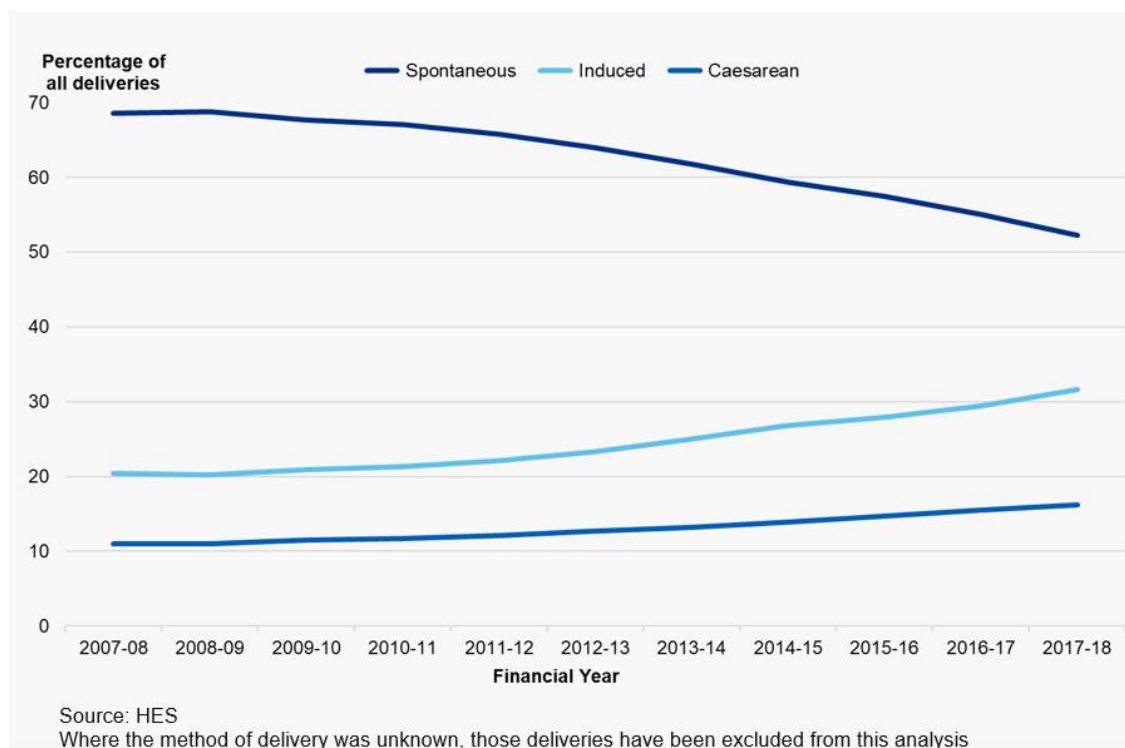


Figure 2. Birth by method of onset of labour rates in England from 2007-18.³

More recent mapping by academics used responses to a national survey of maternity services in England to generate evidence about the facilitators and barriers to optimal birth, with particular focus on the configuration and operation of AMUs and FMUs (Walsh, et al., 2018). Walsh and colleagues (2018) found that, since 2010, AMUs have doubled, and, on average, 14% of women give birth in midwifery units, a three-fold increase, but FMU numbers have remained relatively the same, and 24% of maternity services did not offer midwifery unit options. The increased rate of average midwifery unit use obscures the fact that this varies from 4% to 31% (Figure 3) across trusts that do offer this option and that most of these births are occurring in AMUs, not FMUs (Walsh, et al., 2018). This organisational – rather than proportional – trend was iterated further in the National Maternity and Perinatal Audit (NMPA)’s 2019 report of maternity services in England, Scotland and Wales, finding that, between 2017 and 2019, the proportion

³ Image source: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2017-18>

of sites with AMUs increased from 124 to 132 out of 186 hospitals. However, the number of FMUs decreased by four, from 95 to 91, and long-term FMU closures increased, with a further eight FMUs closed for several months to more than a year (NMPA Project Team, 2019).

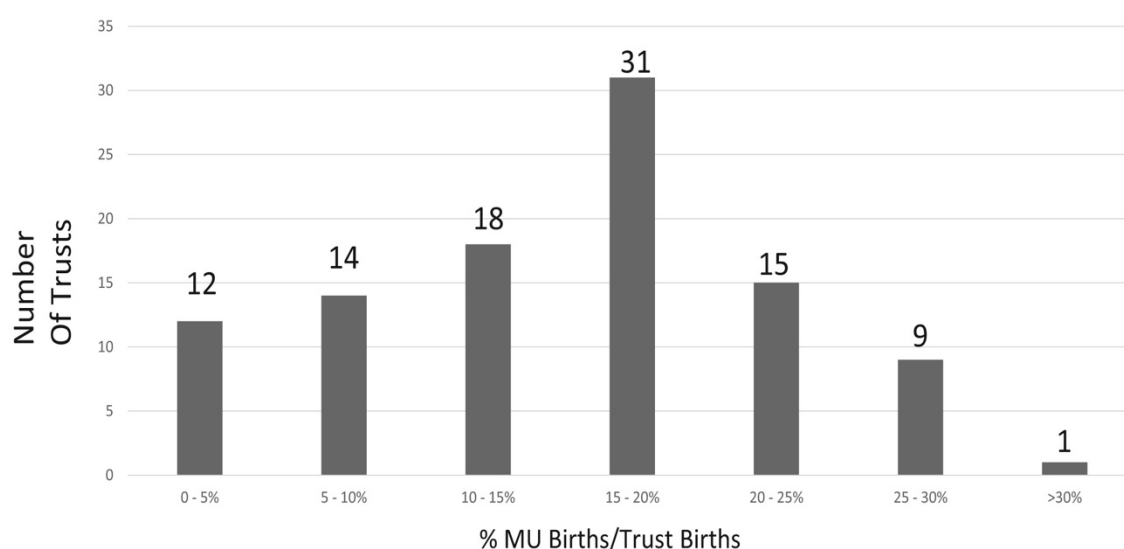


Figure 3. Percentages of midwifery unit (MU) use and number of trusts by percentage bands of that use⁴.

In the context of UK maternity care policy and NICE intrapartum guidelines, these findings are less than encouraging. A limited number (17%) of English trusts have both an AMU and an FMU, even though NICE recommends that the ideal provision of birthplace settings include midwifery units both in the hospital and in the local or ‘neighbouring area’. *Better Births* recommends access to the four settings, though not all *had* to be available within each local maternity system. The language of guidelines and recommendations is conveniently vague and non-regulatory, meaning that there is still no requirement for trusts to invest in more birthplace settings, thus “exposing women to increased risk of caesarean section and running a more expensive service, without any benefits in overall safety of the baby” (Walsh, et al., 2018). Moreover, favouring AMU over FMU development also disregards an increasingly positive body of evidence about the latter, including: lower transfer rates (Birthplace in England Collaborative Group, 2011), reduced labour and birth interventions (Hollowell, et al., 2017), higher rate of physiological birth (Hollowell,

⁴ Image source: (Walsh, et al., 2018)

et al., 2017), higher midwifery staff satisfaction (McCourt, et al., 2016) and less issues with staff recruitment and retention (Kirkham, et al., 2006). They also have a unique capacity to provide a woman-centred, social model of care (Rocca-Ihenacho, 2017) and are the most cost-effective setting besides home birth, especially for first-time mothers (Schroeder, et al., 2012).

With this promising research and the weight of policy recommendations, one has to wonder why there has not been a more concerted effort to embrace not only FMUs but also home birth as integral parts of larger institutions. Walsh and colleagues (2018) found inequality in maternity service provision was more significant in trusts without midwifery units, which is potentially leaving 45,000 low-risk women per year without these options. Disparities in service provision mean inequalities in choice accessibility, which is now stratified geographically as well as ethnically and economically. Without consistency in provision and promotions for the optimal utilisation of birthplace options, women's choices will continue to be constrained and, like policy intentions before it, the National Maternity Review's vision unrealised.

The shifting landscape of maternity services

Without a doubt, the past 60 years has seen broad changes to maternity care and policy in England. There are, however, consistent themes that run through policy since the Cranbrook report: birth should be supported in a variety of settings; for some women giving birth in non-hospital settings may be better; and OU care benefits women with complications or complex needs, yet my analysis highlights the dominance of hospital birth within this policy history. In retrospect, maternity services in England have been operating within a pluralistic system for a large part of 20th and 21st centuries, with the Peel report marking the only departure from this, the repercussions of which appear to be deep-rooted. Much of the resulting critique (Tew, 1977; Oakley, 1980; 1984; Campbell & Macfarlane, 1987; Tew, 1990), shaped in part by US-based anthropological research (Jordan, 1978; Martin, 1987), has been employed by policymakers, midwives and service user advocate groups to support the claim that women want safer, more physiological births and fewer medical interventions (Department of Health, 1993; NCT, 2009; Hunter, 2010). The fluctuations in home births rates, the relationship of policy to women's choice and the rise of midwifery units have all contributed in some way to the service that we have today, as well as to the future aspirations for it, yet,

even with the commitments to choice and birth in non-hospital settings, a majority of women are still giving birth in OUs.

The answer, perhaps, is not as simple as uneven provision of birthplace options, though this is certainly a part of it. While many researchers, HCPs, health organisations and service user advocate groups may have reconsidered the role of medicalisation in birth, this does not mean the lay public has done the same. Choice in maternity care may be important to women, embedded as it is in neoliberal ideals of socio-economic well-being, but this does not mean it extends to birthplace, especially when people have strong culturally and historically contrived notions of risk and safety in relation to birth (Coxon, 2011). Although physiological birth has become more mainstream, there is lack of consideration “to account for women’s reliance on and relationship to obstetric medicine” (Murphy-Lawless, 1998, p. 30), evidenced by the notable pushback to RCM’s campaign for ‘normal birth’ – since called ‘physiological birth’ – after it was insinuated that it partly contributed to the maternal and infant deaths in Morecambe Bay NHS Foundation Trust, and that it made women feel like “failures” if they did not achieve one (Sandeman, 2017). In a move towards inclusivity, not only has “less value-laden” rhetoric been embraced but also the notion of ‘optimal birth’ (Sheridan & Sandall, 2010), which focuses attention on all women’s birth experiences, including those with high-risk pregnancies, and away from the mode of birth. The last six decades, then, have made clear the importance of establishing an evidence base, both quantitative and qualitative, to inform and buttress policy, particularly thorough assessments of whether health systems are ready for such vast policy changes, both organisationally and socially. Moreover, researchers should continue to interrogate clinical institutions, choice policies and service implementation, staying mindful of the dichotomies and discourses that they co-produce or perpetuate while attempting to bring about changes and improvements.

There has been movement both towards and then away from medicalisation and industrialisation, to and from a care philosophy that conceives childbirth as more of an illness than a physiological, life-altering event, and this has been more or less reflected in more recent policy. The governmental recognition of this is a worthy starting point, but public commitment alone will not ameliorate inequalities related to choice, care accessibility and birth experiences, particularly when logistical challenges, such as the shortage of midwives, and vague recommendation rhetoric are not addressed. Reductions in interventions and increased uptake of non-hospital settings remain crucial markers of the success of policy and of wider promotion of physiological and optimal birth, but the verdict is still out as to whether either

of those is currently being achieved in a sustainable way. Even with a better evidence base about place of birth and a shifting landscape of maternity services that is moving towards a more pluralistic medical system, there is still insufficient knowledge about the process of parents' decision-making and the extent to which they make informed choices about their care. In the following two chapters, I will review place of birth and maternity decision-making research, both from the UK and beyond, delving into the socio-cultural, historical, political and institutional contexts that underpin each.

Chapter 2: Contributions to place of birth research

Research has played a key role in shaping place of birth-related health policy, and evidence, depending on how it is generated and interpreted its use can have an enduring effect on service provision. According to the NICE clinical guidelines, not only should a woman have support and her wishes respected to “help her feel in control of what is happening”, but she should also have information about “all available settings when she is deciding where to have her baby, so that she is able to make a fully informed decision.” (NICE, 2014). This echoes *Changing Childbirth’s* assertion that women need “unbiased information”, so they can make a “real choice” (Department of Health, 1993, p. 11), but “informed” decisions are hard to assess if women do not perceive their ability to choose or if their choices are constrained in any way, as continued low uptake of non-hospital settings suggests.

This chapter explores contributions to place of birth research, both from the UK and elsewhere, reviewing what we know about the preferences for different settings and the outcomes that are associated to each. This body of literature is large and diverse, so special attention will be paid to significant contributions, women’s and their partners’ experiences and discussions of choice, as opposed to HCPs’ experiences. The geographical scope will also be limited to research from countries with health systems that are analogous to the NHS or are located in a country that is culturally similar to the UK, such as the US. Finally, this chapter will focus on research from the 1980s onwards, as a more modern configuration of maternity services and technologies started coming to the forefront.

Research on place of birth options

Birthplace research from the UK

By the end of the 1980s, research about birth setting choice was emerging, though ‘choice’ at this point meant deciding between two or more hospitals. *Great Expectations*, a study conducted in 1987, found that 46% of women reported they did not feel they had a birthplace ‘choice’, though 93% were either content or “did not express any dissatisfaction” with where they booked (Green, et al., 1998, p. 52). Deference,

politeness, conservatism and women's "accepting nature" were all cited as reasons for the mentality that "what is, must be best" when it came to antenatal care (Porter & Macintyre, 1984). This conclusion might be chalked up to the mentality of the era, in which women had preferences, rather than made decisions. In 1996, the *BMJ* published two home birth studies, the first of which found that home birth and even labouring at home was a valued experience, one which was connected to being in control of care and having a relaxed, family-oriented setting (Davies, et al., 1996). Women did, however, report receiving little support and hostile responses to their desire for a home birth, and a majority were not offered birthplace options. In the second, the Northern Region Perinatal Mortality Survey Coordinating Group (1996) reviewed neonatal deaths in Northern England for planned and unplanned home births, showing that there were more hazards associated with the latter, urging health systems to accommodate women's birthplace choices, in light of *Changing Childbirth*, and advocating for a home birth service that was integrated with the wider medical system. It also highlighted the importance of incorporating nuance into research, in order to clearly communicate what is safe and what is unsafe, what is planned and what is unplanned, rather than making generalisations about home birth as a whole. Further research published in 1997 also showed that women with straightforward pregnancies did not put themselves or their babies at any greater risk by planning a home birth, and predicted that the home birth rate would most likely jump to 4-5% nationwide in the coming decade (Chamberlain, et al., 1997). It, like the *BMJ* articles, stressed that the health service had to make changes to support women's decisions to pursue non-hospital births, though not necessarily encourage it; it was simply recognised that women were going to make these choices, and it was in the best interest of the NHS to respond openly and accordingly.

Despite the claims that some women do have birth preferences outside of the hospital, more localised studies conducted by HCPs (Johnson, et al., 1992; Jones & Smith, 1996; Fordham, 1997) argued that, in fact, this desire was not as strong as previously suggested. Fordham's study found that most women viewed the hospital as safer for mothers and infants than home, and, most likely as a result, a "substantial minority of women who took part expressed their opposition to any woman having a home delivery" (1997, pp. 78-9). Moreover, most women had limited knowledge of the differences between and benefits of home and hospital, revealing a lack of information on which to make an informed choice, a central point of *Changing Childbirth*. Birthplace research was not just confined to choosing between hospital and home. Decision-making between hospitals was also explored, particularly the factors that led women to choose

one hospital over the other. Jones and Smith (1996) found that distance from home, room for partners and knowing the midwife attending their birth were key deciding factors in choosing hospitals. It is important to note that these studies rely wholly on questionnaire-derived data and, as a result, miss the depth of maternal experience that comes from qualitative research; however, they do show that the women had embedded feelings of safety and reassurance in specific birth settings and conditions.

With the emergence of a market mentality in the NHS system, women were described as ‘consumers’ in research, whose wishes and views in relation to choice should be taken seriously. Health economics and related methods became increasingly important in the analysis of birthplace preferences. Longworth et al (2001) found that, though their analyses revealed few or no differences in clinical outcomes between hospital and home, women ascribed different values to each setting, such as continuity of carer, control in decision-making, pain relief and transfer, which were not often taken into account in traditional valuation measures. For women, deciding to give birth at home over the hospital appears to be a balancing act, one in which trade-offs are made between medical facilities and well-being, and their conceptions of safety extended beyond health outcomes to encompass environment and family (Edwards, 2005). Edwards (2005) points out, though, that women birthing at home are still subject to the structure of the NHS, as midwives employ a ‘clock time’ rhythm when observing progress in labour. Time is a resource, and, like any other, it should be managed in a way that optimises the efficiency of the system, regardless of where midwives are practicing⁵.

Greater Expectations, a follow-on study to the original survey conducted in the 1980s, claimed that increasing rates of interventions were demand-led rather than part of medicine’s legal concerns (Annandale, 1989), owing in part to a change in women’s expectations (Green, et al., 2003). First-time mothers were anxious about pain and more willing to accept interventions, such as epidurals, since *Changing Childbirth*, effectively placing the onus of rising rates on women while revealing a mismatch between what women were choosing and what service user advocate groups claimed women wanted (Coxon, 2011). Some researchers have highlighted that women’s choices are shaped by the information they receive and access, as opposed to shifting expectations. After *Changing Childbirth*, a study suggested

⁵ McCourt and Dykes elaborate on this further: “For the traditional midwife, work was need orientated, in that it was entirely centred on the patters of women’s pregnancy and birth. The use of the word ‘attended’ to best describe the midwife’s role is apposite, since her use of time was different. She waited on labour. By the 20th century we see pregnant women reconstituted as ‘patients’” (2009, p. 28).

that only 5% of midwives routinely offered home birth as an option during booking appointments (Floyd, 1995), and a later survey found that 43% of first-time mothers wanted more information about maternity choices (Singh, et al., 2002). Madi and Crow (2003) reported that midwives were still not initiating discussions about home birth availability, even though they supported women who knew about it and requested it. Were women's expectations increasingly inclined towards hospital-based care, or was it simply a lack of awareness of other options that constrained expectations?

Research from the mid-2000s and onwards indicates that birth options and awareness of them was proliferating, even if uptake of non-hospital settings remained low. One study found that, among women who could choose between OU, AMU and home birth, few planned to use the 'alternative' choices because they regarded the hospital as the safest place to give birth, and they lacked confidence in non-OU birth given the conflicting advice they received from midwives (Barber, et al., 2006). Jomeen (2007) elaborated further on this theme, finding that choices were constrained by the HCPs that women were in contact with, inequalities, social discourses surrounding birth and pregnancy complications. Contrary to Green et al (2003), her research suggested another dimension to women's expectations:

There is an increasing expectation by women that they will be offered choices, yet women's accounts illustrate that 'real choice' remains elusive...There is a clear expectation and desire among women for expert support and intervention across their maternity experience...Women who choose midwifery-led care options are not rejecting expertise but seeking a different kind of birth experience. (Jomeen, 2007, pp. 489-90)

Pitchforth et al's (2008) discrete choice study conducted in rural Scotland also highlighted the predominant perception among parents that hospital care led by an obstetrician was safer than midwifery-led care, managing any eventualities more effectively. Women expressed willingness to travel up to two hours from their area to receive their preferred care, and even though midwifery-led care was connected to enhanced social support, this was ultimately weighed against the perceived safety of the hospital. A companion paper reporting on focus groups conducted alongside the larger study found that women's choices were shaped around their notions of safety, as well as the type of 'chooser' they were: 'acceptors' did not engage actively in choice – not because they lacked agency, this could be an intentional decision – while others, 'active choosers', did (Pitchforth, et al., 2009). Some women were surprised to find they were eligible for non-hospital options, though this eligibility sometimes had to be negotiated throughout pregnancy, and HCPs

restricted choice by failing to provide options or discouraging home birth. Despite the recognised supportive and comfortable care of midwifery units, the draw of ‘everything is there’ and perceived safety inherent in this were often powerful enough for women to make the trade-offs between distance to and quality of birth settings.

Ethnographic research has been particularly elucidatory for researching midwifery units. Walsh (2006) found that an FMU in the Midlands of England elicited ‘nesting’ behaviours in order to nurture a woman’s becoming as a mother, what he entitled ‘matrescence’, which is rooted in relations between women and staff, rather than clinical skills. His further research suggested that FMUs are sites of “intense contestation” and paid attention to the relationship between discourse and agency, finding it “layered and non-linear” (Walsh, 2007). In many ways, the FMU was a space in which prominent discourses about biomedicine and patient-provider relationships were challenged to the benefit of both midwives and mothers. Moreover, the birth centre’s model of care confronted established notions of safety and traditional clinical methods (Walsh, 2007). Midwifery units are often cited as places with a ‘home-from-home’ environment. Research on four AMUs reported that women valued the family-centred, relaxed environment that facilitated physiological or ‘natural’ birth, even if they had to make trade-offs between these and pain relief in the OU (McCourt, et al., 2014)⁶. The presentation of spaces in midwifery units is fundamental to communicating its “function as a protected space, one which uses domestic features as metaphors of home in order to promote a sense of wellbeing and to re-normalise concepts of births” (McCourt, et al., 2016, p. 17). A recent ethnography based in London reiterated the importance of the FMU model of care in the transition to parenthood, highlighting that units generate health for women and focus on individual needs (Rocca-Ihenacho, 2017). Midwifery units, thus, provide socially meaningful, therapeutic environments, while simultaneously functioning as sites of resistance, offering ‘eclectic’ care that is an intermediate between disparate modalities of birth.

Even with this promising research and the policy commitments of *Better Births*, mapping of midwifery units and OUs since 2010 show that service provision is patchy in England, and there are areas where women do not have access to a local midwifery unit (Walsh, et al., 2018). Similarly, uptake of the

⁶ This report and McCourt, et al., 2016 are ethnographic follow-on studies to the Birthplace in England study. Birthplace in England Collaborative Group analysed the qualitative data before they had their quantitative results, to avoid biasing the analysis for the ethnographic case studies.

latter varies between maternity services, despite the three-fold increase in use. Walsh and colleagues (2018) argue this reveals that many are still under-utilised, and they estimate that 36% of women could potentially give birth in midwifery units after obstetric referrals during pregnancy and labour. The mapping also found an increase in the number of AMUs nationally, but that their development is often opportunistic, with many managers, senior professionals and senior obstetricians seeing them as cost effective and positive contributions to service improvement (McCourt, et al., 2018). Though AMUs are progressively being accepted as valid within the health service, the units studied by McCourt et al (2018) were only being used by around a third of eligible women, and there were no plans in place to boost uptake, revealing that they are still seen as alternative, optional or extra, while OUs remain essential, particularly in a financially constrained situation.

The perceived cost-effectiveness of AMUs relative to FMUs potentially shields them from closure, a mentality that is not afforded to the latter. Since 2010, their numbers have remained stagnant (Walsh, et al., 2018), with 14 closures between 2008 and 2015 (Rayment, et al., 2019). Rayment et al's (2019) analysis of media reporting on the closures found that articles focused on underuse – a point not attached to AMUs – and financial constraints on maternity services, despite the fact that FMUs are one of the most cost-effective birth settings for women with straightforward pregnancies (Schroeder, et al., 2012). Reporting framed closures from perspectives of managers and commissioners, as opposed to women, and reinforced the neoliberal notion that user demand drives service changes (Rayment, et al., 2019). Moreover, the arguments for closure perpetuated the idea that birth is better and safer the nearer it is to obstetricians, and that FMUs are “unaffordable luxuries” (Rayment, et al., 2019, p. 8). Given that AMUs are in hospitals rather than outside has made them more palpable to managers and commissioners, and their close proximity to OUs obfuscates similar criticisms that could be leveraged against them. The fact remains, however, that FMUs and home are the most cost-effective settings for women to plan their births, depending on parity (Schroeder, et al., 2012). The Birthplace in England group (2012) assessed the short-term costs (all health service costs from start of care in labour to postnatal discharge, including neonatal or higher-level care) related to birth in each of the four settings, including the costs of clinical care, pain relief and other interventions. Because FMU and home births result in fewer obstetric interventions, which are costly to the NHS, and reduced adverse outcomes, they are ultimately less expensive in the short term (Schroeder, et al., 2012).

A small body of quantitative research exists on birthplace preferences among women with straightforward pregnancies in the UK since 1992, the methodological quality of which is “generally poor,” according to a systematic review published in 2016 (Hollowell, et al.). A large proportion of women had a strong preference for a hospital setting, where medical staff were available but not necessarily involved in their care. A number of service attributes were explored, but those “universally valued” by women were local services, involvement in decision-making, preference for control and continuity of midwife, especially being attended by a known midwife during labour and birth. Given the limited number of quantitative studies – only three have been published since 2000 – qualitative research has provided the best picture of birthplace choices nationally, and it tracks closely with what has emerged from the former. Two recent qualitative studies (Hinton, et al., 2018; Naylor Smith, et al., 2018) found that women are still not receiving consistent and comprehensive information about all of their birthplace options, even if there are fewer obstacles to exercising their choices than there were in the past. Women want more than just control and involvement in decision-making; they also want the ability to consider and discuss these options throughout pregnancy, not just at a fixed point (Hinton, et al., 2018). Additionally, the way information about choices is accessed and used has shifted over the past decade, in that midwives are no longer the most important source, and instead, women draw on a variety of information sources besides what they receive from midwives to make decisions (Hinton, et al., 2018). Hinton and colleagues (2018) also reported that many women said their appointments felt rushed, with no time to ask questions, and that information about options was given without further detailed discussion. Naylor Smith et al (2018) found that women retain the expectation that birth takes place in the OU, and lacked key knowledge about the realities and practicalities of giving birth at home, suggesting that women are still not receiving comprehensive information about their options.

Does casting such a wide net for information make up for the uneven and depersonalised sources that women receive from midwives, as has been suggested (Sanders & Crozier, 2018)? Hinton et al did not come to this conclusion but fixated on matching birthplace discussions to women’s decision-making, which is an “on-going process”, through removing fixed choice points, focusing on “user-friendly materials” and promoting increased digital technology use (2018, p. 13). The crucial factor to the success of restructured appointments and birthplace discussions is having “adequate time”, which is not as heavily emphasised in the article. Deferring decision-making, signposting and developing online sources in a system fraught with

staff shortages and financial precarity are superficial solutions that may not affect meaningful change towards more personalised birthplace care. This is because they do not address the root issue that there is simply not enough time to adequately address each woman's needs within an infrastructure underpinned by a market mentality prioritising efficacy and resting on unchallenged assumptions about what efficiency entails.

Birthplace research from other countries

Birthplace research from other countries has offered beneficial insights, though health systems and policies are not analogous to the UK. Studies from the US have been particularly illuminating theoretically. McClain's (1981; 1983) research from the early 1980s delved into American women's assessment of risk when choosing home or hospital birth, as much of the professional debate about each was centred on issues of medical risk at the time. Reviewing 'social literature', McClain (1981) found that mainstream obstetric perceptions of medical risk did not align with those held by women, and that women evaluated social as well as medical risks and benefits connected to birthplace when they made their choices. Women "discount the risks and magnify the benefits of the chosen birth service, and exaggerate the risks and minimise the advantages of the rejected services", and their strategies for making birthplace choices depended "more on avoiding risks than on obtaining benefits" (McClain, 1983, pp. 1857, 1861). American women's relationships with medical care and its perceived risks were also stratified by class. Nelson's concurrent research argued that lower- and middle-income women pursued different birth ideologies, which reflected back into the type of care they chose, in that lower-income women wanted "more passive birth experiences with more medical intervention" and "middle class women wanted...active, involved births free from medical intervention" (1983, p. 284). However, as previously discussed, what women want in terms of medicalised care and childbirth may be difficult to elucidate. Davis-Floyd (1993), for instance, found in her research that white, middle-class women actually appeared to prefer highly technological obstetric experiences, recognising that preferences can vary within socio-economically similar groups of women. Birthplace decisions were connected to women's deeper beliefs about separation from pain and labour, technological success and medical authority. By accepting and engaging with this 'technocratic'

model birth, they perform and uphold the ideals of American society, which is empowering for these women (Davis-Floyd, 1993).

While women choosing hospital birth frequently left birth management to medical professionals, keeping in line with socially salient conceptions of maternity, those opting for home birth were left with “extra identity work” (Coxon, 2011, p. 49) to demonstrate their maternal responsibility for their pregnancy (Davis-Floyd, 1993; Cheyney, 2008). This ‘extra work’ has also been observed by others in New Zealand (Abel & Kearns, 1991) and Finland (Viisainen, 2000) researching home birth. Though a large prospective American study found that home birth for low-risk women using certified midwives was associated with lower medical interventions and similar intrapartum neonatal mortality when compared to low-risk hospital birth (Johnson & Daviss, 2005), pursuing one is still a “system-challenging praxis” and a “transgressive rite of passage” (Cheyney, 2011) that requires subverting established forms of authoritative knowledge and “valuing alternative more embodied or intuitive ways of knowing” (Cheyney, 2008, p. 254). International research about birthplace sometimes underscores the lengths women, their partners and their caregivers would go to fight both health and legal systems in order to attain their chosen settings. In the US, for instance, there are several types of midwifery certification, but only one, Certified Nurse Midwives, is legally recognised in all 50 states. In Finland, where 99.9% of births are in the hospital, those planning a home birth and hoping to avoid the iatrogenic risks of medical intervention inevitably become “enmeshed in the moral jeopardy of electing to have a home birth where this is considered risky, dangerous and even illicit” (Viisainen, 2000; Coxon, 2011, p. 49). Similarly, in the US, women reported being accused of being selfish and irresponsible and of taking unnecessary risks by friends and family, as well as being shamed by doctors:

When I told my doctor I was thinking of having a homebirth, he said “Cool, and while your [sic] at it, don’t bother with a car seat.” (Cheyney, 2008, p. 258)

Though medical knowledge occupies an authoritative space socio-culturally in Western countries, parents pursuing home birth in the face of censure and purported risk suggests that parallel systems of knowledge (Jordan, 1997) about birth exist. Generally, women planning home births value control during labour, seek to avoid interventions, want continuity of carer and favour giving birth in their own environment surrounded by their families, regardless of their country’s political context. While this choice is associated

with middle-class women following a 'natural' birth philosophy, there are indications of nuance within this group. Davis-Floyd (1994) found that some women fully ascribed to a 'holistic' model of birth, in which they had an integrated vision of self and body, while others still prioritised control and felt their bodies and their selves to be separate, features more commonly observed among women choosing hospital birth. While there are many who may fall within a 'grey' area within the natural/medical explanatory model of birthplace, as Davis-Floyd points out, "[e]xtremes, on both ends of the spectrum, play an important role in defining the outer edges of the possible and the imagined" (1994, p. 1139).

What is it like, then, to give birth in a Western country where there is strong political and socio-cultural support for home birth? The Netherlands is often considered a case study of high home birth rates, good outcomes and independent midwifery, and was explored by Jordan in her seminal work, *Birth in Four Cultures* (Jordan, 1978). However, the home birth rate has been falling, from 68.5% in 1968 (Wiegers, et al., 1998) to 29% in 2009, which may be related to Dutch women's increasing desire to access pain relief during labour and subsequently opting for hospital settings (Pavlova, et al., 2009). In response, research from the Netherlands has focused on the decline in home birth rates, rather than aiming to understand socio-cultural disinclination to it and reluctance to accept it as a 'real' choice. A survey from the late 1990s found that demographic factors, like age and education, did not have an impact on Dutch women's preferences for home birth, save those living in urban areas, where it was linked to higher education; instead, "social factors", particularly partners' confidence in this setting, were more likely to be predictors of choice (Wiegers, et al., 1998). Despite the changes, researchers have claimed that there remains a 'strong preference' for home birth, with 44% of first-time mothers reporting that they planned a home birth (Pavlova, et al., 2009). Congruent with other research, home birth preference among Dutch women is connected to seeing birth as a physiologically normal process and socially meaningful event.

However, even with historical support for non-hospital settings, the good outcomes of the Dutch maternity system have been called into question over the last decade (de Jonge, et al., 2009; Evers, et al., 2010) – albeit with different conclusions as to the safety of home birth services. As De Vries and Buitendijk (2012) pointed out, the Netherlands is not just a guide for organising a maternity system that supports home births but also a case study for how and why it is under pressure. After the publication of Evers et al's paper (2010) in the *BMJ*, Dutch media honed in on a narrative of system failures and midwifery-led care safety issues, despite the fact that data used in the study are 'questionable' for several reasons (De Vries &

Buitendijk, 2012), and de Jonge et al's study (2009) had only just concluded that home birth was just as safe as hospital birth for low-risk women. In the wake of these issues, De Vries and Buitendijk (2012) crucially unpack the gendered nature of Dutch pregnancy and birth research, which is mainly conducted by obstetricians, the limited knowledge regarding place of birth, models of care and low-risk women's experiences and the cultural shifts that ripple through science and public consciousness. They also reveal biases that linger under the surface of academic publishing:

Interestingly, Dutch researchers challenging home birth found it difficult to publish their results in Dutch-language scientific journals, while Dutch researchers whose work supported home birth found it difficult to publish in English-language scientific journals. Of course, researchers on both sides assumed that when their research was rejected it was for ideological reasons, and when it was accepted it was for scientific reasons. (De Vries & Buitendijk, 2012, p. 16)

Debates, such as these, indicate the continued professional, academic and socio-cultural tensions that shape place of birth conversations, which are interwoven with the moral imperatives of maternal responsibility, and choice, now a focal point of ethical discussions. Moreover, given the cultural influence of obstetricians, "it is unlikely that many women will choose to challenge its paternalistic warnings and insist on exercising their right to home birth, especially if they are made to feel that their choice might jeopardise their babies' health" (De Vries & Buitendijk, 2012, p. 17).

In response to the suggested deleterious impacts of home births, a Dutch obstetrician considered the possibility of moving to a system in which all women give birth in either a hospital or a "birth centre" (referred to as 'midwifery units' from this point forward) (De Vries & Buitendijk, 2012). With the growing diversification of services, which settings are deemed acceptable by medical professionals and why are further dimensions to highlight in birthplace research. Where midwifery units are located, in the case of the UK, can affect their legitimacy and visibility as 'alternative' forms of care, or obscure other settings that have the potential to provide better experiences and outcomes for low-risk women. The Dutch Birth Centre Study found that, while women valued midwifery units for their home-like environments and transfers from them to OUs were unproblematic, mothers who planned home births had significantly better experiences than those who planned midwifery unit births (Hitzert, et al., 2016). In some aspects of care, women who planned midwifery unit births had significantly higher satisfaction scores than those planning hospital

births, but, ultimately, the authors concluded that midwifery unit and hospital experiences were markedly similar, which they interpreted as a positive reason for those who do not want to birth at home to choose a midwifery units (Hitzert, et al., 2016).

Early international research on midwifery units surveyed women's preferences for different options. An Australian survey, though "methodologically problematic"⁷ (Coxon, 2011), found that 61% of expectant mothers preferred hospital birth, 31% home birth and 9% midwifery unit, even though the home birth rate in the area was 0.5% at the time of the study (Cunningham, 1993). Since the 1990s, midwifery units have become increasingly common, so research on them has begun to proliferate, as it is in the UK. An American study found that safety outcomes among low-risk, lower-income women and their babies receiving care in an FMU with a collaborative management model were the same as those receiving traditional obstetric care (Jackson, et al., 2003). There were also fewer assisted births and less medical resources used in the FMU (Jackson, et al., 2003). A further survey of non-hospital birth trends in the US suggested that the rates of home and midwifery unit births were increasing, though they accounted for 1.36% of births in 2012 (MacDorman, et al., 2014). The number of midwifery units increased from 170 in 2004 to 248 in 2013, but, like the UK, the provision of non-hospital settings and percentages of births taking place at them varies by region, mainly due to state laws pertaining to midwifery and 'alternative' forms of care (MacDorman, et al., 2014). Finally, a more recent Danish study found that women who planned births in FMUs were more likely to have a straightforward, vaginal birth with good maternal and neonatal outcomes, and less likely to have an assisted birth or an epidural (Christensen & Overgaard, 2017). Most of these studies are quantitative and provide excellent overviews of emerging and shifting trends in maternity care internationally. Mixed-methods research from New Zealand evaluating midwifery units and exploring what enables women to choose them over obstetric-led care found that confidence in the birth process, their midwife, the setting and their ability to give birth all contributed to successfully planning to give birth in an FMU and making what might be considered a 'countercultural' decision (Grigg, et al., 2015).

Despite the range of social and medical contexts that this body of research is derived from, there are common threads. For instance, American and Dutch women were more satisfied with their births when they took place in a setting that was ideologically normative within their respective countries (Davis-Floyd,

⁷ "Cunningham's (1993) survey is methodologically problematic having sampled a high proportion of home birth and birth centre advocates" (Coxon, 2011, p. 53).

1993; Christiaens & Bracke, 2009). Certain birth settings have higher satisfaction rates than others (Cunningham, 1993; Christiaens & Bracke, 2009) and are connected to specific ways of seeing and knowing the birth process (McClain, 1983; Davis-Floyd, 1994; Viisainen, 2000). There are also recurrent issues about non-hospital births and how they are moralised, politicised and, ultimately, constrained by discourses of safety, risk and medical ascendancy over other forms of care and knowledge. What is remarkable are the silences in the literature from both the UK and elsewhere, particularly, the professional silence regarding risk associated with unnecessary, potentially dangerous interventions, and the silence of fathers, partners and birth partners.

Partners and place of birth

Currently, research focusing on partners' birthplace perspectives and choices is very limited; however, as Weiger et al's (1998) study suggests, they certainly have sway over how decision-making unfolds. Viisainen's (2000; 2001) studies about choice, risk perception and home birth incorporated both parents' views on the subject, finding that partners often worked together to find information and carry out risk analyses when approaching their decision to have a home birth. They were united in their views about childbirth, birthplace and risk, and there are indications that men can have powerful, embodied experiences of place of birth:

[Eero:] Yes, especially towards the end [of the pregnancy] a lot of people tried to raise fears in us... even after we had made up our minds [about home birth]. But still we had this strong inner feeling that nothing bad will happen.

K: Where did that feeling come from?

Eero: It somehow came... it is just such a feeling inside. Such a strong feeling that this is what we have to do and this is what we do. (Viisainen, 2000, p. 809)

Moreover, Viisainen's (2001) study found that cultural models of birth and practical possibilities for birthplace choices equally shape partners' understanding of home birth, and that their definitions of 'natural' and relationships to biomedical practices are aligned. A more recent article explored Irish fathers' experiences of planned home birth and found most knew very little about it until their partners introduced

the idea during searches for alternative birth experiences (Sweeney & O'Connell, 2015). Though fathers often find it difficult to engage with childbirth due to biological barriers and side-lining in hospitals, they still needed to be convinced of the viability of home birth as a realistic, safe option, even feeling anxieties linked their perceived responsibility in the decision until the baby was born. Despite this tension, planned home birth allowed men to actively participate in childbirth and positively changed them, giving some new outlooks on life and strengthening their bonds with their families (Sweeney & O'Connell, 2015).

Research from England showed that men often trust medical care and hospital environments and contribute to women's decision-making, a motivation that can stem from their own beliefs, feelings of vulnerability or desires to protect their partners (Bedwell, et al., 2011). This could even hypothetically involve 'nudging' women towards a choice they are more comfortable with, such as hospital birth over home birth, echoing Weiger et al (1998). In general, Bedwell et al (2011) found that there was a lack of discussion about birthplace between partners and with HCPs, which they suggest reinforces men's ideas that hospital birth is the safest option, further perpetuating the normality of the setting. Though pregnancy and childbirth are also periods of apprehension and anxiety for men, as they are for women, fathers often feel isolated and ignored by HCPs (Fenwick, et al., 2012). With men's expanding social roles in reproductive and family life, it is essential to not only investigate their experiences and decision-making about birthplace more deeply but also begin to think about how they can be included and considered more in maternity care giving and practices.

Location matters: health outcomes and birthplace

Some of the birthplace research appears to not only focus on showing that non-hospital settings are safe but providing evidence that they are *as* safe as hospitals, where most of the safety-risk discourse is centred. Providing clinical evidence of maternal-infant outcomes is essential for achieving this. In an early review, Walsh and Downe (2004) found a small number of studies on FMUs, the results of which did not indicate any reason to reject their use on grounds of adverse outcomes, though the findings of research at that point could not be generalised. An eight-year, prospective cohort study conducted at an FMU in Northwest London indicated that nearly half of the women who planned to give birth there were transferred either in

the antenatal, intrapartum or postnatal period, and, of the women who were admitted to the unit, 95% achieved a spontaneous vaginal birth (Rogers, et al., 2010).

The Birthplace in England study (2011) is one of the few reports in recent years that attempts to bring together a variety of data sources and produce a more detailed illustration of service provision and maternal-infant health outcomes for low-risk births. Using a prospective cohort design, researchers found that giving birth in England is “generally very safe” for low-risk women, and that “midwifery units appear to be safe for the baby and offer benefits for the mother” (Birthplace in England Collaborative Group, 2011). In both AMUs and FMUs, there was no difference in adverse perinatal outcomes when compared to OUs planned birth, and women choosing midwifery units experienced fewer interventions, particularly caesarean sections. For first-time mothers, planned home births slightly increases the risk to infants, and there was 36-45% transfer rate to the OU, depending on the setting (Table 1). For multiparous women, giving birth in a midwifery unit or at home is as safe as the OU, and substantially reduced their odds of having a caesarean sections, instrumental delivery or episiotomy (Birthplace in England Collaborative Group, 2011).

Parity	Planned AMU birth	Planned FMU birth	Planned home birth
Primiparous	40%	36%	45%
Multiparous	13%	9%	12%

Table 1. Rates of transfer to OUs, by parity and planned place of birth⁸.

Subsequent follow-on studies⁹ investigated factors that shape interventions, transfers and other outcomes. The first explored the influence of service configuration on interventions and maternal outcomes among low-risk women, showing that there was variation in intervention rates across all settings

⁸ Source: (Birthplace in England Collaborative Group, 2011)

⁹ Another analysis, done a bit later, compared AMU and FMU outcomes directly, as originally both were compared with OUs as a reference point. This confirmed that the lower rate of interventions in FMUs was significant as compared with AMUs. The original analysis showed that rates of serious maternal morbidity were significantly lower in FMUs, though this was not discussed in the *BMJ* report. This is often overlooked but is located in the supplementary tables of the report.

which could not be explained by chance or maternal characteristics (Hollowell, et al., 2015, p. 19). Though non-OU intrapartum care could reduce intervention rates among women with straightforward pregnancies, the study suggested that the size and location of midwifery units were associated with intervention rates and outcomes (Hollowell, et al., 2015, p. 19). A second analysis looked at differences in intervention rates and outcomes for low-risk women by ethnicity, deprivation and maternal age, finding caesarean sections were higher among non-white women and chances of physiological birth decreased with maternal age, but there were no significant differences in intervention rates among groups when they planned births in non-OU settings (Hollowell, et al., 2015, p. 51). Moreover, a third study did not indicate any variation in transfer risk based on ethnicity or understanding of English (Hollowell, et al., 2015, p. 71). Researchers also found a modest but significant downward trend in transfers with increased planned home births, and that trusts with more home births had lower rates (Hollowell, et al., 2015, p. 71). Though transfer rates varied throughout the day, there was no discernible pattern to fluctuations, whereas a fourth study revealed that interventions, especially epidurals and inductions, were used more frequently during 'office hours', suggesting that there were non-clinical factors causing their "excess use" (Hollowell, et al., 2015, p. 103). Finally, a fifth analysis focused on 'high-risk' women who were excluded from the primary analysis and, although they had more adverse outcomes than 'low-risk' women overall, found no evidence to suggest that home settings were worse for their outcomes compared to the OU (Hollowell, et al., 2015, p. 121). This has implications on the ways in which services treat 'high-risk' women who want to plan a birth out of the OU, as there is currently no concrete evidence to support such women being sanctioned as irresponsible.

The Birthplace in England study signifies the movement towards illustrating the nuances of maternity care and clarifying the notion of safety as it is related to birth settings, providing clearer information that can improve the provision of maternal care and enable women to make more informed decisions about their health. It was a significant moment for place of birth research, providing evidence of the excellence of the NHS England maternity services and shifting the conversations around safety and setting. Though it may feel obvious that giving birth is generally safe in 21st century England, the persisting and overwhelming narrative of birth is one that is still deeply interwoven with uncertainty and danger. For researchers, it is not simply about providing evidence of safety but also disseminating findings that are salient for rewriting the birth narrative, from one of precariousness to one of positivity. Outside of

academia, grassroots movements, such as the Positive Birth Movement¹⁰, are also working to change conceptions of birth, using social media and both digital and localised communities to offer perspectives and advice that promote a revitalised, affirmative vision of the maternal experience. Despite the encouraging evidence of safety and benefits associated with non-OU settings, birth rates remain low in FMUs and at home, leading to questions of whether or not parents and HCPs consider these viable options for a larger portion of women. The public response from the RCOG to the *BMJ* publication of the Birthplace in England findings was quick to highlight the differences in primiparous and multiparous mothers, as well as the less favourable findings from the study. They “advocate[d] that first-time (primiparous) mothers should be advised of the benefits of delivering in OUs or alongside midwifery units (AMU) unless geography prohibits” but conveniently left out any mention of FMUs or home births unless except to raise concerns about the causes of adverse perinatal outcomes, thus subtly linking these settings to questionable safety (RCOG, 2011).

The Birthplace in England follow-on study on time and interventions (Hollowell, et al., 2015, p. 103) complements the body of evidence that increased rates are not always clinically justified and are associated with maternal-infant morbidity and mortality (Petitti, 1985; Johanson, et al., 1993; Allen, et al., 2003; Liu, et al., 2007; Jansen, et al., 2013). Uncertainty remains regarding the nature of the effects of labour and birth interventions, but there are indications that they are associated with short- and long-term health problems (Peters, et al., 2018), and theories have been formulated about the implications that high levels of stress induced by interventions have on the epigenetic regulation of gene expression in the immune system (Dahlen, et al., 2013). There is little doubt that labour and birth interventions save lives, when they are optimally employed; however, given the irresolution concerning the enduring consequence of high usage, researchers should remain critical of their use and of the potential erasure of FMUs and home as beneficial settings. As the NICE guidelines state, “Birth is a life-changing event” (NICE, 2014), and the experience has a long-lasting impact, especially emotionally. Experiences in labour have been cited as a risk factor for postpartum post-traumatic stress disorder (Grekin & O'Hara, 2014), and women planning home births often cite previous negative or traumatic experiences in hospitals as a reason for avoiding it in

¹⁰ <https://www.positivebirthmovement.org/>

subsequent pregnancy. Given how indelible this emotional dimension of maternity can be, parents' views on and experiences of maternity care should be treated as equally important as clinical outcomes.

More localised work from East London on the Barkantine Birth Centre has described positive outcomes for both mothers and babies. Not only was the midwifery unit found to be more cost-effective than the connected hospital (Schroeder, et al., 2017), matching the cost-effectiveness conclusions of the Birthplace in England economic study (Schroeder, et al., 2012), but a survey found that women who booked at the Barkantine benefited in the antenatal period as well. They were more likely to attend antenatal classes and find them useful. Women who started their labour care at the FMU were also more likely to experience continuity of carer during the intrapartum period (Table 2) and less likely to be induced than those who booked at the hospital (Macfarlane, et al., 2014a; Macfarlane, et al., 2014b).

	Hospital (%)	Midwifery unit (%)
Women cared for by a midwife they had already met	4.8	42.7
Women had one-to-one care throughout labour	51.0	87.8
Women had same midwife throughout labour	48.6	66.7

Table 2. Percentages of women receiving continuity of carer during the intrapartum period in the hospital versus the midwifery unit¹¹.

Macfarlane and colleagues (2014b) also found that women who planned their birth at the midwifery unit were more likely to have higher rates of birth pool use and of established breastfeeding compared to those who planned an OU birth. Retrospective analysis of 10 years of audit data from the trust on the FMU found a high average rate of spontaneous vaginal birth (80.8%) among women who started their labour care at the Barkantine Birth Centre (Figure 4). The national average, comparatively, is 52.2% for spontaneous vaginal birth (NHS, 2018). Finally, there were lower rates of transfer (Table 3) among women who started their care at the unit when compared to national average rates from the Birthplace in England study. (Yuill, et al., 2018).

¹¹ Sources: (Macfarlane, et al., 2014a; Macfarlane, et al., 2014b)

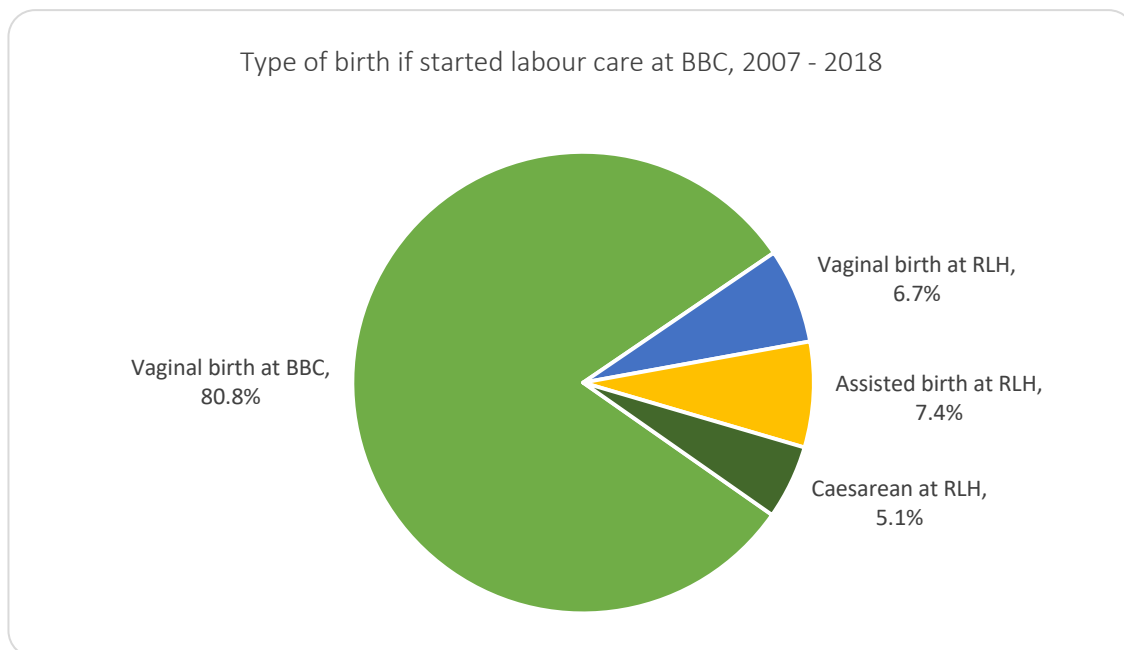


Figure 4. Percentages of mode and place of birth if labour care was started at the Barkantine (BBC), 2007 – 2018.

Parity	Intrapartum transfer, BBC	National intrapartum transfer rate from FMUs ¹²
Primiparous	32%	36%
Multiparous	5%	9%

Table 3. Intrapartum transfer rates, by parity, from the BBC to the RLH, compared to the national rates from the Birthplace in England study.

Given the intense debate both in academia and in public about the safety of home birth and midwifery units, reviews are key for producing a cohesive and comprehensive summary of research, with the chance to highlight strengths and weaknesses in this body of literature. A number of researchers have identified favourable maternal outcomes for women who planned their births at home or in midwifery units, yet findings on infant outcomes in different settings are more controversial. While the Birthplace in England study (2011) did find a slightly higher rate in perinatal mortality among first-time mothers who planned home births compared to those who planned hospital births, Scarf et al's review (2018) did not

¹² Source: (Birthplace in England Collaborative Group, 2011)

find any difference, regardless of parity, nor did they find any differences between settings in terms of still birth or early neonatal death, regardless of study quality. Even more recently, Hutton et al's meta-analysis (2019) did not find any differences in perinatal or neonatal mortality between births planned at home and in a hospital. Outcomes, like these, continue to call into question the overwhelming narrative that non-hospital birth is unsafe for both mothers and their infants, even if they should be approached with caution. The high variation in service provision, setting, models of care and integration of maternity services from country to country, as well as the diversity in the quality of studies included in Scarf et al and the definitions they used to describe women's risk status and outcomes, limit the power of overviews. Though, as this review makes clear, high quality, more methodologically homogenous research could have important implications on health care services around the world, and the findings do support the expansion of midwifery units, home birth and systems that facilitate them. They also have ramifications on birthplace information provided to parents, as means to enhance choice and autonomy about their options (Scarf, et al., 2018).

Control and choice in place of birth

Choice and control have become so thickly intertwined that it is a formidable task to untangle them completely. After the Peel report, choice was relegated to one hospital or the other, and critiques were quick to champion greater control for women over their care and their bodies. *Great Expectations* found that women's positive expectations were associated with greater control in birth and higher emotional well-being (Green, et al., 1998). In the *Journal of the Royal Society of Medicine*, a highly critical review of *Great Expectations* charged: "The word 'control' appears so often that you might think there was a fight between various birth attendants to manage the labour; and the pregnant woman gets ready to fight, too, with anybody who suggests a course of action that is unacceptable to her" (Thom, 1999, p. 50). Though Green and colleagues had published work clarifying their concepts and meanings, it further illustrates how hostile the environment was that they were seemingly claiming should not be viewed as such. Research following the Cumberlege report, which promoted the idea of an empowered consumer in health, focused heavily on the intricacies of control: who has it, and who does not?

In the 1990s, research began to suggest that women still did not perceive that they were offered choices about their care (Gready, et al., 1995; Davies, et al., 1996; Chamberlain, et al., 1997). How information is framed can profoundly shape choice (Levy, 1999), and perception of informed choice may differ depending on duration in pregnancy, service provider and personality (O'Cathain, et al., 2002a). Levy's research (1999) described midwives' "gently steering" of women towards decisions with which they feel comfortable. Madi and Crow (2003) found that women planning a hospital birth were not as well informed about their options as women planning a home birth, and that they assumed the hospital was their only choice. Midwives, though open to supporting those who knew about home birth, did not initiate discussions of it (Madi & Crow, 2003). Even though this study came a decade after *Changing Childbirth*, there was little evidence that women had the 'real choice' established by policy, or that they, not midwives and other HCPs, were the ones who steered and controlled decisions about care, echoing previous research (Green, et al., 1998; Levy, 1999). It gradually became apparent that "choice is a myth" (Lothian, 2008, p. 36), and that "the rhetoric of choice has been grafted onto the restrictions on autonomy" (Edwards, 2005, p. 88). Edwards' (2005) research findings suggested that even the most knowledgeable, assertive women could be coerced by HCPs into decisions. While safety concerns underlie women's decision-making about birthplace, what is safe is dictated by obstetricians, and it is wielded in a manner as to sway women's choices, so the core issues are relationships of autonomy (Edwards, 2005), rather than risk, which is simply used as a tool to provide authority to one party over the other.

Edwards' (2005) study, which was conducted with 30 women planning home births, also brings in the importance of the body in choice and control, in that these mothers use "embodied knowledge" that is experiential and intuitive to guide their notions of safety and security. Decisions about childbirth are oriented around the body, and, for women choosing home birth, the clearest way to achieve autonomy on several levels is to pursue non-hospital care, employing personalised knowledge about safety and risk. Similarly, in Davis-Floyd (1994) and Cheyney's (2008) research, women use parallel forms of knowledge to inform their care and guide their decisions about the birth process, taking the control of these out of the hands of obstetricians. Davis-Floyd, in particular, explored the connections – and separations – between women, their bodies and their babies, and how this unfolds with regard to control in childbirth. For several of the women choosing home birth, there was no difference between themselves and their bodies; they had an integrated view of mind and body that allowed them to relinquish control over the physiological

changes of pregnancy and birth, finding that surrendering this type of control was valuable to the birth process and allowed them to truly take part in it:

Well, I didn't consider having a baby something I wasn't supposed to take part in. That I was just there to grow this baby and he was going to take it out of me...I knew that it was me 100% that was going to get this baby through the birth canal and out into the world. (Davis-Floyd, 1994, p. 1134)

In this, there are two forms of control. There is control internally and bodily, and control that is external and peripheral. Women who chose hospital birth tended to be more focused on control of their bodies, seeking to manage the 'out of control' process of childbirth through medicalised and technical care. A high value was placed on making their own decisions about specific care, such as pain relief (e.g. "No one has the right to tell you that you have to go through that kind of pain"), rather than location or who was attending them (Davis-Floyd, 1994, p. 1132). Neither group, home nor hospital, wants to wholly give up control; they simply prioritise different kinds, based on the birth philosophy that they ascribe to.

There has been a wealth of birthplace research that extols the virtues of home over hospital, natural over medical, which some have criticised, as it assumes that home immediately equates bodily autonomy and agency for women. There is an inherent dualism in this writing, which is reproduced over and over again, which diminishes women's empowering experiences of hospital birth and promotes a conception of childbirth that is connected to class and gender identity norms (Mitchie, 1998; Fannin, 2003). In discussing Mitchie's article, Fannin asserts that "[t]he idealisation of home is problematic, given its status as the site of both women's reproductive and productive labour. Home does not signify autonomy and bodily control for all women, nor is domestic space always the safest place for women," (Mitchie, 1998; Fannin, 2003, p. 521). The meanings of home and hospital, in fact, are not fixed to physical, material spaces but rather notions of safety, feelings of control and ideals of feminine identity. Home, once a place of disenfranchisement for women, has been reconstructed by many feminist reproductive scholars as a space of empowerment, where control over one's birth, body and agency is most possible.

This criticism is crucial because it highlights the question of *who* exactly home birth promotion is for, given the struggles of poorer women and women of colour for fairer treatment and equal access to care. While medicalisation has co-opted women's agency, pitting it against women's rights and feminism is, in a sense, ahistorical. During the 1920s and 1930s, upper-middle-class women, suffragettes and

feminists were outspoken supporters of anaesthesia development with the promise of ‘painless’ birth, even though this was potentially inaccessible to poorer women whose social circumstances made it difficult to give birth in hospitals (Barid, 1960)¹³. Given this historical lens, it is possible to expand my initial questions even further: when it comes to place of birth, *who* is choice and control for? Lazarus found that low-income American women had few or no choices concerning their antenatal care, and “neither expected nor desired control but were more concerned with continuity of care” (1997, p. 25). Choices and control, then, are often not considered for poorer women, or those with a ‘high-risk’ status, for that matter, since a majority of birthplace research focuses on women with straightforward pregnancies, even though, as mentioned, the secondary analysis of higher risk women in the Birthplace in England study suggests that they should also have more options (Hollowell, et al., 2015). *Changing Childbirth* had lofty claims that control was for all women, emphasising the need for “a service that is respectful, personalised and kind, which gives [women] control and makes them feel comfortable” (Department of Health, 1993, p. iii). Yet, as Coxon points out, “[t]his line of reasoning suggests that although consumer choice is available to women, the reasons for wanting choice and control over childbirth originated in a humanist critique of excessive medical interventions during birth rather than a consumer oriented demand for choice of provider” (2011, p. 61). However, as shown over the course of Chapters 1 and 2, the reformed maternity services were underpinned by a neoliberal ideology that contributed to the creation of an internal market within the NHS and continues shape care provision to this day (Rayment, et al., 2019).

Upon reflection of this chapter, it is clear that birthplace is no less complex, enmeshed as it is in socio-cultural, political and economic modalities, meaning we must tread carefully and critically in the promotion of more settings and choice, remaining conscious of this can exclude those who might benefit the most from emerging services and of how policy works towards specific ideological agendas. While maternal health researchers have more and more promising literature at their fingertips about the benefits of non-hospital settings and de-medicalised models of care, choice is illusive in this edifice, as women overwhelmingly continue to plan hospital births and continue to report having limited information and options (Hinton, et al., 2018; Naylor Smith, et al., 2018). With the present emphasis on augmenting

¹³ Maternity homes, the original iteration of FMUs, were set up initially to provide a more suitable environment for women in poor housing; however, now middle-class women are more likely to know about and opt for them.

decision-making and 'informed' choice in maternity care, each deserves further elucidation and conceptualisation, which will be discussed in the following chapter.

Chapter 3: Meta-synthesis of decision-making and choice

Despite the long-term health policy commitment in the UK to promoting women's decision-making and facilitating informed choice about their care, how to achieve each is less concrete. Some researchers have argued that informed choice, in particular, is, "at best, illusory" (Jomeen, 2012; Jenkinson, et al., 2016), yet there are few systemic reviews related to it or women's experiences of decision-making about maternity care, particularly intrapartum care. In order to address this gap, three colleagues and I conducted a systematic review, the process and findings of which are detailed in this chapter. As the review encompassed published qualitative data, we employed a meta-synthesis approach to explore the relevant literature, which is anchored around "bringing together and breaking down of findings, examining them, discovering essential features and, in some way, combining phenomena into a transformed whole" (Schreiber, et al., 1997, p. 314). This new interpretation of, or 'going beyond' (Thomas & Harden, 2008), research is one of the key aspects that sets a meta-synthesis apart from a meta-analysis, which aggregates findings to establish 'truths'. The review sought to re-conceptualise the concept of informed choice and establish a more 'women-centric' definition that fits the maternal health care context in which it is often used.

Background literature

Initially, this review sought to focus solely on informed choice, keeping with the overarching aim of my research. Over time, however, I realised that there cannot be a discussion of informed choice that does not involve decision-making because each are inextricably linked. Their relationship is seemingly bi-directional, in that an informed choice is not only the outcome of a process of decision-making but also is simultaneously constituting and influencing any related or future decision-making. In thinking about each as bi-directional and intertwined, it is then possible to begin to break down more linear conceptions of decision-making and informed choice, which often assume that the decider uses a rational process to weigh

up and decide amongst all of the available options (Bekker, et al., 1999). This 'rational process' is connected to the tenets of classical decision theory, a concept that stretches across several disciplines, statistics, economics, neuroscience, physiology and psychology, and has been developed and discussed since the 1950s (Edwards, 1954). Classical decision theory is essentially:

[T]he collection of axiomatic models of uncertainty and risk (probability theory, including Bayesian theory), and utility (utility theory, including multiattribute utility theory), that prescribe the optimal choice of an option from an array of options, where optimality is defined by the underlying models and the choice is dictated by an explicit rule, usually some variant of maximization of (subjective) expected utility (Beach & Lipshitz, 2015, p. 21)

The theory is commonly seen as both normative and prescriptive, in that it is an abstract framework designed to illustrate choices of an ideal, hypothetical decision maker, whose decision-making is assumed to be the most rational and appropriate process. The quality of human decision-making, in actuality, has been frequently evaluated using the standards of classical decision theory, which would not have to be normative or prescriptive if only people behaved as they should (Beach & Lipshitz, 2015). However, this does not rectify the persistent issue that human behaviour does not conform to classical decision theory and cannot be adequately described by it. Moreover, the long-held, assumed prescriptive and normative functions of the theory means that contemporary models of decision-making continue to inhabit these roles. The well-established health care model of 'shared decision-making' (SDM), "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences" (Elwyn, et al., 2012, p. 1361), is essentially the description of an idealised process and interaction.

In some ways, the vision of choice in *Better Births* (National Maternity Review, 2016) runs counter to SDM, the approach of which is, perhaps, a response to the increasing importance of service user decision-making and informed choice, particularly as an ethical principle that guides 'patient-centred care'. The model based on the concept allows HCPs to facilitate service users' movement from 'initial preferences' to 'informed preferences', using a series of strategies, 'choice talk', 'option talk' and 'decision talk'. It ensures that services users are made aware of their choices and highlights that preferences are based on 'what matters most' to them. Although the model steps away from clinicians making decisions outright for

people, 'preferences' implies that service users are still not in full control of the ultimate care decisions or choice outcomes. Furthermore, care is still shaped by the clinician, rather than around the service user, as emphasised by the 'Personalised care' statement from *Better Births*. The authors of the SDM model do acknowledge that it "is a simplification of a complex, dynamic process", and as an educational tool for clinicians, it may prove effective; however, the extent to which it gives service users more power in the decision-making process is not well established, nor is there evidence of any association between SDM and service user health outcomes (Joseph-Williams, et al., 2014; Aubree Shay & Lafata, 2015).

Decision aids

Given humans' inability to make decisions in a consistently ideal and rational manner or to cohere to models geared toward augmenting informed choice, decision aids are frequently solutions aimed at smoothing over the fissures between theory and reality, but are they effective? Vlemmix et al (2013) conducted a systematic review of 10 RCTs, showing that decision aids related to pregnancy care significantly increased knowledge and decreased anxiety and decisional conflict. Despite the apparent positive effect decision aids have on informed decision-making, only half of the studies included assessed whether participants had made their decision in line with their values, a key aspect of informed choice. Dugas et al's (2012) systematic review and meta-analysis, on the other hand, distinguished between impact on knowledge, decisional conflict, final choice and final outcome. Decisional Analysis Tools (DAT) help people make a choice when there is more than one option and include techniques that allow for the clarification of personal values about each option and their benefits and consequences. DATs were found not only to increase knowledge and decrease decisional conflicts but also influence final choice and outcome (Dugas, et al., 2012).

One of the most comprehensive reviews of quantitative decision aid research, specifically those aimed at decisions about health treatments and screening (Stacey, et al., 2017), found that people using aids feel more knowledgeable and informed. Additionally, they tend to be more aware of their values, have more active roles in decision-making and have more accurate understandings of risk. The review also found emerging evidence that increased knowledge and accurate risk perceptions were associated with decision aid use during consultations or in preparation for them. While this review is thorough, it is limited to

published studies that employed an RCT design, leaving out a large portion of research, particularly qualitative studies, which are relevant for understanding decision-making processes. Moreover, only a small breadth of research from reproductive and maternal health was covered, specifically five studies focusing on obstetric choices and four on prenatal screening choice, and it cannot be assumed that the findings would be transferable to decisions about pregnancy or birth care.

Stacy et al's review only covered studies employing quantitative methodology, yet their findings are reflected in qualitative research. In Frost et al's (2009) interview study, women reported that decision aids reduced their decisional conflict and uncertainty about mode of birth after a previous caesarean section. They also found that aids affect knowledge and anxiety, and have a mediating role in the relationship between preferences and actual outcome, in that they helped women reconcile any dissonance between the two (Frost, et al., 2009). Perhaps this is because decision aids, especially DATs, elucidate individuals' values in the context of the decision: if a tool's result is not the actual outcome, it can help women make sense of this disjunction. However, there is little evidence about real world use of decision aids in health care settings, outside of controlled trials, due to ideological barriers, such as embedded practice norms and practical obstacles, for instance time pressures in already "time-poor" settings (Stevens, et al., 2016). This facet of decision aids highlights the importance of looking to qualitative research for deeper evidence about the nature of decisions related to health, particularly those integral to a transformative event like childbirth, in which choices implicate both a mother and her baby. Such insights can clarify and direct further decision aid development and their use in care settings; therefore, the aim of this review was to not only produce conceptual framing and new research avenues for decision-making and informed choice, but also to identify implications for future decision aid designs.

Design

The search and screening was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, an evidence-based framework used for reporting in systematic reviews (Centre for Reviews and Dissemination, 2009; Shamseer, et al., 2015), and was registered on the PROSPERO (Ref: CRD42017053264) database of protocols for systematic reviews. Because it focused on published

qualitative data, a meta-synthesis approach was employed to explore the relevant literature (Thomas & Harden, 2008). The full protocol registered on PROSPERO can be found in Appendix A.

Systematic search and screening

The search for articles was conducted on EBSCO (Academic Search Complete, CINAHL, Medline, SocIndex, PsycARTICLES), OVID (Embase, Global Health, Maternity and Infant Health Care) and Web of Science. The grey literature was searched using OpenGrey and EThOs. Study content was not limited to a specific geographic region; however, the article had to be published in English. Studies also had to be published after 1990 due to the health policy developments (Department of Health, 1993), which created a consistent rhetoric about choice in maternity care not present before. The searches focused on pregnancy and childbirth and did not include family planning, infertility, abortion or postnatal care. The search was filtered for studies employing qualitative or mixed methods research designs and analyses, which was key for the data extraction and synthesis process. Quantitative studies and quantitative findings from mixed-methods studies, RCTs and open-ended questions from survey studies were excluded but retained as background information. The search strategy included Boolean phrases of “AND” and “OR”, and terms were generated using MESH headings, database thesaurus and free text. An example of the search strategy that was used on EBSCO is detailed in Appendix B. Articles were screened for fit with the inclusion criteria independently by two reviewers, first by title, then by abstract and following this by full text. In cases of uncertainty or lack of agreement, the third and fourth reviewers’ views were sought. Appendix C defines the inclusion and exclusion criteria that were used during the study screening processes.

Quality appraisal

Three reviewers independently carried out a quality assessment of the included studies using a tool (Rocca-Ihenacho, 2017) for qualitative research that was adapted from Walsh and Downe (2006). Initially, we intended to use CASP (Critical Appraisal Skills Programme, 2013) for the qualitative research appraisal; however, this tool, though popular, was found to be less sensitive to validity than other critical appraisal tools for qualitative research (Hannes, et al., 2010). We amended the tool by Rocca-Ihenacho during our

quality appraisal, decreasing the number of items on the checklist and adding in a more nuanced scoring system. The resulting tool in Appendix D uses 33 items to appraise research on the basis of scope and purpose, methodology, research design, sampling strategy, data collection and analysis, interpretation of data, discussion of results, reflexivity and ethical considerations. Studies were scored from 0-2 for each item to denote the quality of each item and were given an overall quality rating (0-22 = low; 23-44 = moderate; 45-66 = high). The quality ratings for this review were: five low quality, 20 moderate quality and nine high quality.

Data extraction and synthesis

The first reviewer extracted data from the selected studies to assess quality and to synthesise reported results with supervision from the second reviewer. No discrepancies were identified during this process. The extracted qualitative data was coded line-by-line in NVivo to enable the translations of concepts from one study to another and to build a qualitative synthesis, following Thomas and Harden's (2008) methodology. This approach enables the synthesis to 'go beyond' in order to identify key concepts in the studies and translate them into one another. The process of translation allows the recognition of similar concepts used within studies, even if they are not explicitly stated as such. The theories associated with these concepts are extracted so that a line of argument can be developed and concordant concepts can be put together, bringing fresh interpretations.

Search results

Electronic databases identified 1,646 records, and after screening both titles and abstracts, 69 were selected for full text review. One article was known to the author, bringing the total to 70 records. Of these, 35 were excluded for a number of reasons. The most common was because the study focused on an aspect of women's experiences outside of decision-making about pregnancy and birth care, or there was little to no inclusion of decision-making or informed choice in the study aims or findings. From the remaining records, five were removed because they were scored as low-quality during the quality appraisal, leaving 30 records that were included in the meta-synthesis. A majority of the studies included in the final review

were peer-reviewed journal articles. One PhD dissertation (Madi, 2001) was included; however, the findings extracted from the text were done with care so that the extended format did not dominate the analysis or the emergent themes. The search results can be viewed in Figure 5.

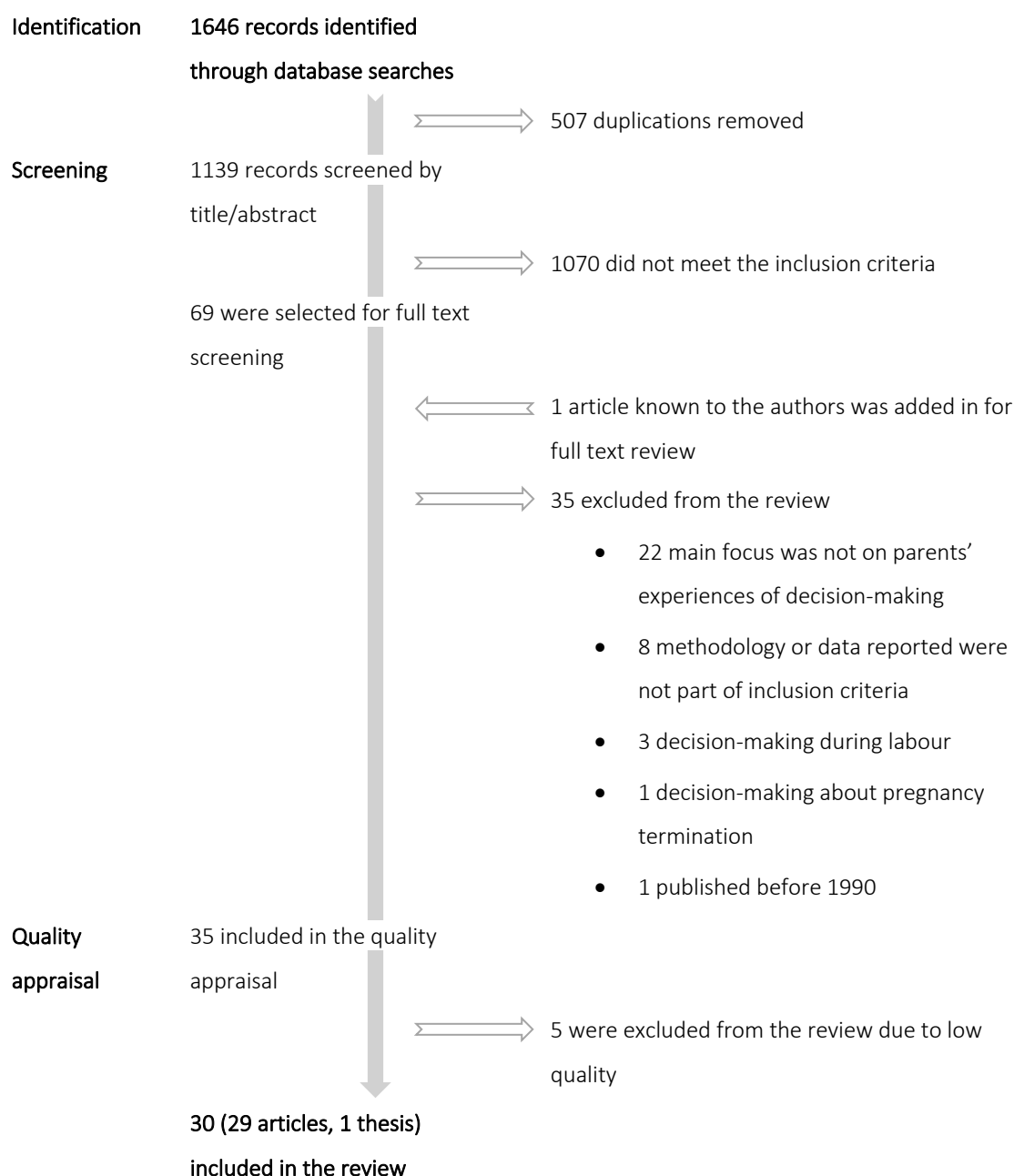


Figure 5. Flow chart of results of the record identification, screening and quality appraisal for the review

Findings

Descriptive findings

All of the studies reported in the review were conducted in six countries, the UK (14), the US (7), Canada (5), Australia (4), New Zealand (4) and Finland (2). Several of the articles included in the review reported on studies that were conducted in multiple countries, most notably Lagan et al (2011), which was undertaken in five countries. The range of countries included is small because the inclusion criteria was limited to research published in English, which may have eliminated research from Europe, and to studies conducted in countries with comparable medical systems to the UK. Appendix E provides a summary overview of the included studies with their corresponding numbers.

While all of the research broadly focused on decision-making and informed choice, there was a range of study topics, methods, sample sizes and analytical frameworks used to investigate the aims. A majority of the research centred on place of birth (1-5, 7-13, 18, 20, 21, 25, 26, 30). Of these, eight focused exclusively on home birth (1, 3-5, 10, 20, 25, 30) and one on free birth (11), though Miller and Shriver (2012) discussed women's decisions to free birth extensively in their article. The next most common study topics were decisions about birth (22-24, 27) and influence of information sources (15, 16, 29). Only two studies (19, 28) were concerned with informed choice as a primary study aim, and, finally, three studies explored birth experiences (6), natural birth (14) and pain management (17). Overall, place of birth research, particularly of home birth, was disproportionately represented in the studies identified.

There were several different types of study designs employed in the research under review. Most (1, 2, 4-6, 8-10, 14, 15, 17, 18, 21-23, 25, 29, 30) exclusively used interviews to collect data. Five studies (3, 12, 13, 16, 26) gathered data using focus groups, and the rest used a combination of qualitative methods, usually interviews with either participant observation (20, 24), non-participant observation (19, 28), narratives (11) or focus groups (27). Sample sizes ranged from four to 135 participants, although one study (Stapleton, et al., 2002) did not report their cohort size. The average study size among the records reviewed was approximately 32. Most of the studies (1, 2, 5-8, 13-18, 20-22, 25, 26, 30) used thematic analysis to generate results, while the remaining studies employed either theory-guided analysis (9, 11, 19, 23, 29),

qualitative content analysis (3, 12), close textual analysis (10, 24) or consensual qualitative research analysis (27). Two papers did not state their analysis methods (4, 28).

The review included only two papers (2, 30) that incorporated partners' experiences of choosing place of birth, and, of these two, only one (Bedwell, et al., 2011) focused exclusively on fathers. Research about men's experiences in other areas of maternal health is equally limited but does suggest that they feel disembodied from pregnancy and vulnerable during labour birth (Locock & Alexander, 2006; Johansson, et al., 2015), showing the need for the development of an evidence base to enhance support. There are also few ethnographic studies (20, 24) of decision-making and informed choice in maternal health, and most of the records we reviewed employed either grounded theory (4, 9, 19, 25, 29), phenomenological (1, 11, 23) or narrative (7, 8, 14) approaches as study designs. In general, the reporting of theoretical and methodological aspects of research was not as frequent as expected; for example, only 13 of the 30 studies reviewed stated their methodological frameworks. Because decision-making and informed choices are not straightforward processes and are enmeshed in wider socio-cultural relationships, it is important to situate the qualitative methodology within social theory. Moreover, there is little anthropological or sociological research on decision-making in maternal health, despite a rich body of work already established on reproductive and maternity experiences, both in the US and UK (see Davis-Floyd, Kitzinger, Lazarus and Martin).

At this level of analysis, three descriptive categories were identified, 'Relationships with choice', 'Influences on decision-making' and 'What makes women feel informed', and these are discussed below. All quotes in the following discussion are from the texts and participants of the original studies under review.

Relationships with choice

There were four prominent relationships with choice that emerged: no need for choice, restriction of choice, no choice presented as a choice and choices as comfort or security. It is important to briefly highlight women's relationships with choice in maternity care, as it can reveal power dynamics between HCPs and parents and begin to clarify the trajectory of decision-making processes. Relationships with choice also show the diversity of women's maternity experiences, particularly during a period of

heightened efforts to ensure they have options available and are truly making informed choices. In this light, it may seem counterintuitive to emphasise that some parents do not have an explicit desire for more choices and would rather rely on the advice of medical professionals:

“Well, I mean, I wasn’t so much interested in the choices that I could make. I would rather be advised, “this is best for you and this is best for your baby.”” (Pitchforth, et al., 2009, p. 44)

Nonetheless, the restriction of choice in maternity care was reported across half of the studies reviewed, signifying that this remains a common finding despite health policy efforts to increase choice in the UK and elsewhere. Choice may be restricted due to health concerns; however, there are many cases in which women report that this restriction comes from HCPs, regardless of individual clinical considerations:

"I do think you can be bullied into things, particularly if you're not strong minded about what you want It's quite easy for them to bully you, they say things like 'The baby will die' if you don't do so and so. Or: 'You'll be in danger.' It's very easy for them because you don't really understand the medical stuff. (service user, intervention site)" (Stapleton, et al., 2002, p. 641)

Risk, uncertainty and lack of medical and experiential knowledge, as the above quote illustrates, can be used as tools by those in positions of authority to redirect, limit or restrict women’s choices, effectively placing them on a care pathway that the HCP believes is best. Women report feeling pressured, bullied or shamed into making decisions, or not receiving any choice at all:

Choices within the hospital setting seemed to some women to be perceived choices rather than actual choices. For example, one participant was told by her provider at a challenging point in her labor that her only options were to have either an epidural or a cesarean, when she really wanted neither. (Bernhard, et al., 2014, p. 162)

In this case, a straightforward, natural birth was removed as a viable opinion and replaced with the illusion of choice, though the choice for more medicalised care has already been made by the clinician. This echoes previous work on interactions between midwives and women during antenatal appointments in the UK, during which consenting to Down’s syndrome screening is presented by midwives as the norm and those

declining this care were challenged on their knowledge (McCourt, 2005). Our review found, though, that simply having opinions provides a sense of comfort and security:

“...So the option to actually go to the hospital at any time that I felt unsafe or insecure or whatever, so that was beautiful like it didn't frighten me at all knowing that I had back-up.” (Catling, et al., 2014, p. 896)

Limitation and restriction of choice can be confusing and distressing for women without clear explanations of why and how they will benefit from specific care pathways. Even if women who do not have a strong desire for more choices, navigating their care and opinions on their own terms may render their relationships with it more positive than that of women who are restricted in their decision-making.

Influences on decision-making and what makes women feel informed

Our analysis identified nearly 20 different influences that parents reported shaped and guided their decision-making about maternity care during pregnancy. Four of the most prominent influencers were social and familial networks, uncertainty, medicalised care and spaces and birth philosophy. Several of these are echoed in the synthesis findings of the review, showing that they have significant roles in shaping and informing women's choices. For example, the meaning of uncertainty will be discussed in the synthesis section to follow. Social and familial networks often appeared in women's experiences of decision-making, focusing on how others' experiences and word-of-mouth information from close, trusted people are more influential than HCPs when it comes to choosing care:

“It's very likely it was from my sister-in-law ... And I'm pretty sure it was one of her friends that had used a midwife for their second [pregnancy] ... That was what pushed me further in that direction. I'd been considering it before.” (DiFilippo, 2015, p. 54)

Often influences are overlapping, for instance stories from friends and family augment the influence of uncertainty in pregnancy and childbirth, merging in a way that encourages women towards a specific care option. These two areas of uncertainty are often compounded by women's attitudes to medicalised care and spaces. Women's relationships to them may be a source of reassurance or one of anxiety, in that they are conceived as either a system that relieves a degree of uncertainty or one that causes more of it:

Outi [participant] did not want any technologies to be used during pregnancy or during birth. She did not want a Doppler to be used for listening to the baby's heartbeat: "There is no proof it is good. Only children who are still growing up have been examined with these technologies. There might be problems later." (Viisainen, 2001, p. 1113)

The availability and accessibility of "everything" in one building is a strong deciding factor for some women, while for others avoiding or limiting their interactions with medicalised care and spaces is a key component in their decision-making process:

"No, I wouldn't. I might go to a birthing centre, but not at home. I want to be certain, to have the medicine available – it's there, and there's no reason to not use it." (Malacrida, 2015, p. 643)

Not only do women's relationships to medicalised care and spaces reveal what makes them uncertain (e.g. not having 'proper' medical care in the event of an emergency) but also discloses a great deal about how parents conceive of and view birth. This view is a key component to the process of decision-making about maternity care because it often dictates how women engage with the medical system. Social and familial connections also play a large role in helping women to feel informed and able to align their beliefs about birth with their maternity care choices. Information outside of what is provided by HCPs is another:

"What is interesting about the stories of people who have had children is that it makes you take with a grain of salt everything you read. Because ... you read things that are very rigid. That's it! ... So, you read theoretical stuff that gives you a guideline, but the stories of people teach you that it's up to you to see and also you must trust yourself and respect what you believe and value ... (FTF, Nadine, patient of an obstetrician)." (Jimenez, et al., 2010, p. 163)

Seeking information beyond HCPs appears to be a more prominent activity among women choosing home and free births, but women, as shown in the quote above, pursuing all forms of care seek information outside of the medical sphere. The differences appear in what extent this outsider information is essential to the facilitating support for and acquiring knowledge about a care pathway, such as free birth. Regardless of how much this information is relied upon, the key driving factor for seeking it is the lack of support from practitioners.

Synthesis findings

Informed by women and their partners' accounts of their decision-making experiences and the descriptive level of analysis, three overarching analytical themes emerged – 'Uncertainty', 'Bodily autonomy and integrity' and 'Performing good motherhood'. These core themes are interwoven and overlapping as they reinforce and feed back into each other, and certain aspects of one can be confluent with those of another. There are three inter-linking actions – 'Information gathering', 'Aligning with a birth philosophy' and 'Balancing aspects of a choice' – as decision-making is an active albeit abstract process. The themes and inter-linking actions are framed by a 'Temporal dimension' that provides multidimensional depth to the process of decision-making and concept of informed choice. Figure 6 provides a visual conceptual map of the synthesis findings. All quotes in the following discussion are from the texts and participants of the original studies under review.

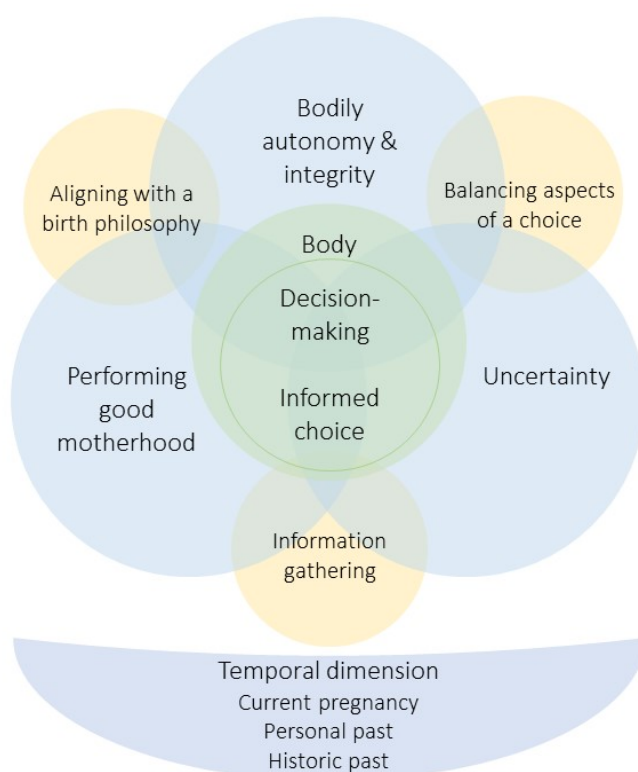


Figure 6. A conceptual map of the synthesis findings, depicting the interaction of the themes and inter-linking actions involved in the process of parental decision-making, underpinned by the temporal dimension.

Inter-linking actions

Information gathering

This action illustrates the multiplicity of information-seeking and what women specifically gain from different sources. While women may seek information from other sources outside of the medical sphere, this does not mean that they do not rely on information from HCPs, who are still seen as valuable providers, particularly as active rather than static sources:

“I have had the pamphlets that the midwife gave me but I feel that if there were anything I really wanted to know then I would ring the midwife--my own midwife at the surgery...it's just that you can have a conversation about it...in a book it's just written there, whereas you can discuss it when you are with the midwife.” (Levy, 1999, p. 114)

Trust as a crucial strategy for navigating convoluted decisions, particularly trust in experts with the appropriate skills and knowledge (Mishra 1996, Seligman 2000, Zinn 2008). As the participant above mentioned, the pamphlets from her midwife only provided so much, it was rather informal conversations, external to scheduled appointments, which she relied upon. Though HCPs are still seen as key information providers, women repeatedly reported looking for information, particularly for a more detailed knowledge and understanding, outside of their appointments and beyond the sources they received from clinicians, mainly family, friends and the Internet. Using these equally trusted sources may provide a more comprehensive picture of care or specifics about different options, or be used to ‘fact-check’ or confirm what HCPs have said:

Many wrote that they used the Internet to clarify information received from other sources—health professionals, family friends, or literature, such as pregnancy books and leaflets: “For me it was more to confirm what a doctor had said. Silly, I know, but I just wanted to understand it some more, which it helped me to do.” (Lagan, et al., 2011, p. 342)

Other sources of information can also be personal experiences, and care choices may stem from this internal history, particularly when women come to trust themselves and their bodies, which is common among those who chose to home or free birth:

“I knew that with my second, I was searching for a greater depth to the experience, something more intuitive as I had come to trust myself more than I had previously, not just through experience, but through research that supported my beliefs in understanding the science behind mammalian instinct, physiological birth and the huge value of the hormonal and emotional process.” (Feeley & Thomson, 2016, p. 7)

Triangulating information about pregnancy and care is common, given the scope of resources available; however, the act of confirming suggests that relationships of trust can still be difficult to manage with the overwhelming ‘risks’ attached to maternal health. Information is a way to counteract uncertainty, whether it pertains to fear or safety, while simultaneously functioning as a space in which women perform good motherhood, gathering all the resources possible to demonstrate their knowledgeability and responsibility as a mother:

“I had a lot of fear around pain and what I considered to be this maiming experience of birth. I didn’t read anything for 9 months except birthing books, I swear. I mean, I just studied it. I knew it so well that the birthing classes suggested that I become a teacher. By the time I was in preparation for her birth, I had a lot of very, very positive expectations around the birth.” (Dahlen, et al., 2008, p. 27)

The woman above has not only used intensive research to overcome her uncertainty and dread but has also been socially bestowed as an expert who is so knowledgeable that she can teach a birthing class herself. Information gathering can be used to shift an emotional outlook, whether it be for better or worse, relieving or inducing uncertainty, and it can also function as a strategy to forge or strengthen trust in sources of knowledge and in the self, by confirming what a HCP has advised or empowering the belief that birth can be positive, rather than maiming.

Balancing aspects of a choice

The next inter-linking action is concerned with looking at how parents consider the different options available to them and, essentially, weigh the advantages and disadvantages of those they encounter. There are different everyday strategies that parents use to navigate the many care decisions, including comparing information about an option or actively assessing and managing the uncertainty that is associated with

their choice. 'Balancing aspects of a choice' focuses on the decision, itself, how it is considered in relation to the self and the external world and how this shaped the ultimate choice outcome:

"I knew I had the information I was looking for generally after searching a number of sites and comparing a number of sources of information and when I felt satisfied I had learnt all that I could on a particular topic. I also liked to compare / discuss what I had found on the Internet with other sources, such as my midwife, obstetrician, GP, textbooks, etc." (Lagan, et al., 2011, p. 341)

"I have heard, of course, of the possibility of giving birth in a birthing center, but I thought it was not appropriate for me, because I think that it suits women who are calm and confident better. Me, I have more of an anxious nature. As I reflected during the course of my pregnancy, I came to the conclusion ... I am too able to imagine all the problems that could occur. It makes me feel safe to be in a hospital." (Malacrida, 2015, p. 163)

The quotes above illustrate just how often different decision-making strategies intersect over the course of pregnancy, how information is collected and scrutinised and how options are weighed within different boundaries. Feelings of satisfaction, anxiety and safety are used as an inner guide for making a decision, demonstrating the extent to which emotional and bodily well-being are considered when choosing significant care options, such as birth setting.

Balancing involves understanding and managing uncertainty, developing "safety nets" in the event of a complication during labour and childbirth. This phenomenon is not a recent one. McClain (1981; 1983) found that women's choices of birth services were based on balancing the risks and benefits of each option. Risk and benefit have thus remained strong vectors along which decisions are made against others; the central question being: what is the risk to my body and my baby?

"We just won't let labour go on that long – if things aren't progressing, we'll ask for a caesarean section...I've done everything I can to be fit and healthy. I've done NCT [National Childbirth Trust] – very helpful apart from they're a bit mad, and you have to take it with a pinch of salt. They are very pro- 'active birth' and anti-drug." (Coxon, et al., 2014, p. 61)

"So once I got past the anxiety issues, and making that final decision, and knowing that if I didn't want to go ahead with it then I could always back out and still go to the hospital." (Catling-Paull, et al., 2010, p. 125)

Women pursuing non-hospital births reported assessing and managing uncertainty regularly throughout their pregnancy, revealing the extent to which uncertainty is embodied and how bodily parameters orient decisions. Balancing the aspects of 'alternative' maternal care choices acquire legitimacy and potency as medical tests and clinical appointments confirm a 'low-risk' status, and optimal fitness, by these standards, is affirmed. So powerful are these biomedical definitions of health and risk that they determine pathways of care, even if it is generally outside its bounds and setting:

"I didn't actually decide to have a homebirth until I had had my 28-week gestational diabetes test, because I had had a false positive with that, so then after I'd had my second test for that then I decided that yes, I wanted to go ahead and have a homebirth. I needed to have everything clear in my head that everything was going to be healthy for me to be able to have a homebirth." (Catling-Paull, et al., 2010, p. 125)

Through this action, we can see how blended decision-making can be: it must encompass both physiological and social considerations, reflecting the dynamic nature of childbirth knowledge, itself, which is comprised of biological processes and social praxis (Lazarus, 1997). Balancing is an effective strategy for navigating these complex decisions and myriad information sources pertaining to them.

Aligning with a birth philosophy

In terms of decision-making, an important part of the process is aligning with a specific 'birth philosophy', or perspectives that inform the ways in which people understand the world and life in it, further shaping the information women access, the care opinions they ultimately choose and the ways they justify their choices. Birth philosophies, as they are presented in the literature reviewed, fall primarily into two camps; one views pregnancy and birth as medical events, while the other sees each as 'natural' events. Many women's perspectives reflect the medicalisation of childbirth in Western countries and as a result, they entrust their bodies to medical care. This commitment is justified because the maternal body is viewed as a site of danger, while the hospital is viewed as a site of safety:

"I had a couple of people going 'oh but it's all just a natural process and it's all good and you should be all fine'; well actually if you look around the world most of the women die in childbirth, that's the riskiest thing women do; I wasn't terribly impressed with that argument." (Grigg, et al., 2014, p. 10)

“I mean, it’s a medical thing. I’m not going to stay home if my appendix bursts either. I want the people who are trained and know what they’re doing to deliver my baby. Why wouldn’t you go to the hospital? That’s crazy!” (Miller & Shriver, 2012, p. 712)

Through this lens, placing one’s self anywhere but in a hospital and into medical care is “crazy”; however, women who see pregnancy as a ‘natural event’ view certain medical care as unnecessary and even harmful to their progression and birthing, and certain care opinions offer opportunities to maintain their physical agency. They often evoke the histories of women who have given birth outside of the hospital and the desire not to interfere with their bodies’ physiological processes. They do not conceive of their bodies as sites of danger, rather as those undergoing an organic event, and that care should indicate this:

“For me, pregnancy is a totally natural thing. If one is in good shape, in good health, there is no reason why one should go to the hospital to have access to medical help. Yes, things can go wrong, and this is why it reassured me to know that midwives are paired up with the hospital ... But if things go well, I have no reason to ask for a doctor’s help.” (Jimenez, et al., 2010, p. 163)

“I think [TMH]- it’s a hospital, which if you are sick or if you’ve had an accident, that’s great, that’s exactly what you want; but I wasn’t sick, I was having a baby – it’s a perfectly natural process that millions of women all around the world have managed to do without nice shiny hospitals” (Grigg, et al., 2015, p. 600)

The insinuation that alternative care opinions are right for – if not, limited to – women who are in “good shape” and “good health” reveals the overwhelming burden of risk discourse in maternal health. Moreover, the literature reviewed shows the extent to which “good shape” is often not quite enough, requiring women to be beyond just ordinary fitness and health. Despite this crossover between the ideological camps, there were indications in this review of emerging perspectives that allow each to dovetail, but increasingly underscore the importance of individualised choice as a way to display and promote appropriate motherhood and maternal care:

“For me a birth is natural when I can keep the child close to me and do what I feel right in the process, whether I will use technologies or I won’t. First and foremost the natural in birth means my choice and my

decisions. If I feel that an intervention is necessary it is not against the idea of a natural birth, nor is the use of medicine.” (Jimenez, et al., 2010, p. 163)

Engaging with, forming and embracing a birth philosophy are all important steps along the decision-making process and contribute to a woman’s ability to make an informed choice about her care; however, it is essential that these ‘ideologies’ or ‘philosophies’ are critically examined. Each ideology contains slippages, and their co-existence can still be regarded as contentious, yet they are repeatedly spoken of in decision-making about maternity care and remain integral to this process.

Analytical themes

Uncertainty

‘Uncertainty’, along with the following two analytical themes, encompasses several different experiences that are related to mothers’ concerns about the unknown and potential risks of pregnancy, childbirth and maternity care, all of which shape women’s decision-making and the options they ultimately pursue. Uncertainty about the unknowns of pregnancy and childbirth is most prominent among first-time mothers, who do not have previous experience to inform their choices and may approach care with a level of wariness:

“You don’t know how painful it is going to be, it’s the fear of the unexpected.” (Lally, et al., 2014, p. 3)

“The birthing center, I knew it existed, but I didn’t really know. But for a first baby I felt safer at the hospital, because they have all the technology, and if there are problems ... I am already at the right place. So, the fear of the unknown, I’d rather be in a place where I know that everything is readily available.” (Jimenez, et al., 2010, p. 163)

Anxiety and uncertainty about having a straightforward pregnancy and birth and fear of encountering pain, as well as the overarching lack of experiential knowledge, means that women gravitate to what they view to be the safest pathway of care, using what they perceive as less risky to guide their decisions. Uncertainty, which encompasses risk, safety and fear, was frequently cited as an influence on decision-making,

regardless of parity. Fear, such as fear of pain, can be a powerful motivator for choosing a specific place of birth:

“Well, of course I am gonna go in and have an epidural, because that’s what the hospital is there for. And of course I am going to take whatever is – I don’t want to handle pain, I’m scared of pain, so I’m definitely going to do it the easy way.” (Malacrida, 2015, p. 644)

Fear of pain is not the only anxiety that mothers experience; some women expressed uncertainty about the safety of the hospital environment, which directed their pregnancy and birth care decisions:

“You come out of the hospital and you feel like you are covered in germs and you just wanna have a shower and change your clothes so why would I wanna take a newborn who doesn’t have any kind of antibodies in their system yet into a hospital? It didn’t make logical sense to me.” (Murray-Davis, et al., 2012, p. 579)

Safety and risk are constructed in several different ways in these cases. Some women view medical interventions and environments as inherently risky, down to the microscopic level of “germs”, while for others, interventions and hospitals connote safety, security and quality care. Risk appears to be part and parcel of uncertainty:

“So, I went on a hospital tour and I said to myself ‘I don’t feel safe here,’ anyone can come in and out and I’m not in control.” (Lothian, 2013, p. 270)

As the quote illustrates, risk is co-constructed with loss of control, but, at the core, what makes this woman feel unsafe is her uncertainty about *who* will come in and out of her room. Likewise, fear about childbirth, particularly pain, is strongly connected to the unknown, as opposed to concrete calculations of risk, displaying how uncertainty is remains enmeshed with ‘being in control’.

Bodily autonomy and integrity

Control, and how it is linked to choice, is a topic widely covered in reproductive and maternal health research (Chapter 2, section Control and choice in place of birth). Parents frequently discuss their maternity experiences in terms of control, whether it be losing it, maintaining it or reclaiming it. We chose to shift the

perspective to bodily autonomy and integrity because 'control' is not always explicitly stated by participants, and experiences often refer back to the body. This theme, as with the others, is multifaceted, encompassing a range of experiences. My discussion will first touch on the denial of bodily autonomy, which is commonly coded as "loss of control":

"[Y]ou can be in whatever position you want, you can have whatever doctor you want, but then the nurses come in and they tell you to do this, so you do it" (Shirley). Andrea also noted, 'During prenatal classes, they had shown us some labor positions to try and stuff, but [in hospital] they were like, 'Oh, just try and rest. Lie down.' " (Malacrida, 2015, p. 645)

"I felt violated and humiliated. It ended up with the doctor telling me my baby was stuck and she would try to pull my baby out, in theatre, with an epidural, surrounded by strangers, in case it didn't work in which case they would perform an emergency c-section. It was the most awful experience of my life." (Feeley & Thomson, 2016, p. 5)

Experiences in this category may be quite subtle, such as threats of induction or discussions that aim to limit women's decisions about their bodies and care, to more transparent, like being forced to lie down, to traumatic, in which women are left feeling "violated". During these experiences, women's control over their care is restricted or removed completely, and this is embodied through the type of care received and the way it is received. If a 'good birth' is one that is smooth, normal and secure, where intervention is minimal but control is essential (Melender, 2006), then how do women protect their bodily integrity and exercise agency in their care?

"...you've got control over your environment, you can decide what position you're in, whether you need something to eat or a bath or a scented candle or, you know, you might want none of those things, you might have time for none of those things... And being somewhere that is familiar and safe and happy and that is not intruded on by other people and their various dramas, positive or negative. And where you can control the cleanliness and the food and anything else, and you can go to your own bed afterwards and ... yes. It just feels to me some ... more comfortable." (Coxon, et al., 2014, p. 62)

The review outcomes, which included eight studies of home births and one of free birth, suggest that birthing outside of the hospital is a common route taken by women if they are concerned with control over

their bodies and agency in their care. It is also perhaps telling that so many of the studies were focused on home birth in that the issue of choice or decision-making becomes more prominent or obvious as an issue because it is not the norm, and the hospital is the 'default' position. Pursuing home birth, in which limited medicalisation is ideal, can be viewed as an embodied practice that reflects women's desires for autonomy and integrity, and those who choose this type of care often centre their motivations and experience on their bodies.

Performing good motherhood

The final analytical theme is 'performing good motherhood' and is related to responsibility and risk, which are often ascribed to mothers to manage (Coxon, et al., 2014). This theme revealed a pervasive, gendered cultural norm that 'good' motherhood and birth takes place in a hospital with a team of medical professionals. It may be one of the reasons why women planning home births often describe thorough information gathering and risk assessments, and speak about negotiating their care within the purview of biomedicine:

She [participant] used biomedical knowledge to support her view that birth can safely be conducted at home when risks have been excluded by prenatal care. For this purpose she and her husband had searched medical databases to find research on home births. To secure her own low-risk status she had extra examinations done during her pregnancy. She organised her home birth to represent conditions in the hospital as far as she could. (Viisainen, 2001, p. 1117)

Re-creating the home to mimic a hospital, the space most associated with responsibility and safety, can be viewed as a behaviour that reinforces the authoritative position of the medical system and the norm that maternity optimally takes place within it, while simultaneously demonstrating this woman's responsibility as a mother, despite her decision to choose a birthplace outside of this system. 'Performing good motherhood' is associated with management of risk, using biomedical knowledge and sanctions to do so. In the quote above, the participant takes part in extra examinations in order to ensure her 'low-risk' status, as an act of self-management aimed at gaining knowledge about risk in her pregnancy and birth and justifying the safety of choosing home over hospital. Despite her efforts to clarify and secure this status,

hospital birth remains the ultimate act of risk management and thus, epitome of good motherhood. For parents choosing the hospital, risk may be spoken of in terms of danger and death, each a possibility in the spaces outside of it:

“I said, ‘Look, don’t worry, I’m not going anywhere there’s no doctors.’ And he [GP] said, ‘Yes, I’m just saying, you know, because you know the chances are ... It’s a 40 minute journey [referring to transfer to OU during labour]. Do you want to risk that?’ No! [Laughs] But yeah, that’s all he really said, but he was right...I’m not risking that, I’m not risking the baby’s life or my life.” (Coxon, et al., 2014, p. 58)

“Why would I want to put my baby in danger? What if something went wrong?” (Miller & Shriver, 2012, p. 712)

Within biomedicine and wider social discourses, pregnancy is constructed as a time of risk and its reduction (Edwards & Murphy-Lawless, 2006), and childbirth, subsequently, an event that requires not only hospitalisation but also one that acquires a moral subtext, making it difficult for parents choosing alternative care to escape blame and stigmatisation (Viisainen, 2000). Coxon and colleagues (2014) argue that discourses of responsibility continue to constrain women’s decisions and the way they discuss birth options outside of the norm, and many of women’s reported decision-making experiences uphold this idea.

Temporal dimension of decision-making and informed choice

There are several levels in which temporality underpins decision-making and informed choices about maternity care during pregnancy and for birth. On the most immediate level rests a continuum from ‘early pregnancy’ to ‘late pregnancy’, during which options are considered and decisions are made. There is not necessarily a pattern of when decisions about maternity care are made along this continuum, and there may not be specific decisions points along it, but rather decisions can build or shift over time. On the other hand, significant influences, such as attending a friend’s home birth early in pregnancy, can provide a more concrete time stamp for a decision shift along this continuum:

“I had a powerful experience when I was early on [in my pregnancy]. It was home birth of my friend’s...I think for me, deciding to go with home birth had somewhat to do with being there at a home birth...That seems

worthwhile: I want to be a part of that. I want that. And so early on, we made that decision.” (Regan, et al., 2013, p. 175)

“[F]rom the beginning I knew [hospital birth] was the course of events” (Lee, et al., 2016, p. 47)

“Just wanted to leave the window open, because I liked the idea of doing it but I wasn’t completely ready to make that decision, and I think as I got further along in my pregnancy, it was easier for me to make that decision.” (Catling-Paull, et al., 2010, p. 125)

The next level within this temporal dimension of decision-making is constituted from past personal experiences, which encompasses before pregnancy, previous birth(s), significant life events and family experiences of the recent past. Like the themes of maintaining bodily integrity, managing uncertainty, and performing good motherhood, it also has the potential to be a highly emotional layer, where memories of trauma or loss reside and shape how decision-making is approached and which care options women and their partners take seriously:

“I don’t want it to go like it went last time. I had quite a traumatic first birth and I had basically a series of events happened and I felt that I had lost control and I hadn’t been informed properly when I was in labour. So, things kind of went out of control. This time round I’m, I’m planning to be at home because that gives me an element of control that I didn’t feel that I had when I was in hospital.” (Lally, et al., 2014, p. 6)

“My brother had ... well his wife had a baby at home and the baby died ... and I think that affects ... that sort of affects the family for a long time, you know, anyone in the family who was involved with that or remembers that, you can’t, [home birth is] just a no-no for us.” (Coxon, et al., 2014)

The deepest layer of this temporal dimension of decision-making is the historic past, which often is embedded within women’s perspectives of birth and their decision-making processes. The ‘past’ or ‘old days’ are often used to justify a decision, particularly when it comes to place of birth. This justification occurs along two lines: either it is connected with traditional birthing practices, inherent biological drives or mammalian physiology to strengthen the choice to home or free birth, or it is connected with historical maternal and infant mortality rates to make a case for hospital birth:

“I accepted that like any other mammal, I can give birth so the implicit trust I have in my biology played a fundamental role in this acceptance of birthing alone.” (Feeley & Thomson, 2016, p. 8)

“I just know that bad things can happen, like to the baby’s blood or heartbeat or whatever. Birth is really dangerous and women used to die all the time before hospitals, and I guess they still do in poor countries and all that.” (Miller & Shriver, 2012, p. 712)

In conceptualising temporality, it is easy to present it linearly, reflecting how individuals move forward in time, which is not necessarily the case for such cognitive process like decision-making. Instead, women may shift between or draw from different temporal nodes when they working through and making a decision.

Discussion

Few studies in this review focused primarily on the *process* of decision-making, as opposed to the influences on it, perhaps as an artefact of the research methods used, or placed informed choice as a primary research aim, which means elucidating maternal health decision-making was tenuous at times and tracing the development of informed choice in literature published since 1990 was difficult. In their analyses, many of the review sources failed to materialise deeper themes within this vein, leaving questions about what we are missing when we talk about parents’ decision-making in relation to birth, for instance how social and institutional power might come to be embodied through decisions about care. The literature under review suggests that relationships with choice are complex but also dynamic, and given the wide range of information now available to parents and the variety of influences on decision-making reported, this comes with little surprise. Ultimately, we found that decision-making is not only dynamic but also a temporal process, in that it is made within a defined period and invokes the past, whether this is personal, familial, social or historical. Few of the papers reviewed explicitly explored timing of decisions; instead, time was discussed within reported influences on choice. Considering this temporal dimension, researchers qualitatively studying decision-making and informed choice should draw less from linear and rationality-based models and embrace more fluid concepts and theories.

Within motherhood, there can be a multitude of experiences, narratives and identities that, like information seeking and relationships to choice are consistently unfolding and in flux, within a dynamic decision-making field of maternity history, uncertainty, birth ideology and care options. Aligning with a birth philosophy, whether consciously or not, is a crucial component of making an informed choice. Generally, birth philosophy is pushed, by researchers and parents alike, into two fundamental camps, in which pregnancy and birth are treated either as a medical event or a natural event. This dichotomy is consistently generated and reproduced within pregnancy and birth discourse, rhetoric and research, reinforcing a binary tendency in analysis that does not necessarily reflect the realistic ways women consider maternity. However, the 'natural event' ideology features predominantly in this review. Because nearly a third of the included studies focused on home birth or free birth exclusively, this may not be representative of the wider population; however, focused research into non-hospital birth is unsurprising, as this type of decision-making is more 'visible' as a process because it is not normative. The 'medical event' ideology remains the authoritative narrative of pregnancy and birth, and this is most obvious in that women seeking care outside of the norm still rely on biomedical sanctions to do so, and by the fact that approximately 2% of births in England and Wales take place at home (ONS, 2017).

Triangulation of sources is a strategy often used for making sense of manifold information and complex choice contexts, yet its functions are twofold, in that it is also beneficial for balancing the aspects of available care options, in accordance with personal values and experiences. As this review shows, there are several influences that do come through more strongly than others. Decision-making is heavily enmeshed in experiences of uncertainty and desires to manage it, and most choices about maternity care revolve around or consider it, especially risk and safety. This could account for the many women who describe the importance of 'being in control' during their pregnancy, labour and birth, opting for care that enables them to reduce their perceived risks and augment their and their babies' safety. Balancing aspects of a choice, then, is moderated through the body, its autonomy and its integrity, and further serves to manage uncertainty.

This review further highlights the importance of the body in maternal health. Embodiment underpins women's pregnancies and births (Downe, et al., 2017), reflecting the liminality of these events, even if it is not explicitly discussed. Embodied experiences are central to maternity, evidenced by the importance mothers place on bodily autonomy and integrity, and how indicative emotions are within this.

“Emotions affect the way in which the body, illness, and pain are experienced and are projected in images of the well or poorly functioning social body and body politic” (Scheper-Hughes & Lock, 1987). Good motherhood continues to be heavily associated with concepts of the appropriate maternal body. Research has previously suggested that a fit, pregnant (or post-pregnancy) body is idealised and celebrated, and thus can be seen as a mark of responsible, good motherhood. We would extend this further to include a good maternal body is one that is *safe and informed* as well as fit. A maternal body out of control, uninformed or medically unregulated induces uncertainty, anxiety, judgement and, to a certain extent, distrust, and this, in turn, shapes decision-making about care. The key actions that emerged may shift emotional and ideological views of pregnancy and birth, and help individuals to calibrate care options to themselves, their families and their environment. These considerations, strategies and actions are all mediated *through* the maternal body, meaning that they should be considered as *embodied practices*, and future qualitative research on decision-making should incorporate theories of embodiment in response to parents’ lived experiences.

An informed choice in a maternity care context, then, is one that takes into account all the information gathered and is aligned with a woman’s birth philosophy, the aspects of which have been considered and balanced against those of the other options. However, it is moderated by the desire to maintain bodily autonomy and integrity, discourses of uncertainty and motherhood performativity, framed temporally and embedded in emotional and spatial considerations. From the research reviewed, it can be hard to pin down to what extent women regularly make informed choices about their care; however, the instances of it are relatively clear when they are articulated, and this is often by women who choose home or free birth. These women appear more likely to consider multiple options, opting for those that are deeply connected to their values and their bodies, and research extensively. This may be endemic of medical systems constructed to support one pathway of care, but there is no reason a woman receiving pregnancy care and giving birth in a more normalised settings should not be facilitated to have similar decision-making experiences. In researching women who choose hospital or more medicalised care, their relationships with choice are key to unpacking whether or not their choices are informed, according to public health policy. This conceptualisation of informed choice is one of many that researchers have put forward since it became a buzzword in public health, yet it remains that, given the persistent power imbalances in biomedicine, it will continue to be defined by policymakers and HCPs. While we may have “a cultural ideal of choice as a

shared symbol of a decent society”, it may, in fact, be that women “are exposed to frameworks of choice rather than being explicitly able to formulate their own choices.” (Sleeblom-Faulkner, 2010; Fitzgerald, et al., 2015, p. 414). If the latter is the case, then it is clear we need to interrogate the possibilities of making informed choices in such a framework.

Chapter 4: Social theory and birth

This chapter is primarily concerned with introducing the disciplinary and theoretical approaches that underpin my study of place of birth, the discussion of which provides the basis for my rationale in employing ethnography, as covered in Chapter 3. It briefly reviews the anthropological contributions to childbirth research since the 1960s to illustrate the importance of using a socio-cultural perspective, arguing for its necessity when studying the complexity of maternal health, and moves on to describe my application of two key concepts, *habitus* and the *lived body*. Since the 1970s, there has been an upsurge of anthropological interest in reproduction and birth, and the nuances unpacked at the intersection of health systems, choice and power by anthropologists will no doubt be spun nicely alongside the growing complexity within the body of birthplace research around the same period of time.

Anthropology of birth

Since the 1970s, anthropology of birth has been a thriving area of scholastic energy as women became more prevalent in the field. The earliest contributions were actually made in the 1960s (Kitzinger, 1962; Newham, 1965; Mead & Newton, 1967); however, alongside the burgeoning Women's Movement, anthropological studies of reproduction and childbirth truly flourished, taking interest in examining both Western and indigenous maternity and birth practices (Shaw, 1974; McClain, 1975; Raphael, 1975; Newman, 1976; Cosminsky, 1977; Jordan, 1977; Jordan, 1978; Kitzinger, 1978a; Kitzinger, 1978b; Kitzinger, 1979). The nature of this output is diverse; subjects range from unwanted pregnancy (Newman, 1976) to self-diagnosis of early pregnancy (Jordan, 1977). One influential work, Kitzinger's *Women as Mothers: How They See Themselves in Different Cultures* (1978b), breathed life and legitimacy into the natural birth movements in Europe and the US. Another, *Birth in Four Cultures: A Cross-Cultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States* (Jordan, 1978), a comparative study positing that each culture's birth practices are a system that internally make sense and can be compared to other systems of birth, firmly placed childbirth in anthropology as a subject for in-depth ethnographic enquiry. The book advanced a 'biosocial approach', the mutual feedback between biology and culture, and

introduced an alternative model of birth called “fruitful accommodation”. While Kitzinger is credited with bringing “anthropological awareness of the cultural variability of birth practices into the popular consciousness” (Davis-Floyd & Sargent, 1997, p. 7), it is Jordan’s work that has persisted as a central focus for maternal health researchers and birth professionals.

Following this early work, a variety of ethnographies centred on pregnancy and childbirth appeared (MacCormack, 1982; Morsy, 1982 ; Laderman, 1983; Konner & Shostak, 1987; Tronick, et al., 1987; Browner, 1989; Jeffery, et al., 1989) with the consensus that culturally embedded indigenous systems of birth were under threat of being disrupted by an increasingly technological medical system that was ill-suited to the areas where it was being implemented. Common themes run through this research that attest to this: little or no validation of indigenous peoples’ own knowledge or practices, practitioners with little knowledge of or regard for indigenous systems, inadequately or inappropriately applied biomedical information in necessary areas, poor understanding of medical machinery and lack of expertise or funds to fix them and provide them widely. Vital as this work is to the foundation of the anthropology of birth, it is impossible to conflate or discuss the issues facing indigenous women in tandem with those prevalent in Western societies, which is why I primarily concentrate on the anthropological literature about birth in European settings and similarly developed countries. This also reflects the approach to the meta-synthesis in Chapter 3, which was limited to research areas with health systems and socio-cultural backdrops that are comparable to the UK.

The 1980s and 90s saw a continued proliferation of anthropology of birth research, with a focus on Western settings (Davis-Floyd, 1990). The ‘politics of reproduction’ (Paige & Paige, 1981; Handwerker, 1990; O’Neil & Kaufert, 1990; Ginsburg & Rapp, 1991) examines the relationships between reproductive health, politics and power, with the intention of synthesising both the local and global perspectives and reframing the way reproduction was studied by anthropologists (Ginsburg & Rapp, 1991). The framework, in essence, married both feminist and political-economic analyses of reproductive experiences and power. The implications of ‘politicising’ reproduction further are vast, in that it “focuses on the intersecting interests of states and other powerful institutions such as multinational and national corporations, international development agencies, Western medicine, and religious groups as they construct the contexts within which local reproductive relations are played out” (Ginsburg & Rapp, 1991, p. 312). Research falling under this umbrella is rich, touching on state and market interests in reproduction, social

movements, medicalisation, fertility, teen pregnancy, birth, birth attendants, infant care, childrearing and menopause. All of these topics are covered by Ginsburg and Rapp's (1991) meticulous review, and the field continues to be a dynamic part of feminist anthropology, covering topics, such as obstetric violence and surrogacy.

The politics of birth can be discussed along several lines, interrogating the assumed homogeneity of Western medicine and investigating the women's experiences in giving birth. Jordan's (1978) cross-cultural study of birth was one of many that compared Western, medicalised births with non-Western, non-medicalised birth practices (see Kitzinger, 1982). More relevant for my thesis, these comparative studies have also highlighted the variations in birth care between Western countries, teasing out different practices with regard to birth positions and birthplace choices (McClain, 1981; McClain, 1983). As Ginsburg and Rapp point out, these studies are beneficial for deconstructing Western medicine as a "monolithic category" and provided an avenue for comparative research to become "increasingly political" during the 1980s (1991, p. 321). Whiteford and Poland's (1989) edited volume, in particular, included essays on patient autonomy, informed consent and power distribution in medical decision-making, most of which were situated in the US and rely on American data. Only one chapter reaches outside this context and focuses on commercial surrogacy in the UK, which was banned by Parliament in 1985. This volume is indicative of Western birth research, as the American setting appears to dominate edited books and reviews. Ginsburg and Rapp's own review of "politicised" birth narratives touches only on American studies that brought attention to how birth aspirations and experiences differ across social, economic and racial lines. Still, these studies provide valuable insights into how individuals' aspirations and experiences are mediated by their conceptions of nature and relationships to medical technology (Davis-Floyd, 1987; Davis-Floyd, 1992).

Medicalised birth reflects American "cultural assumptions about how nature is most appropriately controlled and technological interventions reinforce their basic worldview" (Davis-Floyd, 1987; Ginsburg & Rapp, 1991, p. 322). Technological language and mechanistic metaphors abound in this section of birth research literature, reflecting the cultural acceptance that birth should be managed this way. American ways of doing childbirth were first conceived as employing an assembly-line structure by Shaw (1974), and this concept was developed further by Martin (1987), who wrote on views of menstruation, birth and menopause in terms of production and dysfunction. Martin's research extends the idea that maternal health experiences are distributed along lines of class and race to individual relationships with

medicalisation, finding that working-class women resist it, while middle-class women are more likely to accept it. Davis-Floyd's (1992) study of 100 white middle-class women's pregnancy and birth experiences affirms this, finding that many both accepted and were satisfied with the "technocratic model of birth". In retrospect, this patterning of resistance and acceptance is unsurprising in Western, especially American and British, medical systems where poor treatment of minority and lower-income women has been well documented and continues to be an issue (Lazarus, 1988; Fraser, 1992; Henderson, et al., 2013; Redshaw & Henderson, 2015; McLeish & Redshaw, 2019).

More often than not, when anthropologists extended a critical gaze to the Western biomedical model of birth, they found "a system of health care that objectifies the patient, mechanises the body, and exalts the practitioner over patient in a status of hierarchy that attributes authoritative knowledge only to those who know how to manipulate the technology and decode the information it provides" (Davis-Floyd & Sargent, 1997, p. 8). A politicised, critical anthropology of birth reflects wider changes in the discipline as post-colonialism and postmodernism swept through the field, opening up space for more "engaged and enraged" (Scheper-Hughes, 2004, p. 35) research. For anthropological work on human health, the establishment of medical anthropology, a branch of anthropology that investigates health, illness and care systems, as a more coherent field buttressed this burgeoning critical praxis. By the 1980s, medical anthropology was developing a more sophisticated understanding of the ways in which society and culture are not only built around health but also influence human experiences of illness, disease and well-being. While the cohesion of medical anthropology is a welcome evolution for the field, it is entirely possible to critically unpack health issues and maintain the traditional "detachment involvement" of anthropological research. At the close of the 20th century, it appears that this disciplinary stance was no longer acceptable, and presented anthropologists with a number of quandaries pertaining to the ethics of professionally profiting from critical engagement with human illnesses, health inequalities and deleterious aspects of the biomedical system. Applied anthropology, in which anthropological methods and theory are used to analyse and generate solutions for practical problems, works to address this gap, providing a sphere for impact-based praxis and activism. Much of this thesis will be grounded in this critical and applied anthropological praxis, as, in my opinion, an ethically sound and robust anthropology demands this perspective.

Moving forward in my review of the anthropology of birth, I will now shift to look at the work that has been concerned with place of birth, choice and change, mirroring the health policy changes that were taking place in the UK from 1993 onward. As the research often shows, choice is intertwined with control, and the ways in which they interact (or do not interact) exist along professional, socio-economic and racial lines, particularly in the US (Lazarus, 1994; Martin, 1987). Lazarus (1994) found that lower-income women focused on continuity of care, rather than control over their birth experience, whereas middle-class women viewed making choices about their care as a way to exert control. This is due the fact that “choices and control are more limited for poor women, who are overwhelmed with social and economic problems...and this affects their ability to acquire knowledge about birth and their ability to act on this knowledge” (Lazarus, 1988; Lazarus, 1994, p. 26). It is essential to acknowledge that decision-making and birthplace will always contain socio-economic and racial dimensions. For example, in the UK, home birth is commonly seen as an empowering opportunity for women to exercise agency over their care and their bodies, whereas in the US, with a radically different health system, it can also indicate socio-economic constraints for poor, young and minority women, who cannot afford to give birth in the hospital (Fraser, 1998).

Home birth has stimulated a rich body of work that further articulates the lengths to which the biomedical system constrains women’s choices and control, and the ways that mothers and home birth proponents seek to subvert this authority and create spaces for empowerment. Davis-Floyd and Davis (1996) extended the concept of authoritative knowledge to midwifery care and home birth in the US, providing a more nuanced look at how it drives decision and action. Intuition, as opposed to technological and biomedical expertise, was found to guide midwives’ decision-making during home births, and they placed higher value on this “inner voice”, despite the risks of criminalisation for providing care outside of medico-legal bounds. However, other social scientific research into intuition does not separate it from expertise, finding instead that its attunement rests on a high level of expertise rather than in spite of it. An issue with the Davis-Floyd and Davis (1996) article could be, that, at the time, the expertise of midwives was not formalised or recognised as authoritative. Ólafsdóttir (2009) found that the act of “being with” or “sitting over” women during birth is key for the development of midwifery skills, and facilitates a deep connection with the birth process, which allows midwives to learn how listen to their “inner voice” and to form an “inner knowledge”. Midwives described their “inner knowledge” as an amalgamation of skills,

knowledge and deep perceptions stored in the unconscious mind. Intuition in other professions has been studied more closely, with Sennett's classic work on craft, which:

[E]xplores these dimensions of skill, commitment and judgment... [and] focuses on the intimate connection between hand and head. Every good craftsman conducts a dialogue between concrete practice and thinking; this dialogue evolves into sustaining habits, and these habits establish a rhythm between problem solving and problem findings...There is nothing inevitable about becoming skilled, just as there is nothing mindlessly mechanical about technique itself." (2008, p. 9)

Anthropologists have not paid particular attention to women's and midwives' embodied knowledge and practices but have focused more on experiences or relationships with biomedicine and health systems. As such, some of the discussions of knowledge and practice remain on the level of the spiritual, ritualistic or symbolic, but how intuition works and how it relates to skilful logic are rarely deconstructed or examined closely. A particularly disquieting ethnography describes how American state and medical discourses attempt to delegitimise out-of-hospital birth and midwifery, by linking mothers who choose to home birth to women have been deemed "pathological" (negligent mothers, child abusers and drug addicts) (Craven, 2005). Craven (2005) found that women pursuing home birth were effectively placed outside of "normal" American mothers, who accepted the "logical" and "natural superiority" of the biomedical model of birth. Cheyney (2011) observed the presence of ritual performance in home birth practice and how this plays a role in the construction of home birth as a "transgressive rite of passage". She views these rituals as purposefully manipulated to subvert technocratic obstetrics and "reterritorialize childbirth spaces (home) and authorities (midwives and mothers)" (Cheyney, 2011, p. 519). More recently, research, like other birthplace work, has focused on the reasons why women decide to give birth at home, using themes that emerged to develop recommendations for improving hospital birth experiences (Hazen, 2017), and highlighted fathers' role in birth, exploring the ways in which masculinity is disrupted and shifted during home births (Driesslein, 2017).

There is little doubt that birth is infused with cultural meaning, enmeshed in protocols and taboos, but it is also an embodied process. However, there has been little sociological and anthropological engagement with it as such (Jordan, 1978; Walsh, 2009; Lupton & Schmied, 2012; Chadwick, 2018), even though the politics of reproduction, as Lock pointed out, "implicate the body" (1993, p. 133). Moreover,

birth has a spatial dimension that should be moved to the forefront of discussions of choice and control, as place is crucial in narratives about birth and politicised in nature (Hazen, 2017). My thesis is concerned with decision-making about place of birth as a process and a practice, which endeavours to reframe the previous anthropology of birth considerations and to highlight the embodied modality of maternity events, as opposed to the symbolic and ritualistic meanings of knowledge and actions. To conclude, as I begin to introduce my study design and findings, there are several strings – knowledge, bodily practice, space, decision-making and childbirth – that I hope to bring together by the end. Working from an anthropological, as opposed to a sociological or geographic, perspective, this research will attempt to reconsider and reframe place of birth as a new site for critical and applied medical anthropology to explore health knowledge and care practices, to interrogate the persisting implications of biomedicine and to develop recommendations for improving childbirth services.

Re-thinking the body and practice through place of birth

Research on women's experiences, bodies and motherhood can comfortably drift into feminist theory and gender studies. In developing my theoretical perspective and thinking about decision-making in a maternal health care context, I first naturally gravitated towards Jordan's (1997) concept of 'authoritative knowledge', in which one system of knowledge is privileged and legitimised over others. Because this thesis is primarily concerned with knowledge and information, as opposed to gender roles, beginning in this direction aligned easily with my initial question. Choice is another core aspect of my doctoral research, and, while feminist theories can be helpful in unpacking the various issues related to a woman's autonomy, preliminary research among women in East London did not reveal themes overtly related to gender or power that would warrant such an approach.

In several ways, Foucault's (1978) seminal work, *Discipline and Punish*, has been an important theoretical guide for anthropological research on reproduction. For instance, his concept of biopower was useful as an analytical framework for studying decision-making and antenatal screening for Down's syndrome. Much of the foetal screening work from anthropology provides a detailed look at the moral reasoning that underpins and shapes the decisions whether to have a screening and, then, whether to terminate a pregnancy, and it is also critical of choice:

“[F]ew participants think of choice as the process that they engage in for moral reasoning and despite the press of principalist arguments that suggest it is the provision of informed choice that makes difficult clinical decisions ethical. This critical reading of choice is also noted in Gammeltoft and Wahlberg (2014), who argue that choice is experienced by many as ‘obligation,’ for example.” (Fitzgerald, et al., 2015, p. 15)

Foucault also clearly influenced Jordan’s ideas about authoritative knowledge. Fundamental to *Discipline and Punish*, besides power, is the concept of discourse, and the idea that modern knowledge is related to human behaviour and nature, which is measured against a norm. Normalisation and ordering of the body’s functions increases docility and utility. This leads me, and others in the maternal-infant health field, to conceive the hospital as a system that regulates and to some extent seeks to exert control over the birth experience, emboldened by the prevailing discourse of biomedical knowledge, which has defined hospital birth as normal and safe, and non-hospital birth as abnormal and unsafe. The hospital as the site where birth normally takes place is prevalent and powerful because the knowledge system that supports it is prevalent and powerful. As Jordan wrote, “several knowledge systems exist, some of which, by consensus, come to carry more weight than other, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger base (structural superiority), and usually both” (Jordan, 1997, p. 56). The construction of authoritative knowledge is a ceaseless “social process that both builds and reflects power relationships within a community of practice”, where people come to see “current social order as natural order” (Jordan, 1997, p. 56). Much of what Foucault writes about the prison system translates easily onto the hospital system, where he states methods of observation and control originated. His idea of “positive economy”, or modern timetables that push more and more activity into a day (Foucault, 1978), is particularly poignant in a time when the NHS staff and services appear to be stretched to the breaking point as funding is cut and demand increases.

Amidst this sweeping social critique is the acknowledgement that alternative knowledge systems and practices must exist as a foil to the authoritative knowledge system. Devaluing these systems provides the mechanism by which “hierarchical knowledge structures” are generated, presented and perpetuated. This mechanism of generation and perpetuation owes much to the work of Bourdieu. Unlike Foucault, Bourdieu and, to a lesser extent, Jordan built flexibility and movement into their theories, the idea that a dominant apparatus of knowledge and discourse can change. Furthermore, while Foucault and Bourdieu

directly address and incorporate the body, it is strangely diminished in both Jordan's conception of authoritative knowledge and Davis-Floyd's (1993) discussion of the technocratic model of birth. In short, the body is perceived and treated as a machine, drawing from Martin's (1987) work, and hospital birth is reduced to a ritual. Davis-Floyd's (1993) description of the hospital birth ritual is elegant and intriguing when the obstetric practice and technology are framed as a performance, a method similarly employed by Jackson (1983) to illustrate the initiation rites among the Kuranko of Sierra Leone. Jackson also analytically navigated his description through Bourdieu's (1977) ideas of habitus, as well as Merleau-Ponty's (2012 [1945]) concept of the lived body. This framework allows the anthropologist to move away from dichotomous systems (e.g. body-as-machine) and semiotic models, and instead emphasise "patterns of bodily praxis in the immediate social field and material world" (Jackson, 1983, p. 327).

An aim of this thesis is to attempt a reconceptualisation of decision-making through the lens of place of birth, particularly how it relates to bodily practices of everyday life. Despite the diverse body of research on place of birth and decision-making, little has been written from this perspective, even though choosing where to birth is fundamentally constituted by small actions that intimately involve the body. These could be speaking to family and friends, attending an antenatal appointment or reading a website. This is not to say the body has not been incorporated into anthropological work on maternal health, particularly in considering the politics of reproduction (Ginsburg & Rapp, 1991). The new synthesis that I am proposing emphasises these actions as key points of how individuals encounter and know the world, as sites where bodies are shaped by the shared social environment. Bourdieu's (1977) theory of practice is grounded in these unconscious and mundane actions, and it endeavours to conceive of the body as more than a representation or a conduit of communication, in an effort to oppose rigid dualism, whether it be that of Levi-Strauss or Descartes, where body is split from mind. This view makes no space for the body as anything more than "an object of understanding, or an instrument of the rational mind, a kind of vehicle for the expression of a reified social rationality" (Jackson, 1983, p. 329). The concept of 'informed choice' is rooted in this separation, in that, ideally, it is a "reasoned choice made by a reasonable individual", based on all relevant information and the individual's values, after they have weighted the disadvantages and advantages of each option (Bekker, et al., 1999, p. 2). This understanding is all cognitive, dissociated entirely from the body; the body is passive or, more likely, absent. This may be one of the reasons that the discussion of birthplace choice is still framed as a contentious dichotomy between the medical and the

natural, since the underlying understanding of decision-making and care relegates the body to in an inert position; it is either governed by the individual or acted upon by clinicians.

The re-engagement with body and birth, however, has been bubbling among social scientists, notably Walsh and Chadwick, who want to confront the silences in the substantial research on birth, body, corporeality and politics. There is a reluctance, argues Chadwick, to interrogate “birth as a *bodily event*” and a tendency “to ignore the fleshy materiality of birth as a topic of empirical investigation” (2018, p. 1). Hesitation to ground birth research in the ‘corpus’ has had negative implications for parents and HCPs, alike, as well as researchers, who have little to grasp in the way of birth embodiment theory (Walsh, 2010). As I underscored in Chapter 3, the body remains unaddressed though often invoked in parents’ narratives and experiences of maternity care, and I argued that this could be linked to omnipresent dichotomies (mind-body, medical-natural), which continue to obscure approaches to analysis and dissemination of research. Chadwick (2018) has also found this, in addition to the constraints of current ‘choice’ frameworks, lending weight to the idea and elaborating on how they limit the scope of understanding.

While Chadwick focuses especially on birthing bodies and the bodily event of birth, my research is concerned with *pre*-birthing bodies, in which the event itself is enmeshed in the imaginary and loaded with risk discourse before it even begins. There are similar silences when it comes to the bodily modalities of decision-making and choice, despite the centrality of each to Western maternal policy and experience. Limited bodily engagement is perhaps the cause of “unreflective endorsement” of parents’ birth choice, ignoring the social relations and politics that shape decision-making (Beckett, 2005; Walsh, 2010, p. 496), in that embodied inequalities resulting from prohibitive choice frameworks are obscured because they are not considered. Chadwick, taking stock of inequalities and politics reified in birth, turns towards the birthing body as multiple and emergent, using concepts from Foucault and Kristeva to capture this. While this may be helpful for making sense of the bodily event of birth, my research is pre-birth, situated in the abstracted process of decision-making and in the messy picture of choice, meaning I draw on a different set of theories and methodology. In the following two sections, I will outline my two key theoretical resources: Bourdieu’s idea of habitus from his theory of practice, and Merleau-Ponty’s concept of the lived body from his work on phenomenology and perception. Both Merleau-Ponty and Bourdieu were concerned with collapsing subject-object binaries that had persisted through philosophical and social theoretical thought of the time, developing theories to move beyond, using embodiment as a means to do so.

Habitus, practice and the socially informed body

My primary theoretical concentration is restoring the body in decision-making, situating this process as an *embodied practice*. This effort is largely tied to the ‘bodily turn’ in social science, in which knowledge is treated as “situated, embodied enskillment” and culture as embodied practice, rather than an abstract semiotic system, and is increasing becoming mainstream in anthropological and sociological analysis (Ignatow, 2015, p. 7). The bodily and postmodern turns in social science have had epistemological, methodological and analytical implications, making space for researchers to not only interrogate relations with and between subjects and structures but also relations to self and positionality, which I will cover in more depth in Chapter 5. In *Outline of a Theory of Practice*, Bourdieu took issue with anthropologists’ epistemological “distance” from their subjects, and, from this perspective, they were “condemned to see all practice as a spectacle” (Bourdieu, 1977, p. 1). While *Theory of Practice* is broadly a critique of dichotomies that shaped theoretical thinking at the time and of the postures and methods employed in social science, it is predominantly an account of how human action should be understood, and habitus was conceived as the negotiation between objective and culturally acquired structures and practice. For Bourdieu, “theory of practice puts objectivist knowledge back on its feet by posing the question of the (theoretical and also social) conditions which make such knowledge possible. Because it produces its science of the social world against implicit presuppositions of practical knowledge of the social world” (Bourdieu, 1977, p. 4). The theory of practice is constituted of three key elements, habitus, field (social space) and capital, which each have been widely developed, expanded or, even, misconstrued; however, I will be focusing especially on just the first, which is the central concept.

The word *habitus*, itself was borrowed from Mauss, who used the term when discussing¹⁴ how he had noted different *techniques du corps* (techniques of the body) over the years, for instance swimming, digging, running and walking:

I have had this notion of the social nature of the 'habitus' for many years. Please note that I use the Latin word-it should be understood in France-habitus. The word translates infinitely better than 'habitude' (habit or custom), the 'exis', the 'acquired ability' and 'faculty' of Aristotle (who was a psychologist)...These 'habits'

¹⁴ Mauss first gave *Les Techniques du corps* as a lecture in 1934 at a meeting of the Société de Psychologie, and it was later published in the *Journal de psychologie normal et pathologique* in 1935. It was translated by Ben Brewster for *Economy and Society*, where it was published in 1973.

do not just vary with individuals and their imitations, they vary especially between societies, educations, proprieties and fashions, prestiges. In them we should see the techniques and work of collective and individual practical reason rather than, in the ordinary way, merely the soul and its repetitive faculties. (Mauss, 1973 [1935], p. 73)

Interestingly, his lecture argues a consideration of the body must be “a triple consideration instead of a single consideration...It is the triple viewpoint, that of the ‘total man’ that is needed” (Mauss, 1973 [1935], p. 73). In fact, “we are everywhere faced with physio-psycho-sociological assemblages of series of action. These actions are more or less habitual and more or less ancient in the life of the individual and the history of the society” (Mauss, 1973 [1935], p. 85)¹⁵. This triple view pre-dates ideas, such as the ‘body multiple’ (Mol, 2002) and the ‘mindful body’ (Scheper-Hughes & Lock, 1987), and is only just beginning to be considered in clinical fields (see ‘bio-psycho-social model of care’ in Rocca-Ihenacho, et al., 2018). Bourdieu both used and expanded upon habitus and Mauss’s classic work, *The Gift*, as have others, notably Fox, who developed a postmodern notion of health, reconceptualising traditional caregiving as ‘care as gift’, in which care is given without the expectation of anything in return (1999).

The Gift explores how gift exchange and reciprocity builds relationships between groups, viewing the gift phenomenologically – as it is experienced. Unlike Fox, Bourdieu grasped onto transactional and reciprocal phenomena, finding the interval between gifting and counter-gifting to be key, in that “to abolish the interval is also to abolish the strategy” (Bourdieu, 1977, p. 6), and he opened and explored the strategy, conceptualising a “dispositional theory of action” in the process (Wacquant, 2011). At its core:

The structures constitutive of a particular type of environment (e.g. the material conditions of existence characteristic of a class condition) produce habitus, systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations... (Bourdieu, 1977, p. 72)

¹⁵ Mauss came to this supposition after going to great length to classify *techniques du corps*, including birth and obstetrics, of which he wrote: “The forms of obstetrics are very variable. The infant Buddha was born with his mother Maya upright and clinging to the branch of a tree. She gave birth standing up. Indian women still in the main give birth in this position. Something we think of as normal, like giving birth lying on one’s back, is no more normal than doing so in other positions, e.g. on all fours” (1973 [1935], p. 79).

Habitus is rooted in “generative principles of distinct and distinctive practices” (e.g. what I eat and the way I eat it, my political opinions and how I expresses them will be different than someone from a Southern US state). They “make different differences; they implement distinctions between what is good and what is bad, between what is right and what is wrong...but they are not the same” (Bourdieu, 1995). Importantly, though, people are not passive beings enacted upon by external forces but rather construct social reality through “categories of perception, appreciation and action”, which form a “generative matrix” (Wacquant, 2011). Furthermore, these categories are “resilient and shared” but not universal or unchanging.

The concept of habitus is constituted of several parts, which are at once theoretical, methodological and analytical, the first of which is the systems of dispositions that structure practices are *acquired*. These systems “vary by social location and trajectory. Individuals with different life experiences will have gained varied ways of thinking, feeling and acting” (Wacquant, 2011). Practice, underpinning thoughts and actions, operates beyond consciousness and discourse. Given that practice is located in the *au-delà*, Bourdieu’s theory necessitated methodological and analytical tools because subjects may be unaware or conceal the truth of their practice, particularly the manipulation of time, which the anthropologist brings to light and renders into a model that is no longer timeless but “works itself out only in and through time” (Bourdieu, 1977). To study habitus means looking at “organised practices of inculcation” (e.g. reading a website or watching a video) through which it is layered (Wacquant, 2011). Wacquant, who worked closely with Bourdieu in the beginning of his career, laid out three ways to detect the “architecture” of habitus, including a “*synchronic and inductive*” approach, which traces the “connections between patterns of preferences, expressions, and social strategies within and across realms of activity so as to infer their shared matrix” (Wacquant, 2014, p. 6). Habitus is not only composed of cognitive structures but also conative ones, and it is these that make habitus “malleable and transmissible” because they come from “pedagogical work” (Wacquant, 2011), contrary to the common misconception that habitus is rigid, stagnant or unchanging. Habitus alone does not generate definite practice – there is also the social space, or ‘field’ – but unveiling it does reveal the production and assemblage of “cognitive categories, bodily skills and desires” (Wacquant, 2011, p. 87).

For Bourdieu it was “necessary to abandon all theories which explicitly or implicitly treat practice as a mechanical reaction” (Bourdieu, 1977, p. 73), which means there are cognitive, corporeal – what he calls *hexis* – and affective dimensions within habitus, in an attempt to break from the mechanical, the

objective and the shadow of mind-body dualism. There are perceptual categories, which are products of history, through which individuals make sense of the world and inscribe it with pattern and meaning, the mastery of which entails becoming part of this categorisation. This enskilment, however, is also transmitted without and beyond discourse, through physicality, or body hexis, which “speaks directly to the motor function, in the form of a pattern of postures that is both individual and systematic, because linked to a whole system of techniques involving the body and tools, and charged with a host of social meanings and values” (Bourdieu, 1977, p. 87). Bodily actions and movement have intention, whether an individual is conscious of this or not. I will delve further into this concept through Merleau-Ponty’s lived body, which I view as a more fluid notion of body use than Bourdieu’s iteration, where “every society provides for *structural exercise* tending to transmit this or that form of practical mastery” (Bourdieu, 1977, p. 88). Bourdieu’s theories attempt to consider life and practice in totality: thinking, moving and *feeling*. This is essential in habitus, in that:

[T]o grow into a full-fledged member of a given microcosm, it still does not suffice to be able to interpret it and to act in it in conforming fashion; one must also aspire to be in it and of it; one must be motivated or moved by it over time...It entails the vesting of one’s life energies into the objects, undertakings, and agents that populate the world under consideration. (Wacquant, 2014, pp. 8-9)

The affective component of habitus is linked nicely to the proposition that the “spring of human action” is, in fact, a “highly emotive search for a *reason of being*” (Atkinson, 2016, p. 3). Acquiring habitus, then, is serious, all-consuming business, though the individual may be unaware of their consumption. Once consumed, what is generated from habitus, which can be adjusted to particular conditions that constitute it, seems locked within it. The “habitus engenders all the thoughts, all the perceptions, and all the actions consistent with those conditions, and no others” (Bourdieu, 1977, p. 95). There is flexibility within it, but no way to move outside of it.

Nearly 20 years later, Bourdieu did concede that his concept is less cut and dried, writing that “habitus is neither necessarily adapted, nor necessarily coherent,” and it can be “driven by internal contradiction and division”, as well as “have its failings, critical moments of perplexity and discordance,” which generate unforeseen and challenging practices (Bourdieu, 2000 [1997], pp. 160, 162). The everyday and the individual are indeed messy and contradictory, and, for all of his advancements in social theory,

Bourdieu firmly stated that individual was not the “true object of social science” (Bourdieu & Wacquant, 1992, p. 107). Accordingly, there are elements missing in Bourdieu’s theory of practice, in that the “social agent”, the individual and the aspects of the modern, the everyday and mundane are absent (Atkinson, 2016). As Atkinson (2016) points out, his analysis starts with the social space and works back to individual experiences – rather than focusing on people in their totality, which is what anthropology is primarily concerned with. He suggests that “we *can* start with an individual or a cluster of individuals in a particular sample gathered to illuminate a specific research problem, and attempt to unravel the *total* social structuring of the phenomenology of everyday life and their dispositions as an ensemble” (Atkinson, 2016, p. 14). This reveals, in turn, what was overlooked or left undeveloped in Bourdieu’s work.

Atkinson identifies three dimensions that were marginalised, despite their crucial role in lived experience and formation of habitus, the first of which is multiplicity. “Everyday experience”, all dispositions, perceptions and practices, is not structured by a single social space. Instead, it is the result of a combination of forces, in that a subject’s position and habitus in one social space can affect their position and habitus in another. As I have highlighted, habitus can shift as the conditions constituting it are altered but there is singularity in this, inasmuch as there is always one positionality that is structured and produced. The second missing element is time-space, or the physical location and movement of the individual, objects, and other people or entities that make up the “immediate material and social milieu” (Atkinson, 2016, p. 16). Space was not entirely ignored; however, Bourdieu’s rumination on physical space was always organised around and relational to oppositions in the social world, for instance the arrangement of the Kabyle house reflected gendered separations. Temporality and consciousness were considered, but not the movement of people and objects in time. He did not take into account the “regulated nexus of spatio-temporal movements, distributions and encounters of people and things keeping the whole social order going – connecting people and position-takings” in social spaces (Atkinson, 2016, p. 18). Finally, social networks and relationality, which build this “regulated nexus”, were not conceived of as shapers of habitus, alongside one’s position in a social space, but effects of habitus. For Atkinson, this is too “one way” and implies that social networks have no bearing at all on people’s dispositions and practice. The structuring of habitus, then, is helpful for making sense of how systems of dispositions, moulded within history, generate decision-making and how it comes to be embodied, but there are limitations that cannot be looked past, given that this thesis’s main topic of enquiry is centred around *place* and individualised notions of choice.

Perception and the ‘lived body’

Atkinson’s elaboration of Bourdieu’s theories is important for finding the spaces and working through how these may be addressed and developed. His primary concern is reconceptualising the ‘field’; however, I want to focus on habitus and expand it into a synthesis that takes into account multiplicity, time-space and social networks, fusing it with Merleau-Ponty’s concept of ‘lived body’ and making an argument for *embodied practice*. To do so, it is helpful to trace back into how exactly I will employ phenomenology in this way, as it is articulated and used in health research in a variety of ways, particularly as a methodological framework. I aim, however, to focus on phenomenological concepts of embodiment, which first views the body as the primary way of knowing the world and considers the body and the subject who perceives it as inextricably linked and inseparable (Merleau-Ponty, 2012 [1945]). Merleau-Ponty, whose work was heavily influenced by Husserl, proposed a phenomenology of embodiment in an effort to confront the established ideas about the nature of perception. Like Bourdieu, he attempted to collapse dualities, particularly that of subject-object, invoking embodiment as a “methodological principle” and “moving the study of perception from objects to the process of objectification” (Csordas, 1990, p. 10). This view of perception may be beneficial when interrogating the process of how individuals make a specific birthplace option a lived reality. For Merleau-Ponty, the body is a “certain setting in relation to the world” (2012 [1945], p. 303), and it is from here that I would like begin to analyse how socio-cultural notions about birthplace, different forms of birth information and varying systems of knowledge are involved in the establishment and evolution of this setting during and after pregnancy. Decision-making, an abstract but deeply cognitive process, is not necessarily *about* the body; however, when it comes to choices about health care, it always concerns the body, in that it originates from it and affects it. It is through these ‘mindful’ bodily actions that we can reveal how individuals encounter, sense and know the world.

The introduction of *Phenomenology of Perception* is entirely devoted to classic approaches to perception, both physiological and psychological. Through the deconstruction of each, Merleau-Ponty aims to critique both empiricism and intellectualism, considering the implications they have on phenomena, lived experiences and bodies. His concern is built upon prompting “us to recognize that objective thought fundamentally distorts the phenomena of our lived experience, thereby estranging us from our own selves, the world in which we live and other people with whom we interact” (Langer, 1989, p. 149). He took issue

with empirical understandings of sensation, finding the assumptions about the senses produced by scientific approaches revealed the prejudices of objective thought. However, if we return to phenomena, rather than empirical understandings of sensation, the goal becomes to describe how an immanently meaningful experience in the present can access the past, which envelopes it, or, as Bloch (1977) phrased it, the “past in the present”. For decision-making, objective thought has given way to classical decision theory, where a hypothetical person moves from weighing up their options to their decision along a straight line or algorithmic process, which researchers seek to analyse and then formulate into an explanatory model. Merleau-Ponty’s phenomenological conceptualisation of decision-making would frame it as a more cyclical, temporal process, as I described in Chapter 3, one which accesses the personal, familial and historic or ‘deep’ past.

In shrugging off classical notions of sensation, Merleau-Ponty argued that indistinct and contextual parts of what is perceived are instead positive and phenomenological, inseparable from a complete account of the world. Sensing is a “living communication with the world that makes it present to us as the familiar place of our life” (Merleau-Ponty, 2012 [1945], p. 53). He wanted phenomenological reflection to clarify the perceptual origins of lived experiences rather than be situated in a ‘ready-made world’, and “return to the lived world beneath the objective world” (Merleau-Ponty, 2012 [1945], p. 57). As Langer highlights in her critical reading of Merleau-Ponty’s work, this ambiguous domain, or *phenomenal field*, “is neither ‘objective’ nor ‘subjective’, where being is not fully determinate and significance not entirely clear” (1989, p. 14). It is in the phenomenal field, where perceiving subjects are located, and perceptual experience can be found. Importantly, a phenomenal field is not a dimension laid out before a disembodied mind, as Merleau-Ponty intended to move away from Cartesian dualism and positivist understandings of perception. He argued against using theories that conceived of bodies as pure and objective, governed by chemical and physiological properties, without perspective or ambiguity.

Consider how classical decision theory views human behaviour, something to be optimised, and how it coalesces with cognitive sciences. The body is not considered beyond how its chemical and physiological processes delineate when an ‘optimal’ decision is made. In seeing the living body as an object like all others, science interprets sensing, emotions, attitudes, gestures and actions differently, in that they are mechanically received, transmitted, and reproduced via these properties, such as stimulus-response and nervous system functioning. The living body is more a machine than an expression of our being-in-the-

world. The body-as-machine and the disembodiment inherent to it was explored by Martin (1987) in her book, *The Woman in the Body*, highlighting how women's reproductive experiences do not correspond to the mechanical metaphors in medical texts. The middle-class women in Martin's study mimicked mechanical terminology when describing their menstruation, focusing on its 'purpose', but their answers often did not account for how the bodily events were actually experienced. They are, as Merleau-Ponty put it, estranged from themselves. The prejudice of objective thought makes people forget that consciousness and reflection are rooted in lived experience.

Phenomenology of Perception critiques classical psychology for its failure to significantly distinguish our bodies from objects, maintaining that the body is an 'affective object' quite different from other things. Merleau-Ponty claims, however, that experiencing the body is different from experiencing an object, for instance "we cannot perceive our body perceiving"; we can touch an object, but "the activity of touching cannot itself be touched" (Langer, 1989, p. 37). Body image, when the body is seen as an object, is the totality of associations and impressions indicating where the parts of our bodies are at every instant, but psychologists advanced this into a more dynamic notion of a comprehensive bodily *purpose* though studying phenomena like phantom limbs, seeing body image instead as people's awareness of their bodies as embodied intentionality. It also suggests a move from the body as an object to the body as *experienced*, or the lived body, which cannot be separated from the world. Body image provides a knowledge about the location of limbs, though Merleau-Ponty is more concerned with the way that these limbs enter into 'projects' that people set for themselves. It is about the "situation spatiality" rather than position. The lived body enables us to take up a position, and the bodily space enveloping our limbs allows us to know where they are without thinking about or looking at them. This awareness is interwoven with perception, in that things that are perceived are always done so in reference to the body. The body's existence is essentially "being-in-the-world", a project with lived goals and an intentional arc, expressed through spatiality. This arc "projects around us our past, our future, our human milieu, our physical situation, our ideological situation, and our moral situation, or rather, that ensures that we are situated within all of these relationships" (Merleau-Ponty, 2012 [1945], p. 137).

For Merleau-Ponty, the world is "built up", not ready-made, and following this, all things bodily – senses, dialectical movement, the body itself – are constituted of "powers" that are inseparably integrated; they cannot be isolated from one another. The body, in particular, is a synthesis of powers: bodily spatiality,

bodily unity and bodily intentionality. Bodily spatiality composes the backdrop against which physical space is constituted and has a layered way of relating to objects, entities and people. This means the body does not simply take up space but inhabits and lives it. Spatial existence can be elucidated through an analysis of movement and manners of engagement with particular goals. Jackson (1983), for instance, re-analysed his fieldwork in Sierra Leone, examining girls' dancing and gender imitations during initiation rites to clarify gender construction and subjects' relationships to environments and one another. In a built up world, dialectical movement cannot be separated into fragments; to learn habits, such as playing an instrument, "is to be transplanted into them, or conversely, to incorporate them into the bulk of the body itself" (Langer, 1989, p. 48). In studying of habits, bodily knowledge and significance become evident, revealing that the body is, in essence, an expressive space. Moreover, Jackson's study shows how "subject and world form an organically related whole", just as the consideration of lived experiences reveals the body has a "dynamic synthesis of intentionalities" (Langer, 1989, p. 48).

Where does habitus fit into this schema? Merleau-Ponty's notion of the horizons, which partially constitute the perceived world, is most akin to Bourdieu's idea; however, horizons are more distant and indeterminate than habitus, related to the givenness of the world. In regard to perception, the horizon "is what guarantees the identity of the object throughout the exploration" (Merleau-Ponty, 2012 [1945], p. 68). The concept aims to work through perceptive spatiality and temporality, but horizons do not generate or structure action or practice, rather they delineate the object of a gaze and, as such, provide "no obstacle to me when I want to see the object" (Merleau-Ponty, 2012 [1945], p. 68). There are many horizons – the world is the "horizon of horizons", for instance – and they are infinite, as habitus can be in its shifting, but the latter is more immediate and implicit in everyday practice. More importantly, the concept of lived body provides a roadmap for considering the spaces in Bourdieu's theory of practice, particularly his limited engagement with the individual.

Intention, sensory experience, temporality and spatiality are all contained by and emanate from the body-subject. The body as an expressive force of intentionalities and energies renders subjects as movers and shakers, fundamental for enquiry into human life. A lived body interconnected to a built up world exists in and has multiplicity but is not necessarily multiple, and, by re-establishing the body-subject as central and a "certain setting to the world", their relations and networks take on a significance that was lacking in Bourdieu's theory, where social space, as opposed to bodily spatiality or lived experience, is taken

as a starting point. For Merleau-Ponty, the social space is formed of both the body's spatiality and the phenomenal field, which stays ambiguous, rather than being singular and unmoving, as is Bourdieu's field. Through the phenomenal field, Atkinson's time-space can be clarified, providing scaffolding upon which researchers can build their understanding of spatial existence and its related people, entities and objects, as well as how they are formed by the past, moved in the present and implicated in habits and enskilment.

Temporality and decision-making

In several ways, Bourdieu and Merleau-Ponty overlap in their visions; each develop the importance of corporeal, cognitive, intentional/conative and affective modalities of human experience and life, and they each take temporality into deeper consideration. I set this dimension apart from the others because it has been underdeveloped in relation to the embodied dimensions of decision-making. Time and decisions are entwined in complex but ambiguous ways, and I am not the first to ruminate on their twining. In *War and Peace*, for instance, General Kutuzov considers his place and actions during the Franco-Russian war, finding himself never at "the beginning of some event" but always in the middle and questioning when he chose his decisions:

Have I really allowed Napoleon to reach Moscow, and when did I do so? When was it decided? Can it have been yesterday when I ordered Platov to retreat, or was it the evening before, when I had a nap and told Bennigsen to issue orders? Or was it earlier still? (Tolstoy, 2010 [1869], p. 888)

Fundamentally, Kutuzov struggles with the temporality of decisions, their making and his place therein. Philosophical perspectives of decision-making and parenthood, as well as decision theory, have emphasised the rationality or irrationality that is ascribed in child-related choices (Paul, 2015). However, in describing decision-making as embodied practice, temporality, rather than of rationality, is a more helpful dimension to emphasise, as the core theoretical issues have always been concerned with where decision-making begins, where it transforms, and where it ends.

Bourdieu addressed temporality and its importance to his theory of practice in the beginning pages of *Theory of Practice*. He paid attention to the calendars and rhythms that guide efficiency, expectation and future, in that:

[T]ime derives its efficacy from the state of structures of relations within which it comes into play, which does not imply that the model of that structure can leave it out of account...When the unfolding action is heavily ritualized...there is still room for strategies which consist of playing on time, or rather *tempo*, of the action...holding back or putting off, maintaining suspense or expectations, or on the other hand, hurrying, hustling, surprising... (Bourdieu, 1977, p. 7)

Structures define *tempo*, and there can never be a structure that does not have temporality. For Bourdieu, time was paramount, and “[t]o restore to practice its practical truth, we must therefore reintroduce time into the theoretical representation of a practice which, being temporally structured, is intrinsically defined by *tempo*” (Bourdieu, 1977, p. 8). He was critical of empirical conceptions of practice as either free-floating, without attachment to the past, or as a mechanistic response to external stimuli:

The detemporalizing effect...that science produces when it forgets the transformation it imposes on practices inscribed in the current of time...is never more pernicious than when exerted on practices defined by the fact that their temporal structure, direction, and rhythm are constitutive of their meaning. (Bourdieu, 1977, p. 9)

Bourdieu emphasises the harm that can come from detemporalising practice that is defined by *tempo*, through which it gains meaning. I see this issue within attempts to study decision-making and informed choice in a disembodied way and imposing assumptions of fixity – single moments in which decisions must optimally be made despite recurrent uncertainty – and linearity – forward, never backward – in that these remove each from time, particularly the past, and, by doing so, overlook what is elemental to them.

The core of habitus recognises the “socially conditioned temporal horizon of consciousness”, drawing from Husserl’s elaboration that “what we take to be ‘present’ experience is in fact always stretched forward and backward, that is, fringed by a halo, or horizon, of history and futurity furnishing a sense of continuity” (Husserl, 1991; Atkinson, 2018, pp. 4, 2). Time and space are fundamental to the structure of perception, into which Merleau-Ponty, also drawing from Husserl, incorporated the horizon. *Phenomenology of Perception* employs an example of a house to describe his ideas. We perceive a house from a certain perspective, and taking up a particular position from which we view it implies that we can take up others. We can explore and move around the house with our gaze but can only do so insofar as the house is part of a certain setting, for instance the horizon of the surrounding countryside. This perspective

is also temporal in that no object of experience is absolute, which would require the co-existence of an infinity of different perspectives and, ultimately, the destruction of temporality.

For Merleau-Ponty, time is not a 'flowing substance', such as a river running from the past into the future, rather "time comes into being from our relationship with the world and has no existence apart from that relation" (Langer, 1989, p. 124). In this sense, for the observer on the riverbank, the water is not swept into the future but instead runs into the past. It is the observer, not the river water, which is the temporalising subject. We are connected to the past and the future through our intentionalities, and time is a relational, overlapping network of these intentionalities, whose centre is the body-subject itself, as opposed to a line of instances and retained events. As follows, decision-making is not a staccato of key moments and ideal conditions but a winding process through past, present and imagined future. Framing human existence in time as being intrinsically connected to the past and being able to access that past in the present, reaching across temporal domains indeterminately, means that "[w]e temporalize ourselves by existing; hence there is no need for any explicit unification or synthesis of [temporal] dimensions" (1989, p. 125). This notion of temporality is useful for considering and expanding my conception of decision-making initialised in Chapter 3, in that my framework placed the body-subject at the centre surrounded by overlapping intentionalities – 'analytical themes' and 'inter-linking actions' – which are enmeshed in a multi-layered temporal domain. In my synthesis, there was little connecting the different layers of temporality, save that they were all related to time, and employing Merleau-Ponty's theory, it is unnecessary to unite them further.

Studying process and embodied practice

From my overview of anthropological and social theory, what I want to take forward into the following chapters is that humans are dispositional, temporal, intentional and expressive beings, with bodies that are lived through space and practice. This setting, or being, in relation to the world, as Merleau-Ponty would phrase it, grounds and constitutes embodied practice. However, my introduction of habitus and the lived body is not intended to entirely dovetail these theories, but rather function as an overview of the theories that were considered throughout my fieldwork, revisited and reassessed during data collection and

analysis. My ethnographic study of decision-making about birthplace in East London will endeavour to elucidate my ideas about embodied practice and temporality. Without presenting my ethnographic data, ruminating further on each feels premature. The intention, since the beginning, has been to develop a study of decision-making that focuses on process, and process entails a project that is layered and built up and forward over the course of time. The two theorists I have covered in most depth focus on skills and habits that are incorporated into the flesh, into ourselves when they are acquired, and I wonder that decision-making, as a process, practice, habit and skill, should be seen any differently.

Instead of aiming to provide a coherent synthesis, I will close this chapter with some of the queries and avenues of thought that the systematic and theoretical reviews have left with me, especially how decision-making and choice are expressed as embodied practice. Much of anthropology of birth has focused on how pernicious and hegemonic biomedical maternity has become, but what happens when you try to alter the dominant knowledge system to incorporate alternative narratives while simultaneously maintaining it as a powerful discourse that is ultimately aimed at continuing to define what is right and what is wrong? With the shifting landscapes of maternity, researchers and medical systems alike must consider the possibilities of reevaluating the current iteration of this discourse to reveal how it could be re-invented to normalise 'countercultural' care decisions and to place the individual back in control of their body, now a 'pragmatic' and 'mindful' subject with agency, rather than an object acted upon by the health care system. Furthermore, does the internal decision-making become externalised as an informed choice, an actualisation of intentionality and, eventually, an event in a tangible space? Parents' are emerging as interlocutors in their health care, through policy changes falling in line with postmodern ideals of choice, but to what extent are the systematic and social horizons of maternity still constraining rather than equitable, in terms of decision-making practice and birth experiences. Concerning maternity, both theoretically and in praxis, more movement is needed towards embodiedness (over bodilessness), cyclicity (over linearity) and multiplicity (over compartmentalisation), and, over the course of following chapters, I plan to push and extend this motion.

Chapter 5: Methodology

This chapter describes the setting and methodology of the research, particularly how the latter sought to address the principal questions of the thesis. From here, I lay out my ethnography of ‘process’, which is comprised of two studies, each of which focused on expectant parents’ information use, decision-making and informed choice about place of birth: one based in the East London community, involving focus groups and participant observation, and a second based in Barts Health NHS Trust, using a longitudinal diary and interview design. The design was such that the exploratory, community-based study acted as a sounding board for the latter, illuminating key points of interest about birthplace for East London parents, providing feedback on Which? Birth Choice usage and identify emerging themes. The second study aimed to explore the birthplace decision-making process, while simultaneously examining the feasibility of an experimental research design that could be used in the future to test the impact of different forms of information provision. This section also goes into more detail about the development of each arm of my research and production of an online diary for data collection called the Birth Decisions Diary, which my interlocutors were asked to use during their enrolment in the NHS-based research. I also introduce my analytical approach, describing the building of a multi-layered analysis that responded to the cyclical and embodied facets of decision-making and informed choice, attempting to preserve the temporality and ‘bodily energies’ of parents’ experiences. Finally, I close with a discussion the driving methodological framework, ethnography, and the epistemological considerations that underpins it, moving on to consider the place of the researcher, or the ‘self’, in this edifice.

Research Setting

Each study, community-based and NHS-based, took place in East London, specifically the boroughs of Newham, Tower Hamlets and Waltham Forest, and Barts Health NHS Trust, which provides health care to these areas. Each borough is demographically different, but they all have large, multicultural populations. As of mid-2016, the population of Newham was around 338,600, the highest of the three boroughs, and there were 6,226 births in 2015. The area ranks 8th on the Index of Multiple Deprivation (IMD) out of 326

areas of England, with 1 signalling the most deprived area. Around 79% of Newham residents report that they can speak English 'Very well,' which is slightly lower than the London average of 81.5%. As of mid-2016, the population of Tower Hamlets reached 304,900. The population has doubled in the last thirty years, making it the fastest growing local authority in England. Between June 2015 and June 2016 there around 4,600 births. Tower Hamlets is one of the most linguistically diverse areas in England and Wales, with 35% of adults speaking a main language other than English. The borough is slightly more deprived than Newham, ranking 6th on the IMD. The Waltham Forest population was projected to rise to around 274,800 by mid-2016. The borough not only has the smallest population of the three target areas, but it is also the least deprived, ranking at 35th in England on the IMD. Around a quarter of the population (26%) does not speak English as their main language. For a more detailed breakdown of demographics, please refer to Appendix F.

Volunteering in East London

I began volunteering with Social Action for Health's (SAfH), a community health organisation based in East London, Maternity Engagement project in late April 2017, having first contacted the organisation in January of that year to attend a large focus group that they facilitated for women living in Tower Hamlets. The aim of the meeting was to obtain feedback about women's maternity care experiences, different information sources they received about this care and what they would like to see incorporated into a new online resource. My observation afforded the first opportunity to hear real accounts of maternity care from local women of diverse ages, backgrounds and parity. Besides offering access to a number of maternal health, clinical and parent networks, SAfH events and meetings were instructive for me, as someone with limited knowledge of East London and local maternity services.

My volunteer role primarily consisted of providing extra support and taking minutes during Maternity Voices meet-ups and Maternity Voices Partnership (MVP) meetings, as well as generating short summary reports from these. Maternity Voices meet-ups are opportunities for local parents to provide feedback on maternity services in their boroughs and to share their experiences and recommendations for improvements to the MVPs. The MVPs are committees of parents and representatives from the NHS maternity services, local maternal health organisations and Clinical Commissioning Groups (CCGs), who

work to co-produce and collaborate on improvements to services. In return for my volunteering, my contacts in SAfH were open to providing small pieces of support for my community-based study, specifically publicising calls for focus group participants and welcoming me to conduct participant observation. My role as a volunteer ended in March 2019.

Ethical approvals

My ethics application to City, University of London, School of Health Sciences for the community-based study was submitted on 2 February 2017, and approval was granted on 5 July 2017. I applied for an extension and amendment to the exploratory design on 2 October 2017, and the School of Health Sciences REC granted these on 10 October 2017 (Appendix G). The end date of the first phase of research was moved from October 2017 to July 2018. I requested to add participant observation during SAfH's meet-ups for East London mothers to the research design. HRA approval for the NHS-based study was sought on 17 August 2017, and the application (17/LO/1510) went to full review with the London – Brent Research Ethics Committee (Appendix H). Mary Olusile, Consultant Midwife at the Royal London Hospital (RLH), agreed to act as the local Principal Investigator for the feasibility study in July 2017. Cathy Falvey-Browne and Felipe Castro Cardona, Consultant Midwives from Newham University Hospital (NUH) and Whipps Cross University Hospital (WCUH), respectively, joined as the Local Collaborators during this time. City, University of London approved indemnity for the NHS-based study on 9 November 2017 (Appendix J). Soon after, HRA approval was granted on 15 November 2017, and the Confirmation of Capacity and Capability at Barts Health NHS Trust was granted on 12 January 2018 by the Clinical Research Network (CRN) North Thames (Appendix K). Though I applied, the study was not approved to be included in the CRN Portfolio, which would have allowed me to work with Research Midwives to facilitate recruitment. No amendments to the ethics application were made during the study. The research protocols, ethics applications and supporting study documents can be found in the Appendices G-K.

Research objectives

The general question driving this research was: how is a woman's decision-making about where she gives birth influenced, informed and enacted? This question is tied to theoretical considerations of this thesis, which are concerned with the inextricable link between knowledge, place and practice, and it is through them, as well as other more tightly defined aims, that I planned to make sense of this nexus and how it is shaped. More specifically, I wanted to understand to what extent women are embodying decision-making and making informed choices about where they give birth in an urban, Western setting, where all birthplace options are available to 'low-risk' women and diverse forms of information about birth are easily accessible. How do the parameters of 'being informed' change according to the types of information accessed and knowledge gained? In an effort to elucidate my questions, each study honed in on birthplace information, decision-making and choice outcomes, aiming to:

- To provide an ethnographic account of women's decision-making about place of birth in East London and the extent to which they are making informed choices about this
- To generate preliminary findings on the feasibility of conducting a longitudinal, qualitative study on information use, decision-making and informed choice and of an RCT to examine the impact of the Which? Birth Choice tool on decision-making
- To generate a qualitative evaluation about Which? Birth Choice and provide insights into the use of the resource

Both the community-based and NHS-based studies have more specific objectives that worked to address these aims. The community-based study was related to establishing the research context and themes, through participant observation and focus groups, addressing women's perspectives on information use and decision-making. Building from this, the NHS-based study was concerned with investigating the first three primary aims in more depth, while simultaneously working to develop and assess the feasibility of an experimental research design. Though I will be discussing the two studies separately, they are meant to fit

together in a final, synthesised whole, in which data from each is integrated to produce an ethnographic account of decision-making and conceptualisation of informed choice.

Community-based study

This stage of research was initially exploratory, providing an opportunity to record the maternity experiences of parents living in East London and to observe women navigating Which? Birth Choice, the insights from which were then used to inform and shape the subsequent NHS-based study. Thus, the objectives of this initial research study were to:

- Investigate relevant issues about place of birth decision-making not yet incorporated in the scope of the project
- Observe women's use of the Which? Birth Choice site and record their opinions of it
- Inform and refine the design a larger study to be conducted with Barts Health Trust

The project was originally going to analyse video footage provided by Which? Birth Choice of women navigating and discussing the site. Unfortunately, only a small amount of edited footage was available as the full-length originals were destroyed. The remaining footage was too short in length to provide data that was substantial enough to analyse in NVivo, and the editing process could have influenced the content in ways not easily identifiable. After a meeting with members of the Which? Birth Choice team, I decided to pursue other methods of capturing parents' feedback as they navigated the site. As the exploratory study was already in the planning stages at this point, I grappled with how to record women 'talking through' the website, in an organic way, while acknowledging their individual perspectives as service users in East London and delving into what information, both medical and non-medical, was relevant to their decision-making.

Ideally, new video footage could have been recorded with individual women, but focus groups incorporating a navigation of Which? Birth Choice appeared more feasible and time-effective. Focus groups allowed me to explore the birth plans and decision-making, whether it be past or current, of women before

presenting the site, thus situating their 'talking through' in experience and background. I hoped that this method would produce a richer sketch of decision-making considerations and reactions to engaging with the Which? Birth Choice tool and site content. Organising the focus groups in East London led to partnering and volunteering with SAfH and, in an indirect way, to the further development of this exploratory phase to incorporate participant observation, which I discuss at length in the next section. Appendix G includes the information sheets and enrolment forms for the community-based study.

Data collection

Three focus groups were conducted in East London boroughs of Newham, Tower Hamlets and Waltham Forest, and facilitated by SAfH. The focus groups opened with participants discussing their birthplace plans, how they arrived at this decision, what information sources they used and what influenced them to choose a certain setting over another. They were then given the chance to navigate Which? Birth Choice, after which we discussed their opinions of the site, and if it affected their birthplace plans or views. I also allocated some time at the end of the sessions to receive feedback on an online diary, the Birth Decisions Diary, which I planned to give to participants during the NHS-based study. Each focus group lasted no more than two hours, and a refreshment break was offered mid-way through each session. Participants received a £5 gift voucher for taking part. Focus group sessions were audio recorded, and I transcribed the audio for thematic analysis.

I aimed to recruit 18 to 24 women, limiting the group size to no more than six to eight parents. The inclusion and exclusion criteria were similar to those¹⁶ of the upcoming feasibility study; however, at this preliminary stage, I decided not to exclude women who had 'high-risk' pregnancies, as the focus groups were built around looking at and talking about Which? Birth Choice. Women with 'high-risk' pregnancies also do not necessarily begin their pregnancies as such and would still have an opportunity to access general birth information, explore different birth-related options and consider their birthplace choices. Even after

¹⁶ The inclusion criteria for the NHS-based study were: aged 18 or older at time of recruitment, uncomplicated pregnancy (as defined by the NICE intrapartum guidelines) and English proficiency or fluency. The exclusion criteria were: under the age of 18 at time of recruitment, high-risk pregnancy and issues with substance misuse or are a vulnerable adult.

being placed on the 'high-risk' care pathway, women still have a number of decisions to make related to birthplace (e.g. which hospital to give birth in) and their care, and some women may also exercise their right to plan their births at home. The content of Which? Birth Choice is not just relevant to women with 'low-risk' pregnancies, in that it provides information on pain relief and hospital reviews. Without a more significant reason to exclude women with 'high-risk' pregnancies and given the exploratory nature of the focus groups and participant observation, I decided to keep the eligibility criteria slightly broader than planned for the NHS-based study.

Eligibility criteria

- Aged 18 or older
- Women who are pregnant or gave birth in the last year
- English proficiency or fluency (Which? Birth Choice content is published in English)

Ineligibility criteria

- Under the age of 18 at time of recruitment

The focus groups were undertaken starting from July 2017, which was several months later than I had planned, originally aiming to begin the study in April and finish by June, in order to allow time to shape the feasibility design and revise my NHS ethics application before submitting it to the HRA. The participation in the groups was low (see Chapter 6), so I pursued an amendment to the exploratory phase research design (Appendix G), adding participant observation and extending the end of the study from September 2017 to July 2018. The observations took place during SAfH's Maternity Voices meet-ups for mothers from Newham, Tower Hamlets and Waltham Forest, during which there were discussions about maternity care in the boroughs. I was already volunteering at these meet-ups and during the MVP meetings, so many of the regular attendees and SAfH staff members knew me and were aware of my role. The aim of these observations was to capture experiences related to birthplace information and decision-making, particularly from women who may not have been eligible for the NHS-based study or are considered 'hard

to reach.’ Additionally, they contextualised the NHS-based study research by tracking any changes to service provision in each area over the course of nearly two years.

NHS-based study

Aims and design

The NHS-based research focused on exploring the process of birthplace decision-making during pregnancy, while simultaneously examining the feasibility of an experimental research design that might be used in the future to test the impact of different forms of information provision. In order to achieve this, outcomes for feasibility were considered during the study, with the aim of providing feedback on the acceptability of such a research design. This was combined with an ethnographic approach, with the aim of enabling me to produce a detailed ethnography of process and to provide a deeper understanding of how decisions about place of birth are made, as well as address the more fundamental questions around whether such a trial would be appropriate or worthwhile. In this design, parents who consented to participate were randomised into either the control group, who received the routine leaflets from midwives, or the intervention group, who were introduced to and encouraged to use the Which? Birth Choice tool, in addition to the usual information provision. In order to capture and develop an ethnography of process, women were asked to keep a decision-making diary, using an online template created for the study, and invited to give interviews during their third trimester and up to two months after they gave birth. As the feasibility assessments aimed to explore methodological viability and a diverse group of women’s experiences, the research design was less concerned with demographic similarity of the research sites and between the two groups of participants, as would be the case in a pilot for an RCT.

Outcomes

Outcomes for feasibility

- Proportion of eligible and demographic diversity of women recruited
- Rates of and reasons for attrition

- Fidelity to the intervention or control arms (e.g. what other information sources do participants use)
- Key outcomes to consider for the full trial and how they could be measured
- Solutions for information provision about a trial that is ethical but does not highlight alternative informed choice options

Anticipated primary outcome for future trial

- Efficacy of Which? Birth Choice increasing informed birthplace choices, positive birth experiences and choice outcomes among women and their partners

Anticipated secondary outcomes for future trial

- To what extent are key variables moderating the impact of the Which? Birth Choice website
- How and why are women and their partners using other information sources on birthplace
- To what extent is Which? Birth Choice impacting on individuals' interactions and relationships with HCPs

Recruitment and enrolment

Recruitment was conducted in the three primary hospitals in Barts Health NHS Trust that provide maternity services: Newham University Hospital (NUH), Royal London Hospital (RLH) and Whipps Cross University Hospital (WCUH), as well as the Barkantine Birth Centre, an FMU located in Tower Hamlets. Women were recruited when they were between eight and 12 weeks pregnant. I aimed to recruit 20 women living in each of the three boroughs, Newham, Tower Hamlets and Waltham Forest, totalling 60 participants in all. There is little guidance on feasibility study sample sizes, even though their justification is a key aspect in the design of trials. This sample size is based on an analysis (Billingham, et al., 2013), which found that feasibility and pilot trials have, on average, 30 participants per arm. This is consistent with other recommendations by Browne (1995) and Julious (2005), who provide minimums for feasibility and pilot trials of 30 participants in total and 12 per group, respectively. A power calculation was not used as the audit suggested that formal calculation of sample sizes may not always be appropriate in these studies. I

doubled the sample size to account for a high withdrawal rate, which was expected to be 30-50%. Those eligible for participation were first identified by their booking midwife, who asked women if they are interested in hearing about the study. Partners or birth partners were invited to take part in the study, with the permission of the women being recruited. Women and their partners had to meet the following eligibility criteria:

Inclusion criteria

- Aged 18 or older at time of recruitment
- Uncomplicated pregnancy (as defined by the NICE intrapartum guidelines¹⁷)
- English proficiency or fluency¹⁸

Exclusion criteria

- Under the age of 18 at time of recruitment
- High-risk pregnancy
- Issues with substance misuse or are a vulnerable adult

Withdrawal criteria

- Express a desire to withdraw from the study
- Experience a miscarriage or stillbirth

If parents were interested taking part, I explained the project and requirements of participation verbally, as well as answered any questions that arose, and asked potential participants to fill in a consent to contact form so that I could get in touch with them after the appointment and follow-up about completing enrolment. Women and their partners were given a study information sheet and enrolment and consent forms to take away with them. They were encouraged to discuss participation with their family members

¹⁷ NICE guidance defines an uncomplicated pregnancy as “a singleton pregnancy where the mother is healthy and does not require additional care” (2014).

¹⁸ Which? Birth Choice is only published in English at this time, so English proficiency or fluency is essential to navigating it and therefore, reflected in the eligibility criteria.

prior to enrolment and were able to return the enrolment form via post or e-mail. Potential participants were given one week after this initial contact with me to enrol into the study. Once all participants, mothers and birth partners, provided informed consent, they were asked to complete the enrolment form, entered into the study, randomised and given a study I.D. number. They then received a link to the online diary, entitled the Birth Decisions Diary, and were asked to fill out a short questionnaire on the diary site in order to complete their profile. The questions covered where they want to give birth, why they want to give birth there and what kind of role they like to take in when decisions are made about their care. Participants remained enrolled in the study until two months postpartum, unless they expressed a desire to withdraw or experienced pregnancy loss. Appendix H includes the information sheets and enrolment and consent forms for the NHS-based study.

Randomisation and introduction of Which? Birth Choice

Women and their partners were randomised into two groups after they enrolled into the study. In order to prevent myself from influencing or predicting which participants were introduced to Which? Birth Choice, I used the sequentially numbered, opaque sealed envelopes (SNOSE) approach, which is a method to ensure allocation concealment (Doig & Simpson, 2005). I chose this technique as it does not employ specialised technology and presents an accessible as well as straightforward approach to allocation concealment. Doig & Simpson's (2005) guide is a useful reference for this method, as it is targeted towards a "typical" 50-participant trial, a sample size that was close to my own recruitment target. The guide has several steps that involve preparing the envelopes and setting up the randomisation, and it offers different randomisation techniques depending on whether a study includes stratification, which is used to balance participant characteristics across the groups or has multiple sites of recruitment. My adapted steps were as follows:

- Step 1 I gathered 60 brown envelopes and 60 pieces of envelope-sized paper. I then wrote 'Control' on 30 pieces of papers in pen and 'Intervention' on the remaining 30.

- Step 2a I prepared 30 'Control' envelopes by placing each piece of paper inside an envelope, sealing it and signing my name in pen over the envelope seal. I tested the opacity of the envelopes by holding them up to a strong light and attempting to read them, which I could not.
- Step 2b I prepared the 'Intervention' envelopes in the identical way to the 'Control' envelopes.
- Step 3 To account for the fact that I would be recruiting 20 participants in each of the three boroughs, I divided the 30 'Control' envelopes into three groups of 10 and then 10 Intervention envelopes to each block. This meant each group of 20 had the same amount of 'Control' and 'Intervention' envelopes.
- Step 4 I thoroughly shuffled each of the three groups and then labelled them sequentially from one to 20. These groups were then placed in to separate, labelled plastic containers, in numerical order.

Once these steps were completed, I wrote each participant's study I.D. number (e.g. N01 or TH20), date of enrolment and my signature on the front of an envelope, in order to create an audit trail. This was done sequentially by the envelope number, and the envelopes were subsequently opened in numerical order. Finally, the participant's group allocation was input into a password-protected Excel spreadsheet, along with their enrolment information.

It is important to note that, while the SNOSE approach builds in an audit trail and mechanisms to avoid researcher influence, the method is not infallible. Sealed envelopes can still be scanned with x-ray viewing boxes to reveal the contents, or randomisation master lists can be taken, both of which are published reports of attempts to subvert or discover allocation in clinical trials (Schulz, 1995; Schulz & Grimes, 2002). These are extreme examples, as often researchers decipher the concealments simply because the materials are ill-prepared (e.g. translucent envelopes, sensing different weights of envelopes and deciphering differences in assignment labels) (Schulz & Grimes, 2002). Perhaps these accounts speak more to the professional and economic stakes attached to clinical trials, rather than the reliability of the

SNOSE method, which, when employed with care, can be just as reliable as any other method (Altman & Schulz, 2001).

Those allocated into the intervention group were introduced to, by myself as a research, and encouraged to use Which? Birth Choice. This introduction was done through their preferred method of contact (e.g. text, e-mail). I also posted a leaflet produced by Which? about the site to participants for reference. No attempt was made to prohibit the parents in this group from accessing other information sources, nor was the control group precluded from accessing Which? Birth Choice, as it is difficult to control internet activity. Moreover, if I found the website to be beneficial to the first group, it would be unethical to prohibit the second group from accessing and using it. However, I did not provide specific information about the tool of interest in the participant information sheets, to avoid drawing undue attention to the site (see Appendix H, section Information sheets).

Data Collection

Data collection was conducted online, over the phone and in person, and started soon after participants were enrolled into the study. They first received a follow-up with the link to Birth Decision Diary and guidelines for the photo sharing feature (Photovoice) and directions for accessing support for any issues they may encounter. Women also received a £5 gift voucher in the post for enrolling and taking part in the study. Participants completed data collection from this point up until two months after they had given birth, unless they withdrew from the study. I contacted participants regularly, once a month to ensure they were still happy to take part in the study and to provide any support they needed. All support and prompts were done either over the phone, by text or on e-mail, depending on the participant's preference for contact. I was hoping this, coupled with the face-to-face recruitment, would enable me to build a rapport with participants, so they would be comfortable with speaking to me for interviews. Women and their partners (if taking part) were invited to the interviews during and after pregnancy, and those who took part received a £5 gift voucher following each interview.

Birth Decisions Diary

The Birth Decisions Diary (<https://blogs.city.ac.uk/birthdiary/>) is an interactive data collection tool aimed at tracing the decision-making processes of women during their pregnancies and measuring to what extent their decisions about care constitute an ‘informed’ choice. The design of the diary, which was hosted on the Edublog system and supported by City, University of London, was intended to be easy to use, with two key features: making diary entries and sharing photos. Because this study was also evaluating feasibility, data on the accuracy and acceptability of the tool were also collected. Women were asked to create a ‘profile’ at the beginning of their participation, which they filled in once with key information, such as their estimated due date. Prompts to complete the data collection were sent once a month by post, e-mail or text, depending on the participant’s personal preference, reminding women to complete the diary and providing support for using the diary site, if participants required it.

The diary feature of the blog site incorporates items that focus on what influenced women’s decision-making during pregnancy and the extent to which they felt their choices were ‘informed’. The diary questions were adapted from O’Cathain et al’s informed choice survey (2002a; 2002b; personal correspondence). The antenatal diary entry form measures the “components” of making a choice, while a postnatal diary entry form focuses on the “consequences” of making a choice. The diary entries are semi-structured with text box fields for responses to most of the questions. The antenatal diary was filled in throughout the participants’ pregnancies. Women were recommended to fill out an entry form whenever they had a significant discussion or reflection on a decision about place of birth. The postnatal diary entry was completed once and gave participants the opportunity to reflect on their care, birthplace decisions and birth experiences. A survey feature was created to explore knowledge based on birth information available on the Which? Birth Choice site, and initially, participants were going to complete it once towards the end of their pregnancies; however, due to low engagement with the diary, it was not provided as an option. Furthermore, the survey was redundant, as several of the diary entry questions assess knowledge levels about birthplace information, and the interviews afforded opportunities to explore this dimension of informed choice.

The Birth Decisions Diary aimed to adapt paper-based diaries onto a digital platform, creating a method that follows a woman’s engagement with place of birth options over the course of her pregnancy

via self-reporting, resulting in a decision-making narrative that she can reflect on after she gives birth. It incorporated a multidimensional assessment to explore informed choice qualitatively. The goal of formulating a diary tool was to address several of the methodological challenges of assessing informed choice in health care, capture the complexity of information use and advance data collection onto a digital space. *Changing Childbirth* firmly established the importance of informed choice in maternity care policy, emphasising the need for easily accessible information that can be used in decision-making (Department of Health, 1993). Since then, debates have focused on what informed choice means in this specific context of care and whether or not it is achievable.

What do we mean when we talk about ‘informed choice’? Its definitions vary, relying on different theoretical predispositions, and attempts to reconcile these often result in a concept that does not fully reflect how individuals make decisions in practice. Bekker et al’s definition, for instance, was one put together based on their systematic review of informed decision-making, and one, they admitted, that does not accurately describe informed choice in real life:

[An] informed decision is one where a reasoned choice is made by a reasonable individual, using relevant information about the advantages and disadvantages of all the possible courses of action, in accord with the individual’s beliefs (1999, p. iii)

Though I group this under the umbrella of ‘informed choice’, it could also be seen as a definition of an ‘informed decision’, generalised to address a variety of decision-making contexts. O’Cathain et al (2002a) developed a different definition, formed from their research on women’s perceptions of informed choice in UK maternity services, which aligns itself more concretely within the realities of maternal health care:

Having enough information and discussion with midwives or doctors to make choices together about all the things that happened during maternity care. (2002a, pp. 137-8)

This definition includes discussion with HCPs; however, it does not incorporate the importance of individuals making decisions that are based on their values and beliefs. Additionally, allowing individuals to weigh and analyse all of their options after being presented with the advantages and disadvantages of each has been shown to be a more effective structure for decision aids supporting decision-making in pregnancy and birth (Dugas, et al., 2012), and should be highlighted when describing informed choice. Taking these

definitions and points into consideration, I developed a description of informed choice, as it pertains to maternal health:

A choice that is made, in accord with the individual's beliefs, after receiving enough relevant information and discussing the advantages and disadvantages of all possible maternity care options with practitioners.

Although it might be troublesome to submit another definition for consideration, a reworking appears required in order to establish a more pertinent concept for a maternal health context. With this entry, I take into account the realities of service user experience and provider practice and maintain the two key characteristics of the concept, making a choice after reviewing relevant information and basing it on individual values (Marteau, et al., 2001). It is not intended to be an absolute definition, but rather, it framed my initial thinking about informed choice and its assessment.

Not surprisingly, assessments of informed choice also appear to be as varied. Bekker et al's (1999) report found less than a third of the studies reviewed measured the decision-making process, and only a handful met their criterion for high-quality. Moreover, studies looking at informed choice may not be assessing the concept as a multidimensional whole, which befits its complexity, using instead single dimension measures, such as knowledge level (Marteau, et al., 2001). A more recent review from 2015 reported that 20 different measures of informed choice were used in the 34 studies reviewed, many of which "lacked adequate validity and reliability data" (Ames, et al., 2015, p. 8). With this in mind, I adapted my multidimensional assessment from O'Cathain et al (2002a; 2002b) and Marteau et al's (2001) work, both of which took steps to validate and assure the quality of their measures. The tool has five 'elements' that are covered by the questions on the diary entry form and birth information survey:

- Knowledge level about key items of birth information
- Value and utility of information
- Influences on decisions
- Health behaviour (e.g. attitudes on performing behaviour, perceived barriers, uptake)
- Effect of choices (e.g. levels of satisfaction)

Once I established these five key areas of informed choice, I aimed to create a tool that continuously traces the decision-making process, and to capture at what points women appear to feel more informed about their choices and through what routes this was achieved, creating a self-reported narrative during pregnancy. O’Cathain et al’s (2002b) research was helpful for this; however the studies relied on retrospective reporting of perceptions of informed choice. This can be problematic, as “[s]tudies of informed choice should assess knowledge and values before a decision is made. This is to prevent the outcome of the decision colouring an individual’s view of the choice they made. The nearer in time to a decision that measures are taken, the more valid the measure of the extent to which the choice was informed” (Marteau, et al., 2001, p. 100). Recording self-reported health behaviour can be tricky, particularly when it involves a questionnaire that requires recall from experiences. The validity and reliability of this method is often challenged on the basis that over time a memory is reconstructed in a way that may introduce inaccuracies and biases (Stone, et al., 2003; Burton, et al., 2007). Diaries rely on capturing experiences, like decision-making, closer to the time of the occurrence, while simultaneously providing a space for participants to keep an account of personal feelings, interactions and, in the case of maternity care, life-changing events.

Traditionally, paper diaries have been used for data collection; however, Stone et al (2003) demonstrated that actual compliance to their paper diaries was 11% as opposed to the rate of 90% as reported by participants. The electronic diaries actual compliance, by comparison, was 94%. A subsequent systematic review of studies using electronic diaries in symptoms research confirmed their ability to generate valid data, reporting compliance ranging from 76-100% (Burton, et al., 2007). These papers, useful as they are, were published in 2003 and 2007, respectively. Since then, much has changed in the digital world. The ubiquity of Internet use and high uptake of social media sites in recent years means there are opportunities to employ innovative, flexible – or at the very least, more streamlined – data collection tools online. In light of these considerations, I designed the Birth Decisions Diary in attempt to ameliorate the obstacles to recording decision-making. My goal with the diary was to emulate a social media or blog site, where many people are accustomed to posting regular updates and details about their lives. The host site, Edublog, is compatible with mobile phones and tablets, so participants were able to fill out the diaries whenever, wherever they may be. I asked women to fill out the diary whenever they had a significant

discussion or reflection on a decision about place of birth, and Appendix H includes a copy of the Birth Decisions Diary's content and questions.

Photovoice and Interviews

The Birth Decisions Diary adapted and incorporated a visual method, Photovoice, as a feature that participants could use while they are filling out the entries. Photovoice allows participants to identify and represent community strengths and concerns and ultimately enhance these communities through photography. The technique encourages individuals to record and reflect on their realities, using the photos to start a dialogue about perceived issues and experiences. This dialogue may be critical in nature, and the outputs are aimed at reaching policymakers (Wang, 1999). When applied in a women's health context, it aimed to centre "the relationship among the representation of women's bodies, lives and, health" (Wang, 1999, p. 186), and was considered useful for this study as it is focusing on information and decision-making about a health choice that is situated in the bodily, social and cultural experiences.

All those taking part received guidelines for the photo sharing feature and a theme, 'What is important to you when deciding where to give birth?', to focus on when taking a picture. Participants were made aware of how the photos they shared were going to be used over the course of the study and after it finished. Participants were asked to upload their photos onto the Birth Decisions Diary, which provided a comment box where participants could briefly describe or explain the picture. Consideration was given to whether the diaries and Photovoice feature should be viewable by all participants rather than only by the researcher. Reflection was given to the fact that this approach might be more engaging for women if the photos, in particular, felt shared and viewed by others, as they are through social media. However, for two main reasons it was decided this would not be appropriate: the first concerned data privacy and confidentiality issues and the possibility that, while some women might welcome this approach, others may not; the second was the concern that such an approach could form an intervention in itself, by creating a new forum for birthplace information and discussion.

I planned to use the photos to facilitate discussions during the interviews about the embodied dimensions of maternity experiences, asking women to select and contextualise photos as well as codify themes and issues, thus aiding in opening deeper conversations about the birthplace decision-making,

what influences it and how it is enacted. All participants were invited to give a semi-structured interview during their pregnancies, which took place in women's third trimester. Partners were asked to participate in these interviews, as their perspectives on decision-making about place of birth, as well as in wider field of antenatal care, are underrepresented in maternal health research. Participants were also invited to take part in a postnatal interview, giving them an opportunity to reflect on their decision-making and birthplace choice outcomes. Each interview was planned to be no longer than one hour, and participants were given the option of doing them over the phone or in person. Mothers and their partners were invited and encouraged to take part in the interviews, but they were not required to give them in order to remain enrolled in the study. These interviews were included to add more depth and richness to parents' experiences than might come forward in the stand-alone diary narratives. Moreover, they were important for Photovoice, offering a space for parents to reflect on and discuss the context of their photos beyond the short, explanatory captions they provide in the online diary. In essence, the interviews along with participant observation were the heart of my ethnographic work, revealing meanings that either may not emerge or may only be hinted at in the diary data.

Data Analysis

All data from the diaries and interviews were analysed descriptively, using the Framework Method, which is a type of thematic or qualitative content analysis method. These methods are used to identify similarities and differences in qualitative data, extracting themes and exploring the relationships within and between sections of the data. The Framework Method uses a matrix output of cases, thematic codes and summarised data so that the researcher can systematically reduce data in order to compare and contrast across cases as well as within the cases themselves. This analysis structure ultimately allows the researcher to draw rich, descriptive conclusions centred on each of the themes and their intersections (Gale, et al., 2013). This method of analysis is suitable for qualitative research conducted in health care settings and is most often used to analyse semi-structured interviews (Gale, et al., 2013), although it can be employed for other types of textual data, including diaries (Jones, 2000). In this research, the framework (see Appendix L for an example) was derived from an initial analysis of the community-focus groups and the meta-synthesis outlined in Chapter 3, and then refined once all of the data, from both studies, were integrated.

All focus groups, field notes, diary entries and interview transcripts were thematically analysed using NVivo, a specialist software package for qualitative data.

There were several stages of analysis throughout my research, which began with the exploratory work in the East London community, then focused on developing a conceptual framework for the meta-synthesis outlined in Chapter 3, leading to the framework's application for the analysis of the research data and culminating in a deeper, 'embodied' analysis. Each 'phase' is detailed below:

- Phase 1 During the community-based study, I undertook a preliminary thematic analysis by entering the focus group conversations and initial observations into NVivo and coding the sources with common themes that emerged as I transcribed the data. Using open coding to establish a network of themes and sub-themes, this preliminary analysis allowed me to view the relationships among them both within and between individual cases. This was an exploratory in nature and, therefore, not as thorough as the next phases of analysis.
- Phase 2 I extracted and analysed data for a meta-synthesis, following Thomas and Harden's methodology (2008). The extracted qualitative data was coded line-by-line in NVivo, enabling the translation of concepts from one study to another and to build a qualitative synthesis. This approach enables the synthesis to 'go beyond' in order to identify key concepts in the studies. The process of translation allows the recognition of similar concepts used within studies, even if they are not explicitly stated as such.
- Phase 3 I continuously integrated data from each study, both community- and NHS-based, so that I could eventually interpret the sources as an ensemble. For the next stage, in which all of the transcribed field notes, interviews, focus groups and diary entries were brought together as an ethnographic whole, I began by using the conceptual framework produced from the meta-synthesis to build my analysis through the Framework Method.

Phase 4 An ‘embodied analysis’ focused on interpreting speech about the body, including ‘energies,’ perception and movement. I adapted my strategy from that described in ‘Embodied methodologies: challenges, reflections and strategies’ (Chadwick, 2017).

After the systematic review, I was struck how little the body was considered in research about decision-making in maternal health beyond that of an instrument of control, to be pushed and pulled between different actors. I wanted to dig further into embodiment. I wanted to hear and make sense of the different bodily experiences and decisions that were connected to place of birth, which meant building another layer into this analysis, as described in Phase 4. While pieces of my methodology attempted to capture embodied experiences, specifically through photo and visual means, it was also crucial to bring this mentality into analysis, or, as Chadwick frames it, “hearing bodies in qualitative data” (2017, p. 58), looking beyond the frameworks and matrices to what was perceived, what was felt and whose voices came through besides the participants’ and my own. While Chadwick focuses more on the semiotic and symbolic inherent to retrospectively articulated birth experiences, I wanted to focus on speech about the body in a different way, paying attention to energies and perception. Using Chadwick’s (2017) analytical strategy, I noted when talk about the body was imbued with ambiguity, incoherence, contradiction and excess, while also being aware of what was seen, when women mentioned being seen and how perception unfolded, whether it was explicit or passive via surveying and monitoring. In highlighting energies and perception, analysis could move into a more indeterminate territory beyond action, while simultaneously throwing movements into sharper relief. On this body focus, Latour wrote, “[b]y focusing on the body, one is immediately – or rather, mediately – directed to what the body has become aware of. This is my way of interpreting James’s sentence: ‘Our body itself is the palmary instance of the ambiguous’ (James, 1996 [1907])” (Latour, 2005, p. 206). Latour advocated for moving away from theorising the body directly to “‘body talk’, that is, the many ways in which the body is engaged in accounts about what it does” (2005, p. 206), and my own embodied analysis aimed to incorporate this corporeal-centred thinking.

Towards an ethnography of process: epistemological considerations

This final methodological section focuses on opening up ethnography from the traditional, 'bounded' field site, arguing for an ethnography of process and experience, composed from a multifaceted methodological framework that reflects the nature of the field site, East London, and patterns of modern British sociality. Since the postmodern turn in anthropology during the 1980s, the epistemological and methodological infrastructure of the discipline has been called into question. The old guard of lone anthropologists, roaming exotic field sites, conducting comparative studies and producing an ethnography of 'otherness' was ripe for critique, primarily concerning its colonialist roots and undertones (Passaro, 1997). Of these efforts, those unpacking the assumptions about the field, challenging the routes to ethnographic output and reconceptualising the focus of ethnography itself are especially relevant for my work. I want to revisit the arguments, using them as scaffolding for my own contribution to the conversation, which positions alternative methods as equally efficacious and valuable as participant observation when working in unconventional, unbounded sites.

Ethnography, by way of participant observation, has been the dominant methodology in social and, to a lesser extent, medical anthropology since the beginning of the 20th century. In its traditional iteration, ethnography may involve intensive, years-long observation of a community, during which the anthropologist lives and partakes in daily rhythms, activities and environment. While participation is theoretically just as important as observation, Fabian argues that in anthropology, "the ability to visualize a culture or society almost becomes synonymous for understanding it" (1983, p. 107). One only has to look to Geertz's ruminations on cockfighting for an extraordinary example of the power of this visual interpretation, as well as on the importance of being in a place:

[T]he cockfight renders ordinary, everyday experience comprehensible by presenting it in terms of acts and objects which have had their practical consequences removed and been reduced (of, if you prefer, raised) to the level of sheer appearance, where their meaning can be more powerfully articulated and more exactly perceived. (1972, p. 23)

The 'raising' of the visual and of the action that occurs in the anthropologist's personal and ocular fields in a carefully chosen, bounded setting to such a high methodological status persists; however, I argue that participant observation alone cannot adequately capture social phenomena in urban Western spaces, particularly those related to process and experience. It relies on a singular perspective, one physiological and cognitive viewpoint that can shift according who is present in that field at a particular moment in time. "Vision is *always* a question of the power to see," wrote Donna Haraway (1988, p. 585). This has led to controversies regarding ethnographic data and its validity, most famously that surrounding Derek Freeman's (1983) challenge of Margaret Mead's *Coming of Age in Samoa* (1928)¹⁹. The Mead-Freeman debate throws into sharp relief how a researcher's physical and social being can influence the types of access they achieve, the events they witness in the field and their interpretations of practice. Moreover, it highlights the drawbacks of participant observation and how it is reported, which, for some, has chipped away at the robustness of anthropology as a discipline.

To be clear, I do not think that the traditional approach to ethnographic output diminishes legitimacy of anthropological research nor do I believe that controversies like Mead-Freeman should cause any epistemological crisis. Participant observation, like many data collection tools, is effective and useful when applied to the appropriate context. What appears to be required is a reconfiguration of the assumption that participant observation is central to ethnography, which, in turn can only be accomplished by long, intensive fieldwork. The idea that "the guts of the ethnographic approach is found in direct, prolonged, on- the-spot observation" (Spindler & Spindler, 1992, p. 63) is, however, ill-fitted to post-industrial Western settings. Silverstone and his colleagues (1991) found, when researching British families and communication technology, that weekly participant observation was not an adequate enough tool to make sense of their subjects in a multidimensional way:

It quickly became clear that 'hanging in' would certainly provide a more or less coherent account of family life (though powerfully mediated through the person of the ethnographer) but it would not provide, within

¹⁹ Margaret Mead's *Coming of Age in Samoa* is her seminal study of youth, mainly adolescent girls, on the Ta'u island of Samoa. It covers adolescents' sexual lives and posits that cultural demands and expectations have a significant influence on an individual's psychosexual development. In 1983, Derek Freeman published *Margaret Mead and Samoa: The Making and Unmaking of an Anthropological Myth*, which challenged all of Mead's findings, claiming that she was tricked by her informants. The debate about which anthropologist was 'right' was argued both within anthropology circles and outside among scientists, covered by both *Nature* and *Science*. A majority of the anthropological community has rejected Freeman's claims, on the basis that his data provided neither a complete picture nor an accurate representation of Mead's work and the interviews he conducted. Further reading on this subject can be found in Paul Shankman's *The Trashing of Margaret Mead: Anatomy of an Anthropological Controversy* (2009).

the relatively short period we had to undertake it, either a systematic analysis of technology and family interaction, or a strong basis for any point-by-point comparison between families, and it would not enable us satisfactorily to contextualise families historically and geographically – within time and space relations. (pp. 210–11)

Participant observation, in this case, provides only a flat account of the families, limited to exterior movements and interactions. They, too, elude to the problematic quality of observation, an account is always filtered through a particular ethnographer's lens. The incompatibility of participant observation and Western settings, like the UK, is rooted in how individuals use and inhabit spaces, especially those which are public and outside (Forsey, 2010). The *en plein air* anthropology of Malinowski, where time spent in outdoor spaces led to long conversations, is just not as feasible in Western settings where sociality is "spatially dislocated, time-bounded and characterised by intimacy at a distance" (Hockey, 2002, p. 211). It is less feasible and less rigorous for the anthropologist at home to produce cultural interpretations strung together by data from a bound group on the material circumstances, belief systems and structural actors that underpin humans' behaviour and the meanings they ascribe to it. That being said, should we even strive to impose boundaries in the post-industrial West? Passaro underscores the concerns about breaking up people and spaces into "manageable", bounded sites and objects of analysis, charging this practice as driven by assumptions created by an imperialist worldview, in which "methodological and epistemological control" are exerted through defined cultural areas, where the knowledge we uncover simply reproduces what we already know (Passaro, 1997, pp. 150-1; see also Haraway on the God Trick). Contemporary constructions, or *deconstructions*, of social space and how it is lived in also forms the focus of the ethnographic product. "At a time when the study of 'a culture' and the production of a portrait of a people is less desirable, and perhaps less attainable, than it once was, there has been a shift in focus towards themes and processes as 'objects of study' that are not always amenable to observation" (Forsey, 2010, p. 67). If a "shift in focus" is truly in hand, it is essential then that we establish a different kind of heuristics to accommodate it.

This epistemological separation from what ethnography *should be* opens up new intellectual possibilities, allowing anthropologists, as well as other social scientists, to explore diverse methods and new avenues of critical engagement. Hockey (2002) and Forsey (2010) both interrogate the ethnography

of anthropology in their articles and seek to reiterate it for the researcher doing 'anthropology at home' or in a Western setting. Hockey argues that interviews should be considered ethnographic because they are a culturally appropriate way of participating in British society (2002). Verbal accounts of life reflect "the ordinary features of everyday social interactions which Westerns currently live with and negotiate" (Lofland, 1971, p. 220). The question is thus, how to engage ethnographically with a Western, "interview society" (Silverman, 1993)? Forsey (2010) presents the idea of "engaged listening" as a salient method more in tune with the key goal of ethnography, which is to make sense of social phenomena through the perspectives of those who engender and experience them. He calls on anthropologists to pair interviews with "ethnographic imaginaries", which are constituted by asking questions "beyond" the primary research question, focusing on biography and locating cultural influences in people's lives.

This approach, as well as interviews-as-ethnography, emphasises listening over observing, linking personal stories to wider contexts, whether they be historical or social, allowing more flexibility for what can be considered ethnographic data. It responds to the "chaotic" spaces of modern life (Passaro, 1997) and "disembodied" social relationships mediated by technology and relegated to the private household sphere (Hockey, 2002). Being unbounded in the field means anthropology 'at home' is more concerned with categories, processes and meanings rather than groups, communities and cultures, which are the ethnographic 'units' anthropologists feel most comfortable with. Hockey writes of her "relief" when she found such a unit:

[M]y relief at finding a bounded social group blinding me to the insights which became possible only when I realized that I was studying social categories – aging and death – which transcended the bounds of space and are all about time. Anthropology has now set category alongside group as a focus, whether social, experiential or cognitive. When we work at home, through interviewing, those categories are likely to be ones we inhabit or think with or belong to (2002, pp. 220-1).

My own research studies delve into the processes of and the meanings attached to decision-making during pregnancy, which are entrenched in the broader category of informed choice, a construct that many of us confront at one point or another during our interactions within health care systems. We all make decisions about our health, and I am reminded that it is often hard to separate fieldwork and writing from the "other narratives which constitute our consciousness" (Cohen & Rapport, 1995, p. 9). Encountering and reflecting

on our own consciousness and experiences along with participants is demanding and requires a robust, reflexive research process if we are to work through the “messiness” of the urban field and establish a coherent ethnography at home (Baker, 2017).

Reflexivity or being a “positioned observer”

A great number of anthropologists have written on reflexivity and its role in ethnographic research. As in the other social sciences, reflexivity was not widely written on or incorporated into anthropology until the mid-20th century. The inception of postmodern and anti-colonial critiques in the discipline were crucial to championing reflexivity as a necessary part of a robust and ethical anthropological methodology, as well as concept of self-reference, in which individuals to call attention to themselves and cultural practices. I will focus on reflexivity as a methodological imperative, reviewing how this turn has affected the way anthropologists consider our production of knowledge and how we write ourselves in the subsequent text. Reflexivity, in essence, sprang from the “increasing willingness of anthropologists to reflect on their discipline’s relationship to the history of Western colonialism and hence to question the ways in which anthropologists have typically classified and represented the anthropological ‘Other’” (Lane, 2000, p. 87). This engagement has methodological implications for ethnography, which I have already discussed, as well as ethical and epistemological ones that were elaborated upon by Bourdieu, Deleuze, Derrida and Foucault, all of whom were critical of structuralism, highlighting the problematic nature of anthropological representation.

Reflexivity, then, addresses the distance and relationships between anthropologists and the societies that they study and interpret. Historically, this was often Western anthropologists classifying and representing non-Western communities. Until reflexivity entered anthropological methodology, the distance or relationship between the researcher and the researched was not seen as problematic or indicative of a colonial worldview. Moreover, the inherent distortions created by this dissonance were not conceived as such, but rather frameworks, like structuralism, were regarded as upholding the empiricism of scientific enquiry. An important imprint of reflexivity is recognising that a researcher’s positionality during fieldwork and in the text is shaped by their background, whether it be social, ethnic, religious or political. This is most often discussed in the anthropology as the different types of “roles” researchers take

on when conducting an ethnography, moving from academic to insider, from observer to participant. Moreover, because ethnographic fieldwork is “relational, intersubjective, and often emotionally charged” (Dilger, et al., 2014, p. 5), this transition between roles is not always seamless. It is not sufficient or sustainable to view your place in the research as anything but interconnected with that of participants. Writing reflexively and ensuring this intersubjectivity is academically robust but not as easy as it appears. “Finding somewhere to stand in a text that is supposed to be at one and the same time an intimate view and a cool assessment is almost as much of a challenge as gaining the view and making the assessment in the first place,” wrote Geertz in *Work and Lives: The Anthropologist as Author* (1988, p. 10). Swapping from researcher to insider should not affect the critical and analytical frameworks constructed within the text but instead should work with the ethnographic data to fortify and enrich them.

More recently, as medical anthropologists seek to strengthen their positions at the interface of anthropology and health research, some have called for the examination of discipline-level reflexivity that reveals and acknowledges biases within the field (Bolton, 1995; Closser & Finley, 2016). This “new reflexivity” aims to go beyond reflexivity at the individual-level and uncover how anthropological ways of seeing the world could affect how public health and medical researchers engage with ethnographic research. Given the diversity of anthropology, it is difficult to characterise the field and, therefore, pin down encompassing biases. The most common ones often lay within “our philosophical leanings, the tendency to romanticize the exotic over the mundane and the marginal over the mainstream; and our professional conventions, which tend to preference the elegantly articulated over the ruthlessly triangulated” (Closser & Finley, 2016, p. 389). Multi-level reflexivity, then, should be considered a tenet for applied work with the public health and medical communities. Just as we ask how our positionality influences our ethnography and where we stand in a text, we should review how we write and discuss anthropological work and tailor output so that it encourages wider visibility and translates to other related fields. Effectively, this “new reflexivity” bridges a similar intellectual detachment that initiated Bourdieu to critique the armchair anthropologist and develop his own ideas on reflexivity, since many medical anthropologists research biomedicine, clinicians and systems of public health and medical care.

While conducting this ethnography, I recognised that I would be shifting between a variety of roles, between anthropologist, student, maternal health researcher, volunteer and friend. As a white, middle-income woman without children born in the US, there are aspects of maternity and parenthood in

East London that would simply be closed to me due to lack of experience. Would women and their partners feel comfortable speaking to me about birth given my absence of first-hand, insider knowledge? Would men, regardless of their socio-economic background, contribute to the study in a meaningful way given my gender? How would my position of inherent privilege as white and Western influence responses to my interview questions? Beyond the individual level, this research intersected with a number of different stakeholders, the NHS, the university, Which? and SAfH, so how it is translated and presented to each could shift depending on the organisation. How would I overcome potential anthropological biases to appropriately disseminate my findings across several platforms to inspire the most effective impact? The responses to these questions will be suffused throughout the rest of my thesis, since, as I have highlighted, it remains a challenge to fully detach from ethnographic research and avoid placing yourself somewhere in the text.

Chapter 6: Myth and making in East London

The eastern region of London is an informally defined area of six of the city's boroughs – Tower Hamlets, Newham, Waltham Forest, Barking and Dagenham, Redbridge and Havering – and the greater area of the borough of Hackney. My research was conducted in the first three of these boroughs, which are a patchwork of cultures and communities, with high population density and increased migration into the area. Parts of East London have experienced rapid gentrification and regeneration over the past decade, creating a checkerboard along income and deprivation lines. In the end, my research in the community and with the NHS lasted for nearly two years, beginning in July 2017 and ending in February 2019. During this time, I used a range of methods, including participant observation, interviews, focus groups and online diary entries, primarily aimed at producing an ethnography within East London about birthplace decision-making when accessing Barts Health services. In all, 42 parents, both services users and those associated with a local community organisation, Social Action for Health (SAfH), took part in the research.

In the area historically known as the 'East End', there is level of "distinct mythology" that developed during the Victorian period, when it was often "seen as a site of danger, depravity and destitution, and hence to be avoided by genteel and respectable persons." (Marriott, 2011). In the following chapter, I will briefly summarise the history of the area, providing a discussion on what has changed and what has broadly remained the same, before laying out a reflexive account of modern East London and Barts Health NHS Trust. To do so, this account draws from a variety of sources: my readings of historical texts, local documents and observations about context, my community focus groups with women and my observations and notes from the meetings I participated in.

Participation in community-based study

The community-based study was conducted from July 2017 until July 2018, during which time I collected ethnographic data through focus groups and participant observation. I was volunteering in East London by April 2017, and, though this, I was able to gain insight into birthplace options and their local provision that was beneficial. I did not incorporate any of my notes from this period into my analysis because I did not

seek ethical approval to conduct observations during SAfH meetings at this point; however, this engagement informed my thinking about and knowledge of East London maternity services, and is communicated through my reflexive account. Overall, 23 parents were part of this study, five of whom participated in the focus groups, which were held between late July and early October 2017. Two women attended the Newham focus group, one the Tower Hamlets session and two the Waltham Forest group. They were all recruited either during SAfH meetings for local mothers or through the SAfH network, though this recruitment was less successful than projected. At the onset, I hoped to have five or six parents in each group, and the low turnout might have been related to a number of factors, such as the summer holidays in August and the challenges in advertising widely and effectively on social media platforms. It also may have been difficult for new mothers to attend a one-time group, with little flexibility in dates and times

Even with a smaller group of women, I was still able to use my intended approach, opening with an exploration of information sources that my interlocutors used and discussing Which? Birth Choice, as well as their past childbirth experiences and current place of birth plans, if they were pregnant. The women who took part all came from different backgrounds and had unique birthplace experiences that they were able to speak about at length. I asked them for basic demographic data during the enrolment and consent process, and audio recorded our conversations. Each focus group was between one and two hours long. Table 4 details the reported demographics of each woman. To preserve anonymity, I have not included the boroughs where parents live, and all names have been changed.

Name	Age	# of children	Education	Marital status	Ethnicity
Faith	18 - 29	1	University	Married	Black/ Black British
Faiza	30 - 39	3	University	Married	Other ethnicity
Famida	30 - 39	3	University	Married	Asian/Asian British
Felicity	30 - 39	1	University	Married	Asian/Asian British
Fiona	18 - 29	2	University	With partner, living apart	White/White British

Table 4. Pseudonyms and demographics of the women who took part in the focus groups in East London.

The remaining 18 parents were part of participant observations that took place during these meetings. There was some overlap between each group, with two of the women from the focus groups also taking part in the participant observation. Those taking part in the observations were not audio recorded, and I did not ask for demographic data; however, I did record gender and role in the SAfH meet-ups (Table 5), to provide clarity in the conversations that were recorded in my field notes. Participant observation started in September 2017 and ended in July 2018, and, during this year, I was able to observe 10 meetings, about 20 hours in total. To preserve anonymity, I have not included the boroughs where parents live and meet-up organisers are based, and all of names have been changed.

Because my observations, made possible through my volunteering role with SAfH, were embedded in regularly occurring meetings, I interacted with far more parents in these settings than in the focus groups, and these also provided interesting insights into relationships between services users and HCPs:

Maybe they can't speak English or feel they aren't educated or will make a mistake, so they will be judged. It's a culture thing. Then you are put off from even going. I try to tell [parents] to put it from their mind. The health care professionals stay quiet like there's a boundary, but when we are sharing information though, there's no boundary. It's not like working in a clinic or hospital, you have to be more close. (Faiza, Focus group, Waltham Forest)

Faiza's discussion of a "boundary" that HCPs seem to carry with them from clinical settings into non-clinical spaces, and the closeness required for MVPs, where knowledge is shared on a levelled ground illustrates themes that I will expand upon in the later sections of this chapter. Boundaries are acceptable in some places but not others, under certain circumstances, and are difficult to dismantle in the situations that require close and fluid relations. As Faiza suggests, the inability to set aside boundaries, particularly when information is shared, can alienate women – Muslim women of colour, in this case – from being involved in meetings, which are meant to benefit them. Identifying boundaries, but also working through and around them, is fundamental to ethnographic fieldwork and anthropological inquiry, and, with this in mind, I now turn towards my account of East London.

Name	Gender	Role
Amira	Female	Meet-up organiser
Caterina	Female	Service user
Chiara	Female	Meet-up organiser
Claire	Female	Service user
Emma	Female	Service user
Fulshana	Female	Service user
Giada	Female	Service user
Halima	Female	Service user
Inese	Female	Service user
Jasmin	Female	Service user
Jessica	Female	Service user
Michelle	Female	Service user
Roberta	Female	Service user
Sara	Female	Meet-up organiser
Sophie	Female	Service user
Valentina	Female	Meet-up organiser
Yasmin	Female	Service user
Zahra	Female	Service user

Table 5. Pseudonyms, gender and role of my interlocutors during participant observation in East London.

A short history of East London

The East End first emerged in the medieval period along the Roman roads of Bishopsgate and Aldgate and, since this time, has developed a colourful history marked by immigration, industry and deprivation. By the 17th century, London, though smaller than the sprawling metropolis it is today, was “geographically and symbolically divided between the City of London, bounded by ancient walls and inhabited by merchants, traders, financiers and craftsmen, and the City of Westminster, the ancient seat of the Court, government and established religion” (Marriott, 2011, p. 7). During the 1600s, London drew people from more rural areas looking for employment, as well as Huguenots, immigrating to escape religious persecution in France. Much of the growth during this time was shaped by the inability to expand westward, due the City of London wall, which “served to define the line between the order and wealth of the city and an outlying region seemingly beyond the reach of authority” (Marriott, 2011, p. 24). This divide still exists today, usually delineated by the Bank Underground station, but it is less to do with order and authority and more to do with socio-economic status and life expectancy: people living to the west of Bank station have a higher projected life expectancy than those living to the east of it (ONS, 2018). During the 18th century, East London experienced increased industrialisation, and the London Hospital – now the Royal London Hospital (RLH) – moved to Whitechapel in 1757, subsequently beginning its medical school in 1785. It was during this period that many migrants, particularly a larger labouring population, moved into areas inhabited by middle class residents, and “of greater consequence in the longer term for the social topography of London was the exodus from East London of the metropolitan bourgeoisie” (Marriott, 2011, p. 60) into West London. According to Marriott, the area became synonymous with criminality and excess, and with a culture of dissent and riots that had developed in the 1600s and was often tied to immigration; however, this did not stop the influx of migrants from a variety of religious and social backgrounds in the 1800s.

Besides immigration, the first half of the 19th century in East London was marked by an intensification of industry, pressure to hire cheaper, unskilled workers and competition from businesses abroad, but rapid industrialisation and urbanisation meant that the growing population lived in “squalid” conditions, and the quality of life for the working class is indicated by their health. A number of cholera and typhus epidemics, which killed thousands across London, spurred the government to take disease control and public health more seriously. East London, with its large, lower-income population, featured heavily in

the debilitating about sanitary and public health reforms. Contemporary views of the poor were that poverty and harmful environments not only affected health but also degraded social life and created moral pathologies. In 1848, the Public Health Act was passed, and the General Board of Health was established. Many accounts that Marriott cites from the 1800s reveal the anxiety that the poor – both British and non-British – were somehow “degenerating” the English population, as well as the deep-seeded racism and stereotypes of the time. East London was an intensive focus for writers and journalists who sensationalised the poverty of the area, which developed a “myth of outcast London”, where all manner of depravity and degradation occurred. There are no accounts from those living in poverty in East London; however, local pastors and teachers who did write about the area paint a different picture, one that was both orderly and moral. However, this is not the image that has endured.

This mentality was translated into the 1900s, and “much of the social and political discourse of the early 20th century centred on the physical well-being of the nation,” (Marks, 1996, p. 87), and infant health played a large role in this debate, as well as considerations of maternal mortality. Hitherto to the 20th century, maternity care for poor, unmarried women living in East London was provided within workhouses, as opposed to patients’ homes or voluntary hospitals, which did not accept single mothers until the 1880s (Marks, 1993). The 20th century, nation-wide, brought improvements from infant and maternal health, particularly in morbidity and mortality rates. The beginning of the century was markedly different from the end; however, there is evidence that the declines in infant mortality began in the early 20th century, due to improvements in public health measures and the reduction of post-neonatal mortality. Infant health in London during the first decades were linked to social and economic deprivation, especially population density and housing conditions, as well as single parenthood since social and medical resources were still continually restricted to unmarried mothers (Marks, 1993). For instance, infant mortality was much higher in Stepney (East London) than Woolwich (South London), as the population density was much lower in the latter (Marks, 1996). Maternal mortality, on the other hand, was determined partly by the quality of care received, and more often the result of clinical factors (Marks, 1993) interconnected with social factors, such as poor nutrition, gender inequality and high numbers of pregnancies. In general, motherhood came to the forefront of the social and political discourse and policies during the early 20th century, and, as vessels of the future of the nation, women’s mothering practices were associated with infant health, as John Burns foregrounded at the first National Conference on Infant Mortality in 1906:

First concentrate on the mother. What the mother is the children are. The stream is no purer than the source. Let us glorify, dignify, purify motherhood by every means in our power... In every aspect of this subject let us have good motherings; that is at the bottom of happy, healthy children. (Marks, 1996, p. 14)

As I have demonstrated in Chapter 3, a discourse of “good mothering” persists to this day in women’s reproductive lives, and the mother is still a conduit, though the focus is now predominantly on safety rather than purity. The power to ensure this purity and safety is still extended through and attributed to obstetric practices, which constrain women’s decision-making in the name of healthy children:

A lady I knew, she thinks they made a bad choice. She said they knew the heart rate was going back down, but they did the C-section anyway. She said the midwife started taking her socks off and rushing her into the thing, not giving her the time to think. She was like, ‘Wait’ and the lady said, ‘Do you want your baby to die?!’ This was to a woman who doesn't speak good English. (Halima, Participant observation, Tower Hamlets)

By the early 1920s, there was a relatively high rate of hospital birth in East London, with more births taking place in hospitals than at home compared to the rest of London and the country as a whole. Marks (1993) attributes this to the presence of several large voluntary teaching hospitals, such as the RLH, as well as the poor housing conditions. Given that the area was a focal point for social and national betterment through reproductive health, it is little surprise that there were higher levels of institutionalised births. The early 20th century also saw hospital birth and pain relief during childbirth become *feminist* issues, which, as I highlighted in Chapter 2, were somewhat different from contemporary feminist reproductive concerns, though not entirely dissimilar. Each are predicated on control of the body, the freedom to have a painless birth or to make decisions about one’s care; however, these liberties were and still are not granted to those with outsider status: the poor, the non-white or the non-English speaker. It appears that some women in East London remain outsiders, as they were over 100 years ago and, within the modern health system, they can have no say over actions as simple as taking their socks off, let alone emergency caesarean sections.

During the 1950s, East London, specifically Bethnal Green, was the subject of community studies aimed at imbuing the socialist policy of the Labour Party with “the interests, hopes and fears of the people whom the policy was supposed to benefit” (Young & Wilmott, 1986 [1957], p. xii), but ended up discovering a complex network of kinship relations that centred on mothers. It also articulated social research in Britain,

resulting in one of the first post-World War II ethnographies of working-class life. The study also focused on the effects of rehousing policies on family and community life, finding those who moved from Bethnal Green to municipal suburbs were cut off from their network of relatives. These findings were significant in that they ran contrary to contemporary stereotypes of working-class people as socially isolated in the city (Young & Wilmott, 1986 [1957]). Post-war East London contained the worst housing in London, and the area's population had started falling in the 1800s, meaning it was a prime space of regeneration, causing further movement – both involuntary and voluntary – outside of the city. Young and Wilmott pointed out that people were not forced to leave Bethnal Green due to municipal planning; they ultimately chose to be rehoused or moved on their own accord, with little public policy incentive to stay. Despite the popularity of *Family and Kinship in East London*, the book's criticism of policy was swept aside, and tower and flat blocks were vigorously constructed throughout the mid-century.

Young and Wilmott revisited their influential work 30 years later to survey and reflect on the social changes in Bethnal Green, whether they be connected to municipal planning or not, remarking on evidence of shifts in demographics and social networks. First, during this period, a new wave of immigrants from Bangladesh settled in East London, and “as far as London is concerned, they belong to an older tradition” (Young & Wilmott, 1986 [1957], p. xiii), in which newcomers enrich the life in the area, while also facing the harsh realities of deprivation. The migration of older families out of areas such as Bethnal Green to make way for municipal flats, reportedly disliked by many, meant that kinship ties were stretched. Moreover, the impersonal architecture of tower blocks and “barrack-like” council housing means that social networks were hard to reestablish (Young & Wilmott, 1986 [1957]). During my fieldwork, there were indications that housing was potentially shaping where women planned their births, inadvertently directing them away from home birth, in addition to service-related factors:

A midwife shares an internal Barts Health survey about birthplace decisions, which showed that the OU was seen to be the safest, most “normal” place to give birth and the most convenient. Homebirth was seen as unsafe, and this was mainly due to misunderstandings about midwifery care during homebirths. One mother said she was not surprised by this and felt that midwives spread this misinformation themselves, “My midwife told me that I couldn't have a homebirth because I live in a second-floor flat.” Women seemed to shy away from home birth due to the perceived lack of family support. They saw the home as not the right environment, and a place that could lack privacy. (Participant observation, Tower Hamlets, 2018)

Research focusing on community studies during the 1980s indicated an emerging isolation from the surrounding community and a loosening of family relations (Holmes, 1985). These stretched networks – more social rather than kinship – persist to this day, affecting community engagement in subtle way, including the outreach conducted by SAfH:

We meet in a building adjacent to the cricket fields in Leyton. There are only the usual SAfH staff members, myself, and three local mothers, one of whom leaves early, before we begin the meeting's conversation. The Waltham Forest meet-ups are not particularly well-attended, and there is concern about how to reach local women and record their experiences, so they can be communicated to the NHS in meaningful ways.

(Participant observation, Waltham Forest)

East London in the 21st century

Several currents continue to run true into 21st century East London: immigration, housing and health. The “myth of outcast” also prevails in East London, particularly in Whitechapel where it is not uncommon to come across a Jack the Ripper walking tour, in which tourists are guided around approximate sites of the murders and key streets where slums once stood. I not only took one of these tours but also would pass by them on my way to interviewing my interlocutors. Many of the tours sensationalise the murders, focusing on the unknown perpetrator, the horror of the crimes, and the vile underbelly of 1800s East London, as one site promises: “Step by blood-curdling step, you will find yourself spirited back to the mean streets of the 19th century East End²⁰.” The one I went on discussed his victims, their lives and the harsh realities facing poor, single women in that time period. While many walking tours capitalise on the violence inflicted on the bodies of women, the one I took sought to circumvent this objectifying lens of history. Not all of the women were sex workers, it has recently been suggested, despite having few choices for livelihood and being socially stripped of any decision-making power about their health and safety. As Rudenhold states, “[t]heir worth was compromised before they had even attempted to prove it” (2019). In fact, the modern East End streets are hardly mean, and the illusion of macabre London begins to unravel when you realise that much of Whitechapel was razed during The Blitz in World War II, that Dorset Street, once one of the

²⁰ <https://www.jack-the-ripper-tour.com/>

worst places to live in the city, is a mere, unmarked service road, and that much of the area has been developed two or three times over.

What I mean to say is that there is the myth, and then there is the reality. East London is now a sprawling, urban area, dominated by glass and concrete, where tens of languages are spoken, and increasing population density is problematic. There are thriving high streets and encroaching gentrification, and throughout there is still a sense of assemblage; it's even topographical, from the towering financial buildings in Canary Wharf to the quieter, leafier suburbs in Leyton. The three boroughs that constituted my 'field site' are each, themselves a microcosm within London, each with a hospital, each with a Clinical Commissioning Group (CCG) and a local government; health care and the services available within them are by no means identical. They are also a far cry from poor law institutions and workhouses, where lower income women would have received their maternity services in the 1880s. Yet, it is resonant that much of the East End's mythology is tied to the social and historical mishandling of women's lived experiences, creating contention about their capacities to manage their lives in ways that are perceived to be safe and decent. In many ways, there remains an uneasiness of a woman's body out of place; she remains beholden to moral economies in life, reproduction and death.

I concentrate on the history of East London because of its famous mythology gives it a more defined sense of place, but also because the temporality of maternity is rooted in the past, in that social and policy histories demarcate many of the services and structures within which parents interact. In East London, childbirth has been heavily institutionalised under the aim of a 'better society' or a 'better birth' for nearly 100 years, and this echoes through the present. As Bloch wrote, "cognition of society, like that of time, is double"; there is both "the past and the present in the present" (Bloch, 1977, p. 287). He argued for seeing duality in cognitive systems, one that is based on universal notions of time, the other that is more culturally specific and made up of "certain moments in a long conversation". The bend of this thesis has been to argue for less linearity in conceptions of decision-making, so seeing cognition and time as "double" is beneficial, yet I would extend these ideas of temporality and sociality towards cyclicity and multiplicity. The latter are mirrored in the two impressions that I take away from East London's history. First, there is cycling; cycling in and cycling out of people and industry, bringing changes to population and landscape, reflecting its relation to the docks, where the coming and going of ships from the British Empire defined the area but also contributed to the uneven patchwork of livelihoods and health. Second, there is a

recurrent assemblage²¹ of industries, people, identities, architecture, institutions and histories that bestows a sense of shifting reorganisation and compartmentalisation, which resonates within the local health system to this day.

Barts Health NHS Trust

Barts Health NHS Trust, which provides health care to the boroughs, is the largest NHS Trust in the UK and serves around 2.5 million people. It was established in 2012 after the merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust. The trust has five hospitals, three of which – Newham University Hospital (NUH), Royal London Hospital (RLH) and Whipps Cross University Hospital (WCUH) – offer maternity care services. A majority of some 16,000 births a year still take place in the OU, making Barts Health one of the largest maternity services in England. Since 2015, Barts Health has received either ‘Inadequate’ or ‘Requires improvement’ ratings from the Care Quality Commission (CQC) (CQC, 2015; CQC, 2017; CQC, 2019). These poor ratings, particularly the ‘Inadequate’ rating from 2015, which highlighted poor organisational culture and weak leadership, led to the roll out of an improvements plan to increase the quality and safety of care, under the slogan ‘Safe and Compassionate’. Maternity services in all of the hospitals have been rated either ‘Inadequate’ or ‘Requires improvement’ over the past four years, but there are signs of improvement – albeit improvement that is inconsistent across the trust, as NUH services received an ‘Inadequate’ rating while RLH and WCUH received ‘Good’ ratings. Barts Health also has financial issues associated with the RLH Private Finance Initiative building, and, as of September 2016, has been in Financial Special Measures due to inability to reduce their deficit.

²¹ Deleuze and Guattari developed the notion of ‘assemblage’ in their book, *A Thousand Plateaus: Capitalism and Schizophrenia* (1987), to describe a multiplicities, or “emergent and relational networks, which include a wide variety of heterogeneous elements and forces, including: machines, discourses, architectures, animal and human bodies, biologies, norms, histories, technologies, institutions and materialities. These merge and collide in potentially unexpected directions, creating new entities and outcomes” (Chadwick, 2018, p. 11). Similarly, Ingold’s concept of ‘meshworks’, or the “entangled lines of life, growth and movement” (2011a, p. 63) approaches life not as a series of connected points, branching out, but rather as a series of interwoven lines. Although I do not have the space in this thesis to heavily incorporate either of these ideas, each is helpful for considering broader scopes of relationality and becoming, as well as rejecting maternity and birth as simply biological and decontextualized phenomena (Chadwick, 2018).

The flows of funds from the UK government and NHS England to local maternity systems, CCGs and, finally, to the community and organisations, like SAfH and Maternity Voice Partnerships (MVPs) are complex, to say the least (Figure 7). One of my interlocutors would often illustrate these networks for new attendees at Maternity Voices meet-ups, in an attempt to describe how SAfH and MVPs fit in the schema.

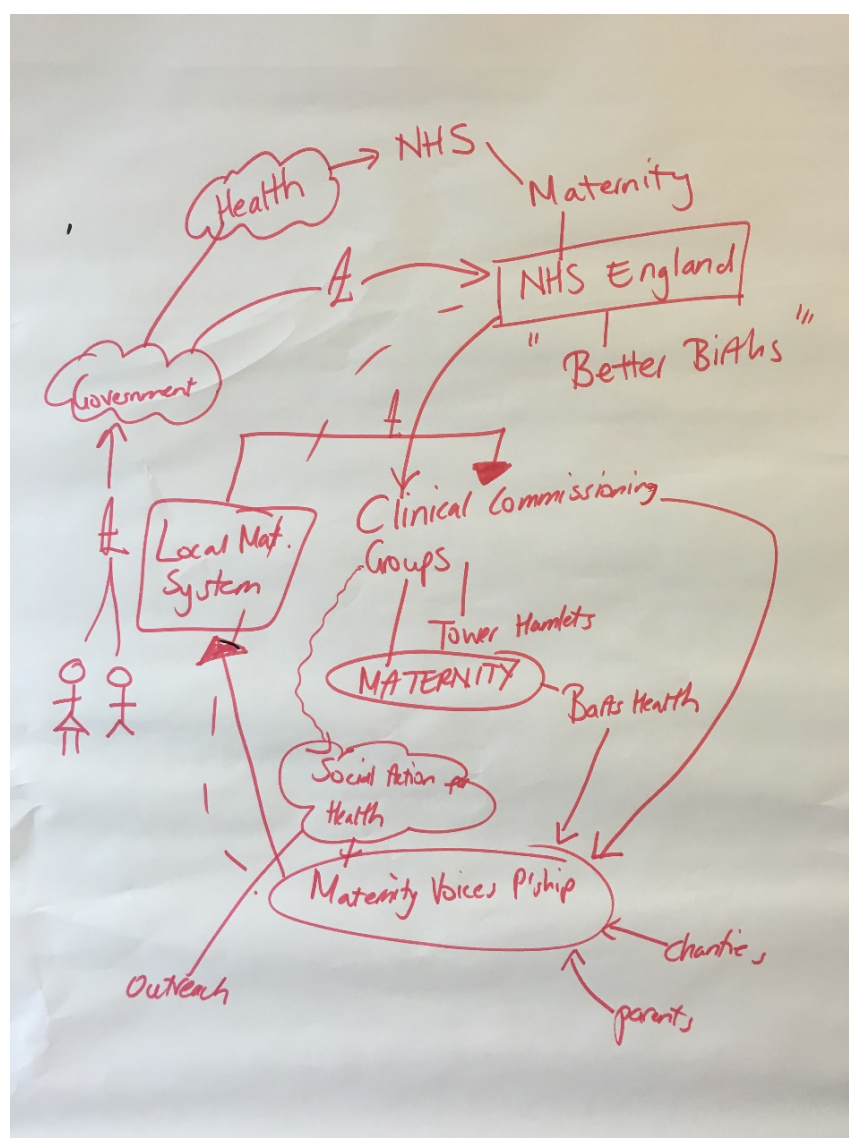


Figure 7. One of my interlocutor's illustration of the network of funds from NHS England to the MVPs.

During my fieldwork, SAfH was commissioned by the Newham, Tower Hamlets and Waltham Forest CCGs to facilitate community engagement in improvements to Barts Health maternity services. While volunteering with SAfH, I was involved this engagement, and I sat in and took minutes for the MVP meetings where members discussed, among many other topics regarding maternity services, CQC ratings, issues

surrounding birthplace, and pilots of new models of care. With *Better Births* and recent public health policy commitments to continuity of carer, the service was under pressure to evolve, and there was, to me, an atmosphere of transition, whether it was to improve CQC ratings, to adapt to policy or to respond to concerns from the community. I did not attend these meetings in the role of researcher, but they inevitably shaped my views and knowledge about the Barts Health over the course of two years, and I was privy to information about maternity service that was not easily accessible to the general public. It is important to note that many of my reflections on Barts Health are partially formed by my presence at MVP meetings.

Community births in Barts Health

Clinical Commissioning Groups (CCGs) in Newham, Tower Hamlets and Waltham Forest have prioritised moving maternity care into the community and closer to the home²², responding to the challenge for existing services to accommodate the projected increase in births across East London (Maternity and Newborn Care Clinical Working Group, 2016) and in line with national policy (National Maternity Review, 2016). Integral to this strategy is providing multiple birthplace options, in particular supporting home birth, to women with straightforward pregnancies. Mapping research suggests the more birthplace options a trust offers, the more common it is for families to plan home births (MCourt & Redshaw, 2011), Whether this was the effect in Barts Health is difficult to ascertain because there is little available about home birth rates across the trust, and reporting of place of birth statistics within each borough is patchy. While the London average is 1.8% (ONS, 2017), it was 0.9% in Tower Hamlets between 2015 and 2016 (Healy & Gillen, 2016). When I began volunteering with SAtH, only Newham provided home birth through a designated team, the 'Sunshine Team', who were based at the Barking Community Birth Centre, a freestanding midwifery unit (FMU). Waltham Forest had begun a pilot commissioning independent providers, called Neighbourhood Midwives, to support home birth and provide continuity of care for some women; however, this was unceremoniously shuttered in January 2019, leaving women using their services without care, an event covered by the *BBC* and *The Guardian* (BBC, 2019; Sherwood, 2019). By this stage, however,

²² Around the same time each CCG made this commitment to supporting maternity care in the community, they also centralised all booking in the local OUs.

Waltham Forest maternity services were in transition into a more community-based model of care that incorporated a home birth team and continuity of care for 20% of women. Tower Hamlets, on the other hand, finally proposed a dedicated home birth team in mid-2017, which was launched in January 2018.

On the surface, it appeared that Barts Health supported home birth, but, when I started my fieldwork, it quickly became apparent that this provision was more superficial than tangible. Home birth services differed borough to borough, and women reported that their care was organised in a way that did not facilitate its successful planning:

"People need to hear it from the professionals that it's ok, it's normal, it's safe because people don't know."

Zahra says, during a meet-up for local mothers in Tower Hamlets.

Michelle agrees, "They don't talk about [birthplace options] until 37 weeks because they don't want to get women's hopes up...I get this all the time. I'm, like, I've done the research. I know the risk. I've read everything about home birth...Unless you bring it up yourself, there's no discussion about home birth and birth options.

A class on home birth is helpful but not information that you would get normally. It's extremely important for me to have a home birth – I don't think I will survive another C-section."

Zahra discusses the "obligation" that midwives have "to tell women their rights and what they are entitled to access, to talk about birth as a beautiful, positive experience." She talks about her experience trying to plan a home birth in the borough, "I declined scans before the labour. They said that it wasn't safe. I thought it was safer to have it at my home because the hospital is closer to me than the Barkantine is [in the event of transfer]." A midwife told her that it might not actually be closer because the ambulance comes from a different area than where the RLH is located. "My confidence went right down. They are trying to do that though, by telling you the risk on one side, but not on the other." (Participant observation, Tower Hamlets)

There were also further indications of HCPs' reluctance to adopt an altered care discourse that includes birthplace choices. In our interview, Faith told me about her midwife's efforts to find "something" wrong with her, after she expressed a desire to home birth: 'conditions' that were not a problem before suddenly became the reason for an additional scan, one scheduled without her knowledge. It appears that these actions, searching for health issues and booking scans, were intended to keep Faith in the hospital system, where movement is ordered and monitored, and the way birth 'should be' has been calculated, memorised and normalised.

Barts Health contains two of the three FMUs in London, and the Barkantine Birth Centre, located in the Isle of Dogs, is unique, in that it was one of the first purpose-built FMUs established in an inner city in England. The centre opened in January 2008, five years after women living in Tower Hamlets started a campaign to build a new birth centre as a response to an increase in the projected birth rate and the limited capacity of the local maternity unit. The development of the centre was guided by two key principles:

[W]e wanted to create a birth centre where the social model of midwifery could flourish and to provide truly family-centred care. We aimed to foster a positive and non-hierarchical working culture in an environment where midwives and students could learn about truly physiological labour and birth. (Rocca-Ihenacho & Redfearn, 2010, p. 1)

A multidisciplinary steering group, the Birth Centre Network, was established and proceeded to apply for a funds to open a centre on an available floor of a health centre with a GP practice that was under construction. The success of the Barkantine's application was in large part due to the involvement of influential and well-connected individuals in the steering group (Rocca-Ihenacho & Redfearn, 2010), most of whom were community-based HCPs or community representatives rather than managers within the NHS Trust itself. A number of studies have been conducted on the Barkantine's operation and impact, most notably research undertaken by Rocca-Ihenacho (2017), following the centre's achievements, challenges and model of care (Rocca-Ihenacho & Redfearn, 2010; Rocca-Ihenacho & Herron, 2011; Macfarlane, et al., 2014a; Macfarlane, et al., 2014b; Schroeder, et al., 2017). Throughout my fieldwork, the centre received positive feedback, and the care and staff were often highly praised. Researchers have pointed to the Barkantine's social model of care, which differs significantly from that of the hospital, as the key element leading to greater choice and better experiences for women (Macfarlane, et al., 2014b; Rocca-Ihenacho, 2017).

Despite the "gold standard" of care that the Barkantine provides, there were undercurrent tensions about its operation and future, throughout my fieldwork. This centre's case highlights the potential friction that could occur within services that offer multiple birthplace settings. This is especially pertinent for Tower Hamlets, where an AMU, the Lotus Birth Centre, was opened in the RLH in 2016. There were concerns voiced over the new AMU, its location and the impact of its promotion on the birth rate at the Barkantine:

Just tell women they have a choice...I went to training at the Barkantine to discuss the birth centre in the local community and improve the uptake of services, as the centre is underused. [The Barkantine staff] are trying to promote the Barkantine as the first place women go if their pregnancy is low-risk. It should be the default...There's no discussion of birthplace until 36 weeks. Women don't know about the [Barkantine] birth centre, but they know the Lotus because it's in the hospital...The Barkantine has a strict policy of eligibility, you have to negotiate your care by saying, 'I will home birth if you don't accept my plan.' (Michelle, Participant observation, Tower Hamlets)

How the availability and promotion of the AMU options and the extent of their visibility affect both FMU and home birth uptake in Barts Health remains to be seen; however, the numbers from the Barkantine in 2017 were much lower than those from 2016 (Yuill, et al., 2018), which made some of my interlocutors uneasy about how Barts Health might use these numbers to justify the centre's closure. Though the number AMUs has increased in England, FMUs have not, with more being closed than are opened, despite the fact that this setting provides the best outcomes for women (Birthplace in England Collaborative Group, 2011; Walsh, et al., 2018; NMPA Project Team, 2019).

The Barking Birth Centre also suffers from issues related to visibility, and, in discussions about it in Newham, negotiations of FMU care eligibility and to what extent they should be consistent, even within NHS trusts, was highlighted again by my interlocutors, in that keeping them malleable might be in women's best interests. The *Midwifery Unit Standards* state that "[t]he midwifery unit pathway is open to all women for personalised and individualised care" and that women should have discussions about their wishes "regardless of pregnancy complexities", and Standard 8 iterates that units should have localised "guidelines" for women's "suitability for midwifery-led care" (Rocca-Ihenacho, et al., 2018, pp. 13, Standard 8), yet my interlocutors often felt that the eligibility criteria for the FMUs were very narrow. Healy and Gillen (2016) generated the GAIN framework for units in Belfast, based on evidence and localised to fit area needs. However, imposing frameworks has limitations, for instance the GAIN guidelines for both AMUs and FMUs include restrictions related to age (no more than 40 years old) and BMI (no more than 35-40 kg/m² at booking), a problematic measure for determining whether an individual is truly at high risk of poor outcomes, needing routine obstetric care. One of my interlocutors felt that admission criteria, even trust-wide ones, could reduce parents' capacities in their care:

I attend a meet-up in Newham with two staff members from SAfH and six mothers of varying ages who live in the borough. We go around, say our names, and the mothers – I am the only one who does not have children – in the group also share how many children they have, most add where they were born. A majority of the women gave birth in the hospital. The Barking Birth Centre is mentioned, and, though all of the women here know of it, most have either never visited or do not know much about the services. “I’ve never even been there!” says the facilitator of the group, Sara. We decide that a group visit would be beneficial, so we can find out about the different teams there and the structure of the service.

Sara says there is a push to coordinate the criteria for admittance to the birth centres in Barts Health. Currently, all of the hospitals operate on different terms of eligibility for the AMUs and for maternity services in general. I say it could be good to have consistency in the trust, but Sara is less convinced, “It will be good, but you can kind of negotiate your care at the moment because they are all different, so if you aren’t accepted in one place, you can try another. If it’s all the same, then we’re afraid that a lot more women won’t be able to access certain services.”

After the meeting finishes, I talk to Sara about the Barts Health website, wondering why they are advertising the recently opened AMU, the Lotus Birth Centre, in the RLH but still have not managed to put anything on there about home birth. She is surprised by this and goes to check the site for herself, explaining that she is not sure either why the information is not up there. (Participant observation, Newham)

When it comes to admittance guidelines, it is crucial, then, to pay attention to who they benefit and who they leave behind, and how they become reified to constrain women’s decision-making without their knowledge. The NICE (2014) Intrapartum guidelines are more reserved in their guidance than GAIN, recommending that women who are over the age of 35 or have a BMI over 30 kg/m² require “individual assessment” when planning place of birth. Recent research has shown no evidence of significantly increased risk connected to planning an AMU birth for “carefully selected” multiparous women, with BMI 35.1-40kg/m² (Rowe, et al., 2018). However, to what extent are women being “individually assessed” or “carefully selected” by midwives? The *Midwifery Unit Standards* do not impose specific admittance guidelines, leaving these open for delineation by clinical bodies, such as NICE, and for local interpretation, but rather iterates their ideal use and the importance of applying guidelines in conjunction with women’s autonomy. This position certainly affords the possibility, theoretically, of midwifery-led care settings for women with more complex pregnancies, but it is not a given, as there are indications that HCPs are

interpreting and employing clinical guidelines in a prescriptive manner rather than frameworks for more personalised care.

My conversation with Sara throws the priorities of Barts Health into sharp relief; at this point, there was no information available on their website about home birth, though they 'officially' supported it, yet they were able to update the same site with information about the recently opened Lotus centre. A home birth page was eventually added after pressure from MVP members and the launch of the Tower Hamlets Homebirth team in early 2018. Across parent meet-ups, women regularly reported their difficulties in contacting midwifery teams, being unable to find phone numbers or clearly signposted information online. Given my own issues initiating parts of this research with the trust, I often felt, throughout 2017-18, that Barts Health was nearly impenetrable, making itself impervious to contact, criticism or change. Of course, there were small criticisms and changes happening throughout the year, the latter in the shape of 'pilots', new teams, title changes and staff coming and going, but, the real, permanent changes were slower. The Tower Hamlets Homebirth team was years in the making; I heard resistance to promising a certain level of continuity of care, and clinical members of the MVPs were sensitive about what wording was attributed to them in the meeting minutes. There were positive moments, in which progress was seeded in smaller actions, whether it be a webpage about home birth or a CCG representative strongly committed to keeping the Barking Birth Centre on the list of MVP's yearly priorities. It became clear that the visibility of home birth and FMU options matters, and it can be undermined in subtle ways, or by not doing anything at all.

We did eventually go to the Barking Community Birth Centre, which is part of Newham's maternity services, even though it is located in Upney, within the borough of Barking and Dagenham. The meet-up was held on the FMU site, and our visit included a tour around the birth centre:

We are doing an outreach day with local parents at the Barking Birth Centre for feedback to bring to an upcoming MVP. Inese mentions that, during the last MVP, HCPs were discussing issues that did not necessarily match the needs of women. She goes on to say the FMU name is "confusing" because "it's in Upney, but it's called Barking." Not only is the name confusing but the information is also lacking. Claire says she "went to go get a scan, and there was a leaflet about the Barking (Figure 8). But there was only one leaflet, so I didn't want to take it."



Figure 8. An example leaflet produced for the Barking Community Birth Centre.

Amira suggests there may be several factors to causing the under-use, “Some don't genuinely know about it, or it's the one in the hospital. Or they think they have to pay for it. The ones in the antenatal courses aren't getting the information about it. They hear about the hospital and the birth centre there. It's also just too far. I don't know what it is, but they don't want to come.”

Claire says she saw the midwife for the Sunshine [Home Birth] Team at NUH at the beginning of her pregnancy. She had done her research online before, so she knew about it, but it wasn't offered to her. Caterina shares a similar experience, “I knew about it from a midwife, but it wasn't told to me. They don't really tell you the options and then you think, 'What is the Sunshine team?’”

Inese asks if the midwives tell women at booking the options. Caterina tells her, “No, it's not until later [34 weeks]...I think if you don't know about it, they won't tell you. I think the midwives should tell you.”

During Sara's outreach in the community, only two of the five mothers she spoke with knew of the Barking. One woman went there for her antenatal appointments but was unaware that she could give birth at the centre. No one told her she could. Claire highlights the issue of misinformation about birthplace options, “I think they should tell you the options at booking and then you have some time to decide, instead of ticking the box right away...I told my neighbour about my home birth and she said, 'Oh, you went private?' She had no idea that you could give birth at home and she has three kids.”

Yasmin joins the group at this point in the meeting. Amira shares feedback from women who have given birth at the Barking, which is mostly positive, “One woman said she won't give birth anywhere else and recommends it to everyone. She found out about the centre from a friend. It's through word of mouth that people are learning about it. She said there may have been posters, but she couldn't read them that well, so it wasn't that.” Sara agrees, “It has to be word of mouth.”

Yasmin shares a different experience, “I do know about the birth centre because my midwife told me about it. And I looked at some stuff on the internet about it...I have a lot of issues with Newham. The communication is *terrible*. Newham does have the posters and leaflets available, but no one really reads them or is interested...it would be good to have a video playing in the clinics.”

Caterina suggests that “booking appointments should be more information conversations about birth options.” However, midwives have told Sara that “they just don't have time to have a birth choice discussion at the booking appointment”, but Inese points out that when she went to the Barkantine, the midwives had this conversation with her: “Maybe they have more time...”

Sara thinks that six to ten weeks in pregnancy is the best period to inform women, so they can go to booking appointments prepared. Inese adds, “It can't be that expensive to inform women.”

During our tour of the FMU, I walk with Claire, who is pregnant with her second child and planning a home birth. I ask her why she decided to go for that option over somewhere like the Barking Birth Centre. She says that it is easier to give birth at home because she has a five year-old son, although she is unsure how he is going to react to the birth, and whether she should let him be present during it. Claire tells me she has been reading online “every day” and watching a lot of videos. For her, birth stories and support from other mothers who have successfully planned home births have helped her to feel confident in her choice. After the tour, I ask her if any of today's information or the Barking's facilities have changed her mind about having a home

birth. She says no, but "if I wasn't having a home birth, I would come here." (Participant observation, Newham)

This observation suggests that, even 12 years after *Maternity Matters* (Department of Health, 2007a), which promised women further agency in choosing their place of birth, the gap between policy and practice persists, and that this gap is present even in trusts where multiple birthplace options are available. Moreover, telling 'low-risk' women these options, so that they *know* about them is not the same as informing women about their options, so that they *understand* them ("They don't really tell you the options and then you think, 'What is the Sunshine team?'"). Without more in-depth research into the interactions between midwives and parents in Barts Health, it is difficult to know to what extent or why there is a communication breakdown, in which birthplace information is not being provided in a meaningful way, or whether the information is not being given at all.

When I began recruitment for the feasibility study, I first started at NUH, and I spent the most time in that antenatal booking clinic out of all the other sites. While I sat in on the end of booking appointments before my approach to parents, I got to know the waiting area intimately, as I shuffled from room to room with referrals for my study. Here, parents would wait for booking appointments, blood work and scans, while a television played advertisements and informational videos on loop. None of these videos were about birthplace options, and there were usually no leaflets on the several side tables in the waiting room. Posters on the walls were mainly about research, including my own, that people could take part in. There was, however, one standing banner, advertising home birth and the Sunshine team, in a corner of the room. The small waiting area at WCUH was similar, though they were without the luxury of a television, and the sometimes chaotic reception in RLH's antenatal clinic had a play area for children but few leaflets. Booking appointments were 60-80 minutes long, during which time parents were given packs of information, women's 'risk' levels were assessed via lengthy questionnaire, and maternity notes were begun and completed for the appointment, and, somewhere in the midst of leaflets, food guidelines and antenatal classes, birthplace options may be offered and possibly lost in the instructional wave of soon-to-be parenthood. My interlocutors often spoke about the overwhelming amount of information received at this appointment, or the limited amount of time there is to get through every task. Wary of this, I pared my initial 'pitch' for the study down to five minutes.

Once bookings are over, birthplace is not officially on the maternity appointment agenda again until 34-36 weeks of pregnancy. Given the “deluge” of information parents encounter (Sanders & Crozier, 2018), the limited visibility of birthplace in clinical spaces and the priorities of daily life, it is little wonder that people do not ‘know’ about their options for an event months away from a short discussion (if any) wedged into a packed appointment and a leaflet (if provided) that quickly summarises a complex decision. Booking at the Barkantine was longer – 90 minutes – but the model of care diverges from that of the hospitals, and certain aspects of the maternity care pathway might be framed differently or emphasised more. Perhaps, it is simply, as Inese suggested, that “they have more time” than midwives in the hospital²³. As McCourt and Dykes outlined, institutionalised time and shift time, as opposed to pregnancy and birth patterns, has considerably changed the nature of midwives’ work, compartmentalised within and between hospital and community midwifery:

Hospital midwives worked shift systems, organized in order to ensure the smooth running of a large hospital, with rotating shifts to ensure all ward areas were covered. In such a system they would care for many women for short intensive periods, during one particular aspect of their maternity experience...this form of work can be categorized as essentially alienated with midwives performing a quasi-industrial worker role, obstetricians that of production management and women cast as a relatively passive part of the reproductive process...Those midwives who continued to work in the community found their role considerably narrowed and constrained. (2009, p. 31)

The shared care of maternity amongst GPs, midwives, nurses and obstetricians has only enhanced compartmentalisation, meaning NHS tempo must ensure “smooth flow across boundaries” (Mccourt & Dykes, 2009, p. 31), and it is assumed to be financially efficient above all else, even though the prevailing evidence on caseload midwifery models and midwifery units (Schroeder, et al., 2012; Sandall, et al., 2015) does not support this assumption. Time and money are intertwined; the linkages are apparent even to parents (“It can't be that expensive to inform women”), and ‘industrialised’ maternity care reflects the long-

²³ Several years before my data collection, booking was centralised, and all parents had to go to the hospital. There was subsequently drop in numbers booking at the Barkantine, and midwives from the Barkantine campaigned to return bookings to the unit. Initially, managers and consultant midwives argued that this was not possible because of cross-charging for rooms in a community health venue; however midwives were able to address this with the GPs in the venue, and booking for the community midwifery teams assigned to the surrounding area (E14) was returned to the centre.

held cultural attitudes that systems function most efficiently in these areas when they structured like factories.

NHS tempo and birthplace in Barts Health

I want to continue with this thread on temporality because I was always conscious of time and how it affected my place and actions as researcher. The ways in which one interacts with time, movement and language are indicative of one's role in the NHS, which primary falls into two groups: HCP/internal or non-HCP/external. During the NHS-based parts of my fieldwork, I never gained a wholly HCP/internal status, though I wore a NHS badge, ensured I was present and visible in practitioner spaces (e.g. behind the reception desk rather than in front of it) and obsessed about how I could move and speak in order to be like a member of the NHS, not a patient, service user or outsider, in order to fit in and be acceptable to staff as a researcher. I was concerned with the 'presentation of self', using 'backstage' preparation to smooth my interactions with NHS staff, in order to present myself as someone who was entitled to a certain type of consideration and support (Goffman, 1959). Yet, I found that even if I looked the part (badge, comfortable shoes and bare below the elbows) and walked through clinical spaces like I belonged there, when I had a conversation with a midwife or receptionist, they always guided how long it lasted. Rapport was clipped, and responses to questions had to be spoken within five to ten seconds. How many times did I realise that I had spoken for too long? As Goffman described, in every interaction and presentation of self, there are involuntarily slippages or 'leaks' of information that are 'given off' unintentionally (1959). I tried to curtail my speech, which proved difficult, and I attempted to mimic words – 'ladies' entered my vernacular – as well as reflect the assured directness and authority that I saw every day. However, when I went to see my GP, it was apparent that I was still not part of the internal, practitioner sphere, and remained on the periphery with service users.

I also waited. Like Frankenberg's (1992) patients, I was subject to "the paradoxical influence of time within biomedicine as 'patients' endure long periods of waiting interspersed by sudden intrusion upon their temporal and spatial boundaries" (McCourt & Dykes, 2009, p. 32) I waited weeks for HCPs to e-mail me back, only to suddenly, by accident, meet the right gatekeeper in a hospital corridor while volunteering. I waited for booking midwives to come in, so I could tell them I was in the clinic to recruit. I waited for

booking appointments to come to an end, so I could speak to parents about the research. The latter became an art of watching time and knowing the rhythms of appointments across four different sites, down to individual midwives' routines; I knew, for instance, who finished their booking earlier than their colleagues. These 'temporal contradictions' were noted by my interlocutors as well:

Overall, I hear other people's birth stories and I feel like a lot of people who were in hospital had a lot of interventions, their labours took a long time. It feels like this marathon with hurdles and at the end you have your baby and it's relief...There are a lot of women giving birth and the NHS is under a lot of pressure, so the doctors and midwives are working on their schedule as opposed to a woman's. They have in their heads what they need to do. Basically, everyone I know who gave birth in hospital had an assisted delivery, definitely a longer labour. (Felicity, Focus group, Newham)

Shared care and shift time are constituted to maximise efficiency, yet longer, "marathon" labours and "women's schedules" run counter to HCP pace and biomedical mentalities. Women's physiologically normal labours are perceived as long by clinicians, disrupting the efficient flows of people and crowding the OU further, yet birth outside of the OU is not encouraged or facilitated. As Felicity appears to imply, these temporal conflicts and contradictions result in more interventions for women who give birth in hospital. For women planning births in an FMU or at home, avoiding this temporality, not embodying it by becoming the 'patient' and experiencing unwanted interventions or care were strong draws away from hospital-based care, even the AMU:

I knew just being in hospital, you – even if you're the strongest person – the minute you walk in, you're in somebody else's, you're in the hospital environment, you're no longer...that kinda of independent person. You take on...the rules of the hospital, kind of thing. So you become the patient and you kind of...what's the word...get sucked along to the course of things and end of experiencing something you don't want. (Faith, Focus group, Tower Hamlets)

This becoming, taking on the rhythms, structures and rules of the hospital, recalls Fox's ideas about the 'vigil of care', a discourse in which docile bodies are inscribed with "the subjectivity of being the recipient of care", pseudo-boundaries between carer and cared for are imposed and possession is instilled (Fox,

1999; Walsh, 2007). 'Vigils of care' alienate subjects from their bodies, which are passed through a compartmentalised, patchwork network of carers and spaces.

This alienation is pervasive enough that it is felt in physical spaces within the hospital and displayed through their materialities. Though AMUs attempt to create and market themselves as 'home-away-from-home' environments, for some women I spoke to, this did not resonate:

I mention that I've never been to Lotus. Fulshana says, "I was at the launch party when it first opened. The rooms are so big. It's a bit spooky."

Valentina agrees, "The rooms are massive, like you could cut the rooms in half and they would still be big enough. They are so white. It feels like a farm in there...very sanitised."

Fulshana adds, "They are so huge that I found them scary. I don't know how people give birth there."

(Participant observation, Tower Hamlets)

McCourt and colleagues (2016) have previously connected the built environments of AMUs to models of midwifery care, employing metaphors of home that promote well-being and 're-normalise' concepts of birth that are not intrinsically linked to biomedicine and its views of risk. These are intended to function as therapeutic and protected spaces for both women and midwives; however, my fieldwork suggests that AMUs are not as sheltering for women, who saw the AMU as an extension of the labour ward and as a place that was acceptable, given the bounds of conventional, biomedical risk in birth. This finding reflects similar observations raised in the initial Birthplace in England report (2011) about the difference between AMUs and FMUs. Moreover, women who plan AMU births have higher rates of transfer, assisted deliveries and caesarean sections than those who plan FMU births, and it could be the case that, while AMUs tangentially protect well-being and physiological birth, in reality, they are eclipsed and governed by obstetric praxis:

I have heard, even in a birthing centre, which is a bit more natural and holistic than the midwives, it's still their territory, their rules. (Felicity, Focus group, Newham)

We got all of the information and went on a tour of the Lotus and the Barkantine. We went for the Lotus, you know, just for the first time, so if something happened – which it did – we would be right there. (Kate, Participant observation, Tower Hamlets)

I had originally thought I would only want to be on the labour ward because I'm pretty confident I would want an epidural. But after my first meeting with the midwife, she told me that the birthing centre is next to the labour ward and I can be easily transferred if I decide to have the epidural on the day. (Jasmin, Participant observation, Waltham Forest)

Being in a midwifery unit physically located *inside* of the hospital, rather than outside of it, was seen as safer "just in case," despite research showing that planned FMU birth and home birth are more beneficial to women than AMU and OU births (Birthplace in England Collaborative Group, 2011). An AMU, by virtue of being in the same building as the OU, will be governed by similar institutional temporality, structures and knowledge, so it is crucial to delineate who actually benefits from its 'protective' space and unpack sentiments of alienation, disjuncture and contradiction in parents' narratives about birthplace. A recent study from McCourt and colleagues (2018) found that women continued to experience these temporal norms and faced problems accessing AMUs in early labour, as they would in the OU.

In this reflection on internal-external, I am wary of replicating dichotomies that continue to underpin maternity and biomedical systems. In the case of the hospital, there are visible boundaries between inside and outside that make this constructed parallel feel more tangible, unlike mind-body dualism, which cannot be fully seen. Researchers have also highlighted how these physical boundaries align with and in some ways symbolise and materialise philosophical and practice differences (McCourt, et al., 2018). A similar point has been made about experiences of time, in that claiming Western peoples, so accustomed to clock time, cannot enter cyclical time suggests we can only live in and engage with one form of time (McCourt & Dykes, 2009). McCourt and Dykes cite Kahn's touching account of experiencing both clock time at work and then a cyclical, seasonal or, even, tidal time that she would "float" into when breastfeeding her son (2009, p. 33). The ability to live with multiple forms of time ("time, is double") was also cracked and explored by Bloch, who critiqued Geertz's proposition that the Balinese have a non-durational concept of time, finding that "sometimes and in some contexts they do, sometimes and in other contexts they do not" (Bloch, 1977, p. 284). It is certainly in human capacity to co-exist with different forms of time, yet clock time and shift time are employed in maternity services for bodily phenomena and events that are experienced in a far more cyclical temporality.

In East London and Barts Health, one can see how modernity and its notions of efficiency and progress have shaped people, networks and places. The former London city walls, defining who was inside and who was out, altered the trajectories of the city's eastern and western ends, which continue to be embodied to this day in the form of health disparities between the quarters. Governmental oversight into the care of East London's poor women and their children for the betterment of the country means that their bodies and reproduction were entangled with morality and responsibility, aided most efficaciously through burgeoning medical institutions, and each remain tied to the care dispensed from inside hospitals. Mid-20th century advancements and policies stretched social and care networks, but, as Young and Wilmott's work and my time with SAfH demonstrate, these shift, and new ones emerge, despite strain. In terms of assemblage, maternity care and experiences have not been enhanced from the efficiency-related compartmentalisation of services and the convergence of care into one pathway. This formulation is inherently different from an assemblage of a multiplicity of pathways, integrated into a network of care with an intent towards well-being. As I mentioned, Barts Health seemed to be a trust in the midst of a protracted transition but still an amalgamation of past, present and policy. With this history and atmosphere set out, the following two chapters further discuss the outcomes of research I conducted in conjunction with Barts Health and spotlight 'vignettes' of women deciding where to birth in East London.

Chapter 7: Feasibility findings and outcomes

As I highlighted in Chapter 6, my research with and around Barts Health NHS Trust was not straightforward and provided several challenges during my fieldwork. While I was conducting ethnographic research on decision-making about place of birth, the first part of which was the community-based study, I also aimed to generate feasibility outcomes for an RCT and longitudinal study on informed choice, and to contribute an independent evaluation of Which? Birth Choice, both of which were primarily produced by the NHS-based study. This chapter, then, will focus on the findings related to recruitment, attrition and feasibility outcomes for an RCT and a longitudinal decision-making study. It will also discuss the acceptability of the Birth Decisions Diary, drawing on data from the NHS-based study. I will conclude with a brief discussion of the evaluation of Which? Birth Choice, which was built on focus group, diary entries and interview data from both the community- and NHS-based studies.

Feasibility assessment and findings

The feasibility for an RCT and longitudinal study on informed choice was assessed using the following five ‘outcomes’. This section outlines findings from the NHS-based study in relation to the first four assessments (recruitment, attrition, fidelity and key outcomes). The final assessment is discussed in relation to the acceptability of the Birth Decision Diary and evaluation of Which? Birth Choice.

- Proportion of eligible and demographic diversity of women recruited
- Rates of and reasons for attrition
- Fidelity to the intervention or control arms (e.g. what other information sources do participants use)
- Key outcomes for the full trial and how they could be measured
- Solutions for information provision of a trial that is ethical but does not highlight alternative informed choice options

Recruitment for NHS-based research

Recruitment took place at the Barkantine Birth Centre, Newham University Hospital (NUH), Royal London Hospital (RLH) and Whipps Cross University Hospital (WCUH) from mid-March 2018 until the end of June 2018, during booking appointments when women were 10-12 weeks pregnant. I had originally planned to start recruitment in October or November 2017; however, delays in the HRA and R&D approvals, as well as barriers to accessing the booking clinic teams, led to a nearly six month delayed start. I relied heavily on my community connections from SAfH to gain access to gatekeepers within the Barts Health maternity services, and the months I spent volunteering proved beneficial, as I became a more familiar face. Despite these advantages, there were still significant obstacles to contacting and meeting with the right people for facilitating recruitment in the booking clinics, and I found that more often than not, HCPs do not regularly respond to e-mails, and phone numbers are not easily attainable. Chance and 'hanging around' during volunteering became the most useful tools for gaining access, including a random encounter in the hallway of the antenatal clinic in NUH, while working with SAfH, which led to my introduction to the booking team there. Persistence and presence, on the other hand, were essential for successful recruitment, as the booking midwives often forgot that I was in the clinic, and sometimes I faced negative attitudes and dismissive treatment from staff when I first started working in the clinical spaces. Over the three and a half months, I developed strategies for ensuring that recruitment and approaches actually happened, as midwives rarely referred women to me directly: I went to clinics on the same days, I always made the matron and midwives aware of my presence before the bookings began, I gave midwives leaflets (Figure 9) with the key points of the study every morning, and I made sure to check in with each midwife around 15 minutes before the end of their sessions to see if they had eligible service users who would like to speak with me. Without this consistent visibility and tenacity, the recruitment figures might have looked very different.

In the end, I approached 112 parents, and 43 of these women and 12 partners enrolled in the study (Table 6). I generally recruited during the morning booking appointments, usually five days a week, choosing to leave afternoons open for study management, such as following up with those interested in taking part in the study. Depending on the size of the team and the number of appointments, there could

be eight to 18 women seen in the mornings before the lunch break; however, not all of these women were necessarily eligible.

BIRTHPLACE DECISION-MAKING IN EAST LONDON STUDY



I am recruiting 20 women to take part in this study.

This research study is exploring women's information use and decision-making about place of birth during their pregnancy. I would like to know what is important to women during their pregnancy

Eligibility to participate:

Age 18 and over
Low-risk pregnancy
English speaking

Women who enroll will take part throughout pregnancy and up to 2 months after they give birth. It involves completing an online diary. You will also be invited to give 1-2 interviews during this time.

If you decided to take part, you will receive £5 for enrolling and a booklet of your diary entries at the end of the study. Those who take part in the interviews will receive an extra £5.

If you are interested, please let your midwife know or get in touch with Cassandra Yuill (Cassandra.yuill@city.ac.uk, 07840872417). Thank you!

Centre for Maternal and Child Research
School of Health Sciences
City, University of London



Figure 9. Copy of the leaflet given to parents during their booking appointments, introducing them to the study.

Although I did not reach my goal to recruit 60 women, 43 participants still made up an adequate cohort size for generating the feasibility study outcomes. Initially, I aimed to recruit 20 women from each of the three boroughs, but given the time constraints on my study and the delayed start to the research, I had to

stop recruitment at the end of June 2018, before evening out the number of participants in each group. The most participants were recruited from NUH, due to the fact that I spent more time at this site than any of the others. The Barkantine proved to be unsatisfactory as a site because there are only six women booked per day at the centre, as opposed to the 20 to 30 that are booked at the other hospital sites. The numbers at WCUH are low, possibly because there are only two booking appointments in the morning, while there are three at both NUH and RLH. Even though the latter does have one of the busiest antenatal clinics of all three hospitals, recruitment numbers were still low, as I spent the least amount of time recruiting at this site, due issues with initial access to gatekeepers.

Site	Total eligible parents approached	Women enrolled	Partners enrolled	No response	Declined
Barkantine	5	1	0	3	1
NUH	53	19	3	24	7
RLH	27	12	4	10	1
WCUH	27	11	5	8	3
Total	112	43	12	45	12

Table 6. The number of parents enrolled, did not respond to follow-up requests or declined to participate, by each recruitment site in East London.

While targets were not reached, there are two key successes from the recruitment. First, a majority of the women approached were interested in taking away information to look at and having a follow-up about participation. There were very few women who declined after I approached them and told them about the study, meaning that parents are interested in taking part in qualitative, longitudinal research. Second, of those who were interested, over 43% enrolled in the study, including a good number of partners. This shows that recruitment is possible for this type of research and has the potential to be successful, despite taking place in a time-strapped NHS setting. For transparency's sake, it is important to

mention that women did receive a £5 gift voucher for enrolling in the study, which may have augmented the numbers of those taking part. Furthermore, these successes were time-consuming, in that I had to wait through most of the 80-90 minute appointments before I could speak to a service user, leaving a short space of time for me to discuss the study with the women before they had to go for blood tests or scans. If scaled up, a larger recruitment team and a longer period of time would be needed. The ideal research team would need to include booking midwives; however, their appointments are regimented, meaning they would need regular reminders to incorporate this into their routines. Research midwives, who can handle patient notes and are trained to recruit for research, are another option, but these teams were understaffed and overworked at some of the Barts Health sites, so their ability to give every study equal attention can vary site-to-site.

Demography

Demographic information was collected from all of the participants who enrolled in the study, including age, education level, ethnicity, marital status, parity and previous place of birth, if applicable. Of those recruited, who eventually participated in the study, all were women (n = 19), mostly between the ages of 30 and 39 (n = 15). Though partners were recruited with women's consent and encouraged to take part in an interview, none did, meaning different strategies may need to be employed to keep them engaged in research about maternal health. There was some variation in educational level among the women who took part, but over half had higher education at either university or postgraduate levels (Table 7).

Education level	Up to 16	16 - 18	Vocational training	A levels	University	Post-graduate	No answer
Number at recruitment	2	6	4	8	23	5	7
Number of participants	1	2	0	2	10	3	1

Table 7. Distribution of education levels among participants, at recruitment and by the end of the study.

Ethnicity	White/White British	Multiple ethnic groups	Asian/Asian British	Black/Black British	Any other ethnic group	No answer
Number at recruitment	29	3	18	2	0	3
Percentage (%)	52.7	5.5	32.7	3.6	0.0	5.5
Number of participants	12	2	5	0	0	0
Percentage (%)	63.2	10.5	26.3	0.0	0.0	0.0
Ethnicity, Tower Hamlets (%) ²⁴	45.0	4.0	41.0	7.0	2.0	n/a

Table 8. Distribution and percentages of reported ethnicity among participants, at recruitment and by the end of the study, compared to the rates reported in Tower Hamlets.

Ethnicity was recorded, and participants were asked to write this in their enrolment forms, rather than ticking a box, so there was a wide range of ethnicity reported, reflecting the diversity of the area. In the interest of space, self-reported ethnicity has been condensed into five categories that mirror those used by the British government (Table 8). A majority of the women who continued participating in this study were either white or white British ($n = 12$), and when compared to the demography of Tower Hamlets, for instance, is not especially representative of the communities in the East London area. The breakdown among parents who were recruited is a somewhat closer the percentages reported by the ONS; however, the cohort is still majority white and educated, which are groups consistently and overwhelmingly represented in research. Most parents who were recruited were either married or living with their partners (Table 9). Very few were living apart from their partners at the time of recruitment, and no one reported that they were single.

²⁴ Reported by the Borough of Tower Hamlets in February 2013, using statistics from the 2011 ONS census (https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Ward_profiles/Census-2011/RB-Census2011-Ethnicity-2013-01.pdf)

Marital status	Married	Living with partner	With partner, living apart	Single	No answer
Number at recruitment	33	17	4	0	1
Number of participants	12	6	0	0	1

Table 9. Distribution of marital status among participants, at recruitment and by the end of the study.

More first-time mothers enrolled in the study than those having a second or subsequent pregnancy (Table 10), which may be due to the recruitment that took place at NUH, in that 16 of the 34 first-time parents came from this site. Interestingly, Newham also had more participants remain in the study after enrolment than the other two sites, and this might be attributed to the fact that this site had more participants than the others.

Parity	Primiparous	Multiparous*
Number at recruitment	34	21
Number of participants	12	7
*Of these parents, 17 reported previous OU birth, two previous AMU birth, one previous FMU birth, and one participant did not report previous birthplace. No previous home births were reported.		

Table 10. Distribution of parity among participants, at recruitment and by the end of the study.

My intention at the onset of this study was to recruit a group of parents that more or less represented the boroughs, so there were no exclusion criteria, save age and risk status, which would favour one demographic group over another. There are potentially several reasons for this mismatch between the group I recruited and local demographic realities. Risk designation could have demographic dimensions to it, in that women from one group are more likely to be labelled 'high-risk' than others. The English language requirement could also have skewed the demography towards British and European parents. Because the

midwives were the main gatekeepers and determined who was or was not approached, it is difficult to know who was eligible but not approached or how this affected the demographic aspects of participant group. This gatekeeping certainly affected the make-up of the Newham cohort, as many of the booking midwives initially thought the study was only open to first-time parents, which could be the main reason why the number of primiparous parents is much higher at that site than the others.

Participation, attrition and fidelity

Over the course of this study, 10 of the 55 parent who took part withdrew, and there were several reasons for this withdrawal, including miscarriage ($n = 3$), too time-consuming ($n = 3$), pregnancy complications ($n = 2$) and moving out of area ($n = 2$). Women were not withdrawn from the study if they developed complications during their pregnancy, unless they expressed their desire to withdraw for this reason, as I wanted to follow their decision-making after being designated as 'higher risk'. Unfortunately, nearly half of the parents recruited did not respond in subsequent follow-ups after enrolment (Table 11). At enrolment, parents were asked their preferred method of contact, and usually both e-mail addresses and phone numbers were provided, so I was able to contact participants several ways; however, this was not beneficial for staying in contact with them throughout the study.

	Number of women	Number of partners	Percentage (%)
Took part	19	0	35
Withdrew from study	6	4	18
No contact after enrolment	18	8	47

Table 11. Number and percentages of women and their partners who took part in the study, withdrew or could not be contacted.

Given the high rate of attrition from this study, research designs that are longitudinal in nature should consider different methods of engaging participants in the study, whether it be via apps on mobile phones

or regular face-to-face meet-ups in the community. Several women in this study used apps for information, while others mentioned the value of face-to-face contact when receiving information:

With the first I did use this birth centre app thing...I can't remember the name of it, but you could talk to people who were due around the same time as you. I found that really useful. (N04, Control, Antenatal interview)

Pregnant women place importance on social support being built into aspects of their maternity, which could be considered or even emphasised in research going forward, particularly in light of Hunter et al's finding that women in their study valued the social aspect of taking part (2018).

Of the 55 parents recruited, 29 were randomised into the control group, and 26 into the intervention group. The groups were less balanced by the end of the study, with 13 women in the control and only six in the intervention. At the close of the study in February 2019, 19 women had participated, and I collected 60 unique diary entries and conducted 11 interviews with eight women across the antenatal and postnatal periods. Aforementioned, none of the partners recruited took part in the interview, though they were invited, and I did not record reasons why they did not participate after enrolment.

Given the small intervention group, fidelity was difficult to fully access. Based on the diary and interview data, four of the six participants reported that they had at least looked at or used Which? Birth Choice, though this was usually in conjunction with other sources. One participant from the control group reported using the website in her diary entries, finding it "very insightful". I checked my records of contact with her to ensure that she was not introduced to Which? Birth Choice via the study, and she was not, meaning that she accessed the site on her own accord. Whether she found it herself, through word-of-mouth or from a midwife is hard to pinpoint, as the participant did not respond to interview requests.

Sources of information report by women

As noted in other research (Hinton, et al., 2018), the interview and diary analysis revealed that women used multiple sources of information during their pregnancy to inform their choices and help them make decisions, but those most commonly mentioned were other people, particularly HCPs, family and friends:

It's more conversations with friends, with the girls the antenatal classes, midwife, but not really profiles [websites]. I was searching about the episiotomy, that thing, but not really. (TH08, Control, Antenatal interview)

Online sources, whether they were NHS Choices or more specific websites about hypnobirthing or home birth, were the next most commonly mentioned information that women accessed; however, these are used in different ways. A website could be a supplement to discussion with friends or midwives, as the participant above mentions searching for information about episiotomies, or it may be the main source that women access to given them an idea their options:

I research about, like on the NHS website, about the other [birthplace] options...I know more now because yesterday or the day before we had our antenatal class, so we went through the whole thing. But just by searching for information my own on websites for like what was the option, so I knew I had the option. (N14, Intervention, Antenatal interview)

Personal or past experiences were also often mentioned sources of information that women used to inform their decisions about care, especially those have a second or subsequent baby:

Q: Which of these sources has been most important or most helpful so far?

A: Previous experience. If this were my first pregnancy it would be midwife and leaflets, as websites provide little information or are not updated at all. (TH13, Control, Antenatal diary entry, 23 weeks)

As the participant relates above, she counted her previous experience from her past two pregnancies as the most helpful or important source because online information was not reliable. However, first-time mothers do not have this type of experiential knowledge to draw from and might be more likely to use a midwife or NHS-produced leaflets:

I think it would be really good if she could just keep checking in each time, and she was suggesting things that you could do to prepare. She's not given me anything like, 'Oh you could read this or you could read this', this network or whatever. There's been nothing. Everything I've done has been myself. (TH17, Intervention, Antenatal interview)

While women regularly discussed the copious leaflets they received at their booking appointments and admitted to reading them in varying degrees, they usually engaged with at least a part of the information given to them by midwives. The importance of leaflets may shift over pregnancy, as new concerns (e.g. what to pack for the hospital) arise. Books were also frequently mentioned as a source for women, and may be used for more in-depth, specialised information related to a particular birth philosophy:

After visiting the birthing ward today I would like to consider a water birth with minimal pain killers. I have also been listening to a hypnobirthing audio book after a friend recommended this to me. (N21, Intervention, Antenatal diary entry, 33 weeks)

I've read the Positive Birth book, which I think it's quite a new one, which is really good and...I think that the main things that I've read, they're quite – well, hypnobirthing in general I think it's quite pro-home birth. (TH17, Intervention, Antenatal interview)

Tours, as cited by the first quote, and antenatal classes were commonly mentioned as beneficial information sources but to a much lesser extent than HCPs or midwives themselves. Most of these women attended NHS-based antenatal classes and reported positive feedback from them, while others attended NCT courses or both. One of my interlocutors found an extended social network through her antenatal classes, who she continued to meet up with, so they could share information and experiences with each other. In my analysis, I differentiated this type of social support from friends or family members because, while just as valuable, it may be confined to a specific space and time:

There was literally a deadline of the middle of July to get everything done, and maybe I have information gathering right at end. But going to group was really good because it was more verbal and at once than hours reading. (TH12, Control, Postnatal interview)

Mobile phone apps and visual information, such as videos or photos, were also sources that women used and found helpful, though not to the extent as other sources. Media, such as television, documentaries, and print, was also seldom mentioned and not in an entirely positive light, at that:

Throughout the pregnancies I've always used - there are several apps that sort of follow the week to week pregnancies, like the NHS has one, Bounty has one, Pampers has one. I would read those, just, you know, on a weekly basis to sort of entertain myself. (TH13, Control, Postnatal interview)

I think that in TV shows is probably a bit um...embellished, like some of the women in my class they watch *One Born Every Minute*, and I'm like, 'I don't watch that!' but they loved it so...no, I don't watch anything. I read articles in *The Guardian* and in *The Times* by one journalist, one woman who had an elective C-section.

(N14, Intervention, Antenatal interview)

Parents do engage with different sources, though some in a more supplementary fashion than others, and some with ambivalence. There is a sense, in the first of the quotes above, that the apps are interchangeable. Most of the women randomised into the intervention group did find Which? Birth Choice helpful, but sometimes, this was only once they had the chance to read it more closely during an interview. There were two participants who reported outside of an interview that they found the website beneficial:

I just used the recommended page called Which? Birth Choice. I found a lot of valuable information on what to consider when choosing a place of birth, what to check. I'm happy because they are comprehensive and reliable. I got the answers for many questions, I learned many things. For sure, this internet tool has a fairly large impact on the decision for birth. I found also a lot of important information for a young mother, such as breastfeeding, what to expect after childbirth, the first visit of the midwife....I am glad that there is such a tool and I will certainly use it again. (N05, Intervention, Antenatal diary entry, 23 weeks)

It is important to note that women in the intervention arm of the study were not asked in diary entry form if they specifically used Which? Birth Choice, as the same site was used for each group, so fidelity is complex to address from the diary data alone. Given that most participants used multiple information sources, it can be inferred that women in the intervention group, if they did use the website, mostly likely did so side-by-side with several others, which would make fidelity to and statistical effect of Which? Birth Choice hard – though not impossible – to surmise. In general, when the intervention is a readily available online source, fidelity to trial groups will be difficult to control. Even in this study, a small feasibility study, I made no effort to limit the control group's access to Which? Birth Choice, hence the reason that a woman from this group reported using the site. As I wrote in my ethics application (Appendix H), restricting access to a potentially beneficial source of information could be seen as unethical and, therefore, attempts to limit it should not be made.

Key outcomes for future research

Initially, I described the anticipated outcomes for a future trial; however, based on the feasibility study findings, I recommend these outcomes should be amended, and the scope of any future study be narrowed to a certain extent. Table 12 lists the former anticipated outcomes from Chapter 5 and the new recommended outcomes.

Anticipated primary outcome	Recommended primary outcome
Efficacy of Which? Birth Choice increasing informed birthplace choices, positive birth experiences and choice outcomes among women and their partners	Efficacy of Which? Birth Choice increasing informed birthplace choices
Anticipated secondary outcomes	Recommended secondary outcomes
- To what extent are key variables moderating the impact of the Which? Birth Choice website - How and why are women and their partners using other information sources on birthplace - To what extent is Which? Birth Choice impacting individuals' interactions and relationships with HCPs	- Participants' knowledge level about key items of birthplace information - Value and utility of birthplace information - Influences on participants' birthplace decisions - Participants' health behaviour (e.g. attitudes on performing behaviour, perceived barriers, uptake) - Effect of birthplace decisions (e.g. levels of satisfaction)

Table 12. Anticipated primary and secondary outcomes for a future trial versus the recommended outcomes for further research.

In developing the Birth Decisions Diary, I aimed to produce a data collection tool that took into account the anticipated outcomes and the focus on informed choice. Working from a multidimensional assessment of informed choice (Chapter 5, section Birth Decisions Diary), I tailored the questions to cover each 'dimension', in order to explore whether these could be assessed qualitatively and investigate whether the key recommended outcomes would ultimately match the anticipated ones. The assessment of informed choice focused on knowledge of birthplace options, value and utility of information, influences on decision-

making, health behaviour and effect of decisions, all of which I now argue should be considered secondary outcomes for a future study, if pursued. Each of the questions in the diary was formulated to qualitatively ‘measure’ one of these aspects, and one – ‘Do you feel like you have had enough information and discussion with your health care professional to make a choice about where to give birth?’ – was intended to provide the primary outcome. Each of these dimensions are already used as quantitative measurements of informed choice, though they have the capacity to do so qualitatively, as I employed them in my study. One of the significant differences between the anticipated and recommended outcomes is the elimination of looking at the website’s impact on parents’ interactions and relationships with HCPs, which, on reflection, could be an entirely separate study in itself. Some trials have attached qualitative studies to their design, in order to examine certain aspects of the research further, and this approach could be used in any future work to incorporate research looking at this precise question.

Given the small cohort size and disparities in numbers between the control and intervention arms, it was not advisable to run any statistical analysis on each groups’ diary responses or descriptively compare them and offer any kind of conclusion about the impact of the website and tool. However, this was not the intention of the feasibility study. Nonetheless, it is possible to look at an overview of the responses in order to explore what was generally transpiring among the women who took part in the study. The primary outcome question focused on having enough information and discussion with a HCP to make a birthplace choice, and a majority of the diary responses from both the antenatal ($n = 39$) and postnatal ($n = 4$) periods were negative (Table 13). If these frequencies are any indicator, then it can be inferred that many women did not feel like they could make an informed choice about place of birth; however, it is important to unpack the wording of this question to look at its potential effect on the responses. The fact that it included the phrase ‘discussion with your health care professional’ might negatively skew answers and obscure when an informed choice has been made despite this, as one participant wrote:

I haven’t discussed [sic] with my midwife but I have decided to give birth at the Barkantine Birthing Center instead of Whipps Cross Hospital. (WF02, Control, Antenatal diary entry, 32 weeks)

Is it possible to make an informed choice without a discussion with a midwife? Maternal health policy, NICE guidelines and concepts, such as ‘shared decision-making’, imply that is not, and that it must be made

within the view of biomedicine. For this reason, it is beneficial to explore different components of informed choice that exist outside of and are not necessarily contingent on interactions with HCPs but are still shaped by them.

Do you feel like you have had enough information and discussion with your health care professional to make a choice about where to give birth?		
Yes	No/Not yet	No answer
28%	63%	9%

Table 13. Percentages of responses to the primary outcome question for the feasibility study.

Participants' knowledge level about birthplace was explored through several questions on the diary. There was a range of responses to the first two questions in the antenatal diary entries, and, overall, women were not as concerned about the amount of information or discussion they had with an HCP earlier in their pregnancies as they were later:

Q: How much information do you feel you've had so far about birthplace?

A: Plenty, although much of it was during previous pregnancies, there still is lots of time left! So far I have received the initial information pack with numerous leaflets, the majority being a waste of paper to be [sic] honest. (TH13, Control, Antenatal diary entry, 15 weeks)

Q: Have you been able to discuss what you wanted, as much as you wanted when talking to your health care professional about where you are giving birth?

A: No, because it's been 24 weeks and I haven't even met my midwife which is ridiculous. (N09, Intervention, Antenatal diary entry, 24 weeks)

Most women reported having some discussion with and information from a midwife in the beginning of their pregnancy about place of birth, though it was often categorised early on as 'not much'. When asked if they had been given birthplace options, about half of the antenatal entries (n = 19) reported that these were offered. Knowledge about birthplace from an HCP becomes increasingly important as pregnancy goes

on, especially for first-time mothers, and the irritation or anxiety of not having this came through in the some of the entries:

One of the main reasons I've decided on the Barkantine is because I can't seem to be able to contact anyone at Whipps Cross to organise a look around of their birthing centre. I've left messages and emails but have had no response. I would feel uncomfortable going in to labour and not knowing what resources are available there for me to use. (WF02, Control, Antenatal diary entry, 32 weeks)

As I previously discussed in Chapter 3, women still rely on and trust information from HCPs, so questions related to value and utility of birthplace information usually reference them in some way. There can be other features of this, in that parity, gestation and notions of childbirth can influence the extent to which women find information useful. TH13, for instance, who was pregnant with her third child, found a majority of the leaflets given to her at booking to be "a waste of paper". Most entries acknowledged the importance of birthplace information, but, for some, it was less important to have in the beginning of pregnancy:

Q: How important is it for you to have information about place of birth at this point?

A: Not urgent yet but it's reassuring to have some information so you don't have to worry about it being an uncertainty. (WF13, Control, Antenatal diary entry, 12 weeks)

Another participant, much later in her pregnancy, also mentioned this therapeutic effect of information for managing anxiety stemming from her conceptions of birth:

Q: How important is it for you to have information about place of birth at this point?

A: Very important to manage anxiety about pre conceived [sic] ideas of birth (N21, Intervention, Antenatal diary entry, 33 weeks)

The optimal timing of birthplace information and discussion is individual, but there are hints in the antenatal entries that it could be earlier, during the 28-weeks appointment, which would be particularly helpful for primiparous parents. Two women, both first-time mothers and 27 weeks pregnant, expressed a desire for more information and discussion, so they could begin to make their decisions about birthplace. Another, 22 weeks pregnant, wrote:

I'm starting to want more information at this stage in the pregnancy. I have been relying on my own research and asking friends who have had children, so it would be nice to get some advice from the midwife or antenatal team soon. (WF13, Control, Antenatal diary entry)

Many women do their own research and get information from friends and family members, but NHS professionals and resources are also just as important – if not more important – to women's decision-making. Participants were asked in the diary which of the sources they were using at the time were the most helpful or important to them, and the entries primarily mention NHS staff and sources, whether it was HCPs, antenatal classes or leaflets. Friends and family were the next most mentioned sources of helpful or important information, meaning they are still highly valued but, perhaps, not to same extent.

A number of studies have explored influences on participants' birthplace decisions through the lens of information use. Recently, a review of how informal information sources influence on birth decision-making found that there is a 'deluge' of these sources via mainstream media that women access and use to mitigate discordant information from HCPs (Sanders & Crozier, 2018). These informal sources also have a significant impact on decision-making and contribute to redefining power dynamics between women and HCPs while simultaneously challenging pre-existing ideas about childbirth, but they are not singularly the *primary* driving forces, rather they influence as a collective mass. Moreover:

These results indicate that although informal information sources are strongly influential upon women's choices for their birth, these decisions are not made in isolation. Rather, they become woven into the pre-existing phenomenological understanding women already possess, with women's decisions developing out of embodied knowledge interacting with large amounts of pervading informal information. (Sanders & Crozier, 2018, p. 23)

The authors speculated that women created their own evidence bases through informal sources, relying less on clinical sources because they do not trust what HCPs have to give, in an effort to make women-centre decisions in the absence of women-centre care; however, my findings do not support this view. From my own review findings and based on my ethnographic data, most women still very much trust HCPs and the information that they provide about pregnancy and birth. While women could potentially be motivated to personalise and centre their decisions through informal sources in order to fill gaps in care, I

did not find evidence that women do not want to rely on or trust practitioners' information. Rather, the data illuminated that there are gaps and inconsistencies due to time pressures, different models of care across trusts, different professional ideas about pregnancy and birth, uneven training or limited knowledge about the evolving evidence base.

Exploring participants' health behaviour, which extends beyond parents' ultimate choice and into perceived barriers to information and place of birth options, can also help to clarify why they seek out the 'informal' sources. Analysis of the NHS-based study revealed two clusters of perceived barriers, one pertaining to birthplace information, the other to the birth settings themselves. The key perceived barriers to birthplace information were midwives, lack of awareness and accessibility; however, these often overlap, in that lack of awareness may be connected to midwives:

I feel that [sic] midwife have not been helpful this time around. Changes have made things more uncertain and making me anxious (N13, Control, Antenatal diary entry, 27 weeks)

Accessibility is often interwoven with interactions with HCPs, but it can also be associated with the physical design of information sources, such as leaflets, which can be unattractive and, therefore, "less appealing" to read (Figure 10):

I remember quite clearly, it was one of those leaflets but they're photocopies, not entirely straight so...which shouldn't really matter for the content, but obviously it makes it less appealing to start reading, and I remember the midwife vaguely mentioned [the Barkantine Birth Centre], but it's, I mean it's a community midwife, probably because of the fact that not many people go there in this area, she didn't really go into it. (TH13, Control, Postnatal interview)

Accessibility to clinicians is also related to profession. For instance, N04 is a medical doctor working in an NHS hospital and was able to easily access her colleagues whenever she had any questions or concerns about her second pregnancy:

I feel like I did have all of the information I needed, but then again my experience is different because of where I work. I had conversations with my colleagues about the differences between the labour ward and the birth centre, what to expect. Not everyone is able to do that. (N04, Control, Antenatal interview)



Figure 10. An example of a leaflet about birthplace choice produced by Barts Health NHS Trust.

By virtue of her profession and training in maternity services, which is required for a medical degree, she had a level of awareness and knowledge not afforded to others, in that “not everyone knows the right questions to ask or they might not ask them at all” (N04, Control, Antenatal interview). Lack of awareness can also be simply due to parents’ lives, which are filled with other priorities:

It is a really difficult...life was very busy you know. I was finishing my PhD and then I realised I've got to get a job because I have to get contracts and money to get a mortgage to get a house. Trying to prioritise and get everything in order before the baby came. I don't have time. There was literally a deadline of the middle of

July to get everything done, and maybe I have information gathering right at end. (TH12, Control, Postnatal interview)

Priorities, such as work and family, coupled with a lack of insider knowledge about how to ask questions and which ones to ask puts some parents at a disadvantage when it comes to accessing and being aware of a wide, balanced, evidence-based range of birthplace information, unless it is explicitly explained to them by HCPs within an adequate frame of time. This limited awareness of information is grafted onto awareness about birthplace options, which was the most commonly cited barrier:

You don't see it a lot for the Barkantine and I always wonder because, I don't understand why not many people in this area actually use the Barkantine, I know they don't. I mean, I'm the kind of person who reads every leaflet that the GP or the midwife gives me, I'm not sure if other people just don't read it...so maybe that's a reason that the information about the birthing centre doesn't come across to everyone? (TH13, Control, Postnatal interview)

Another barrier to birthplace options is eligibility for different services, and midwives are often the gatekeepers of this eligibility, judging risk status:

She didn't give me any information. I feel like all of the information was from the Facebook group and going to [redacted]'s house. I felt like I went to *her* [midwife] with the information, and she said how do you want your birth, what's your birth plan or something like that, and we said that we wanted a home birth. She didn't give us the option, you know. She just said, 'Oh, you're low-risk, so it's possible.' (TH12, Control, Postnatal interview)

Participants who planned a home birth revealed the ways in which the normalisation of certain settings is a barrier. As they reported, midwives default to offering either OUs or birth centres and did not provide much detailed information about home birth unless pushed by parents. Upon tracing the birthplace choices of parents in this study, I found that more than half ($n = 10$) reported that they were planning an OU birth at the beginning of their pregnancies. Six said they wanted to give birth in an AMU, one in an FMU and two at home. By the end of the study, the distribution between the OU and AMU groups had evened out; seven women reported they were planning an OU birth, while eight were planning theirs in an AMU. Only two

women planned FMU births, and another two home births. These numbers are small, but they show the general inclination towards hospital-based birth settings, that normality of place of birth is still very much skewed towards that location.

What were the effects of these birthplace choices, and were women satisfied? Given the small sample, it is difficult to say anything definitive; however, three of the four women who completed the postnatal diary entry reported that they were satisfied with where they gave birth, even if they did not achieve their initial plan. Of the six women I interviewed in the postnatal period, most reported being satisfied with their births and birth settings. Unfortunately, there were two women who experienced unsatisfactory and potentially traumatic births, but, interestingly, they did not connect these negative experiences to the specific place of birth:

So obviously we were hoping for home birth, as you know, and ended up in the delivery suite, so like that, I would say I'm quite dissatisfied with my birth, not because of the place where it was necessarily, more because of like how it all occurred. (TH17, Intervention, Postnatal interview)

Critics of birthplace choice and birth plans often argue that they raise women's expectations, leading to disappointment if they cannot enact them in actuality, such as planning a water birth at home and ending up with an assisted birth and episiotomy in the OU. For TH17, the issue was not that she gave birth in a hospital but rather the events of care that she felt led to the interventions. Even during a postnatal home visit, the midwife attending her assumed her distress was linked to her ultimate place of birth, and TH17 was left feeling like the midwife was not listening to her:

It wasn't that I was in hospital, not home. I didn't really mind in hospital...I would definitely plan another home birth, and I won't use that hospital. I don't think it's necessarily the hospital's fault, but it's just got so many bad associations for me. (TH17, Intervention, Postnatal interview)

As mentioned in Chapter 3, women planning home births often prepare themselves for transfer to the hospital and take this into account when making their decisions. For TH17, learning about hypnobirthing was important during her pregnancy because she felt it was a strategy that could be used anywhere, in any birth setting. Women appreciate being able to make birthplace choices and personalise their care around

them, even if it does not go according to plan, which may be why there are negative experiences are attached elsewhere and not on a specific setting, and levels of satisfaction were generally good.

Acceptability of the Birth Decisions Diary

Before giving the Birth Decisions Diary (the online data collection tool I created to trace decision-making and access informed choice about place of birth) to participants in the NHS-based study, I asked women in the community focus groups for feedback on the layout, design and content of the diary site, all of which was positive, though, it should be noted, that they only completed the diary once. When it was actually employed, there was limited engagement with the diary, and my interlocutors used it to record their experience to varying degrees; some completed only one entry, while others made upwards of five or six entries. Very few of the participants in this study filled in a diary entry every month when they were contacted, and only four completed the postnatal entry. Part of this feasibility study was looking at use and acceptability of an online diary, and given the wide range of engagement, this could be an issue for any future research.

There were also two sections that were not utilised at all: the birthplace information survey and the photo sharing feature. The survey was removed, as it felt redundant, given knowledge was already being explored in the diary entries, and, logistically, it was difficult to roll out at different times. While the diary site host, Edublog, provides a sleek platform with a plethora of features, it is still built for blogs rather than data collection, and its features work best if visitors are registered users or site administrators. The process to register participants as users with City, University of London, in order to give them more ownership over the site (e.g. they could have registered profiles), was lengthy and not straightforward. Women, then, were always visitors rather than users, making it difficult to time the release of the birth information survey to each individual towards the end of their pregnancies, as originally planned. Moreover, there was no engagement whatsoever with the photo sharing feature, so adding yet another form – women would have been asked to fill in three different forms at this stage of their participation – seemed like overload. As I have demonstrated in the previous section, levels of knowledge can be explored in other ways besides through a specific survey.

Though the photo sharing feature was not successful, I was still able to discuss visual information and data with the women who participated in the interviews. My interlocutors all had smart phones with cameras, and they were, often without prompting, willing to show me their pictures and apps during our conversations. Women are keenly aware of visual information and how it is presented during pregnancy, and there are certain images that work, like pictures of babies:

I mean it's funny because I've never been the typical woman who thinks babies are extremely cute and wants to touch babies all the time, but when you're pregnant and when you're going through this process, the photo of a baby always appeals. Even for me, it's funny - it's funny how your brain works. (TH13, Control, Postnatal interview)

Given how much visual content is freely available, women did not necessarily *need* to have their own photos to elicit deeper conversations. Yet, because visual information – physical or digital - is so integral to maternity experiences today, the lack of shared photos is a missed opportunity, and when a photo was shown during an interview, it added a new texture to our conversation.

While feedback about the Birth Decisions Diary was generally positive, in that it was easy to use, compatible and quick to complete, some participants felt that it would have been better if it were an app with notifications and more interactive content. Some found that the questions became repetitive after several entries:

I think it only took a few minutes to fill out when I did it. I did think that some of the questions were a bit repetitive, like if you were filling it out every month that some of them wouldn't be relevant at the beginning and might be later on. (WF01, Control, Antenatal interview)

I think I kind of did it after appointments that maybe something change in my mind or made another decision or things like that. You do it after an appointment or when you make a decision or you discover something or something in your pregnancy is not going as you thought...because if not, if you don't change your mind, you don't need to answer all the questions. (TH08, Control, Antenatal interview)

Participants appeared to be attracted by the personalisation that apps afforded, whether it was equating their foetus's size to a piece of fruit or recommending short articles that might be relevant at that stage in

pregnancy. Women could log their appointments, note when they had pain, speak to other women with similar due dates or receive notifications about when to feed their infants. Apps are, all at once, instructive, interactive, personalised and supportive. The issue of limited engagement with the Birth Decision Diary may be simply that people engage differently with online platforms than they did over 10 years ago when Burton et al (2007) published their successful electronic diary study. Most of the women I interviewed used the Birth Decisions Diary on their mobile phones, as opposed to computers, and many used at least one, if not two, apps. More and more of the digital world is being migrated into apps that are interactive and social, perhaps in response to the increasing sophistication of mobile phone technology. Unfortunately, app development for data collection was not possible, given time and financial constraints, and though the Birth Decisions Diary was user-friendly, the way in which it was accessed and the content therein was not congruent with what women were using outside of the study, perhaps limiting its appeal.

Evaluation of Which? Birth Choice

Aforementioned, the study cohort was small, so it was not appropriate to run any statistical analysis of the effect that Which? Birth Choice may have had on the intervention group, nor is it easy to tell the extent to which participants accessed the site throughout pregnancy, unless explicitly stated in the diary entries or interviews. However, it is possible to explore the data qualitatively and thematically. The focus groups provided the richest conversations about the site as they were specifically organised to discuss it, and they provided a space for women to bounce their reflections about the site off each other. While most found the site to be well-designed, easy to use and useful, there were two key issues that emerged; first, women felt that information about home birth was not communicated adequately, and second, that Which? Birth Choice was not offering anything unique compared to other sites or apps, such as Bounty. For the women in the focus groups and interviews planning a home birth, they conceived of risk differently than what was reflected in the results of the Birth Choice tool and in the explanations for why midwifery units were their 'best fit' over home. My interlocutors were often confused and surprised that, based on their responses, home birth was not the first option or a very obvious one, despite knowing the Birthplace in England study's outcomes:

TH17: So I mean I guess this is what they do have to do with it, but it feels like there's quite a lot of emphasis on that the increased risk to the baby for a first time, which I know does exist.

Cassandra: Do you think that they're depicting the statistics and the study the right way?

TH17: The way it's making me feel like...it's making me feel like I'm being irresponsible. Like you are definitely going to...what it reads is, 'First-time mothers, your baby and you'll have a problem.' I know that's not actually what it's saying, but that's what I'm taking away from it, but what I know is that, when I looked into ours last month, it's actually very tiny. It's a very tiny increase. It's like doubling a teeny tiny risk. You know it's not doubling from 3-6% or something.

Cassandra: Do you think that that would put people off if they weren't familiar?

TH17: Yeah I think if that was the first thing I read I think I would be like, 'I'm gonna do a midwife unit.' (TH17, Intervention, Antenatal interview)

Effectively, the way each 'fit' is presented and communicated may unintentionally be directing women away from home births, as well as reflecting a more biomedical view of childbirth risk related to place of birth. While conducting this research, I tried the tool myself, inputting with different responses and postcodes²⁵ and, after many iterations, found it rare to receive *just* home birth as my 'best fit'. To achieve home birth as a 'best fit', a user will have to be certain about wanting an epidural, avoiding interventions and planning for transfer. If that latter is answered as 'I don't know', then neither home birth nor an FMU will be recommended as the 'best fit', even if avoiding medical interventions is selected as 'Very important'. Research from the Birthplace in England study found that women who start their care in an AMU have higher rates of both transfer and instrumental birth than those who start their care in an FMU (Hollowell, et al., 2017), which means the tool is inclined to give some options over others, regardless of the evidence base.

Women who were planning or who had home births were critical of the tool, but they were still able to find useful and practical information about it, and one appreciated that certain information was

²⁵ I filled in the birth choice tool with a number of iterations, first using my own postcode and then two from Tower Hamlets. One of the Tower Hamlets postcodes was closer to the RLH, the other to the Barkantine Birth Centre because I was curious to explore if the 'best fit' result changed based on distance to AMUs and FMUs. The iteration using the postcode in Canary Wharf closer to the Barkantine still recommended the AMU in the RLH.

presented in a “balanced” way, compared to other sources she had read about more natural or positive birth:

TH17: I think I will actually check back to this because it says, ‘Are you thinking of having a pool? Make sure you upstairs floor is strong enough for a birth pool!’ See that's an actual thing! I was taking the mick out of [my husband] because I was like, ‘Why are you worrying about that?’ That's very funny. No, this looks decent actually, and I do trust Which?, so I probably would go for that.

Cassandra: Is it because it's a brand?

TH17: Yeah, it's the brand, and I know you gave me the flier, but I wouldn't have even thought to do it. I didn't think, ‘Oh I need to decide where to have a baby, I'll check Which? I need to see if I want to buy a new washing machine.’ ...The other thing that I've just noticed from this is really interesting is about like refusing episiotomy and stuff is that that is the same information that's in the positive birth book, but in a bit more of a sort of pragmatic way, whereas the positive birth book is like, ‘*Never have an episiotomy!*’

Cassandra: So this is a bit more measured?

TH17: It's about consent and things.

Cassandra: Is that something that's attractive to you?

TH17: It's probably more how I think. It's a bit more balanced. What's making me laugh is that it's pretty exact, like it's pretty much written in exactly the same way, but somehow the way it's presented just seems a bit more like, ‘This is an option of this.’ As opposed to, ‘This is bad!’

Cassandra: Yeah, doesn't have to say all or nothing.

TH17: Yeah that's probably more my vibe...I will actually show it to [my husband] as well. I feel like it's a bit – might appeal to him, although it is written like, ‘Can I have a caesarean?’ Something about it feels like it's quite straightforward, and less emotive will probably appeal to him as well.

Cassandra: Oh, interesting. It's sort of geared towards both partners?

TH17: Yes, but the same time it's written for me, which would make him think it less relevant. I'll see what he thinks. (TH17, Intervention, Antenatal interview)

There are a couple of prevalent points from this conversation. TH17 found the way in which Which? Birth Choice communicates the same information as her positive birth book to be more measured and accessible, a register that could be attractive to her husband, as well. The Which? ‘brand’ is well-known in the British public consciousness for its independent reviews and thus, trusted, but this is also a disadvantage, in that

expectant parent do not equate Which? to a resource of health care information. Moreover, those from another country might not have the same attitude towards Which?, like N14, who is originally from France:

N14: I didn't think it was the most reliable compared to the information I can find on the NHS website or on the hospital on the Newham website. I don't know...it looks more like...I'm sure there's very reliable information, but I don't know, it looks like a consumer website. That was my impression...Maybe if you have no clue or no idea, but because I think I had read some information before, I came back talked to a lot of my friends who got pregnant, and I kind of knew what was out there. So after, I just used the NHS and the Bounty Buddy app because I can see websites, and I've got the app and I've got the videos where they to tell you all the things...There's also a lot of kind of advertisement, maybe because they also give you some free stuff. I'm sure that they are sponsored by some of these brands, so you have to be...kind of aware of that.

Cassandra: I know they have the Bounty packs at Newham. So the midwife recommended [the Bounty Buddy app] to you?

N14: Yeah, when they give me my book, and there was the Bounty pack as well. When you go to the hospital to meet the consultant, there's always like this TV, Bounty TV, so they work together with your hospital. I think it's quite good, if the NHS let that happen. I mean it must be quite serious, but I know they are probably trying to promote some stuff. It's sponsored by somebody. (N14, Intervention, Antenatal interview)

Interestingly, though N14 did not find Which? Birth Choice to be reliable because "it looks like a consumer website", she regularly used resources produced by Bounty, a consumer website, which is not independent and gathers personal data, in order to sell products to parents. However, because Bounty is partnered with the NHS, operates within NHS spaces and is provided by NHS employees, she felt this was a more reliable source than Which? Birth Choice. Again, the trust parents place in HCPs and the medical system means that they value the information from or associated with these sources and see it as legitimate.

When I asked my interlocutors in a focus group about whether or not they would recommend the site to others, they suggested that parents should first go to NHS sources or Bounty:

Felicity: I would actually recommend that they go to antenatal classes and if they can't remember the information from that, then probably the NHS website. The information isn't bad, I was just scrolling through the pain relief. If you can't remember all the different things and the pros and cons then it could be useful to remind you.

Fiona: I mean, you can find all of this information on so many other websites.

Felicity: That's true.

Fiona: So it's not actually calling out as a 'Hi, I'm different' in a sense. There's nothing that would make me recommend this one over the Bounty one or one of the pregnancy apps that link you to a website. (Focus group, Newham)

I have already mentioned in this chapter that women are inundated with information about pregnancy and birth, to the point that it could be difficult for Which? Birth Choice to stand out against NHS Choices, Bounty and a smattering of search results from Google. Women reported that the site was easy to use and well-designed but not attention grabbing, in that there was nothing that particularly drew them in on the surface. TH17 admitted that she did not use the site at all until our interview, during which she kept finding pieces of information that were useful to her ("Oh! Birth check list. Look they've got the answers!"). Digging further into the site, even Felicity and Fiona, the harshest critics out of all of the women I spoke to, found something that piqued their interest and that they found positive:

Felicity: I actually think that's the most useful section, 'My Rights', but it talks about all of the different eventualities. I really think it shouldn't get tucked away under a section called 'My Rights' but under a section called 'Planning your birth. Be prepared for...These are questions you need to think about.' Because people might have a short simple birth plan, and they haven't thought about contingencies and what could go wrong. I just feel like people start thinking about this stuff only once they're pregnant and that might be a little bit too late, you're already a little bit a afraid, so your way of viewing things....maybe in old, traditional cultures, having children was so much more a part of life that you knew how to look after a baby and never mind pregnancy and birth. I don't know how you would thread that information through.

Fiona: Also, it's very much about people who are planning to have kids rather than just everyone.

Cassandra: If it could be framed as something you could go to before you have kids...

Felicity: But no one would.

Fiona: I mean if you are planning to have kids, this would be a great source, but if you aren't planning to have kids for two years, then you aren't going to look at it. (Focus group, Newham)

This exchange brings up who this site is for and when it is most effectively introduced and used. Felicity and Fiona identified gaps in knowledge, firstly about rights but also about maternity and parenthood before one is even pregnant. The 'My Rights' section of Which? Birth Choice was buried in the FAQs at the time of

this focus group, October 2017, and, as of September 2019, it was still nested under this heading, rather than a prominent feature.

There remains, in my view, wider potential for Which? Birth Choice if it can rearrange its perspective on risk and rights and gauge where it fits in the scope of maternity information. If NHS partnership in the vein of Bounty is achievable, it would make a beneficial companion resource, where parents can begin and be signposted to more detailed sites, as needed:

I suppose, this website is more...it's like a starting point website. You may check this one first and possibly go to look on some further websites because it's not really, I mean it shows you the names of some medical terms and what an epidural is...but you may go on to look into what an epidural is on other websites. Perhaps, there are some more midwifery websites, websites written by experienced midwives and they may go more into the details, the pros and cons of all these different interventions that are to do with birth. (Faith, Focus group, Tower Hamlets)

Importantly, if this is in the purview of Which?, accessibility for *all* parents must be considered, not just for men or non-pregnant partners, but also for women who do not speak English and for those from different cultural and religious backgrounds. In some parts of East London, nearly 10% of the population cannot speak English well or at all, and significant portions of the population do not speak English as their main language. There are also many in the area who practice Islam: 38% of the Tower Hamlets population identified as Muslim, 32% in Newham and 22% in Waltham Forest. The two women who participated in the Waltham Forest focus group were Muslim, and they brought up issues of accessibility and cultural or “lifestyle” differences when looking over Which? Birth Choice and discussing whether it could be used by HCPs in practice:

Cassandra: Do you think a website like this would helpful, if they could just say, ‘You can go on this.’

Fahmida: Yeah, I think so. Why not?

Faiza: It depends on the mum. Some will be ok to go, some mums will want attention but don't have the time. It's again about the culture. They have other priorities, taking care of children, cooking for their husband, so they don't have the time...Maybe if you have a party, an event that they can come to, make it a fun environment, they would come because it would be more of a social thing. That's the culture...

Cassandra: Make it social...do you think this would be better for mums who have other children and other priorities, like you mentioned?

Faiza: Yes, because they have other things to do. They don't know how to get information and when and when it suits them or their family because when she goes out, she has to get permission from the partner. She has to call him home from work and if he says no, then she will not be able to come out. It's a lifestyle issue.

Cassandra: So you think it's not an issue of using the information, but more of accessing it?

Fahmida: That, and not knowing they have a choice. I think women they don't realise that they have choice and it's not just you go to the hospital, you have a child and then you come home. I think women don't actually realise because of the culture clash and not understanding the language. They don't know that they could have their baby at home if they wanted like they were in their own country. If they did, maybe that would happen. (Focus group, Waltham Forest)

Many parents rely on family, friends and social networks for birthplace information, and women in this study, particularly those planning their births at home or in a midwifery unit, reported that they found birth stories beneficial when making their decision. Yet, Which? Birth Choice features few women of colour, Muslim women or partners in its site photos, videos and birth stories, and it cannot be viewed in other languages. In Chapter 2, I highlighted that UK research found women from ethnic minorities had less choice (McCourt & Pearce, 2000; Dartnall, et al., 2005), and that frameworks of 'informed' decision-making and choice are not as straightforward or equitable as they appear on the surface. As a tool and resource aimed at supporting parental choice and providing evidence-based information, the approach should be less normative and more concerned with levelling the decision-making field for those left out of choice, in rhetoric and reality. In general, decision aids can corner people into making trade-offs that are not meaningful or reflect how they actually think, such as the questions about medical interventions and transfers on the birthplace choice tool. Just because a parent does not mind medical interventions or know about planning for transfer, does not mean they should be directed to an AMU over an FMU or home. While the tool is successful to some extent in building in uncertainty, which more realistically reflects how people consider decisions, it assigns meaning to this uncertainty which has little empirical basis (e.g. women receive an AMU as their 'best fit' if they are uncertain about how planning for a transfer, even though AMUs

have a higher rate of transfer than FMUs or home). Which? Birth Choice, in some ways, subscribes to a conception of decision-making modelled on classical decision theory, imposing assumptions of linearity and fixity on a phenomenon that is dynamic and inseparable from the lived experiences of uncertainty that shape it. Breaking away from these assumptions means finding new ways to describe and analyse decision-making and choice. In the next chapter, I aim to do this through a series of 'vignettes', exploring this uncertainty, along with women's experiences with maternity services, biomedicine, motherhood and time, as I focus more deeply on the lived process of decision-making and its embodiment.

Chapter 8: Deciding where to give birth in East London

Following my reflexive account of the study setting of East London and its local health services and presentation of the feasibility study findings, I will conclude the description of my research with a deep dive into my ethnographic findings, highlighting individual accounts of deciding where to birth and what these illuminate about birthplace decision-making in pregnancy. The data presented are predominantly from 11 antenatal and postnatal interviews that I conducted between September 2018 and February 2019 with eight of my interlocutors, who were taking part in the NHS-based study. I have chosen to organise several ‘vignettes’ according to birthplace setting, rather than breaking up the data thematically, in order to highlight the *process* of decision-making and the nuances therein. For balance, I have also included an account of a women’s birth that did not go to plan, which provides insights into maternal expectations and delivery of care. There will be an initial discussion concerning biomedicine, uncertainty and good motherhood, as well as bodily and temporal dimensions of each ‘vignette’; however, these themes will be more fully developed in the discussion chapter that follows (Chapter 9).

Planning a home birth

The following interview was conducted over the phone with TH12, who I will refer to as Helen, two months after she gave birth at home to her first child. Helen was initially enrolled into the study when she lived in Tower Hamlets, but she moved to Newham before she gave birth:

“I feel lucky that I was low risk and I remained low risk. We were living on a very small boat and I wasn’t sure if it was possible to have a home birth because we were waiting to move into a house, so the birth centre was kind of like a compromise. Then, I had to have a 36-week scan to see if the baby’s head was in the right place and the placenta wasn’t in the way. He was in the right position, the placenta was not in the way, the heart rate was good. It’s good to know that for going ahead with it. And then we moved into a house...and then the next day after moving in, the community midwife came and assessed it and everything.”

Helen relied on biomedical dispensations and delineations of risk as necessary steps along the path to successfully having a home birth, which is symmetrical to the findings of research reviewed for the meta-synthesis (Chapter 3, section Performing good motherhood). We discussed how she decided to plan a home birth, particularly for her first child, which is not usually considered the ‘best fit’ for primiparous women:

“I think I was searching around...it's really kind of been in my head that I wanted a water birth. It's one of things that you think, ‘Oh that would be a really good idea.’ And then just reading the recommended literature and going on to [a] website about positive birth stories²⁶. And just thinking, ‘It's a *natural* process. Why do I need drugs? Why do I need medicines?’ I don't know! My body was made for this why should I be scared of it? It changed my mind set...I don't know it's a feeling I've always had. I've been going to meditation, Buddhist meditation practice and stuff for a few years, on and off. Just trying to kind of chill out and relax and be more mindful, just kind of listen to the body and connect the body and the mind. I don't know...it just kind of made so much more sense - as soon as I knew that it was possible, I thought, ‘Oh yes I jump at the chance’ because I didn't even know that home births were a thing, like I didn't know that I could get midwives on the NHS to come and care for me and the baby.”

Before she became pregnant, Helen already had a more corporeal orientation that she developed through meditation, and her decision to have a home birth appears intuitive, reflecting a notion of her body that had “always” been there. Choosing a birth setting and care that was closely intertwined with this notion was described in bodily and kinetic terms: “I jump at the chance.”

Getting there also unfolded through reading about birth and seeing birth stories, dispelling misconceptions about what kind of maternity care the NHS has capacities to provide and support. The misconceptions about home birth remain deep-rooted, and, within them are the idea that obstetricians hold the superior knowledge of birth over midwives. Helen told me her family thought her home birth decision “was a little bit crazy”:

“My brother and I think completely differently. He was like, ‘The doctors know what they're doing. You just take the drugs and you should have it in hospital. You're crazy. They've been to uni, they've been training for six years. They know what they're doing.’ Like, really? Using forceps and like a vacuum extractor thing, really?”

²⁶ <https://choosinghomebirth.org/>

In all of my interviews, I asked women about what was important to them personally when deciding on a birth setting. Helen told me that, among other things, her and her husband's decision to give birth at home was connected to a wider intention of "trying to question the status quo". Generally, though, she had an adverse reaction to the hospital from the few times that she went there for scans or antenatal classes, and she described this in sensorial and corporeal ways:

"When we did go to hospital for a scan or whatever, it just felt like a very chaotic environment, very stressful atmosphere. And you know, in the antenatal classes and reading about the effects of stress on birth and oxytocin and then trying to be relaxed and everything and then that affecting the progression of the birth. You just think, 'Why would I be in that situation? Why would I put myself in like a bed with loads of screaming women in the same room, you know?' I just thought that it's not for me...I realised that actually when you're surrounded by medical professionals, you almost feel like ganged up on. Because there's so many of them and little old you. You know, when you say, 'Actually I don't want that.' That's even if you have a confidence to say into their face!

"I think it's because I wanted to have a more relaxed birth...and I didn't really want to be hearing screams and having the alarm in emergency, ambulances and things. And also to have my husband to be present, rather than having visiting times. I read a lot what about when you're in hospital, you can't eat or drink. It's like being - they're a lot stricter on the labour and you're more likely to be given drugs. So I think it's just because there was a lot of rules and regulations. When you're at home, it's kind of your own environment."

I heard this perspective echoed earlier in my fieldwork from Faith who also planned a home birth during her first pregnancy and gave birth there. She shared similar apprehensions about the autonomy that would be granted in hospital settings, and was drawn to the opportunity to be in her own environment:

"I thought that I'll be really comfortable at home. I'll be able to relax, and I know when your hormones are flowing and you're much more relaxed, you're able to give birth normally and have a better experience in strong labour. First of all, you're in your own environment, so you have everything where you want it to be. You're relaxed. You can go up the stairs, you can go down the stairs, you can stand up and sit down. There's no machines. It's just like being at home, basically. You can move, do what you like. A lot of the time you'll be labouring, just with your birth partners, the people that you've chosen to be around you." (Faith, Focus group, Tower Hamlets)

The ability to move around where she wanted, how she wanted, without the pressure of HCPs, machines, rules and regulations were essential to Faith. Likewise, Helen told me about how her home environment supported her desire for an active birth and about using birth resources she received during pregnancy while she was in labour:

“I really wanted quite an active birth, so we've got a little garden, so I was kind of walking around the garden, trying to not stay still on the contractions to make it easier to alleviate the pressure of things. We did go on an active course offered free by the Barkantine centre, which was really good, even if we didn't use the Barkantine centre. I was taught by midwife Jude, whose got a website²⁷, which was really good because when the contractions got heavier, me and my husband looked at that website to remind us of how to alleviate the pressure (Figure 11). [*So you did that during labour?*] Yeah, it's YouTube videos. It's so cool. It's just a quick reminder because if you did the course a few weeks in advance, then you just forget.”

Helen and I talked about her evolving connection to her body, which had intensified since giving birth, and one which she was seeking to further along more sensorial lines, such as touch, with her next child:

“And the connection...I don't feel like I am...connected to my vagina. It sounds really weird, like you read all these things, and I feel like with the next one I actually want to put my hand down and feel the head for crowning. I feel like it's part of my anatomy that I have no idea about, like I don't feel like it is part of me. I don't know! I feel like I want to know it a bit more via a competent thinking, rather than reading a theory, actually in practice, thinking, ‘What's happening now?’ Because I love physiology in books, but actually when it comes like that part, I'm a bit squeamish, like ‘Oh my god it's the head! Oh my god what's that?!’”

We touched on perceptions ‘mess’ and ‘cleanliness’ during and after birth because there are often concerns in regard to home birth, and mess from birth is usually cited – as it will be in two of the following interviews – as a detractor from choosing it. Helen's views on messiness and body fluids had changed since planning and giving birth at home:

“I'm like - maybe I don't see it like bodily waste...I don't know. I just see it as part of...as part of what goes in, like, ‘What colour is it? Are there bits in it? Are there bits in my milk?...Someone said to me, ‘Oh it's gonna

²⁷ <https://midwifejude.com/>

be a bit messy.' I was like, 'Really?'...I would love to kind of answer people's questions about it if they say, 'Oh it's gonna be messy or what happens afterwards?'"



Figure 11. Examples of techniques to manage pain in labour as shown in YouTube videos by Midwife Jude.

There continue to be misconceptions about home births, usually about fundamental aspects of care and support, because, as a birthplace option, it remains socially contentious and is perceived as outside of

mainstream care. In order to address these issues, Helen thought that “definitely, definitely support groups, maybe website with a quick YouTube video, could help address some misconceptions about home birth and answer practical questions about it.” She previously cited the importance of learning visually and in person though YouTube and support groups as crucial for realistically planning a home birth with limited time but added that seeing different types of home birth could help people realise the possibilities of tailoring their birth to their circumstances:

“I mean home birth doesn't have to be in a pool birth, right? I've heard quite a few people kind of had that already but they didn't get a chance to use it, and they gave birth on the sofa. They could give birth *anywhere* at home, and in water, I suppose, it's less messy because all you have to do is drain the pool... [For] a lot of people, maybe it's the fear factor or maybe it's a lifestyle? But I suppose, with the birth centre, they wouldn't need to clean up, like you literally just leave the birth centre and they do everything. So I suppose you do have those two options that are different from the hospital, but you know, if you don't want the mess, then you can choose a birth centre.”

Helen's experiences demonstrate that people make decisions with and within view of their bodies, and, for some, their perspectives on bodily mess can mean the difference between choosing a midwifery unit over a home birth.

Planning an FMU birth

I conducted this postnatal interview in a café in Whitechapel with TH13, who I will refer to as Mila. She planned all three of her births at the Barkantine Birth Centre, even though she had always considered giving birth at home, which is common in the Netherlands, where she is originally from. Her husband was opposed to home birth, however, and we discussed this throughout our conversation:

“With my first child, I was like I prefer a home birth because that's my culture basically. My husband wanted a hospital because it's the safest option, and then we came across the birthing centre which is sort of an in-between, and he was comfortable with that. It was very good experience and then we went for that for number two as well. I wanted to a home birth for number three, but that was not going to happen.”

She knew about the new Tower Hamlets Homebirth team, and she spoke to them “but it was my partner who wasn't very open to it”:

“I mean I didn't have a very strong preference, so in the end I told him, ‘Fine.’ I didn't have much say. Sounds sad isn't it?” His apprehension to home birth is connected to safety and messiness. “He is a bit OCD, you see, so he wasn't looking forward to having to clean it up.”

In terms of her approach as a decision-maker, she said not much had changed since her first pregnancy, in that she usually took an active role in her care and in decision-making within her relationship, in general, but, when it came to birthplace options, she eventually compromised with her husband:

“I would say...I mean in the relationship, I am the one who makes many decisions...I'm the risk-taker as well, so when it comes to something like birth, he kind of takes the overhand a little bit, because if it's for me, I would have had number one at home, and I realised there's risks involved, of course, but he's a lot more concerned about these risks than I am, which means that compromise is always a bit to his side.”

At the time of this interview, her first child was four years-old, and I was curious to know how information provision about birthplace then compared to now, since their birth preceded the current maternal health policy provisions, the Lotus Birth Centre in the RLH and the Homebirth team. The main difference in information was:

“[A]bout home birthing because that information wasn't around, so I've seen...I'm not sure if it's a campaign, but I've seen the posters around the hospital and even the GP practice I think. I mean that helps and I think it's good for people to be aware...and leaflets, I mean usually they're photocopies, right? Maybe that's a reason that the information about the birthing centre doesn't come across to everyone? I don't know, but the posters that I saw, I even took a picture of one of those.” She scrolls through her phone. She shows me a picture of the poster for the Tower Hamlets home birth team (Figure 12).

“I mean this helps, just to be aware of it. If I hadn't been the kind of person who reads every leaflet, then I would probably not even have known about this. Because you know, the midwife mentions it to you, but you get so much information, especially when it's your first child, you get so much information in 20 minutes.”



Figure 12. An example of a leaflet produced in early 2018 for the Tower Hamlets Homebirth team, which is similar to the poster.

“When I got the first overview of all possibilities from the midwife, the Barkantine was amongst them, and this was before the birthing centre in the hospital opened, and to be very honest, if that one would have been open by the time I had my first child, it might actually be that we had chosen that one, because of my husband's preference to have doctors somewhere in the vicinity, and so I'm glad it didn't exist by then because we went to Barkantine, which was such a good experience that we went back, and Barkantine is a lot further from us than the Royal London.”

Despite coming from a culture where home birth was more normalised, Mila still framed the hospital as the “safest option” and connected home birth with risk. Where the risk is located may be in surprising areas; Mila’s husband was less concerned about distance of their home or the Barkantine from the hospital than he was about being physically in a more medicalised space, attended by doctors. This suggests that distance as a factor in decision-making about birthplace may not be conceptualised by parents in the same way as has been presented in research or hold the same meaning as it does for HCPs. This data provides further evidence that the entire discussion around risk and safety of birthplace options remains fundamentally flawed and does not reflect the evidence base. Mila relied on her lived experiences from the Netherlands to enrich her knowledge of birthplace options rather than the health system:

“I mean in the beginning I made very clear that I didn't want to have a typical hospital birth, and I also mentioned the idea of home birth at that time which wasn't really presented to us as a possibility? But I just mentioned it to him because of my, you know, just the knowledge I have from back in the Netherlands...and because of me saying home birth, you know already shifted discussion a little bit.”

With the discussion shifted, it was about “halfway” through her first pregnancy before she and her husband were able to fully decide on the Barkantine. The turning point was a hospital visit, which, like Helen, made Mila uncomfortable, and her husband finally settled into the idea of an FMU birth:

“There was one specific point during the pregnancy where I think he became okay with the birth centre, we had seen it all, he was already pretty comfortable but was still worried about the fact that there were no doctors, and then I spent a day on the labour ward because there was no room elsewhere, and it's just so clinical. I wasn't happy being there at all because I just don't like the place, and he dropped by as well, and that's when he told me, ‘Okay, birth centre is fine.’

“Second pregnancy, as soon as we found out I was pregnant, we told each other, ‘It's gonna be Barkantine again right?’ Yeah, so that was from the outset. And then with her, I tried a little bit. He was really not open to it, and I also didn't go into the...you know I didn't make...my preference wasn't that strong that I would put a lot of effort in making a case for a home birth.”

As Helen told me, having a supportive partner is essential in deciding where to give birth, particularly when planning a home birth. Partner experiences should be explored further in regard to birthplace, if maternity

care aims to become more inclusive to families. When partners' personal research about birthplace was highlighted, women often said they did so separately outside of antenatal classes and appointments, meaning that not only is birthplace information gendered but so is engagement with it. When I asked Mila whether her husband did his own research about place of birth, she said:

"I doubt it...but he's - he's one of those people who definitely doesn't read leaflets. So, if there were an app or anything, online he reads everything, but if it's leaflets he's never gonna read it... So I don't think he did the amount of research that I did." She does not think that he did any research about home birth during this past pregnancy. Mila explains that her husband is Dutch Caribbean, so he did not grow up with the same "cultural thing" that she did. He is also from a family of doctors, which she thinks helped "skew" him towards having a "medical birth". When I ask her if his family had any advice for her about birth, she shakes her head and replies, "I wouldn't listen to them."

For Mila, her satisfaction was less related to the environment, rather it was the care and the 'hands off' approach that appealed. Her retrospective account of the decisions made during her first birth highlight the bodily entanglements of control, healing and memory.

[A]ctually he Barkantine has it all...it's calm, they have all the facilities you want, there's no people walking in and out, and you have one person who takes care of you who is with you. So my third child, having done it twice before, you kind of know what's happening? And I took control myself quite a bit...and I didn't wait for midwife to advise me to do this or that. With the first one, they maybe should have...transferred me earlier²⁸? But in hindsight, I'm glad they didn't, you see. Recovery from my first child was long because of that, but at the same time, I'm glad it went this way, so it's you know, it's a bit - it's a bit double...But does it impact my satisfaction about the whole experience? No, not really. I mean, I'm realistic, rational enough to see that, you know, it's a decision that has to be made at that time, but I don't think they made a wrong decision, and it was also a bit my decision." This time the midwives stepped back and were more 'hands off', which she found "very relaxing".

She cannot name any drawbacks to the Barkantine, except that, "it's a bit too far from me." Mila laughs, "No, I'm definitely really positive about the Barkantine. I mean, they're all very knowledgeable, very experienced, the atmosphere is great, the fact they can stay longer if you want is great. What more can I say?"

²⁸ For clarity, Mila was not transferred to the RLH from the Barkantine during her first birth.

Though she initially wanted a home birth, Mila still felt like her birthplace decisions were right for her, but then she added:

“I actually regret not having pushed for a home birth, but then again, my last two birth experiences were so quick and easy, you never know. Of course something might have happened.”

In this, there is another sense of the ‘double’, of being content with a birth outcome, despite a lingering dissatisfaction that it did not take place in the most ideal of spaces, or, from another angle, of acceptance then being translated into satisfaction. One of the measures of informed choice is satisfaction with a decision, but, given how layered this can be with regard to birth, researchers should assess how appropriate it is and whether it provides the right insights about decision-making, essentially questioning whether satisfaction truly denotes an informed choice.

There was also uncertainty attached to home birth but not to other settings, even though Mila had defined views about risk and pregnancy. She had a statistics degree, so she looked “everything” up:

“[E]ven for the types of food that you're allowed to eat or not, I looked up all the statistics why you're not allowed to eat them, so I pretty much ate everything during pregnancy. Because I remember my first pregnancy, and midwife told me, ‘So you're not allowed to eat this, that or that.’ I was like, ‘So why?’ ‘No, you’re just not allowed to eat it.’ ‘But why, tell me why?’ *[Did she tell you why?]* No she had no clue. Very clearly no clue.” She ended up going checking the information she received every day. “I guess my personal takeaway for the kinds of foods you're allowed to eat is, as long as you know what you're doing, and you're aware of the risks, I mean, life is one big risk right?”

Given her interest in statistics and looking everything up, I asked her about recommendations for deciding where to give birth – had she seen anything?

“Yeah, I remember that it was very hard to find any statistical evidence about this, because every country is so different and every, everything is so localised. I personally also believe that a lot of how easy a birth goes is also impacted by how you, how you are at dealing with it mentally, so I gave up basically looking up statistics for that because it's too muddy...because I can imagine that if you go to Barkantine and you're not at all comfortable with it or you worry about the fact that there is no doctors around, then it might turn out to be less of a good experience because of your own mental worries about it...I visited the birthing centre at the Royal London, but maybe it was because it was empty still when I visited, but it didn't have the atmosphere

that the Barkantine has. Because this is a five minute drive for us, whereas the Barkantine is a 25 minute drive, so it would have made sense to go here. [Of course, but you chose the Barkantine because that was all based on...] Experience and atmosphere, yeah.”

Planned place of birth: outcomes for babies of healthy women at low risk of complications

Birth is generally very safe for women at low risk of complications and their babies. These diagrams show outcomes for babies when birth is planned in different settings. In each case, the green circles represent a baby born healthy, and the blue circles represent a baby with a poor outcome, meaning that the baby was injured, seriously ill or died during or just after birth. These outcomes are very rare amongst healthy women who are at low risk of complications, but they can happen in any birth setting. For women expecting their first baby, a poor outcome, whilst still uncommon, is more likely for planned home births.



Birth Place & You Helping you decide where to give birth 11

Figure 13. A page describing the birthplace statistics for infant outcomes from the *Birth place decisions* leaflet²⁹.

²⁹ Source: (Coxon, 2014)

Mila astutely observed that birthplace statistics were “too muddy”, seeing the problems in generating statistics about a subject that is defined locally and largely moulded by experience. In general, women were not given statistical information about place of birth, though a decision aid leaflet was produced five years ago and includes easily comprehensible, visual explanations (Figure 13) of the statistics on maternal and infant outcomes, emergency caesareans and assisted birth related to each option (Coxon, 2014). It is hard to communicate mentality and atmosphere into numbers intended to demarcate risk and safety. Affective and spatial dimensions of birth experiences, such as a focus on stress, or atmosphere as opposed to built environment, are still burgeoning areas of research about maternal health outcomes, and each deserve more attention than traditional measures, such as satisfaction, when it comes to decision-making and place of birth.

Planning an AMU birth

In Chapter 6, I wrote about the tension between opening of the RLH’s AMU, the Lotus Birth Centre, and maintaining the numbers of parents using the Barkantine Birth Centre, so I want to juxtapose Mila’s account of choosing the Barkantine with the experience of TH08, who I refer to as Lydia, another woman living in Tower Hamlets. Lydia was 38 weeks pregnant with her first child when we met, and, like Mila, she lived close to the RLH, so we met at the hospital and sat in the café area on the ground floor to conduct the interview. At this point, Lydia was planning to have a water birth in the Lotus Birth Centre, which is located on the eighth floor of the RLH, and we spoke at length about her decision to go to the Lotus centre over the OU on the sixth floor and the Barkantine:

“My midwife told me about [the AMU], then we booked antenatal classes. That’s when they informed us really about the eighth floor, about the sixth floor, about all possible options, about the Barkantine centre, as well, which we really didn’t consider because we would prefer to be with medical support, just in case. I think...I didn’t know really about the birth centre for me. The only option was to have it here for me to feel more secure about having the doctors and everything here. And then once we saw the rooms and then the antenatal classes, they explained us everything. I will now try to start in the eighth floor and then let’s see. I mean their rooms are unbelievable (Figure 14). Amazing, amazing, amazing.”

Though Lydia was planning a water birth in the Lotus, she still was not fully committed to the plan and was unsure if she wanted an epidural or not:

“I don't know...I don't know if I want the epidural. I don't know, I'm still a bit...” She pauses, “I want to leave it until the last minute. Depends on the pain, and then leave time for it. I really like to start without the epidural, try it the pool option to cope with the pain by myself.”



Figure 14. A room in the Lotus Birth Centre, an AMU located in the RLH. A poster for the Tower Hamlets Homebirth team is featured in the background³⁰.

³⁰ Source: Active Birth Pools (<https://activebirthpools.com/a-visit-to-the-lotus-birth-centre-at-the-royal-london-hospital/>)

When she first found out she was pregnant, she planned to go to the hospital and have an epidural. We talked about how this initial plan started to change and what was important in making her decision to go to the AMU over the OU:

“Have the doctors close to me, just in case. I mean some of the girls from the antenatal classes they have been in the Barkantine centre, and they told me it’s amazing as well, that they feel that it is like having the baby at home, that they really love it, but I don’t want to be...I don’t know. I don’t want to be in that moment, just I don’t know, if something happens, to have to take an ambulance. It’s just more stress for that moment, so that’s why I decided.

“You know you share with the other couples. They as well help me to make the decision. Because at the beginning, I think because I’m from Spain, and in Spain, it’s an epidural. There is no other way to have babies. I was kind of set in that idea but after the antenatal classes and after having conversation with the other couples, I’m more open-minded to have it without epidural in the birth centre...When I see that everyone here have this way, as well I saw the rooms, the environment in the birth centre as well. The midwife who gave us the antenatal classes explained us everything really well, like the steps of the labour, the possible options that you have to cope with the pain. I don’t know, I want to give it a try. In Spain, it is something that you will never consider.”

Spanish birth practices formed Lydia’s notions of how to do birth, just as Dutch practices formed Mila’s. Lydia never considered home birth, based on her desire to have the doctors “close” and her discomfort about mess, though she did not view home birth as unsafe, like Mila’s husband:

“I think I would not feel comfortable to have at home. For me, I need there to be everything clean. I think I will never feel comfortable to have it at home.’ She tells me that she’s done the birth plan with the midwife, who wrote that ‘She’s open-minded’, and I ask her if she feels like she’s made an informed choice about where to give birth, even if she’s not completely set on the Lotus or the OU. “Yeah, yeah, I think so.” She pauses, and it seems like it is hard to put into words, “No I would never...it’s what I want and where I’m gonna feel most secure to have it...Maybe nothing is gonna happen probably, but just to have the option, just to take the lift two floors down, being with the doctors close, it’s going to make me feel more secure.”

Physical closeness to obstetricians evoked feelings of security for Lydia, in the face of the perceived uncertainty of birth, while cleanliness elicited comfort. Despite her opinions about bodily mess, she did not

avoid depictions and videos of birth. In fact, she spoke at length about watching birth videos on Instagram, when our conversation shifted to the different information sources she was using:

"I'm now watching a lot of videos in Instagram, in some profiles about...I don't remember now, like labour, free labour or it's 'our labour' or 'our birth'. I think there's a profile from a woman who had at home and things like that, but I'm just watching the proper delivery, like I'm kind of obsessed. I mean I thought that maybe they were gonna make me feel more scared about the delivery, but actually, no. I mean I like to watch the videos to see - to see as well if those girls can do it, then I can do it as well. Many of them are in the water, and some of them are in the hospital, but many of them are in the pool. Or they use the pool at the beginning of their labour, with the first contractions, and then they jump into the chairs.

"I think they gave us some leaflets from the antenatal classes and some poses that might help us to cope with the pain. There are some like doing like this in chair, and I've seen some in the bed. I've watched a lot. And I've been doing yoga and some of the poses, as well."

When she first became pregnant, she was afraid of physical pain, but then "because I had a super good pregnancy, I didn't have any concerns. It's just about the labour itself, about the pain, not scared, I just feel a bit weird about it." On Instagram, she continues, "you see as well the process or what they do to cope with the pain, which persons they have, what the partner is doing to help the lady. You see what kind of support as well the midwife or the person who is helping do the delivery, what kind of...what they tell them, how they support the person...Look, I'm going to open my Instagram, so you can see." She gets her mobile phone and opens up Instagram. She scrolls through the Instagram search feed (Figure 15) and taps on a picture, "This is a clinic from Spain, as well. They have Instagram. I mean the Instagram itself it gives me the information that, I don't know, they believe I need or they believe I'm interested in."

As for the leaflets she received from the midwife, "No, of course" she has not read them all. "I go in bits, or when I'm interested, or when I remember I have a leaflet in the maternity notes, so I got for it. Of things that I don't know, for example the vitamin K is something that I never in my life heard about. In Spain, no one of my friends had that information, and here they explained to me...I was like, 'Ok, if you recommend me to do it, I will do it' About the diet at the beginning because you are a bit lost about what you can eat, what you cannot eat, what is good for you ...I think those two are the ones that you use the most because at the beginning you are a bit concerned about the diet because there are many things that you cannot eat. And in the last two weeks, you are preparing the bag and everything for the hospital."



Figure 15. An example of visual content from Instagram.

By the end of our discussion, I tell she seems relaxed and ready. She agrees, “Really relaxed. Every time that we had the scan the baby's fine, so it's been very safe...I don't know. It's because we didn't look for the baby much. We start to...you know to go for it, and it came really quick, so as well, you know, we were kind of relaxed...because everything came very easily – I didn't have even sickness at the beginning – I mean I've been feeling well since the beginning, so I'm kind of relaxed, and sometimes I feel like I have to rest, I rest.”

For Lydia, so much of her decision-making relied on seeing physical spaces and watching how others used their bodies, bodily practice and objects in the spaces around them to manage labour and cope with pain. Underpinning our discussion was how much her care decisions were mediated through her body and how

they were formed by those around her, particularly midwives and friends, and the objects, leaflets or a mobile phone, with which she interacted. Besides being embodied, decision-making about birth for Lydia, Mila and Helen required a certain level of *enskilment*, in that each was involved in learning and unlearning, physical, digital and perspectival posturing and strategic sifting and sorting through myriad information sources.

Planning an OU birth

Planning to give birth in an OU remains the most common and normalised pathway for many parents. In terms of decision-making, is there the same level of *enskilment* as there is for women choosing home or midwifery unit births? As I found, there are complex reasons why women end up planning an OU birth beyond 'what is normal', two of which are opting for a caesarean section and developing complications during pregnancy. The following interviews were conducted with N14 and N04, who will be referred to as Camille and Noor, respectively, both of whom gave birth in the OU.

I met Camille in a café in Forest Gate, Newham for both antenatal and postnatal interviews. During our first conversation, she was 36 weeks pregnant with her first child and planning an elective caesarean section at NUH. Her pregnancy had been uncomplicated, though the baby was breech at the beginning, before turning naturally:

"I was thinking that because this is an IVF baby and we had the IVF done at UCLH because we were living in Camden before, and I got pregnant before the house in Forest Gate, so I decided to change for like the closest hospital, thought it would be easier. So it was Newham. And I've got a friend who give birth the year before, and my friend, she's very picky and...she really told me, 'You should go to Newham,' and I was thinking this anyway, so I think her advice, plus the closest hospital was Newham, were the two biggest factors I think. Then when I started my pregnancy I didn't have a problem."

Camille liked "the fact that it was a big hospital and that if anything goes wrong, I have all the help and support that I need at the time, the emergency room, things like that. For example, at the birth centre in Barking, you have to be transported and things like that if you have a problem. I would...yeah, I like the hospitalization, drugs, doctors, everything is in control. I've never been attracted by having a birth at home...You know, I don't think I have any friends who have done. I've heard of people doing it, like it's kind of coming back into fashion...Honestly, it sounds like something my grandmother would do. It just shows that some people will

feel very comfortable by being in their own home and things like that, but yeah....I don't know if that's on the table for me."

For Camille, she had always envisioned her birth at a hospital, and she was sure of her choices, unlike other women who were still uncertain about their options, even at the time of their antenatal classes. However, her perspective on pregnancy was quite different, given her experience undergoing IVF:

"Yes, I think it was always like how I had imagined before getting pregnant...I was surprised because yesterday at the antenatal class, there's some woman in the groups and we all kind of are giving birth around the same time and some of them they really haven't thought of all the birth choices and options...but yes, I mean, I knew maybe because I have a long time to think about this baby. It wasn't like 'Ah I'm pregnant, what a surprise.' Maybe because of the IVF baby, I've thought more about the pregnancy."

Camille also valued having HCPs close, and the control that she imagined an elective caesarean section held over a protracted labour. The trade-off between labour and recovery times was one she was willing to make, in order to achieve a level of comfort via control of any possible uncertainties in birth. Control for Camille is slightly different than control for Helen, in that she wishes to be "under" control rather than "in" control. Being under control keeps uncertainty at bay and the body in check, while being in control entails free reign to let physiological events flow unhindered:

"I want to have the care of health care professionals around me, who know me. I think that's the main importance. Yes, and I want to be under control...I chose the C-section because I was scared because of the labour and the things that can go wrong, like you can end up being in labour for 48 hours and end up having an emergency C-section. So, I think that was for me that was the best option, and I know that recovery will be longer. Yeah I think that the care...I don't know, everything's more under control. That was important for me that everything is in control, and that's the ideal thing for me. And if I need help, I've got the professionals around me."

Stories and experiences from Camille's friends only strengthened her perception of birth as unpleasant, or even traumatic, and her feeling that control via caesarean section, though also painful, was the only way to completely avoid this:

"I think that all of my friends, and even the UK or France, there seems like there's always something that goes wrong in labour or ended up with emergency c-section or fainting. They just told me like it was horrible. They describe that it's wonderful that you have a baby, but that the whole process is the most painful experience in your life, and so that might have influenced me. I wasn't really scared about labour or natural birth, but I think that definitely led me to go, 'I'm just gonna do something more'...where there's no labour basically, and there's going to be pain but it's different a pain. I know I will have pain around my scar after and moving and things like that. It's not these uncontrollable contradiction pain that you don't know can happen."

Camille's decision-making reveals the contradictions concerning uncertainty and safety within current biomedically oriented perspectives, in that caesarean sections carry more risk, pain and morbidity, as well as entail deeper penetrations and further incisions into the bodily fabric than vaginal birth, yet she equated this procedure with security, certainty and control, as she saw these as more predictable. She framed bodily overflow in labour and birth in a generally negative way, as in the story she told me about her friend using gas and air for pain relief. When her midwife eventually told her, she had had enough:

"She was like, 'Give me my fucking gas and air!' And she broke it so there was no more gas and air for her. So, I think some woman they try to go naturally without the epidural to feel the whole experience but sometimes, it's just too painful." I mention that for some women less medicalised, more 'natural' experiences are attractive. For Camille, not at all. "I'm not attracted at all by that. As long as I have a baby, a healthy baby. I don't know if I'm proud I went through something. I don't care, I don't wanna be proud, I just want to have a baby. I just want to have a baby the easiest way for me."

We discussed how some decisions can change over the course of pregnancy, while others stick in the imagined future of birth plans. Camille was part of the intervention group but did not use Which? Birth Choice very much because:

"I already had my answers in my mind, my ideal of what I wanted in my mind, so I didn't really...it's true, though, it can completely change in the nine months. You know, I wasn't too keen on breastfeeding at the beginning. I wasn't too sure I wanted to breastfeed, and at the end, I want to breastfeed." I ask her what made her change her mind. "More like the information I received about the benefits of breastfeeding. I was seeing that everywhere. I feel like seeing images of women breastfeeding and the bonding, and I was kind of

like I want to have this experience, but I also told my husband that if it's not working, I am not gonna push it."

This conversation highlighted the importance of imagery to decision-making. Camille responded to depictions of bonding through breastfeeding, seeing a bodily connectedness that she wanted to enact and experience. This, coupled with the information of the benefits about breastfeeding, imbuing the action with sense of responsibility to do what is best for an infant, ultimately altered her decision.

Camille's experience and conception of intervention and risk were quite different to that of Noor, who planned her second birth in the OU after developing Grave's disease, an autoimmune disorder that causes hyperthyroidism, during her pregnancy. Her first baby was born in the AMU in NUH, and, as her diary entries indicated, she was hoping that her pregnancy would be deemed 'low-risk' enough for emittance to this setting again. However, she was not disappointed about going to the OU to give birth, when I spoke to her over the phone at the end of her pregnancy. As a medical doctor, she was pragmatic about biomedical care, and when it should or should not be accessed:

"I'm going to the labour ward at Newham. Pretty early on in my pregnancy I was diagnosed with Grave's disease, so I'm going to the labour ward this time, so I don't have a choice. In general, I don't think you need to go there unless it's absolutely necessary...you know, no doctors are needed unless it's absolutely necessary."

Much of her pregnancy – she reported in her diary entries that she had been diagnosed shortly after she was recruited into this study – had been focused on managing her condition, reassessing her risk status as she progressed. Grave's disease can cause a number of pregnancy and birth complications for both mother and baby. In terms of resources outside of what was recommended, Noor said she had not looked at much, relying on her medical background and her colleague contacts:

"With this one, I've been looking at more what my options are on the labour ward, and actually I've found that the decisions are harder with this one because the pregnancy is high-risk. Like, 'Is that going to be ok? Will this be ok?' But yeah, I've been talking to some colleagues in maternity, asking them about what I can get on the labour ward. I'm going to try to have as little intervention as possible, but we'll see how it goes."

Though her decision-making capacities were limited, her attitude towards interventions remained the same, and her 'high-risk' status did not change her views on their necessity. Moreover, she saw her choices as more burdensome and entangled with more uncertainty, which was not the case with her first baby. Noor had a clear vision of what she wanted during her birth and where it this was best achieved:

"For the first one, it was limiting the amount of intervention. I also didn't want a lot of pain relief and I wanted to give birth naturally if I could, but still be close to the labour ward if I needed to be transferred. But also I wanted somewhere that was peaceful because I remember from working on the labour ward that it can be quite busy there, so I didn't want to be around that...I remember it being an instant decision, really. I just had to convince my husband that it was safe.

"[Did you consider any other options, like home birth?] Definitely not home birth for my first, but I did look at the Barking, but my husband, he wanted to have the baby in the hospital, on the labour ward, so we went for the birth centre in the hospital as a compromise." He wanted her to go to the OU because "he was like, 'It's all there.' But you know, I've worked on the labour ward and I wanted to avoid interventions where I could, so we compromised and went to the birth centre."

Like Mila, Noor also compromised with her husband about her birthplace decision because he preferred the OU, citing a common reason for choosing the latter ("It's all there"). Again, there are significant differences in conceptions of safety between partners. For Noor's husband, closeness to all possible clinical and medical care and staff was equated as safe, even though the OU does not have it "all", in terms of atmosphere, social models of care, pain relief (e.g. birth pool) and built environments that facilitate different birth positions. While Noor equated confidence in care with safety, particularly since her first birth:

"It was ok, it was mostly positive. I think the only thing was though that the midwife attending me was nervous and didn't make the right call soon enough. I think she waited too long and I ended up with an episiotomy. I mean she – the midwife – kept asking me things like, 'What do you think?', like asking my opinion. I kept thinking, 'Well, I can't see what's going on down there. How should I know what the best thing to do is? You're the midwife. Just do it already!' It was just a lack of confidence on her part."

The most important aspect of making a decision about place of birth is now "confidence, definitely confidence from the staff. Decisions that are made with confidence. You know, the right decisions are being made for the baby. That's what makes me feel safe."

We planned to schedule a postnatal interview, and I told Noor that I would send her a follow-up e-mail to see how she was doing. She responded, “Yeah, if I survive it.” Thankfully, she did survive, and we were able to schedule another interview over the phone. The first question I asked her was about her experience:

“Yeah, it was great. They let me do my thing. I gave birth standing up. It was all that quick, a lot quicker than the first one. I think I was only there for a few hours before she was born. I was walking around and standing up, thinking this might be getting close and she just popped out about an hour later.”

She did try one final attempt to go to the AMU, but her colleagues in maternity told her she did not have a choice, so “once I knew I was going to the labour ward for sure, I asked about what my options were there, and you actually do have more choice than I think people realise. You know, you don’t have to be monitored and you don’t have to have an epidural, but I only got this information from chatting with my colleagues about it.

“I did have a good experience, yeah, better than expected. I thought the midwives were really great, so it went really well. You know they respected my wishes, with the pain relief and the monitoring. They didn’t try to push anything on me.” *[Do you think they were more respectful because they knew you are a doctor? There is a pause.]* “Maybe, maybe they were because of that. That’s a good point. But they were more confident than the midwife I had at the birth centre, so I’m grateful for that...I was really worried before, as I’m sure you could tell from last time. I would probably go back there again because the experience was so good. But we will see what happens.”

Noor relied on insider knowledge and easy access to medical colleagues to guide her decision-making, which was laden with uncertainty given her condition. As an HCP, she was able to bypass patient-HCP borders and scheduled timing to access this information, and she knew how to speak to her colleagues and ask them the right questions, which she acknowledged was important to improving informed choice when we discussed during her interviews. In Chapter 6, I wrote at length about the extent to which speech and conversations with HCPs can make the difference between HCP and non-HCP positioning within the NHS structure. Noor made decisions, even within the context of the OU, that gave her more bodily autonomy, and she was most likely able to preserve this because of her position as a medical doctor.

When a birth does not go to plan

Most of the women, whose accounts are shared in this chapter³¹, were satisfied with their births, which is why I want to highlight the experience of TH17, referred to as Charlotte, who planned a home birth for her first child but ended up giving birth in the hospital after she went into labour early, at 36 weeks pregnant. I conducted the following interview with her, in person, when she was 31 weeks pregnant, and we spoke about her decision to plan a home birth for her first child:

“[My friend] just said like the most natural thing was just want to stay home and be cosy. And then I was like, ‘Oh yeah obviously yeah that’s what you’d want to do.’ But when I got pregnant...so I guess I was still thinking about it but I didn’t - I thought that we’d probably compromise on the birth centre because they were called ‘home-from-home’ places and maybe my husband probably would be more comfortable with that and maybe it’s more sensible for a first-time birth. And then we went for a tour of the birth centre and the labour ward, and it was quite busy. There were loads of people, there was like a hundred people there, and they were showing you around like rooms and sort of each bit, but basically my impression was that’s not very home-from-home. It just felt like a hospital room to me, and I felt like what I was going for it’s just to be really comfortable. We didn’t feel comfortable, and we came out...I might have then said, ‘Shall we do at home?’ because [my husband] didn’t - I don’t think he’d feel comfortable there either.”

Her husband knew that she was “keen on a home birth but that I was sort of open to it another option. I think we both just wanted to make sure that we were on the same page, so if he’d been really anti-home birth then I would have said, ‘Let’s go to the midwife unit’ because I need him to be comfortable. He definitely did some home birth research before, which I didn’t know about until we came out of hospital, then he was like, ‘I’ve looked at these stats and I’m happy with these risks.’ With first-time mothers I know, there’s a slight increase in risk of something happening to the baby, but it’s very tiny, so we’re happy to take that because we’ll go to hospital if we’re concerned. Just all the way through we’ve just sort of had this caveat of, you know, if we’re given strong evidence that suggests that we shouldn’t have it at home, or I come up with anything that’s high-risk, if the baby’s breech or I go over and they want to induce, then I’ll end up going in.”

³¹ I did not conduct a postnatal interview with Lydia (TH08); however, during an e-mail exchange to organise one, she mentioned that she was due to be induced. She did not respond to subsequent follow-ups.

Charlotte focused on finding strategies that she believed could work anywhere, in any setting, such as hypnobirthing, which she nonetheless saw as “quite pro-home birth”. “Not medicalising” birth made sense to her, echoing Helen’s sentiments, down to the wording:

“That it’s just a natural thing, my body was made to do this, it knows what its doing. And you’re less likely to get that experience in hospital because you’re in a hospital, where the intervention is the norm.”

She wanted to avoid medical interventions, like forceps, and she was concerned about achieving the type of birth environment described in her hypnobirthing courses:

“They keep saying to you, ‘Oh you just have to ask for them to make the room dark and you have to *ask* for them to, you know make sure they don’t examine you, make sure they whisper and stuff.’ And that sounds like they’re gonna need a lot of reminding. I don’t know, maybe they just are nice and that’s becoming more as a norm. But I don’t trust it, and I feel like it’s something that I don’t want in my labour is having to fight about things that...things like that I would like them to do. Yeah so I feel like if we end up there, I’ll probably just get more carried away with what they do normally rather than just having to you know have the energy to disagree with somebody.

“I also think, if I was in hospital I’d be more likely - I mean I don’t know I’ve not done it yet - but yeah one the things I thought was interesting was about like on my birth plan, I put like don’t ask in terms of pain relief because if somebody says, ‘Do you want some? Do you want an epidural?’, then it does psychologically you think, ‘I must look like I’m struggling. I am struggling. I need to an epidural.’ And if I’m at home that just won’t be an option. I’ll be safer, for longer. I feel a bit hard but I’m not like completely anti, it’s not like I will refuse it in all circumstances, but I’d rather not.”

The corporeally-centred visions of fighting or being carried away by what is normal professional practice gave Charlotte’s account, like Helen’s, a more uncontrolled energy than others, and this could stem from the fact that medicalised care and biomedical risk discourse remain embedded in the public conscious, reinforced by digital spaces, such as Mumsnet, and generationally. She looked at the forum at the beginning of her pregnancy, finding it steeped in contention about birthplace and maternal responsibility, and spoke of the differences in perspectives between her parents and grandparents:

“It was quite interesting because it’s quite a lot of people being quite anti-home birth and saying it was incredibly irresponsible and then why would you take this risk and everybody had a story about something

like, 'I would have died if I'd had my baby at home, or we both would have died.' And actually that made me do more research from my experience, and it's low risk compared to their risk, and those risks exist wherever you are...Actually I found like, with the generation thing, is that I think like for the grandparent generation, it's much more common that, to have babies at home. They've been like, 'Oh, cool. That's normal,' and then I think like maybe in the 70s and 80s it was much more medicalised again, so parents' and aunts' and uncles' generation seem to be a lot more surprised."

Though Charlotte was interested in home birth, she still wanted to take what she found to be a more balanced approach to the natural birth movement, home birth information and discourse attached to each, taking issue with the term 'natural' to describe one type of birth but not another:

"I think that sometimes I found that it does go like a bit too far for me because I guess I feel like we're gonna have a home birth but we will take all the advice of medical professionals. That's why I have these caveats, so if I have an appointment next week and they're like, 'Oh you're risking something we wouldn't advise a home birth' then we definitely wouldn't. There's quite a lot of pressure to be like, 'Everyone can have a home birth', and they're not allowed to deny you having one. It's not a case of being *allowed* to have one or not, it's *your right* to have one, and even if people having twins or had a caesarean before where there's high risks. And obviously that's down to an individual to decide whether or not they have risk, but some of it feels quite pressurised and a bit cult-y.

"Because I feel like it's an informed choice rather than a [pauses] I don't know what the word would be. I think that I also am really careful because I don't want to feel like I failed if I don't have a home birth, which is why I think sort of some of the stuff, like hypnobirthing, that I can do wherever I end up that will mean it's been successful...I certainly wouldn't think that somebody who had a medicated birth had failed or was unnatural, so I think that's kind of a weird term to use anyway, like natural birth."

Charlotte appeared to oscillate between accepting biomedical framing and rejecting medicalised care, critiquing hospitals and extending the same critical eye to home birth, occupying a 'grey area' between discourses – medical and natural – both of which reiterate dichotomous structuring of systems.

Midwives typically conduct home assessments around 37 weeks of pregnancy, so she had not received the final 'go ahead' to give birth at home. Charlotte was planning to have a birth without pain relief and to avoid medical interventions; however, she had an assisted birth via ventouse and an

episiotomy. While our conversation about her decision-making about place of birth and planning a home birth provides another perspective, different than Helen's, to this experience, it is her postnatal reflections that can help to further clarify what is important to women about birth settings. Her postnatal interview also highlights the misconceptions about women's expectations about childbirth and birthplace alike:

"It really was probably the opposite in every way to what I'd hoped for. We were hospital, instead of at home. There was no pool. I was on my back my legs in stirrups. There were interventions. There was lot of people and bright lights. There was a lot of examining."

I do not push Charlotte to tell me the details of her birth, but they inevitably came up, and she shared them willingly, particularly about the end of her labour:

"I probably had the transition bit, and I don't know if it was psychological as well, that when they said, 'Oh you're fully dilated.' I think I was like, 'I'm doing it. I'm doing it. I'm managing. I've not had any pain relief. I've done this [hypnobirthing] class. And then this next bit, it's going to be quick and easy, like they said.' Then I had the transition bit, and I actually did fall asleep, I think, for few minutes. I've read about it in a the hypnobirthing bit, like I think that I was sort of changing and had a little rest, a little snooze, and it then was time to start pushing...the other thing that is weird is that, before labour, my main anxiety was something happening to the baby during labour, but when I was in it, I just had this overwhelming feeling...I was like, 'The baby is fine.' I knew he was fine, and you know, I was like, 'I don't - we didn't need this [monitoring] belt on. Can we get rid of the belt?'"

She also tells me about what her husband noticed during labour, and his reaction to seeing the effects of hypnobirthing. "He said that he noticed as new people came in, like I wasn't really aware, but he said when people came in, the contractions would slow down. And when the midwife went to get the doctor, the contractions also slowed down...and there was one point, I think someone came in and turned the lights on, and he said with that you could see it change as well. He'd been a bit like all this hypnobirthing is a bit airy-fairy and then like to see it with his own eyes, like what they said was true."

After giving birth and having a brief "moment" of skin-to-skin contact, "I was like 45 minutes of being stitched up, and all I wanted was to put my legs down because they were still in the stirrups. Everything, everything was agony, but I remember my hips and my back were uncomfortable, like I just want to put my legs down. And in the moment, you kind of don't...by then, people are wondering in and out, and I'm just lying you know naked from the waist down with my legs in stirrups."

At the end of our conversation, we talk about her after care and postnatal experiences. “There was one midwife who was pretty good, the one who came to the house. She came to check my stitches. I literally cried just lying in that position to have her look at the stitches. I felt like not from pain, just from like flashback, you know? She kind of noticed that, but I don't think anyone else noticed. Then at the midwife discharge appointment that we went to, she asked how I was feeling, and I said you know it still makes me really upset to think about it, and she was just dismissive like, ‘Oh yeah well everybody thinks they're going to do it at home and then they end up in hospital. Anyway, see you later.’ I was like you're not listening because that's not my issue. It wasn't that I was in hospital, not home. I didn't really mind in hospital. I actually really cherished the days, like the three days, when I could rest to get someone to come and tell me to eat.”

For Charlotte, the vivid bodily experiences during birth continued to echo into the postnatal period, to the point that simply positioning of her legs as they were in the stirrups caused emotional distress. It was not current pain but corporeal memory that evoked this. This interview was conducted about two months after Charlotte gave birth, and she was starting to feel better:

“I kind of realised that how much it affects me, by the fact that I talk about it so much. I have found for me it's hard because it comes with an awful lot of guilt as well, in that I've got really healthy, happy baby and actually, for a first go, mine really wasn't that traumatic. They say like, ‘That's a bog-standard birth. You had him vaginally, you didn't have any pain relief, you did well.’ And I've met so many people who've had much, much worse experiences.”

Closing thoughts

In presenting my interlocutors' accounts of their birthplace decision-making processes and their births, which are so intertwined by the postnatal period that is difficult to discuss one without the other, I hope to have further illuminated decision-making as an embodied practice and unveiled the “structuring structure” of modern, English maternity. Childbirth has long been co-opted by biomedicine and imbued with feelings uncertainty, and these continue to be upheld by HCPs and professionals alike. Inherent to the predominance of biomedicine in maternity is a separation of body and mind – or “hand and head” (Sennett, 2008) – and parents still frame themselves and their care in this way, depending on what extent they subscribe to these givens, while peripherally melding each when describing their experiences. History

begets an emphasis on good motherhood, once linked directly to the nation's body, now embedded in safety and fitness, placing onus on the mother to manage uncertainty, regardless of which setting she 'chooses'. The approach to temporality in medicine is presented as straightforward: pathways of care go in one line or other (low-risk or high-risk) and build in rationality, during which time an appointment flows linearly, efficiently to another, each designating what will happen within a given period. This, in theory, is smooth and seamless, until one steps off the path. For the women in this study, the path was winding, dipping into the past and rising into the future; sometimes there were several paths that were being woven together to form a picture of ideal care. Along the way, these paths and processes simultaneously use and implicate the body and revolve around it, becoming a kind of enskilment, in which informed choice represents its mastery. In the following chapter, I will unpack my notion of embodied practice, and deconstruct the dispositions of maternity in England, which are constituted of three key components: biomedical and obstetric 'sway', managing uncertainty and notions of good motherhood. These conceptualisations will also build towards my consideration of where informed choice sits amidst this apparatus and how it is shaped by it.

Chapter 9: Maternity, embodied practice and informed choice

The starting point of this research was asking to what extent parents make informed choices about place of birth. From there, it unspooled in several directions, regarding information and knowledge, decision-making and modern British maternity. This chapter works to assemble each strand and weave them back together, coalescing the linkages between them. The discussion will first cover decision-making, working from the experiences of my interlocutors to describe the lived, embodied phenomena of this practice, focusing on how this generated by the dispositional structure – or habitus – of maternity in England, which I argue is loosely constituted of biomedical and obstetric sway, uncertainty and concepts of good motherhood. Regardless of place of birth, these are generative principles that co-produce maternal experience in England and the phenomena interrelated to it. Finally, I revisit the notion of ‘informed choice’, examining its interconnection with embodiment and enkilment, silences – or what is unsaid – market ideology and human rights, and how these meetings and entanglements influence maternal health and place of birth in England.

Decision-making as embodied practice

An individual’s body is not *unlived* or *uninhabited*, and, by extension, decisions that flow from it are not uninhabited either. While definitions of informed choice and decision-making attempt to account for lived experiences under an umbrella term, ‘values’, what these are and how they are constituted or embodied are not fully considered. A woman can value safety, responsibility and control and choose to give birth in either a hospital or at home, yet researchers, policymakers, and HCPs all want to know *why* this bifurcation occurs, in an effort to change the way in which it does. Getting to this split means finding the very origin of when a choice becomes a decision, identifying what nudged an individual down a specific path and distilling this microscopic experience into simpler terms before scaling it up into information provision strategies, models of care and public health policy. Initially, I concerned myself with why a decision is made and when

it is actualised, but I eventually became convinced that this is nearly impossible to answer in a cohesive and meaningful way; it was more effective to consider *how* a decision is made, paying attention to procession and history, through which I could unfold the practices that the habitus of maternity is layered within. Rather than beginning with habitus, my discussion starts first with the “cluster of individuals” who took part in this research and their experiences in an “attempt to unravel the *total* social structuring of the phenomenology of everyday life and their dispositions as an ensemble” (Atkinson, 2016, p. 14). My discussion will also focus on decision-making as a process of enskilment that is indicative of it as an embodied practice, involving “skilled visions³²” (Grasseni, 2004) and assemblages of disparate information and media sources, which are learned before and during pregnancy. Along this line, my thoughts converge with sensorial anthropology, as much of decision-making implicates what is *seen*, as well as what is *felt*. This sub-field of work is helpful because “what has been thought and written in terms of the senses is necessarily embedded in real-life practices of looking, listening and feeling” (Ingold, 2011b, p. 316).

Bourdieu’s theory of practice pays attention to unconscious and mundane actions that reflect the “structuring structure” of habitus (1977), and it endeavours to conceive of the body as more than a representation or a conduit of communication. Our choices and patterns of body use are unconsciously generated through this habitus. For many parents, their habitus, as it pertains to maternity, is made up of dispositions towards the authority of biomedical care, managing uncertainty in childbirth, and maternal responsibility to ensure that one’s body is safe and informed. There are, however, spaces in Bourdieu’s theory of practice, in that the “social agent”, the individual, is decentralised, relegated as unimportant compared to social spaces and habitus; this cannot be ignored because it has implications for how we fundamentally conceive decision-making as a phenomenon. Working back to individual rather than focusing on people in their totality renders decision-making less teleological, in that I focus on conditions from which it arises, as opposed to the purpose that it serves. My findings chapters have presented layered intentionalities of my interlocutors and how they consider, often unknowingly, the location and movement of the self, other people and objects within bodily and designed space, and also incorporated histories and social networks. For instance, Camille’s descriptions of wanting the doctors “close” or Lydia watching

³² The ‘skilled visions’ approach states that “the making, exchange and manipulation of focusing media plays a fundamental part in the ecology of everyday vision and even of imagination” (Grasseni, 2004, p. 44).

labouring women on Instagram and how they use their bodies, the space and the objects around them in a midwifery unit were important during their decision-making.

Women planning home births were equally hyper-aware of how spaces and the people moving and working in them would have an impact on them, corporeally and affectively, especially their core intention to allow their bodies do what they were 'made to do'. Helen, Charlotte, Faith and Felicity intuited that less medicalisation during pregnancy and birth made sense, emphasising the body schema of birth that "rises into consciousness charged with a relation to something that has happened before" (Head, 1926, p. 435). Charlotte even spoke of "being cosy", recalling Walsh's concept of 'matrescence', in which protective and somewhat primordial "nesting" behaviour takes women through the liminal experience of maternal becoming (2006). Helen and Faith each discussed the importance of being able to move where they wanted, eat and drink when they were hungry and thirsty and surround themselves with whoever they wanted and chose to be there. There was always concern of being codified into the hospital's system of time, movement and attitudes, which could happen regardless of determination to avoid this. However, moving away from these normalised thoughts and actions of pregnancy and birth involved "pedagogical work" (Wacquant, 2011) into how birth was done that straddled perspectival, physical, material, informational and social boundaries. Women often spoke of how home birth first resonated with them ("it's a feeling I've always had") and then built up their knowledge of it through reading, speaking to other parents, watching videos of birth positions, buying a birth pool and collecting practical information about them from disparate sources. This is not to say that this work is not performed by women deciding to give birth in the OU, but, given the misconceptions about home birth, the limited information from HCPs and the very recent additions of specialty teams in Barts Health, women planning birth at home must do "extra identity work" (Coxon, 2011, p. 49) and must be far more skilled in their information gathering and decision-making, in order to confront biomedical assumptions, socially constructed uncertainty and moral economies of motherhood (Viisainen, 2000). These are attached to any birthplace decision; however, some choices flow against or away from them, while others enact and reinforce them.

Interestingly, Mila, who comes from a country where home birth is culturally embedded and historically normalised, approached place of birth with this "identity work" already set and then had to move back from it, in order to compromise with her husband. Our conversation about the differences

between her and her husband's perspectives on birth settings revealed the patterns of differences in relations to time-space and which distances matter. For Mila, distance from the hospital, from HCPs seeking to intrude into her birth-space and from a transfer or medical intervention – arguably entities rather than events – contributed to her decisions, as well as to how she perceived the atmospheres of birth settings. She spoke of her ideal and lived care in sensorial terms, wanting to feel calm and to have “hands off”, which allowed her to take control of herself, using the ‘breaking away’ metaphor that women planning home birth often employ when discussing their decisions. For her husband, being inside the physical boundaries of clinical spaces, even if they were further away from the hospital – the nexus of safety – was crucial, though this view is not reflected in evidence and presents a contradiction. This was not the only contradiction presented, in that Mila positioned home birth, not the OU, as an uncertainly risky setting, despite coming from a culture where it is normalised and having knowledge of birthplace research, thus reinforcing the socio-cultural endorsement of hospital birth (Coxon, 2011). In her experiences, there were multiple framings that rubbed against one another, particularly feeling satisfied with her Barkantine births but harbouring regret over the missed opportunity of a home birth. Mila also described how we come to embody our decisions, making corporeal and affective trade-offs that render experience “double”, which was highlighted when her midwives chose not to transfer her during her first birth. She was satisfied with her first FMU birth and the decision against transfer, despite having what she perceived as a longer recovery time postnatally than what she expected to experience had she been transferred.

Her thoughts on information sources shed light into how individuals are sensitive and take in the tactile world and everyday objects within it, in that the visual presentation of leaflets and posters influences what parents reach out to, see and read, or ignore and discard. On surface, these may appear to be mundane actions, but they are indicative of what position an individual is taking up, how they are moving through their social and phenomenal spaces and where their horizons – or habitus – are being constituted and situated. These small embodied practices build what comes into focus and what fades into the background, and this displays the tension between perceiving and awareness. For Merleau-Ponty, perceiving could be ambiguous, but awareness suggests a deeper understanding, more concretely formed; however, awareness, like ‘being informed’, is only the genesis of skilled decision work. As Mila described, she read every leaflet, took tours of midwifery units and meticulously pored through statistical evidence

related to maternal health recommendations, without which her awareness of the home birth team in Tower Hamlets would have been buried under all of the other information from her midwives. Additionally, this enskilment is gendered, in that Mila did more pedagogical work than her husband, managing uncertainty and delineating what was important information for decision-making, which is expressive of the extent to which social responsibility in pregnancy and birth is weighted toward mothers.

This 'good motherhood' is layered throughout the embodied practice of decision-making about birthplace. In Lydia's case, her decision-making heavily relied on seeing physical spaces and watching how others used their bodies, bodily practice and objects in the spaces around them to manage labour and cope with pain. My interview with her was imbued with how much her care decisions were mediated through her body and how they were formed by those around her, particularly midwives and friends, and the objects, leaflets or a mobile phone, with which she interacted. There is reading leaflets or not reading leaflets, touring birth centres or talking to the girls from the antenatal classes, scrolling, tapping, watching, taking vitamin K pills, doing yoga for back pain and packing a hospital bag. Lydia was at ease because there were bodily signals, such as no morning sickness or quick conception, that her pregnancy was uncomplicated, but more importantly, because all of her scans told her that the baby was fine, that her body was 'low-risk,' it was acceptable to feel relaxed and to consider a non-OU birth. Reading the leaflets, attending antenatal classes and appointments, following regimens when prescribed are just some of the ways that good motherhood is expressed. In choosing to give birth in the AMU over the FMU, she reflected the inclinations towards uncertainty and her maternal responsibility to manage it through her body, as she said, "I don't want to be...I don't know. I don't want to be in that moment, just I don't know, if something happens, to have to take an ambulance. It's just more stress for that moment, so that's why I decided." Merleau-Ponty emphasised the indeterminacy and richness of perception, in that perceptual experiences can be indeterminate, given that they are located in social and phenomenal field that is ambiguous domain (2012 [1945]). When I asked Lydia whether or not she felt she made an informed choice about birthplace, she had trouble articulating her answer at first, ultimately talking about feelings of security. Her motivation towards a specific birth setting and how it resonates as an 'informed choice' – as it is understood socially and culturally – are indeterminate, and suggests the real, lived conceptions of it are far more affective than rational theories of choice make it out to be.

If researchers aim to focus on the totality of maternity experience, we need to be aware of the affective modalities within it and move away from seeing the maternal body as object like any others, something that is passive and simply receives care. Following Merleau-Ponty, women's bodies, our bodies and all bodies should be seen as affective, as well as experienced objects, which distinguishes them from other external things. This 'lived body' is interwoven with perception, in that things that are perceived are always done so in reference to the body, as Lydia said, "to see as well if those girls can do it, then I can do it as well". While there is a structuring structure of dispositions about biomedicine, uncertainty and maternal responsibility generating birthplace decision-making, there is also a lived, affective body-subject – an individual – at the centre, which has intentionality towards one setting over another. After all, Merleau-Ponty said that the body is a "dynamic synthesis of intentionalities" (2012 [1945]). There is fluidity, multiplicity or even ambiguity in our intentionalities – for Lydia, there is fluidity between settings, information sources, and other people, a multiplicity in her birthplace choice that is not fully grounded in either the AMU or the OU, and an ambiguity when speaking about the extent to which her choice was informed. Instead of speaking of choice in a rationalised, disembodied way, she expressed it affectively and bodily. Each of these are perceived and taken into the decision-making process; the vivid bodily experiences of birth were electrifying for some, such as Felicity and Helen, and off-putting for others, like Camille, who bulked at the stories of her friends enduring a 48-hour labour or breaking a gas and air machine.

For Camille, her decisions about pregnancy took on a temporality that was less fully articulated in other participants' experiences, which revolved through the history of pursuing IVF down the defined line of having a successful pregnancy. Decisions about her birth were imagined and considered across wider spans of time, taking on conative potency, which is one of the reasons why she did not perceive Which? Birth Choice not as relevant for her, as she had "my answers in my mind, my ideal of what I wanted in my mind". This recalls the dialectic between spaces, action, habituation and bodies, in that habits are incorporated into "the bulk of the body itself", and spatial existence is expressed through movement and engagement with particular goals (Merleau-Ponty, 2012 [1945]; Langer, 1989, p. 48). Decisions, like habits, are embedded in the body, long before they are expressed through movement towards and within a particular birth setting, and this is evident in how their related actions (reading, looking, scrolling, watching) turn in one direction over another. Defined orientation and positioning in one direction – in this case,

elective caesarean in the OU – does not equate to similarly rendered intentionality in another sphere, which Camille was, simultaneously aware of and shocked by. She recognised that her own decisions about breastfeeding had shifted during her pregnancy, after encountering images and videos, highlighting the positive corporeal dimensions of it all around her, but was shocked when women from her antenatal class were in a position of experiencing the feeling of indeterminacy about their birth choices that she had similarly experienced vis-à-vis breastfeeding.

Camille's decision to undergo an elective caesarean section was underpinned, in part, by avoiding an overflow of bodily experience during labour and birth, though this choice is replete with contradiction, if one views a caesarean section as an exceptional procedure that involves extreme, fleshy intervention inherent to surgeries of any kind. In other words, caesarean sections are just as excessive to the body as long labours, contraction pain and vaginal birth but from a different direction. Her plans equally stemmed from uncertainty, entwined with this negative overflow, and marked an attempt to manage it across several lines, including length of labour and type of pain. Camille wanted to control of when, where and how corporeal intrusions, such as cutting and pain, would take place. Uncertainty is not limited to the events and outcomes of birth but also entails intrusions and interventions during labour. Women embody these uncertainties in several ways through preparation and practice: positioning themselves close to obstetricians, removing their care from the hospital setting all together, going to appointments and undergoing screening tests, such as ultrasound scans, to confirm and maintain a 'low-risk' status, writing birth plans and listening to birth stories. The uncertainty of childbirth is steeped in most parents' experiences, and it can result in a fatalistic perspective that runs counter to the overwhelming safety of maternity services in England. "There's always something that goes wrong," as Camille stated. Even Noor, a medical doctor by profession, was unsure of whether she would survive her second birth, given her Grave's disease. For much of her pregnancy, she oscillated between managing her condition, attempting to gain admittance to the AMU and carving out a small space in her care where she was afforded choices and bodily autonomy.

Considering these layered experiences, I want to turn now towards the importance of bodily spatiality and temporality within the embodied practices of decision-making. Charlotte's narrative illustrates the ways in which we relate and live through time-space, through her initial engagement,

disengagement and, finally, re-engagement with medicalised settings and care. She discussed her first visit to the hospital as busy, with “a hundred people there”, and being shown rooms (in an AMU) that she perceived to be more medicalised than home-like. Reactions to the spaces and the people therein were affective – as opposed to emotional – in that the hospital caused discomfort, rather than fear, and home inspired ‘cosiness’, rather than contentment. These affections were connected to how and in what atmosphere Charlotte, as well as Helen, Faith and Mila, intended to move toward the goal of giving birth, that is in a calm setting and in their own time, unencumbered by one room, one bed and a monitoring belt. Charlotte appeared to be aware of how spatial conditions would affect her intentions, speaking of how she would internalise the offer of an epidural as a reflection of her struggle to cope with labour pain or of getting “carried away” rather than “fighting” for space and care on her own terms in the hospital. Drawing from a well of friends’ stories, generational experiences and inherent biological schema, the tempo of Charlotte’s decision-making dipped in and out of past, present and future, with little NHS time grafted on to it, save the scheduling of routine appointments. This tempo completely changed in her postnatal interview, taking on that of the hospital, as she recounted the events of her birth through minutes and examinations. This “clockwork narrative” of birth is embedded in the “ontological logic of biomedical norms and measurements in which birth is a measurable and linear physiological process” (Chadwick, 2018, p. 51). However, this tempo sometimes stretched into sensations that were unconscious of time, hand-in-hand with moments of intense, embodied experiences during labour, for instance “knowing” her baby was safe or falling asleep in preparation to push. Charlotte’s birth highlights the way in which we take spatiality – or the space surrounding us and our awareness of it – into ourselves, how we are intrinsically connected to it, and how it is lived through our bodies, and this is evidenced most strongly when her husband witnessed her contractions slowing down as someone entered the room or turned on the lights.

What I hope to demonstrate is that decision-making is embodied, as well as relational, multiple and temporal. It varies woman to woman, over the course of and between pregnancies, and should not be misconstrued as resting on fixed views, but rather on ones that are emblematic of how parents are interpreting and reifying their experiences and knowledge at that particular moment in their lives. It is not sufficient to focus solely on the psychology of choice, or just the influence of socio-cultural norms on decision-making. By focusing on lived experiences and bodily actions, thoughts and desires as elemental in

these relationships, we can begin to dig into what, in turn, constitutes them and how they may come to be constrained or denied. Seeing decision-making as practice, one that is built up through bodies, time-space and intentionality, reorients the phenomenon as relational and multiple, in that it is defined by women's relations to objects, people and entities within social spaces, and it is shaped – and in turn women's bodies are shaped – by multiple socio-cultural forces, corporeal energies, positionalities, histories and intentions that overlap and mingle and centre on the individual. Furthermore, this conceptual reorientation reveals decision-making as temporal, in the sense that it is a process, rather than a point fixed in time, which rationalist approaches to decision theory rest on. What I find when unearthing the sediment of embodied practices, unfolding the layers of “pedagogical work”, is that the habitus of modern English maternity is constituted by biomedicine and obstetrics, uncertainty and notions of good motherhood, in that parents' actions and dispositions are generated by and continuously reinforcing these principles.

Dispositions of modern English maternity

Biomedical and obstetric sway

There has been substantial research into the role of biomedical frameworks and obstetric praxis in maternity and birth, and this begs the question of why I chose to include it in my discussion. The short answer is that it still matters because its powerful influence endures. Lazarus (1988; 1994) wrote on the interchange between women, control and biomedicine in the 1980s and 90s, describing that, while women often took on the responsibility of birth and their care, they often had very little influence over what happened to them medically. As she pointed out, it was crucial focus on how the authority of biomedicine constrains women's choices about their care, and over 30 years later, this persists. This sway, as is continually demonstrated in maternal health literature and in my own research, directs and structures talk about and movement of the body, which situates women in systems of care that historically have infringed on corporeal boundaries and diminished bodily autonomy. The most explicit way that biomedicine constrains choice about place of birth is through risk concepts and status, but there are many others that do not draw as much attention either because they are taken for granted or because they are obfuscated by normalised practice.

I describe the presence of biomedicine and obstetrics in maternity as ‘sway’ because it actuates thoughts, actions, perspectives and feelings across professional, social, physical and temporal boundaries. Obstetricians are still seen as more knowledgeable than midwives, and their practice more skilled and technologically sophisticated, which is reinforced through subtle actions, such as the RCOG’s approach to place of birth. Their public statements concerning it regularly highlight the inappropriateness of home birth or the high rate of transfers from midwifery-led care for first-time mothers, even though a recent systematic review demonstrated that “risk of perinatal or neonatal mortality was not different when birth was intended at home or in hospital” (Hutton, et al., 2019, p. 1). The RCOG also supported the call for more research into the long-term disability associated with birth settings, after an incendiary article in the *Journal of Medical Ethics* argued obstetricians and parents have ethical obligation to minimise long-term risk by not offering home birth when “there are safe and compassionate hospital-based alternatives” (RCOG, 2013; de Crespigny & Savulescu, 2014, p. 811; RCOG, 2014). The College did not take a strong stance against the article that cites research that is methodologically problematic (De Vries & Buitendijk, 2012), instead calling it an “interesting perspective”, and, as I emphasised in Chapter 6, doing little to support non-hospital settings effectively maligns them and works against any burgeoning positive visibility. The RCOG and RCM’s united stance on birthplace choice and support of the Birthplace in England study is cosmetic, penetrating professional and academic circles without attending to the misconceptions on the ground among parents, journalists and public or critiquing the lopsided local services, in which AMUs (safely inside the hospital) are promoted as beneficial, ‘home-from-home’ settings, but FMUs are portrayed as frivolous and expensive or seen as unsecure or non-viable options by the public, parents and HCPs alike (Rayment, et al., 2019).

My ‘embodied analysis’ (Chadwick, 2017) was fixed not just on the corporeal modalities of decision-making but also the temporality that is inherent therein. Biomedical and obstetric sway as a condition of modern English maternal habitus becomes more apparent as we peel back the layers of systems, discourse and experience to just the body and time. In many ways, I demonstrated how biomedical and obstetric sway is incorporated in the bulk of women’s bodies, whether it was Charlotte’s contractions slowing down when a HCP walked into her room or Faith discussing “taking on” the rules of the hospital and becoming “someone else’s”, in the sense of belonging to them. The women in my study who planned their births at home or in an FMU commonly described feeling like medical spaces and entities were

imposing upon them physically. Moreover, physical closeness to HCPs and distance from hospital settings engendered a range of affections, in the realm of uncertainty: security, fear, alienation, calm, inundation. Becoming “someone else’s”, sucked along with the “course of things”, for some of my interlocutors, meant there was less space and time to move in and through, indicating the hold that biomedical and obstetric sway has on physical and temporal bounds. To move wherever, however and whenever, women had to place themselves at the very periphery of NHS tempo, within their own homes, or slightly nearer, within the FMU. NHS tempo dominates all maternal pathways that exist and unfold under its purview, in that it delegates due dates and appointment dates and timings, as well as *when* birthplace choices are scheduled and formally discussed.

It could be argued that ‘medical’ and ‘natural’ birth philosophies are each, in their own way, forms of authoritative knowledge, in that both are co-constructed by families, HCPs and the public, each vying to be the knowledge that ‘counts’ in childbirth, and each being generated and perpetuated as the story that makes sense and, thus, guiding care decisions (Jordan, 1993). However, this is a false binary, in that both birth ‘philosophies’ are biomedical in some shape or form. They exist within a biomedical system and are constituted by and build upon biomedical knowledge, and, therefore, are disposed to biomedical sway. This is reflected in Davis Floyd’s research (1994) among American women that found some choosing home birth do not necessarily reject the biomedical paradigm. Unless a woman chooses to free birth and outright rejects *all* clinical and medicalised care, pregnancy care and birth, regardless of setting, incorporates biomedicine, through scans, appointments, modern midwifery and obstetric practice, medical definitions of risk, NHS time and mind-body dualism. Researchers have a tendency to generate and perpetuate a dichotomy of birth philosophies, as I highlighted in Chapter 3; however, these ‘philosophies’ fall along a continuum between highly-medicalised care and less-medicalised care. Biomedical and obstetric approaches are not always deleterious. It is possible to maintain bodily autonomy and integrity, while receiving more medicalised care in a hospital setting, just as it is possible to be a ‘good mother’ regardless of the care options chosen. However, parents use biomedical knowledge to delineate what is right and what is wrong, what is secure and what is uncertain, which is often expressed as being in the hospital and not being in the hospital.

Historically, obstetricians came to hold a place of assumed professional authority over GPs and midwives, and, within collective, social memory, have always held this space, though this is easily deconstructed generationally, as Charlotte demonstrated. Stepping away from the obstetric sway and choosing a 'countercultural' birthplace was often framed as "questioning the status quo" and viewed as controversial, even illegal, though enacting these options is generated by and subject to the same conditional matrix as other mainstream settings. The parents planning or supporting hospital-based births cannot fully articulate their security; it simply is that way and exists along the line of closeness to medical objects and people, and perhaps, this is because explicit articulations of security are not expected, as the hospital's safety is normative and, therefore, self-evident. Obstetric sway makes the habitus of English maternity replete with contradictions, in that birth is seen to be most efficiently and safely managed by doctors, although research and maternal experiences state otherwise, and the risk discourse emanating from it excludes the hospital and their praxis, though unnecessary interventions pose both short- and long-term health risks to mothers and their children (Sandall, et al., 2018). Rarely on mainstream platforms or in academic journals is choosing hospital-based birth posed as a potential ethical and *moral* failing on the part of doctors and parents.

In many ways, biomedical and obstetric sway are still constrictive, despite the emergence of evidence which challenges their dominance. Not supporting all birth choices equally, holding on to authoritative positions as the 'safest' care providers, centring maternity around the OU rather than within the community, establishing guidelines on birthplace eligibility as protocols and avoiding reflexive or critical exploration of medical intervention and caesarean section rates and necessity are all mechanisms through which women's choice can become restricted, either directly or unknowingly. These sways, once explicit, have been reconfigured in policy, academic, social and corporeal levels as omnipresent forces that continue to orient parents towards facility-based births. There may be shifts in professional bodies from supporting and enacting exclusively hospital births to promoting more choice in place of birth, but this choice is only appropriate when women are 'best fit' to it, a fitness that remains defined by obstetricians. Nonetheless, habitus is malleable, given the conative components that constitute it, and, as such, contradictions to this leverage of power create opportunities for unforeseen and exigent practices to emerge, and function to re-constitute its components. Through the patterning of perspectives on the appropriate role of

biomedicine and obstetrics in birth, we see how habitus is “driven by internal contradiction and division” with “critical moments...of discordance” that produce these challenging practices (Bourdieu, 2000 [1997], pp. 160, 162). Choosing to free birth is a vital instance of this, but there are others that unfold in more medicalised settings through midwifery-led care. Walsh (2007) found that FMUs, as contested spaces, confront biomedical discourse and parent-practitioner relations, to the benefit of midwives and mothers, and, in the US, Cheyney (2008) described home birth as a “system-challenging praxis”. Given that the dispositional sets of our world are flexible and transmissible, then each could, theoretically, be transformed to be less constrictive and less dominant; however, as a generative principle, biomedicine and obstetric sway continues to be on the horizon of maternal health in England.

Uncertainty

Uncertainty, as I define and discuss it, encompasses feelings of insecurity, fear, risk and anxiety about pregnancy and childbirth. Though biomedical and obstetric sway are “not necessarily adapted...or necessarily coherent” (Bourdieu, 2000 [1997], p. 160) components of English maternity, uncertainty is always adapted by parents in some shape or form or action. In my discussion of the meta-synthesis findings, I highlighted that decision-making and informed choice are moderated by a sense of uncertainty, which was enacted and managed primarily through information gathering and balancing aspects of choices. Some of my key remaining questions after the systematic review were about uncertainty, and whether it continues to operate across maternity experiences, given the advancements in health care: whether it is still dispersed within parental and clinical actions and positions. Despite the consistently low maternal and infant mortality rate in England and the positive findings from the Birthplace in England study (2011), women, particularly those in the UK, are still uncertain about the safety of giving birth, whether it be in the hospital or at home. Pervasiveness of uncertainty in maternal health renders it a powerful condition dictating care decisions, informing choices and underpinning actions and feelings related to maternal health. At the core, there is physiological uncertainty of an undefined *something* happening to the baby or the mother during labour and birth. This ‘something’ takes many shapes, often an adverse event or an intervention, but it is ever-present and conditions where women place themselves in labour and for birth, who they gather around them and what objects they choose to use or not use in their spaces.

As several women pointed out, there is uncertainty in everything, in all everyday activities, from eating food to crossing the street; however, these mundane activities are rarely inflamed by such a strong risk discourse that it is pervasive across a diversity of experiences. Douglas, whose work in *Purity and Danger* provided a significant insight into risk, wrote on these delineations, between danger and risk: “Dangers are manifold and omnipresent. Action would be paralysed if individuals attended to all of them; anxiety has to be selective...Arguments about risk are highly charged, morally and politically. Naming a risk amounts to an accusation” (Douglas, 2002, p. xix). Socially, politically and historically charged with insecurity, decision-making related to maternity and birth is then anything but mundane, though it usually entails reading, looking, scrolling and talking. Even eating and drinking while pregnant becomes an obstacle course of risk. Likewise, the biomedical designations of eligibility for different birthplace settings are delineated by risk; a woman is either ‘low-risk’ or ‘high-risk’, never in-between risk or without risk, which saturates the experience of pregnancy and birth with precariousness from the initial booking appointment, and reflects the binary thinking that is heavily embedded in maternal health. For Douglas, logics of risk are formed by symbolic systems and expressed through systems of classifications, such as the low-risk/high-risk designations used in health care; however, her cultural theory of risk is grounded more in underlying social processes and semiotic structures, as opposed to the role of the individual (Alaszewski, 2015).

There are limitations in Douglas’s structuralist approach that defined modern anthropology and how it reflected on fundamental issues in human existence. In traditional accounts of exchange and gifting, which I touched on in Chapter 4, where individuals deal with many uncertainties, their active roles in managing these is swept back to emphasise the structure of exchange, extracting it from time (Alaszewski, 2015). Bourdieu was critical of practice and structures removed from time, in that “the ‘automatic laws’ of the cycle of reciprocity are the unconscious principle of the obligation to give, the obligation to return a gift and the obligation to receive...the analyst reduces agents to status of automata” (Bourdieu, 1990, p. 98). He was interested in the intervals between gifting and counter-gifting, in which uncertainty was “constant”, particularly in routine, ordinary or seemingly improvised exchanges, giving them both “charm” and “social efficiency” (Bourdieu, 1990, p. 99). As I have already established, individuals not only live within systems of tempo but are also temporalised through existing, and decision-making is indicative of this temporality because we make sense of and account for the past and plan for the future. Constructivist and

structuralist approaches to exchange, whether it be exchange of information or gifts, are predicated on cycles of interaction that eventually come to completion, thus bringing uncertainty to a close on the surface of social life. However, if we temporalise practice and focus on its dispositions, we see that this cycle, as in the case of decision-making, is unending, and uncertainty remains constant. Decision-making does not run from point A to point B, only to cease but is cyclical, through the past, with the present and toward future, and within its embodied practices, researchers can investigate how individuals manage the uncertainty immanent to it.

Where does this uncertainty spring from, and how is it inculcated through practice? As described in earlier chapters, obstetric pre-eminence was achieved through the legitimisation of the field and then ascension over GPs and midwives, and biomedical conceptions and delineations of safety provided scaffolding for this. Moreover, historically, pregnancy and birth were socially constructed as periods of risk (Edwards & Murphy-Lawless, 2006; Reiger, 2006), a reaction to stagnant rates of perinatal mortality, remaining interlaced in maternal health policy until the 1990s. Birth and its potential harm have seeped into the cultural imagination (Scamell, 2014), from which they have been difficult to extract. Then, against backdrops of high maternal and infant mortality rates in lower-income countries, widespread medical interventions, obstetric violence, birth trauma and information overloaded with risk, there appears to be danger and death within any maternity experience, regardless of place of birth but particularly concentrated in any settings seen as alternative. Everyone has a story, or has a friend who has a story, about ‘something’ going wrong. For women living in East London, uncertainty was sowed into the very geography of their borough and construction of their homes (e.g. midwives telling a woman she could not have a home birth while living in a second floor apartment or dissuading another from one based on the distance an ambulance would have to hypothetically travel to her home). During participant observation, my interlocutors spoke about the absence of HCP rhetoric describing birth as safe or positive and the timing of information about birthplace – the lack of which, itself, induces anxiety, as evidenced by their diary entries – as pernicious, and it is through this relationality with practitioners, through what is said but also what is left unsaid that parents build up uncertainty. One woman wrote in a diary entry that she felt her midwife was not helpful, and “changes have made things more uncertain”, while another chose to give

birth out of her borough because she could not contact anyone at her local hospital, stating she “would feel uncomfortable going in to labour and not knowing what resources are available there for me to use”.

Parents’ uncertainty is often multiple, layered or contradictory, related to the unpredictability of the movement of objects and people through different physical and bodily spaces but also enmeshed in the oddity and irregularity of life. Because uncertainty concerns the future, it “implies recognition of change and awareness that states of affairs are not static; they can alter drastically” (Boholm, 2003, p. 167), and this temporality of uncertainty is one of the crucial reasons to focus on individuals’ thoughts, intentions and strategies of practice which moves away from the construction of ‘risk’ as a phenomenon formed by cultural processes. This approach is beneficial for reconceptualising decision-making because risk is then a “cognitive frame” or “relational order” through which linkages between individuals, objects and outcomes are built up (Boholm, 2003). Without uncertainty there is no risk, and it has tangible impact, in that, if people feel like their health or well-being is being jeopardised, then they organise coping strategies, socially mobilise or amalgamate the two (Rappaport, 1996; Zinn, 2008), which I have illustrated through my fieldwork and analysis of movement, corporeality and relational networks of parents, HCPs, information and birth settings. Thus, I propose a theoretical turn away from risk and towards uncertainty. This has interdisciplinary and practical implications that could aid researchers and policymakers in reconciling the disjointedness of scientific ‘risk’ assessments and lived, everyday decision-making. Risk is associated with bureaucratic codifications that deal more with imagined humans, rather than real, lived human beings, who cannot be uniformly codified, act ‘irrationally’ and have agency, and uncertainty, as a concept, presents a more viable tool for discussing actual actions and their implications in the future.

Good motherhood

Birth, like many aspects of reproduction and parenthood, is tied up in responsibility, particularly the responsibility of the mother to make the best decisions for the well-being of her child. Historically, women, their actions and the maternity services with which they interacted were linked to the well-being of the English nation, and, thus, good motherhood has much more at stake than just raising healthy children. The meta-synthesis (Chapter 3) emphasised the extent to which good motherhood is performed, and because

birth decision-making is gendered, as well as performative, it is helpful to focus this discussion through the lens of Judith Butler's theory of gender performativity (1990), although it will by no means be a thorough look at her work or how it has been applied to parenthood. She argued that gender is performed through behaviours that have been deemed appropriate and consistent, and these behaviours are learned and accessed through social conditioning and cultural discourses. In performing them, we perpetuate and reinforce norms, meaning that gender is 'reiterative' (1990) and performing it is not entirely a choice, as there are social sanctions for not doing so correctly. Within birthplace decision-making experiences, there is judgement on which choices are chosen, as highlighted in the systematic review, and 'precarisation' of chosen settings by HCPs, as evidenced in Chapter 6, and parents, which is emphasised in Mila's interview. Furthermore, the moralisation of actions related to pregnancy and birth, such as opting for care outside of what is normalised (e.g. that which remains safely in the hospital boundaries), or for decisions going against the prescriptions of clinicians, forms a powerful structure through which choices are modified and perceived. Despite this and feeling "safer" from intrusions at home, Charlotte still evoked and performed good motherhood, through strategies such as ceding when necessary to medical knowledge and direction, always calculating risk of some decisions against that of others.

Motherhood is not always consciously performed with the intentionality towards conditioned goodness. Because it is still a dispositional component of modern English maternity habitus, the actions and thoughts related to it may be invisible to parents themselves. It is when decisions create friction against the established structuring of how motherhood is 'done' that this foundation is revealed. Women planning a home birth – and those planning births in an FMU to a lesser extent – often describe their conflicts with the medical system and HCPs over their choices and their difficulties in receiving adequate information about this option and support from clinicians, family and friends. The public indictment of these choices as unsafe, irresponsible or unethical, despite evidence to the contrary, means that choosing these options involves bodily work and practice that is not ascribed in the same way for women planning AMU and OU births. In Chapter 3, a woman discussed re-creating her home to mimic a hospital, the space most associated with responsibility and safety, which simultaneously reinforces the authoritative position of the medical system and the norm that maternity optimally takes place within it and demonstrates her responsibility as a mother, despite her decision to choose a birthplace outside of this system. Women's

maternity remains deeply entrenched in this system, in the sense that, regardless of birth settings, we continue to centre it in biomedical knowledge and examinations, perpetuating the notion that good motherhood, and by extension appropriate femininity, is formed around and within it. This blurring of home space, clinical space and woman space gets exaggerated even further in midwifery units, which are meant to be 'home-from-home' environments but are cosmetically so, at best. Meanings of home are affixed to notions of safety and control, not physical spaces (Mitchie, 1998; Fannin, 2003), which is perhaps why women are so aware of their bodily spatiality and its objects and entities in birth settings. Given that home is enmeshed in energies and affections, midwifery units should prioritise bio-psycho-social models of care (Rocca-Ihenacho, et al., 2018) as a vector for engendering 'home-like' spaces and atmospheres, as opposed to focusing solely on built environment, which may inadvertently reinforce gendered idealisations of domesticity.

Good motherhood is also enacted through relationships with uncertainty, particularly the knowability and management of risk in pregnancy and birth. Research from the Chapter 3's review and the parents in my studies frequently performed acts of self-management, such as having extra examinations in order to ensure 'low-risk' status for home birth, aimed at clarifying and controlling 'risk' levels throughout pregnancy and justifying the safety of making certain birth decisions. Noor reported trying to manage her Grave's disease in order to access the AMU in Newham, but, ultimately, she gave birth in the OU, though her insider knowledge and status as a medical doctor privileged her in other ways. Despite the complications that can result from her condition, she was able to forego continuous electronic monitoring, the avoidance of which was not allowed in other cases; for instance, Charlotte was monitored in this way during labour, though she felt she did not need to be. What is rendered irresponsible for some women is not as such for others, and this is reified through the frameworks of choice that women are exposed (or not exposed) to, and further embodied through the simple act of planning and then placing one's self in a certain birth setting. Opting for a hospital birth remains, in the general imagination, the ultimate and most responsible act of uncertainty management and thus, the epitome of good motherhood.

The juxtaposition of Noor and Charlotte illustrates that good motherhood is ascribed differently to different people, and more leniency, in terms of what is considered 'good', may be applied to women with certain professional, educational or socio-economic standings. Some are viewed more skilled at

motherhood than others, despite the fact that much of pregnancy and birth is about inculcation and mastery for *all* parents, even ‘natural’ childbirth, in which women plan and make decisions that facilitate an event when they can surrender and let their bodies do “what they were made for”. Lewis points out that “so-called ‘natural childbirth’...more accurately stands for a regimen full of carefully stylized gestational labor hacks and artifices, a suite of mental and physical conditioning that may be billed as ‘intuitive’ but which nevertheless take time and skill to master” (Lewis, 2019, p. 7). As I discussed in Chapter 4, intuition and expertise are entwined, in that knowledge “become[s] so self-evident and habitual that it seems natural” (Sennett, 2008, p. 183). One does not just become a mother; one must learn along various lines how to be a mother, including learning how to make appropriate decisions about maternity. This reveals a paradox in parenthood: women are told that mothering will come ‘naturally’, with birth marking a moment of profound transformation, when it is the opposite, in that they slowly inculcate motherhood through everyday choices and embodied practice that begins very early in pregnancy.

Good mothering continues to be heavily associated with the maternal body. A fit and informed pregnant (or post-pregnancy) body is idealised and celebrated, and thus can be seen as a mark of responsible, safe motherhood. However, it is considered essential that safety and information are cohesive with biomedicine, and to a certain extent, that choices are made within the limits of this system, using the knowledge that it deems correct. In this light, we can begin to unpack what ‘informed choice’ truly entails in maternity, as being safe in the biomedical sphere can conflict with being informed by knowledge outside of it. Furthermore, recognising the maternal body as one that is fit, safe and informed shows that gendered norms of parenthood remain closely tied to responsibility, coalescing to reduce women’s ability to use or refuse of biomedicine and its efforts to breakdown bodily borders, via examinations, scans and interventions, on its own terms, rather than women’s. As Selacl wrote in *Tyranny of Choice*:

Choice brings a sense of overwhelming responsibility into play, and this is bound up with a fear of failure...In order to avoid feelings of loss and regret, and a pervasive anxiety, one tries to minimise risk or at least make it predictable. The society that prizes choice relies on the idea that we have to prevent all risk, or at least predict it. (2010, pp. 7, 12)

Part of decision-making is regarding how others regard our choices, and good motherhood provides an airtight apparatus of surveillance, monitoring not only what is chosen, but also how it is chosen – is the decision informed or, worse, uninformed?

Informed choice and place of birth

In turning back to informed choice, I want to develop the final part of my argument along several threads: embodiment and enskilment, ‘silences’ and human rights. Relationships with and influences on choice are particularly fluid, multiple and personal, mirroring the temporal and affective modalities of the embodied practice of decision-making. While I want to discuss ‘silences’ pertaining to choice, it needs to be clear that this does not encompass to silences on the part of parents. The absence of a strong desire for choices, which was noted primarily in the meta-synthesis, is often misconstrued as a fixed view or a deficit, though decision-making and what ultimately makes women feel informed are personal, despite being culturally shaped and embodied. Parents gravitate to sources that are flexible and active, using an amalgamation of information that oscillates between ‘informal’ and ‘formal’, such as HCPs and leaflets, which are still regarded as the most trusted and expert sources. However, these ‘formal’ sources vary in how they incorporate and accurately reflect the evidence base about place of birth, so is it justified to see them as experts? Moreover, ‘informal sources’ – which appear to be defined as any source that is not from a clinical origin (Sanders & Crozier, 2018) – preclude bodily and embodied knowledge, such as senses and feelings. As Grasseni and Geiser posed, “how does sensory knowledge stand *vis-à-vis* knowledge *tout-court*?” (2019, p. 8), and the case of informed choice in maternity exemplifies the complexities that arise at this interface.

There is often a hesitance in health care research to approach embodied, sensorial or affective dimensions of choice. Take the discussion of control and how it is linked to choice. It is a topic widely covered in reproductive and maternal health research, as I demonstrated in Chapter 2. My review, which re-examined participants’ experiences, found that these issues of ‘control’ are heavily linked the body, autonomy and agency, leading me to focus on ‘bodily autonomy’ and ‘bodily integrity’ in order to accurately describe the phenomena, instead of ‘control’, which, to me, is oversimplified, disembodied and removed from agency. Bringing in the body and centring it with autonomy means we can begin to look how bodily

actions and embodied practices reflect issues of control and power, while simultaneously working to exercise agency and maintain integrity. There other further issues around using the term 'control'. As Namey and Lyerly (2010) pointed out, the meaning of it is not often defined by researchers in their work nor is there any nuance given to term by reflecting how women themselves define it, arguing that the key paradox here is that women and clinicians want to control what is, in many ways, a uncontrollable experience. If "'being in control' is essentially subjective" (Green & Baston, 2003, p. 236), then basing its discussion within the body, autonomy and integrity provides a better avenue for clarifying its role in maternal experiences.

Choice is a matter of engagement, with different objects, people and knowledges, and most importantly, with oneself; however, "engagement always has to be learned", in that "learning to categorise, decipher and sort the social world is a daily skill, beset by the problem of opaqueness, fuzziness and ambiguous grey zones" (Grasseni & Gieser, 2019, pp. 11, 8). As embodied practice, decision-making about place of birth and its related actions display this process of inculcation, and are learned in the body and through the body. As habitus, decision-making embodies a socially salient moral ordering of motherhood that consists of achieving responsibility and 'goodness' through management of uncertainty and by subjecting oneself to biomedical and obstetric authority. It produces bodily transitions that end in the skilful mastery of informed, responsible parenthood that has been carefully curated, chosen and phenomenologically coded. This process, of course, is socially idealised, and it should be noted again that most of the women I interviewed were well-educated and, thus, more likely to conform to this ideal. Had I been able to interview more women with lower educational levels, a different picture of decision-making and choice might have emerged. Women from more disadvantaged or very different cultural backgrounds are often exposed to being categorised as less fit mothers, not doing pregnancy, parenthood properly or, even, informed choice properly. The fact that definitions of informed choice are so often hypothetical or establish the 'ideal' scenario only strengthens the idea that it is something unobtainable to be mastered.

One crucial part of mastering informed choice is how and how often different sources – or 'media' – are accessed and used to enable enskilment, which is where the concept of "skilled mediations" can be helpful because it is "interested in the forms of training the senses, with and through apparata, devices and interfaces" (Grasseni & Gieser, 2019, p. 10). For informed choice in maternity, it is less about the senses,

and more about the thoughts, feelings and actions that are mediated and codified. Which? Birth Choice and leaflets about birthplace choices are all examples of media that are intended to form and focus decision-making practice:

To mediate is to reconfigure and transform whole practices, ecologies of relations, knowledges, senses and bodies. While the impact of some media in a given practice is marginal, there are usually a few that act as ‘focusing media’ for a practice. These focusing media are so central that much of the learning and enskilment processes revolve around them. It is with them that the powers of reconfiguration and transformation become most apparent. (Grasseni & Gieser, 2019, p. 10)

As Sennett wrote, “[t]here is nothing inevitable about becoming skilled” (2008, p. 9). As my data show, intentions toward one birthplace over another are layered through time, so that even decisions described as intuitive have been built up and inculcated (see Helen’s interview in Chapter 8). This relation to choices becomes embodied, to the point that they become partially transparent and become part of the body and its orientation towards the world, as in the case of the blind man’s cane in *Phenomenology of Perception* (Merleau-Ponty, 2012 [1945]). The mediation of choices and their associated media transform the experience of the world through their transparency. In this sense, the other element of mastering informed choice through practice is this embodiment. In the case of place of birth, the choice is fully embodied through where parents place themselves, to the point that a space becomes part of one’s bodily spatiality, completely transparent and normalised. A lived, maternal body, as the holder of corporal and sensuous experience, is the conduit for the representation of these past bodily sensations of embodied practice through this ‘informed’ choice, as well as being oriented by the dispositions that engender them.

However, to what extent can we count choices as informed and decision-making as skilled? Digging into “skilled mediations” means paying attention to the media itself, which, in my research, incorporated policy and local documents, conversations with HCPs, family and friends, NHS leaflets, books, websites, videos, apps and Which? Birth Choice. In the findings chapters, the women’s stories wove through media, particularly Chapters 6 and 7, in which it became apparent that there was much left unsaid, unwritten or uncommunicated in the media relating to birthplace. There were silences around home birth and the FMUs in Barts Health, online and in practice that rendered these options less visible and normalised

than the AMU and OU options. Anthropological accounts of silences are mostly related to trauma or loss and lived memories of these foreboding pasts; however, this work is important for displaying how silence demarcates presence rather than absence in social life (Kidron, 2009). When it comes to learning and knowledge, silences can take on a more tangible potency along the lines of transmission and communication. Kidron's research with the children of Holocaust survivors revealed how the Holocaust was embedded as a silent presence in survivor homes through "person-object and person-person interactions" and embodied practice, which she argued should be "conceptualized as alternative media of communication/transmission of the past to descendants" (2009, p. 16). My ethnography has shown that, rather than silent practices and interactions carrying the past into everyday life as a "normative co-presence" (Kidron, 2009, p. 16), there are silences within interactions, media and objects that are orient practices and are re-presented through them. These silences, as many of those explored in anthropological research, are connected to the past and to power, in that they usually concern birthplace options that are still considered outside of the norm, and are physically outside of hospital boundaries and out of the gaze of obstetricians, who historically asserted professional dominance over pregnancy and birth.

Crucially, for place of birth and for reproductive health generally, silences need to be recognised increasingly as political and strategic. In terms of maternity care and choice, there is little research analysing this phenomenon – a silence on silences, in a way. McCourt (1998) noted in her discussion – now over 20 years old – of a multidisciplinary research project on continuity of care in community midwifery that managers' and obstetricians' responses to the final report involved not only silencing of the real findings from the economic part of the research, but also distinct silences concerning the social and professional benefits of this model of care and the criticism leveraged by the report. Other studies have highlighted the practices through which women are subtly and coercively silenced, noting that those who are younger, lower-income or from minority groups are more likely to be silent and to be harmfully silenced (Stapleton, et al., 2002; Chadwick, 2019). Stapleton and colleagues (2002) noted the non-verbal, bodily cues midwives unknowingly employed to signal for women's silence, which reinforced the status and power differences between them. In contrast, Chadwick illustrated how silencing of pregnant women and their embodied agency should be viewed as epistemic violence, arguing that "dehumanising and colonising nature of

obstetric epistemologies and medical practices that valorise technocratic knowledge while dismissing and silencing the lived, haptic and embodied knowledge of birth-givers needs to be challenged and recognised” (Chadwick, 2019, pp. 46-7). Though these researchers emphasise the ways in which silence reifies the entanglements of power and practice in maternity, they do not touch on the silences in the knowledge and its communication/transmission that shape women’s pregnancy and birth decisions and experiences. There are a variety of reasons why HCPs might not fully facilitate decision-making, instead constraining women’s maternity care choices (Stapleton, et al., 2002; Seibold, et al., 2010), but previous research on this has written around these silences, rather than engaging with them directly. This failure to acknowledge or interrogate silences gives weight to their own “normative co-presence” in maternity, and how a diverse set of everyday practices, whether it be writing, reading, attending appointments or providing care, can “become the means of self-reproduction and the perpetual re-presentation” of past maternal health policy and historically moulded norms (Bourdieu, 1977; Kidron, 2009, p. 15).

As I outlined Chapter 1, maternal health policy in England has a history of erasing home birth as socially meaningful and safe setting for women and their families. In the Peel Report (DHSS, 1970), there were significant methodological silences pertaining to women’s preferences and data on mortality that tactically strengthened the recommendation for 100% hospital birth. Subsequent reports, *Changing Childbirth* and *Maternity Matters*, also remained silent on the benefits of other birthplace settings, focusing on choice as more of an abstract ideal and dismantling the egregious justification for unfettered technology use and medical interventions through claims of safety. *Better Births* has marked itself as improvement for birthplace choice, and the evidence base is now directly challenging the notion that the OU is as safe as midwifery-led units and home birth, claiming that the latter are actually *safer*. Yet, there is silence surrounding this emerging evidence and these birth settings at every turn, tacitly felt on websites and leaflets, in antenatal appointments, through women’s lived experiences and even in *Better Births*. There is also continued silence around mothers’ health and well-being, in relation to place of birth, and information sources do not frequently provide coherent data about maternal health, focusing instead on infant outcomes and intervention rates (Coxon, 2014). The morbidity for women related to the latter remains hidden, a muted consideration in public information, even though it impacts conceptions of safety and risk

associated with non-OU birth settings. How can parents be expected to make informed choices in an informational framework of deliberate silences?

However, it is reductive to claim that relationships with choice, prominent influences on decision-making and informative sources solely point to the imbalances of power between service users and clinicians within a rigid, technocratic health system, particularly as more alternative care options become accessible and public health – as well as social – discourse increasingly promulgate women’s choice. What matters is the platform from which this is choice promulgated; is it a platform of the free market, or one of human rights? In focusing on the silences within media, objects and practices related to maternity, it becomes more explicit how the platform of choice in English maternity care is constituted on market ideology, in that choice is offered without substance, replete with gaps that, if filled, would foster more holistic decision-making that accounts for the maternity as an embodied and lived experience. Hypothetically, the parent/service user/consumer embodies the market through receiving and making choices, through driving care provision by demand and becomes more empowered through these actions (this is evident in how often choice in maternity is linked to women’s empowerment). When, in reality, they are compelled towards a specific pathway of care that is based in the hospital by the very system they are told to have a hand in controlling, through silences about non-hospital options, sanctions, such as eligibility criteria and risk status, and hierarchies of knowledge, in which their embodied knowledge is held below that of practitioners.

“Critical moment of discordance”

Parents, maternity care services, clinicians and policymakers in England are now caught in a “critical moment of discordance” (Bourdieu, 2000 [1997], p. 303) when it comes to informed choice. As I demonstrated in Chapter 2, the conception of choice in English maternal health policy is based on a market ideology, in which choice begets consumer empowerment and freedom, rather than on human rights, in which bodily autonomy and respectful care are part and parcel of choice. As Chadwick pointed out, “[r]ights to bodily autonomy, freedom of choice and humane, dignified treatment often seem to vanish during pregnancy, labor and birth, particularly in medicalized settings” (Chadwick, 2018, p. 37). The extent to

which human rights remain peripherally considered in matters of choice is reflected in the very construction of Which? Birth Choice website, where the 'My Rights' sections is buried in the FAQs, as opposed to being displayed centrally. However, the level of uncertainty, loss or regret in birthplace decision-making suggests that the current framework of choice in maternity is rendering women more anxious and acquiescent than giving them freedom and empowerment, which is connected to a capitalist espousal of choice (Selacl, 2010).

Earlier in this chapter, I highlighted how notions of good motherhood are nexuses of choice, responsibility and management of uncertainty, and the elements of duty and control in this edifice hint at an ideology of choice, where one is the master of their fate, their well-being and that of their children. Maternity experiences would be better, if only women chose the right options for them; services would improve, if only the demand were there for them to do so. However, this issue is that decisions become even harder when all of this fate and well-being is at stake, and they become entwined with the fear of making a mistake and the desire to minimise risk (Selacl, 2010). Choice and decision-making in maternity are sometimes referred to as "burden", which decision-aids, like Which? Birth Choice, intend to lessen, and I believe this can be attributed to the misleading ideology of choice that is established in policy, embedded in clinical practice and unknowingly promoted in public, informational spaces. Uncertainty and the orientation towards normatively "safer" birthplace options, such as AMUs and OUs, are more or less embodied forms of this ideology. Though birthplace decisions for women with uncomplicated pregnancies should not involve moralised and unrealistic trade-offs concerning safety and 'natural' experiences – as all of the settings are safe and can facilitate physiological birth (see Noor's interview) – they are often presented with this framing. This is because "[u]nder the paradigm of cost-benefit analysis and rational choice theory, estimates and comparisons can be made to serve as guidelines for decision-makers, national regulatory bodies and policymakers as well as individual citizens in their daily lives" (Boholm, 2003, p. 160). Research generates estimates and comparisons (Birthplace in England Collaborative Group, 2011), policymakers render them into guidelines (NICE, 2014; National Maternity Review, 2016), and midwives and leaflets simplify and make them tangible for parents. Their importance is explicit in McCourt's (1998) research and built into Which? Birth Choice and other birthplace choice medias, as well as tacitly

understood in women's interactions with services and enacted through the embodied practice of decision-making.

Essentially, choice work is due for an overhaul, in research, policy, practice and everyday life. When it comes to producing guidelines for choice, "[s]tatistical probability is a mathematical concept that quantifies the chances of an event or occurrence, and it has limited relevance for explaining how people think and act in situations where there is an element of uncertainty" (Boholm, 2003, p. 161), and there are many instances where certain chances are amplified while others are not, exemplified in Mila's discussion of the risk of eating unpasteurised cheese versus that of getting hit by a bus. Choice research has a tendency to cast women into 'oppositions' (e.g. lower-income versus middle-income; home birth versus hospital birth), which obfuscates more structural factors related to power, social determinants of health and evidence on birthplace safety, reflecting the broader, social concealment of these dimensions. Choice is, thus, not interlinked to safety in a wider sense, or even assumed to be in tension with it but recast as frivolous again. This time, instead of all women having superficial preferences, the opposition is between the frivolities of privileged middle-class women and the pragmatism of working-class women. This is to emphasise that, when choice concerns bodily autonomy and human rights, no decision should be regarded as frivolous.

So, where does this leave informed choice? In its current iteration, as a buzzword in care services and a health policy concept, it is little more than, to put it crudely, an artifice for saving money and placing the onus of social change on the individual. Yet, as my discussion has laid out, an informed choice is the culmination of "skilled visions", a phenomenological and embodied event that marks a process of enskilment by way of embodied practices of decision-making. This process is not just corporeal but also temporal and multiple, in that decision-making practices, which are often small and quotidian, constitute a lived pregnant and birthing body that comes to function as a present representation of the past: past experiences and sensations, past familial and social events and deep historical past. In this sense, "[t]he birthgiver is not one but two", often multiple and indeterminate (Chadwick, 2018, p. 37), which is in discordance with biomedical frameworks. It is in these critical moments that unforeseen or challenging practices arise, but it is crucial, as researchers, that we recognise and acknowledge the ontological shifts inherent therein:

Birth is a complex entanglement of affective, ontological, sociomaterial and embodied politics. To move beyond stagnant debates, we need to frame labor/birth as embodied ethicality, involving a psychofleshy, emotional and vulnerable corporeality deeply affected and interpenetrated by relational flows, affective violence and sociomaterial structures. (Chadwick, 2018, p. 203)

When we begin to see decision-making as a phenomenon that is intimate and embodied, and as a process of enskilment that penetrates into the core of corpus, then the need to rebuild the platform of choice on human rights becomes all the more urgent.

Chapter 10: Conclusions

In the Introduction, I wrote that this thesis is fundamentally about where women decide to place themselves, and why, particularly during birth, this is not as straightforward as it might appear. This ethnography has attempted to make sense of the complexity concerning maternity, women's bodies, decision-making and informed choice, in an effort to elucidate the continued discordance between policy and practice in England. I built my investigation on a critical overview of the history of maternal health policy and birth settings (Chapter 1), a discussion of the relevant evidence base about place of birth in England and internationally (Chapter 2) and a description of the contributions of social theory, particularly anthropological work, to my research and understanding of pregnancy and birth (Chapter 4). Chapter 3 described the systematic review of research on decision-making and informed choice about pregnancy and birth care, which produced a synthesis of the concepts from the qualitative findings from the literature included. My colleagues and I found that decision-making and informed choice, contrary to 'rationalist' decision theory, are dynamic and cyclical. The key themes that emerged from our analysis were 'Uncertainty', 'Bodily autonomy and integrity' and 'Performing good motherhood', which are inter-linked through three main actions, 'Information gathering', 'Balancing aspects of a choice' and 'Aligning with a birth philosophy'. This conceptual framework is underpinned by a temporal dimension, and this chapter emphasised the importance of temporality and the body when approaching decision-making as a process and as embodied.

Chapter 4 also introduced the theoretical foundations of embodied practice, and the perspective from which I employed my methodology. This was an ethnography of process, rather than of a specific group of people, which involved two studies: one based in the community of East London, and the other in Barts Health (Chapter 5). Chapter 5 highlighted the epistemological considerations of conducting ethnographic fieldwork on process and practice in an urban, unbounded setting. Given the scattered, compartmentalised and often disjointed nature of the city and the trust, I used a range of methods in each of studies to collect data and address the aims of this research, though this methodological assemblage is not common in ethnographic and anthropological research. I pulled from historical readings, policy and local documents, field notes, participant observation, focus groups, online diary entries and interviews

gathered over two years to inform the reflexive account of East London and Barts Health (Chapter 6), the feasibility and acceptability of longitudinal research on decision-making and informed choice about place of birth (Chapter 7) and the in-depth exploration of deciding where to give birth (Chapter 8). Throughout these descriptions, I have foregrounded the centrality of embodiment and temporality within women's decision-making about pregnancy and birth, as well as the importance of recognising each when developing research and policy.

Given these findings, I want to emphasise the challenges that researchers might confront when pursuing trials of interventions aimed at improving informed choice through information use and decision aids, such as Which? Birth Choice. My thesis has demonstrated the disunity between the established and normalised conceptions of choice and parents' lived experiences of decision-making, in that the latter is an embodied practice generated by the dispositional principles of modern English maternity (Chapter 9). My analysis revealed that biomedicine, obstetrics, uncertainty and concepts of good motherhood structure actions, thoughts and feelings about pregnancy and birth, even though their multiple layering through lived, maternal bodies creates "critical moments of...discordance" (Bourdieu, 2000 [1997], p. 162). This is laid bare in my discussion of informed choice, embodiment and enskilment, 'silences' and human rights. Conceiving decisions as embodied practices places the body more firmly in maternal health, with the aim of making its agency an ethical imperative in notions of informed choice. To close this thesis, I now turn to the future of birthplace: what is taken forward from the limitations and challenges of this research and what the implications are for research, policy, practice and politics of birth.

Limitations and challenges

No research is without limitations in some shape or form. There can be impositions posed by time, logistics, methodological approach and oversights. To begin, Chapter 3's meta-synthesis contained a number of potential limitations that might have impacted the results of the review. The inclusion criteria were not restricted to research about place of birth, and this broader framework allowed 30 sources to be reviewed, which, by some standards, is considered too large for a meta-synthesis design and, therefore, a limitation. There are no strict recommendations on the number of studies included in a meta-synthesis; however,

researchers should be aware that the framework may be better suited for smaller reviews, given the analysis and synthesis stages. We, as a review team, did consider curtailing the focus to just decision-making about place of birth and informed choice in this context; however, we felt that the review would benefit from a wider scope, as the other literature on decision-making might inform the framework for thinking about how women make decisions about place of birth, and our findings would be useful for broader audience in maternal health research. We also felt that including other pregnancy and birth studies fit in neatly with the birthplace research as there are many decisions associated with choosing a setting, such as medical interventions and pain relief. There was a lack of eligible research from other European countries, so further research should also work to address this, and subsequent reviews should include studies published in other languages, when possible, as this would provide a better picture of parents' experiences in these areas and how they are linked to the health care systems. The meta-synthesis procedure, then, provides an excellent guide for making sense of qualitative literature and concepts, but it may require a balancing act of what to include and what to exclude.

Time, money, location and organisational structures within the NHS were all limitations that stymied the development of the Birth Decisions Diary and the recruitment of women for the feasibility study: the quick procession of ethical and institution approval, the ease of research facilitation and the ability to recruit a larger number of participants and to employ a wider scope for the research. First, there was limited space and funds in the three years to develop a website or app that was tailored to data collection, and I was left to improvise with the platforms provided by City, University of London. Platforms for data collection beyond short surveys are limited and less sophisticated than social media websites and apps, where people have been habitually sharing their personal information for over a decade. The Birth Decisions Diary design was intended to mimic social media, but, without individualised profiles, or the sharing aspect of media that do not need to give regard to confidentiality, it was never going to be close to the same experience. Apps are even more difficult to wrangle into development and then out to mobile phones, requiring considerable money to design and licensing from technology companies, such as Apple and Android, to publish. In the end, the design and ethical constrictions³³ of using a university-based

³³ It was difficult to set up profile for participants through City, University of London, who were in charge of the access to CampusPress. The process was, unfortunately, very convoluted and time-consuming because it entailed providing participants, who were not members of the university, with access to university-based services. Finally, forums or any other 'social' feature meant that anonymity was not ensured.

platform led to the development of a weaker digital data collection tool, and this weakness is reflected by the limited engagement from participants. Not a single person uploaded a photo, and most participants did not use the website without solicitation.

This throws into sharp relief what we lose or gain when we move into and create digital platforms for data collection, and how contemporary modes of communication are evolving. Can universities keep up with the fast-paced developments to online spaces? Ultimately, I was not able to definitively answer this or determine whether using an online diary platform, like the Birth Decisions Diary, is beneficial to research, as it was not as effective at capturing the process of decision-making, which was one of the key aims of its design, as the interviews. I was not able to develop a diary approach that more closely resembled social media, and I would argue that this diary method is distinct from that, and future research should carefully approach the conflation or merging of the two as a vehicle for capturing social life and experiences. In certain research contexts, journaling can be an efficacious method for eliciting deeper experiences and exploring life histories. The same reasoning can be extended to Photovoice or other creative participatory action research methods, which gel more seamlessly with subjects related to the senses or activism. These can be employed in health-related research concerning embodiment; however, in hindsight, using diaries and Photovoice to trace decision-making were not well suited to this topic. As highly embodied and abstract process and practice that is mixed with affection and ambiguity, it might be difficult to elucidate through writing and creative work, or might only appeal to some women. While women did make use of visuals in our discussions, which enriched the interviews, talking through decisions and informed choice produced more meaningful and salient data. As researchers, we should consider whether diaries are still culturally appropriate as a method, given the low engagement with paper diaries and now digital ones, or whether methods that are similar to those constituting a “quantified self”, (Padrez, et al., 2015) (wearable devices connected to mobile phone apps) should be phased in, though these have a range of methodological and ethical implications. Studies on the appropriateness and acceptability of a variety of burgeoning digital technologies employed as experimental research methods are relatively sparse, but each of these areas is influenced by the type of platform and design being employed, as well as an individual’s orientation to writing.

There were a number of challenges to this research that were primarily temporal and institutional. Snags in filing paperwork rolled into delays with beginning recruitment, which meant less time allotted to approach parents in booking clinics, in order to reach targets. Like my interlocutors, this research and I were subsumed by and tractable to the tempo of NHS bureaucracy, and this institutional structure became not only a challenge but also a limitation. Barts Health NHS Trust was not equipped to adequately support research that was not added into the Clinical Research Network NIHR Portfolio, which, as I mentioned before in Chapter 6, hinders non-clinical ‘outsiders’ from establishing strong, sustainable connections with the trust. I relied on my local network in the field and luck, in order to gain access, and the fact that the latter played a key role means working with this trust should be regarded as a potential limitation, considering what could have been achieved in another with robust research facilitation. However, an aim of the NHS arm of my research was to clarify the feasibility of conducting a qualitative, longitudinal study of process through the institution, and this includes evaluating the ability of the institution to sponsor it. The time spent beginning my research with Barts Health and recruiting parents at booking appointment reduced the amount of time I was able to commit to working on my fieldwork within the East London community, where I wanted to explore further. Once locked into the NHS study, with a looming, three-year deadline, there seemed little flexibility for change in methods or participant engagement, due to the complexity of ethical amendment procedures.

At the risk of cavilling, although many aspects of this research were successful, and, overall, my ethnography communicates the achievement of the studies’ aims, yet, given the centrality of reflexivity to anthropological knowledge production, I cannot help but find shortcomings, with the hope of future amelioration. The parents who took part in this research were from diverse backgrounds, but the group was still mostly highly educated and higher-income, and majority white in the NHS-based study, all of whom are well-represented in health research but not adequately representative of the wider East London communities. For these two crucial reasons, this should be considered a limitation, as the ethnography subsequently – though unintentionally – promotes some women’s experiences over others. It is difficult to pinpoint exactly why highly-educated and higher-income women predominantly participated in the research, but it is well-known that women from white and middle-class backgrounds are more likely to participate in health research. Common factors include knowing more about research and having more

time and resources to participate. Sometimes there is lack of appropriate focus on the part of researchers to prioritise the inclusion of underrepresented groups into studies. Recruitment was not purposive beyond those with straightforward pregnancies and a good level of English. Including women who do not have a good level of English would have helped, though this was not felt to be appropriate for a study evaluating the use of a tool only provided in English. Moreover, it is not the only issue, and there are plenty of women from minority backgrounds and lower socioeconomic groups who have straightforward pregnancies. These recurrent issues with recruitment and participation foreground how our research inadvertently privileges groups that were historically and continue to be advantaged in virtually every social, political and economic space.

Recommendations and further research

Implications for testing a tool for birthplace decision-making

There are two strands of recommendations that I would like to lay out based on the research that I undertook, pertaining to the development of Which? Birth Choice and potential future studies on it. First, the decision tool on Which? Birth Choice should be updated to appropriately reflect the findings of the Birthplace in England study and remove unrealistic trade-offs that are built into the algorithm that provides the results. The clearest way to do this is to work closely with the researchers involved in the study and academics who work in the maternal health field, before piloting it with parents from a range of backgrounds, with a range of birth experiences, particularly those who have planned or are planning births at home or in an FMU. The site content should work to be more representative of BAME groups, religious minorities and LGBTQ+ families, and include writing and birth stories that are aimed towards partners, as there is currently only one birth story featuring a couple on the site. Once these have been addressed, the site should be developed into a more interactive space, whether this is means developing an app or adding in a 'chat room' with an HCP, for instance. Many participants in my case studies frequently used apps, praised interactive content, responded positively to visual information and valued sources that complimented but did not replace their interactions with HCPs. Parents want personalised information and care, using the NHS and HCPs as their core reference points, and the issue with Which? Birth Choice is that

it provides no opportunity for ownership within its structure, save the decision aid, which can be alienating if parents' results were not what they were expecting. The site is more of an exploratory tool – a good “starting point” – so, once parents' birth choice become more concrete, and there is a greater desire for personalisation, the site may lose its usefulness. Signposting to other sources that provide more depth is a solution for engaging users beyond early pregnancy, which could be built into an app, similar to what the Bounty app provides.

Higher levels of personalisation may entail collecting parents' personal data, such estimated due dates, postcodes and health information, which could bring in more ethical and legal considerations surrounding data protection, management and use. Parents have few issues with inputting their data into websites and apps, but how these data are subsequently used can expose the platform to critical scrutiny from academics, HCPs and health organisations. Which? appears to have a better reputation than Bounty among the public (Garner, 2013; Sawyer, et al., 2018; Mumsnet, 2018), in terms of trustworthiness, ethical operation and handling of information, and it does not involve advertising or commercial revenue from sponsorship, which is an advantage for any future development and broadening scope. Many of the parents and media outlets critical of Bounty take issue with the idea of commercial body collecting their personal information and selling it to third parties, as well as representatives who can access parents on postnatal wards, mere hours after they have given birth. Complaints about these actions coupled with difficulties hospitals partnered with Bounty face in receiving Baby Friendly accreditation from UNICEF has led trusts around England to cut ties with Bounty. If anything, Bounty provides a clear example of what *not* to do when partnering with the NHS, which is useful to Which? Birth Choice, if expansion of the sites and its resources are on the horizon.

The second strand of recommendations pertains to whether the further development of Which? Birth Choice should be tied to larger research studies about the efficacy of the decision aid and the site, with the goal of conducting an RCT to test the effects robustly. Based on the outcomes of my NHS-based feasibility study, I cannot recommend that an RCT of Which? Birth Choice. While parents are interested in taking part in longitudinal research, recruitment may be time-consuming, particularly in trusts that do not adequately facilitate external studies, participation after enrolment may be low, and there are several design challenges, including the fact that such a trial cannot be blinded and a range of web-based information sources, tools and apps are available publicly. There may be more efficacious methods for

recruitment and retention (e.g. face-to-face contact with researchers or more compensation for participation) built into the design in order to engage parents and keep them enrolled, but these would have to be explored in another feasibility study. Another concern is fidelity and how to ensure this; the breadth of information that parents access and the visibility of Which? Birth Choice in search results online may present some challenges in statistically judging effect. These considerations beg the question: is an RCT the right framework for this research topic?

Since the 1950s, the double-blind RCT has been seen as the ‘gold standard’ of medical research, considered by many to produce more ‘objective’ results than other frameworks; however, some have questioned whether it should be assigned such venerated status and whether not it can truly mask bias (Kaptchuk, 2001). As Kaptchuk points out, preceding his article, there were multiple reviews and studies either refuting or supporting that there are discrepancies between the results of randomised and non-randomised trials, but, ultimately “the blind RCT may be objective in a “softer” or disciplinary sense: it is a standardized, explicit, replicable, and impersonal procedure that defines unambiguous and formal norms for medical researchers” (2001, p. 546). Others have highlighted that evidence-based public health must go beyond RCTs, which are often used as the only sources of data on the performance of interventions, when, in fact, the approach is often “not appropriate” for their scientific assessment (Victora, et al., 2004). Randomisation, for instance, does not eliminate the possibility of ‘confounding’ – or the possibility that other variables besides the intervention “may be independently associated both with exposure to the intervention and with the outcome” (Victora, et al., 2004, p. 401) – a very pertinent concern for research about a readily available online tool. Often public health interventions have long and complex causal pathways that involve both biological and behavioural facets, which need to be measured and explored in order to follow the association between intervention and outcome (Victora, et al., 2004). In the case of Which? Birth Choice, we would need to untangle how parents are introduced to the site, how often they access it, how they use it, what other sources they use and how often they use them, in addition to understanding how each individuals’ location, local services, socio-economic status, education level, cultural background and parity are involved in this pathway. For complexity like this, Victora, Habicht and Bryce recommend ‘*plausibility* evaluations’, which aim “to document impact and to rule out alternative explanations by including a comparison group...and by addressing confounding variables” (2004, p. 404).

At the core of my second recommendation is that decision-making and informed choice may not be suitable for wholly quantitative research, particularly that which relies on probabilities, as they are nebulous and subjective. The aforementioned suggested primary and secondary outcomes (Chapter 7, section Key outcomes) for a trial can be used to measure informed choice quantitatively, but, as I have demonstrated in throughout my findings, decisions in pregnancy and about birth take on a depth and vibrancy that simply cannot be communicated statistically. Decision-making and informed choice are living, active phenomena, often without a clear-cut passage from where they begin and where they end, and are embodied and felt rather than simply intellectual, or even emotional, meaning that an RCT framework, which is constituted upon detecting straightforward casual pathways, is incongruous as an approach. The concept that interventions are replicable across different settings also disregards how local realities shape care services and patients' lives. Just as not all decision-making is the same, not all interventions that work well in one setting will be as effective elsewhere.

Implications for wider research on place of birth

There are several implications for wider research on place of birth that emerged from this research. Logistically speaking, pathways of recruitment for longitudinal studies in urban settings need to be carefully considered, as do the locations where data collection, such as focus groups, takes place, because these might affect who and how many new parents take part. Conducting research in established parent groups that meet regularly or holding repeat focus groups, for instance, are ways that might boost participation. Recent research on group antenatal care, for instance, found that women enjoyed that social aspect of the study and highly valued being able to share their experiences and cultures during the care sessions (Hunter, et al., 2018). Going forward, maternal health researchers should consider how their study designs can better benefit pregnant women and mothers, through paying attention to opportunities to emphasise and build in sociality, which may potentially augment recruitment and participation. While this may not be appropriate for all maternal health studies, it could be worthwhile to review or pilot research that incorporates social support into its design in order to see how this affects study retention and participation.

There are a range of topics related to place of birth that could be pursued further, some more urgently than others. Research focusing on fathers, partners and non-heteronormative couples is nearly

non-existent, and parents from BAME, lower-income and socially disadvantaged groups are underrepresented in the literature. There is often a deleterious social perception – or ‘critique’ of place of birth – that home birth, midwifery units and continuity of care are only for and important to White, middle-class women, though research dating back as far as the 1990s suggests otherwise (Lazarus, 1994). This recommendation is not solely aimed at social scientists working in maternal health but also for those specialising in quantitative research, whether it be RCTs or health economics. Black women in the UK are now five times more likely to die in childbirth than white women, and Asian women are two times more likely to die than white women. There is a pressing need to prioritise research involving and benefitting parents and infants from disadvantaged groups, lest we perpetuate the theme of ‘too little, too late’ that was highlighted in the 2016 *The Lancet* series on midwifery (Freedman, 2016). Innovative approaches to interdisciplinary projects, such as the Birthplace in England study, should be pursued in order to generate more definitive, up to date evidence on the safety, health outcomes, financial dimensions and organisation and configuration of local services that can be used to inform policy and, more importantly, practice.

Future research on birthplace could focus on how ‘booking’ conversations can be successfully framed and delivered in a meaningful way, so that women understand their choices rather than just knowing about them, which Henshall and colleagues (2016) similarly highlighted in conclusion of their systematic review of the evidence regarding discussions by midwives, with women, around their birthplace options. Further ethnographic research and social scientific engagement with European midwifery and its models of care, especially along the embodied knowledge and practice, has long been overlooked in anthropology. There is a fruitful opportunity for an applied anthropological perspective on the integration of midwifery-led care and family experiences, with the aim of informing localised service development and improvement, both in England and in international settings. Even with the exciting emerging studies on midwifery-led care, home birth and health outcomes, researchers in England still have little in way of the social history of midwifery units, formerly called maternity homes, which has not been fully researched and published. The body of literature on place of birth would benefit from this historical perspective, to enrich analysis and development of localised models of care.

Finally, I want to return to my initial writing concerning why study place of birth and why study it now. At the core, it is because “all is not well with birth” (Chadwick, 2018, p. 4), so revisiting even the most

fundamental experiences, like being pregnant and giving birth, and our assumptions about them are constructive for re-vitalising research. In the past, anthropology of reproduction and birth has contributed to the radical advancements in the politics of pregnancy and birth, through “engaged and enraged” (Scheper-Hughes, 2004, p. 35) criticisms of biomedicine. However, in contemporary social science research, place of birth is strangely lacking compared to work on assisted reproductive technologies (ARTs) and obstetric violence, even though it straddles a range of topics from the body and agency, to biomedical frameworks and human rights, to enskilment and creativity. Likewise, decision-making – distinct here from choice – in maternal health has received less consideration outside of screening and, again, ARTs. Considerations of pregnancy and birth often suffer from analyses focusing on the ritual or semiotic modalities of these liminal, transformative events. Even I began my own research from this sanctified viewpoint, before finding that pregnancy involves a lot of – yes, embodied and affective – mundane experiences and everyday experiences, but this perspective can actually stunt our enquiries and developments as a discipline, reinforce dichotomies and cause us to overlook dialectic complexities:

[A]lthough microanthropology has traditionally explored mundane lived experience, the mundane experience of culturally sanctified experience (be it ideologically, religiously, or morally loaded) has been ignored in favor of the examination of the way culture publicly structures and celebrates the sacred as distinct from the mundane. A return to the micro sites of silent everyday experience without retrospective narrative accounts that might give voice to the banality of experience—experience that would otherwise be culturally sanctified—would serve only to sustain Cartesian dichotomies and not to consider the more complex dialectic between the mundane/sacred and the private/public. (Kidron, 2009, p. 18)

Much of the anthropological heavy-lifting in my analysis centred on the language, movement and perspectives in the everyday experiences of decision-making about place of birth. It was through these that I was able to follow enskilment via embodied practice and consider the weight of silences in frameworks of choice, while developing an argument for a more corporeal, multiple and affective vision of pregnancy and birth experiences. In this, there is fruitful ground here for anthropological expansion, particularly along the lines of multiplicity, assemblages, sensorial modalities, all of which have been discussed in other subfields of anthropology, and embodied practice, which has been kept on the periphery of our episteme for far too long.

Implications for policy and practice

The policy and practice implications that became evident from this research are far-reaching in their scope. The systematic review (Chapter 3) initially generated several considerations for future development of decision aids about maternity care options and for maternity services. While research (Frost, et al., 2009; Dugas, et al., 2012; Stevens, et al., 2016; Stacey, et al., 2017) shows that decision aids can be effective tools for helping parents make complex care decisions, the realities of information seeking and decision-making behaviours, in that they are emotional, experiential and in flux, means that these tools will most likely be used in conjunction with other sources and in a range of ways. Women taking part in my own research often appreciated sources that are flexible, active and trustworthy, and, if possible, decision aids should try to incorporate this into their design or, at the very least, consider the strong desire for personalisation in decision-making and accurately reflect the evidence base about place of birth. Which? Birth Choice attempts to incorporate this personalisation and the uncertainty innate to everyday life; however, it still fails to fully incorporate evidence about non-hospital settings and mounts unrealistic trade-offs as indicative of maternal decision-making, re-generating silences about the safety and viability of home and FMU options. The tool is also constrained by a linear framework of progression through it, which, as I have stated many times throughout this thesis, is not how people make decisions about their lives. The core issue of decision aid tools is that they are predicated on the conceptualisation of choice as a responsibility or burden, rather than on one of human rights. If choice is prioritised as bodily autonomy and no longer a burden or anxiety-inducing phenomenon, then is there any further need for decision aids?

Similarly for maternity services, HCPs should take steps to promote flexibility and personalisation, as parents still regard them as important and trustworthy sources, rather than simply providing options and information, for the sake of displaying choices and ticking boxes. This could be particularly important for vulnerable or lower-income women, who desire consistency and quality in their care and carer, but often get left behind by the health care system. Maternal health experiences are multiple, embodied and affective (Chadwick, 2018), as well as shaped by society and culture, and there is a need for care systems that are fluid enough to accommodate them. However, hospital care has been compared to an industrial factory, in which women's bodies are reduced to machines and labour care resembles an assembly line (Martin, 1987; Kirkham, 2003), and more recent research suggests that funnelling through specific care is

still occurring (McCourt, 2005; Walsh, 2006). Inflexible information provisions and care pathways imbued with strategic silences may account for women's continued reliance on social and familial networks for support, despite their desire for good quality information from HCPs. Such networks provide opportunities to acquire key maternity knowledge but also leave space for personalisation, in that women are free to embrace or ignore as many pieces of information as they choose. They are also actors who inhabit the same field as the expecting mothers do, that of the patient, and within this field, they share only experiences and knowledge. Decision aids can be useful tools for facilitating informed choices, or simply raising awareness of non-hospital based options for women with straightforward pregnancies; however, it is essential that they do not replace clinicians. Parents still rely on their expertise, but they also seek out those in their social networks for information and hold it with nearly equal weight as the information from HCPs. In thinking of solutions, we should ask: is there any reason that HCPs could not also become extension of these networks? Placing more trust and respect, especially trusting women's experiences, recognising their embodiedness and respecting their bodily autonomy, in care giving and receiving will help to make strides in restructuring not only the services, but also the way we think about relationships within them.

HCPs must fully embrace their emerging roles in women's social networks and 'alternative' forms of maternity care that are based within the community, such as FMUs and home birth. Given the low birth rates in these settings and the silences around them, there is still significant work to be done on normalising these pathways. HCPs, given their trusted expertise, hold the unique position, allowing them to spearhead this, beginning by promoting their safety. There are two key components to consider moving forward with 'community-based' care: what the community means in health services, and how safety is discussed in conjunction with this model of care. As McCourt stressed, "[c]ommunity is a concept which is supposed to bind individuals to social units beyond kinship, the essential material or thread of society and culture. Yet the ways in which it binds are rarely explored and often left undefined" (1998, p. 48). There is a strong, historically-defined community identity in East London, which is marked by engagement in the political and health beat of the area, and gives rise to services, such as the Barkantine Birth Centre. As a community-generated, community-based "hub" providing a "gold standard of care" (Yuill, et al., 2018), it exemplifies ideals for maternity services laid out in *Better Births* (National Maternity Review, 2016). Yet, the unit was habitually marked by persistent silences that obfuscated the benefits of its model of care, even its visibility within its own NHS maternity service, Barts Health. Like concepts of choice, what comprises 'community-

based' in the eyes of the trust is at odds with what it means to the community itself and to the services intimately that involve in it. A coherent, community-led notion of 'community' must be embedded into maternity services, if compassionate, dignified and socially meaningful models of care are to flourish.

Then, there is the matter of risk and safety. Effectively and transparently communicating about the risk in different care settings, and reconceptualising notions of safety will be crucial for shifting services into communities. Given how immanent uncertainty is in place of birth and how biomedical and obstetric sway permeates and directs decision-making, HCPs should consider their handling of risk language and move towards phrasing that does not over-emphasise its presence where unwarranted, shifting from 'shared decision-making' to 'decision-making in partnership' or from 'patient' to 'service user'. Linguistic changes function as reifications of conceptual shifts and re-balancing of who and what is dominant in relations, just as moving away from 'value-laden' rhetoric (e.g. 'normal') about birth works to codify inclusivity (Sheridan & Sandall, 2010). There is also a persistent trope that women's preferences are in tension with safety, or even at odds with it, despite evidence running contrary to this. The RCOG response to the Birthplace in England study, for example, in which they refused to acknowledge home birth has a viable, safe option and listed the OU before the AMU, represented a paternalistic discourse of protecting women from themselves that overshadowed the actual evidence. Moreover, the NICE guidelines do not make explicit the greater safety for women when they plan their births in midwifery units or at home. With the recent publication of Hutton et al's (2019) meta-analysis, which found no differences in perinatal or neonatal mortality between low-risk women planning their births in hospitals versus those planning at home, there is an growing urgency to ask: "is hospital birth safe or sustainable for low risk women in developed and developing nations?" (Dahlen, 2019, p. 1). With the strengthening evidence base, the imperative for obstetricians, midwives and policymakers to acknowledge that the hospital is not as safe – and possibly not as financially or environmentally as sustainable – as home birth and midwifery units will begin to take on increasingly ethical dimensions.

This focus on humanised, embodied, ethical community-based care is not to say that a 'good birth' cannot be achieved in a hospital. In Chapter 2, respect for bodily autonomy was equated with better birth experiences in this setting. Women's experiences featured in the systematic review and in my ethnography highlight aspects of care that reflect Melender's research on what constitutes "good childbirth", which

found that control in birth comprised of “being aware of what is happening, being able to cooperate with the midwife, [and] being able to contribute to the progress of labour” (2006, p. 334). Likewise, Lyerly (2006) argued that ‘good births’ are distinguished by agency, dignity and connectedness. Asking consent and respecting bodily boundaries, wishes and privacy are all key practices that contribute to being cared for “as a person” and having a positive experience in the hospital. Furthermore, women’s experiences suggest that this respect and agency are related to being treated as the primary decision-maker and sharing a bond with a midwife, both of which are possible regardless of birth setting. Women’s values and expectations about birth are mediated through their physical and psychosocial embodied experiences (Downe, et al., 2017), and these shape what matters to women in childbirth and reinforce notion of a ‘good birth’. Yet, the embodied aspects agency, dignity and connectedness are not often recognised in notions of ‘good birth’, and preclude “embodied safety”, which encompasses both “ontological safety” and “physical safety”, all together (Chadwick, 2018, p. 198). Is this re-configured notion of ‘good birth’ possible in the hospital, and, if so, what renderings do the models of care take on beyond family-centred and continuity of carer?

What I propose is acknowledging that the NHS is a pluralistic medical system – or at least a service that is striving to be – one that operates in varying degrees of closeness to biomedicine and within its sway, allowing for multiple maternity care pathways that are not cemented in or revolving around the hospitals. As of now, midwives, working in time- and resource-strapped NHS, are subjected to institutional constraints that prevent them from providing women-centred care (Rayment, 2010). There are policy-based intentions towards community-based care; however antenatal care still extends from the hospital, where most of the bookings in Barts Health take place, and out into the community, before being subsumed back into the hospital. Furthermore, the centres of this community care, such as the Barkantine and Barking Birth Centres and the Tower Hamlets and Sunshine Homebirth teams, are grappling with visibility and legitimacy. Women in each study regularly spoke of the lack of knowledge and information about non-OU birthplace options until late in pregnancy, or the need to initiate conversations about them with their midwives, suggesting that there few active movements from the service to facilitate decision-making about place of birth or to normalise settings outside of the hospital. Effectively, the system still revolves around the OU as the norm and the centre of care, rather than maternity care being more primary-care based, with referral in to specialised care/OU setting as needed, like many other health conditions in the NHS. This would take

an overhaul of the structure of maternity services, and it is not for the HCPs to take on single-handily. We must adapt the system on multiple levels, meaning policymakers and care commissioners must lead broad changes and address maternity service issues with clarity, rather than masking failures to progress behind hollow policy changes that do not trickle down to practice and then suffusing them with silence.

At the end of Chapter 9, I underscored the “critical moment of discordance” in English maternity, in which policy, practice and parents appear to be disjointed in their visions for how services should be improved and how they are actually employed and experienced. Though this discordance is multifaceted, I want to extract the basis of choice from this discussion and focus again on how it is entangled with market ideology and human rights. I have detailed how choice policy and health services are underpinned by a market ideology, as opposed to human rights; however, what does it mean to base a conceptualisation, policy and practice on human rights? Currently, the NHS applies the FREDA (fairness, respect, equality, dignity and autonomy) principles as part of its wider human rights approach, yet these values are often “free-floating, abstract and disembodied”, and human rights conceived from an individualistic stand-point, which is complicated by pregnant woman, who are “not one but two” (Chadwick, 2018, p. 37). What is required is a sustained engagement with human rights principles and how they are reified in policy and practice, and the nascent notions of autonomy and choice that are based on “embodied agency” and ontological shifts of who pregnant people are and what matters to them (Chadwick, 2018) are fruitful and have much to offer to movements focusing on humanising bodies, maternity and biomedicine, as well as the clinical spaces in which they mingle. Suffice to say, simply offering choice and haphazardly facilitating decision-making are not going to be enough to ameliorate the contemporary challenges facing maternity, both in England and internationally. With this in mind, I close this thesis with a quote from Chadwick, who precises the work we, as researchers, policymakers, practitioners and public, have ahead as we move to transfigure maternity worldwide:

The project of vitalizing birth politics requires the development of alternative ontologies of birth that valorize embodied ethics and privilege the embodied personhood of birthgivers. Until we recognize the everyday material implications of the frames we use to think about birthing bodies, there will be no possibility for the vitalization of birth politics or the improvement of maternity services. (2018, p. 203)

Appendix A

Exploring informed decision-making during pregnancy and birth: a meta-synthesis of women's experiences

Protocol

Review team

Ms Cassandra Yuill (City, University of London)

Professor Christine McCourt (City, University of London)

Professor Helen Cheyne (University of Stirling)

Background and rationale

Increasing patients' informed decision-making has long been on the public health agenda, in virtually every area of care. Despite this positive policy shift, promoting more patient autonomy and care experiences that are aligned with personal values can lead to complex trade-offs, as choices are based on more sophisticated, expanding services with less reliance on clinician's intuitive judgment [1]. The commitment to giving and facilitating informed choice is a fundamental aspect of the United Kingdom's National Health Service (NHS) care provision [2-4], but how and if informed choice is actually achieved are less concrete, with some maintaining that it is, "at best, illusory" [5-6]. The issue remains that, while health care professionals believe they are offering patients a choice, in reality, women still have a limited role in decision-making and do not feel their care is presented as a choice [7-8]. The informed choice concept is, therefore, bilateral in nature, and yet, there are few systemic reviews on women's experiences of decision-making about maternity care, particularly intrapartum care.

In order to address this gap, I will conduct a systematic review of studies on women's experiences of making choices about their care during pregnancy and birth. Because this review will be focusing on published qualitative data, I will use the meta-synthesis approach to explore the relevant literature. A meta-synthesis "is bringing together and breaking down of findings, examining them, discovering essential features and, in some way, combining phenomena into a transformed whole [9; 314]. This new interpretation of, or 'going beyond' [10], research is one of key aspects that sets a meta-synthesis apart from a meta-analysis, which aggregates findings to establish 'truths'. My review seeks to re-conceptualize the concept of informed choice and establish a more 'women-centric' definition that fits the maternal health care context in which it will be employed.

Main questions

How is women's decision-making about their care during pregnancy and in birth being explored through qualitative research?

What are women's experiences and perceptions of informed choice and decision-making processes?

What influences informed decision-making about pregnancy and birth care among women?

Outcomes

Primary outcomes

- Follow the evolution of the concept of informed choice in pregnancy and birth care since the early 1990s
- Re-conceptualize the informed choice phenomenon through the lens of women's experiences

Secondary outcomes

- Explore what influences informed decision-making about pregnancy and birth care among women
- Investigate where further research into informed choice in this maternity care context is needed

Databases

I will be searching EBSCO (Academic Search Complete, CINAHL, Medline, SocIndex, PsycARTICLES), OVID (Embase, Global Health, Maternity and Infant Health Care) and Web of Science. Grey literature will be conducted through OpenGrey and EThOs.

Study selection

Content will not be limited to geographic region and must be published in English. Studies must be published from 1990 due to the health policy developments (see Changing Maternity Care 1993 [3]), which created a consistent rhetoric about choice in maternity care not present before. Search included research-based articles in peer-reviewed journals, book chapters and PhD theses. The review will target research concerning decision-making in maternity care contexts, specifically studies about the antenatal and intrapartum periods, excluding professional clinical decision-making. The searches will not include family planning, infertility, abortion or postnatal care. Pregnant women and mothers will be the primary participants in this review, with particular attention paid to their experiences and perspectives in the search strategy. There will be no demographic restrictions placed on the participants being studied in this review. Finally, the search will filter for content employing qualitative or mixed methods research designs and analyses, which will be key for the data extraction and synthesis process.

Search terms and strategy

The search strategy will include Boolean phrases of "AND" and "OR", and terms will be generated using MESH headings, database thesaurus and free text. An example of the search strategy that will be run on EBSCO is detailed in the table below.

Informed choice	(MH "Decision Making, Patient") AB "Informed choice" OR AB "informed decision making" OR AB "decision making" 1 OR 2
Maternity care	(MH "Maternal-Child Care") OR (MH "Intrapartum Care") OR (MH "Perinatal Care") (MH "Childbirth") OR (MH "Pregnancy") AB "maternal health" OR AB "maternity care" OR AB childbirth OR AB birth OR AB labour OR AB "intrapartum care" OR AB "obstetric care" OR AB pregnancy 4 OR 5 OR 6

Women's experiences	(MH "Women") (MH "Mothers") or (MH "Expectant Mothers") AB women N5 experiences OR AB women N5 perceptions OR AB women N5 views OR AB women N5 opinions OR AB women N5 attitudes OR AB women N5 perspectives OR AB women N5 accounts OR AB women N5 narrative OR AB women N5 story OR AB women N5 stories AB mothers N5 experiences OR AB mothers N5 perceptions OR AB mothers N5 views OR AB mothers N5 opinions OR AB mothers N5 attitudes OR AB mothers N5 perspectives OR AB mothers N5 accounts OR AB mothers N5 narrative OR AB mothers N5 story OR AB mothers N5 stories 8 OR 9 OR 10 OR 11
Qualitative studies	(MH "Qualitative Studies") AB "qualitative research" OR AB "qualitative methods" OR AB "mixed methods" OR AB interview OR AB "focus groups" OR AB diary OR AB diaries OR Ab ethnography 13 OR 14
Full search	3 AND 7 AND 12 AND 15

Filter: Humans, from 1990, English language

Inclusion and exclusion criteria

As iterated above, women are the population examined in the review, in particular those who are pregnant or given birth before. Women who have not brought a viable pregnancy to full term, birth partners and health care professionals will be excluded, as the focus is on mothers' perspectives of making decisions during their pregnancy and birth care. There will be no exclusion of participants based on gestational term, mode of birth or location of delivery. The included areas of maternal health will, however, be limited. Studies on maternity service use and access, reproductive choices (e.g. contraception, abortion and delayed childbearing), infertility treatment, HIV/AIDS in pregnancy, health behaviours in pregnancy, foetal screening, decision-making about specific risks or complications, clinical or technical quality of services, and postnatal care will be excluded. These exclusion criteria will restrict the amount of studies reviewed in order to keep the meta-synthesis focused on the primary and secondary outcomes. Special attention will be given to place of birth research, as the review will be incorporated into my PhD thesis on the topic.

This review will include studies using qualitative data collection and analysis to explore women's decision-making about their maternity care and service use, employing a meta-synthesis methodology to do so. This research will often investigate the processes of decision-making and information use without the use of an intervention framework; however, interventions will still be included review if qualitative data collection has been integrated into the intervention's evaluation methodology. These studies frequently investigate the effectiveness of decision-aid or information tool that is provided by the health care professionals to women and seek to influence informed decision-making among women concerning their maternal care. Quantitative studies and findings from mixed-methods studies, RCTs and open-ended questions from survey studies will be excluded but retained as background information and may be referred to in the discussion section of the review.

Research included in the review must contain qualitative data that can be extracted; ergo, only peer-reviewed journal articles, research reports and PhD theses, published or unpublished, will be considered.

Literature reviews, opinion articles and policy documents will be excluded but retained as background information and may be referred to in the discussion. The study selection and screening process will be reported according to the PRISMA recommendations [11]. The following table defines the inclusion and exclusion criteria that will be used during the study screening processes.

	Inclusion	Exclusion
Participants	Women who are primiparous or multiparous, at any gestational term, of any mode of birth, or experienced either a facility-based or non-facility-based delivery	Women who have not brought a viable pregnancy to full term, birth partners, health care professionals
Intervention	Investigating informed choice in maternal health, specifically what influences it and women's experiences of making decisions about their maternity care	Specific focus on maternity service use and access, reproductive choices, infertility treatment, HIV/AIDS in pregnancy, health behaviours in pregnancy, foetal screening, or decision-making about specific risks or complications Post-natal care and practices Clinical or technical quality of care only Women's experiences described by others (e.g. health professionals)
Outcomes	Any	N/A
Study design	Primary qualitative studies, including, but not limited to, ethnography, phenomenology, grounded theory and feminist research. Qualitative components of mixed methods or experimental studies	Quantitative studies, RCTs, quantitative findings from mixed methods designs Open-ended questions in survey studies
Study focus	Exploration of women's informed decision-making about their maternity care and health, specifically what influences choice and women's experiences of this decision-making process	Main focus is not on exploration or women's experiences of informed decision-making in a maternal health context
Setting	High-income countries, middle-income countries with comparable health care system to the United Kingdom	Low-income countries, mid-income countries where health system is not comparable to that of the United Kingdom
Time period	1990-2017	Before 1990
Language	English	All other languages
Publication type	Peer-reviewed articles, theses, research reports	Reviews, opinion articles, policy documents

Data extraction and synthesis

Search results will be exported into RefWorks folders, and duplicates and irrelevant titles will be removed after an initial title screen. A PRISMA flowchart will be employed to record the inclusion of studies, which will be decided on in two phases. The first review author and second reviewer will independently screen

titles and abstracts retrieved using the search strategy in order to identify studies that could potentially be included in the review. The full text of these will be retrieved and assessed by the review author for eligibility with assistance from the second reviewer. Any disagreement will be discussed with the third reviewer.

The first reviewer will extract data from the selected studies for the assessment of study quality and synthesis of evidence. The information extracted will include: study aims, study context, study rationale, study participant demographics, details of the intervention and control conditions if relevant, study methodology, recruitment and attrition rates, qualitative data results, study findings and information for the assessment of risk of bias. The review author will extract data with supervision from the second reviewer. Any discrepancies will be identified and resolved through discussion with the third reviewer where necessary. The qualitative data extracted will be coded line-by-line to enable the translations of concepts from one study to another.

Once the relevant data been extracted, I will use NVivo to build a qualitative synthesis, following Thomas and Harden's methodology [10], in order to identify the key concepts in from the studies and translate them into one another. The process of translation allows the recognition of similar concepts used within studies even if they are not explicitly stated as such. The theories associated with these concepts are extracted so that a line of argument can be developed and collaborating concepts can be put together.

Each sentence from the texts of extracted qualitative findings will have a code applied to it and categorised by code use. The coded text will then be checked for consistency of interpretation and if additional levels of coding are needed. Finally, similarities and differences will be found between the codes in order to start forming a hierarchical structure. The end product is intended to be close to the original studies' findings, which have been combined as a whole through the listing of themes. This aims to create a 'hierarchy of evidence' that prioritises the ability of the included studies to answer the review questions rather than their research designs. As this is a qualitative synthesis, it is not possible to specify the subgroups or subsets in advance, though analyses for these may be undertaken.

Risk of bias (quality) assessment

A quality appraisal all of studies under review will be conducted, using the Critical Appraisals Skills Programme (CASP) framework for qualitative research [12]. The tool structures the appraisal within three board issues:

Are the results of the review valid?

What are the results?

Will the results help locally?

There is a checklist made up of ten questions to facilitate the systematic consideration of these issues and to guide the researcher through the appraisal. Each question has prompts to remind reviewers why the question matters in relation to the three board questions. After they are assessed, studies will be sorted into three groups: low, medium and high qualities. The lower quality studies will be kept separately during the data extraction and synthesis process. If the themes in the higher quality studies are also found in the lowest quality studies, then the latter will be incorporated into the review. Lower qualities studies with themes that do not match will be disregarded. The review author will conduct this quality

appraisal and sorting under the supervision of the second reviewer. Any disagreements between the first and second reviewers will be discussed with the third reviewer.

Similar reviews

- Cooke, A, TA Mills & T Lavender (2010) 'Informed and uninformed decision making'—Women's reasoning, experiences and perceptions with regard to advanced maternal age and delayed childbearing: A meta-synthesis. *International Journal of Nursing Studies* 47 (10): 1317.
- Dugas, M (2012) Decision aid tools to support women's decision making in pregnancy and birth: A systematic review and meta-analysis. *Social science & medicine* 74 (12):1968.
- Elmir, R et al (2010) Women's perceptions and experiences of a traumatic birth: a meta-ethnography Women's perceptions and experiences of a traumatic birth. *Journal of advanced nursing* 66 (10): 2142.
- Lundgren, I et al (2012) 'Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section). *BMC pregnancy and childbirth* 12 (1): 85.
- Reid, B et al (2009) A meta-synthesis of pregnant women's decision-making processes with regard to antenatal screening for Down syndrome. *Social science & medicine* 69 (11): 1561.
- Sanders, R, K Crozier & Sandall (2016) How do informal information sources influence women's decision-making for birth? A meta-synthesis of qualitative research. PROSPERO 2016:CRD42016041491 Available from http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42016041491
- Vlemmix, F et al (2013) Decision aids to improve informed decision-making in pregnancy care: a systematic review". *BJOG : an international journal of obstetrics and gynaecology* 120 (3): 257.

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1. Woolf, SH et al (2005) Promoting informed choice: Transforming health care to dispense knowledge for decision making. *Annals of Internal Medicine* 143: 293-300.
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9. Schreiber, R, Crooks, D., & Stern, P.N. (1997) Qualitative meta- synthesis; Issues and techniques. In Morse, J.M. Ed. *Completing a qualitative project; details and dialogue*. Thousand Oaks, CA: Sage.

10. Thomas, J & A Harden (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology* 8(45).
11. Centre for Reviews and Dissemination (2009) *Systematic reviews: CRD's guidance for undertaking reviews in health care*. Accessed 6 December 2016.
https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf
12. Critical Appraisal Skills Programme (CASP) (2013) *Qualitative Research Checklist*. Accessed 23 February 2017. http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf

Appendix B

An example of the search strategy used on EBSCO.

Informed choice	1. (MH "Decision Making, Patient") 2. AB "Informed choice" OR AB "informed decision making" OR AB "decision making" 3. 1 OR 2
Maternity care	4. (MH "Maternal-Child Care") OR (MH "Intrapartum Care") OR (MH "Perinatal Care") 5. (MH "Childbirth") OR (MH "Pregnancy") 6. AB "maternal health" OR AB "maternity care" OR AB childbirth OR AB birth OR AB labour OR AB "intrapartum care" OR AB "obstetric care" OR AB pregnancy 7. 4 OR 5 OR 6
Women's experiences	8. (MH "Women") 9. (MH "Mothers") or (MH "Expectant Mothers") 10. AB women N5 experiences OR AB women N5 perceptions OR AB women N5 views OR AB women N5 opinions OR AB women N5 attitudes OR AB women N5 perspectives OR AB women N5 accounts OR AB women N5 narrative OR AB women N5 story OR AB women N5 stories 11. AB mothers N5 experiences OR AB mothers N5 perceptions OR AB mothers N5 views OR AB mothers N5 opinions OR AB mothers N5 attitudes OR AB mothers N5 perspectives OR AB mothers N5 accounts OR AB mothers N5 narrative OR AB mothers N5 story OR AB mothers N5 stories 12. 8 OR 9 OR 10 OR 11
Qualitative studies	13. (MH "Qualitative Studies") 14. AB "qualitative research" OR AB "qualitative methods" OR AB "mixed methods" OR AB interview OR AB "focus groups" OR AB diary OR AB diaries OR Ab ethnography 15. 13 OR 14
Full search	16. 3 AND 7 AND 12 AND 15
Filter: Humans, from 1990, English language	

Appendix C

The inclusion and exclusion criteria used during the screening of search results.

	Inclusion	Exclusion
Participants	Parents who are primiparous or multiparous, at any gestational term, of any mode of birth, or experienced either a facility-based or non-facility-based delivery	Women who have not brought a viable pregnancy to full term, birth partners who are not fathers, health care professionals
Intervention	Investigating informed choice in maternal health, specifically what influences it and women's experiences of making decisions about their maternity care	Specific focus on maternity service use and access, reproductive choices, infertility treatment, HIV/AIDS in pregnancy, health behaviours in pregnancy, foetal screening, or decision-making about specific risks or complications VBAC or planned caesarean section Post-natal care and practices Clinical or technical quality of care only Women's experiences described by others (e.g. health professionals)
Outcomes	Any	N/A
Study design	Primary qualitative studies, including, but not limited to, ethnography, phenomenology, grounded theory and feminist research. Qualitative components of mixed methods or experimental studies	Quantitative studies, RCTs, quantitative findings from mixed methods designs Open-ended questions in survey studies
Study focus	Exploration of women's informed decision-making about their maternity care and health, specifically what influences choice and women's experiences of this decision-making process	Main focus is not on exploration or women's experiences of informed decision-making in a maternal health context
Setting	High-income countries, middle-income countries with comparable health care system and socio-cultural background to the United Kingdom	Low-income countries, mid-income countries where health system and socio-cultural background is not comparable to that of the United Kingdom
Time period	1990-2017	Before 1990
Language	English	All other languages
Publication type	Peer-reviewed articles, theses, research reports	Reviews, opinion articles, policy documents

Appendix D

Adapted tool by Rocca-Ihenacho used for the quality appraisal.

Stages	Specific elements	Essential criteria	Score
Rational	Scope and purpose	1. Contextualization with literature	
		2. Aims	
		3. Research question or objectives stated	
Design	Methodology	4. Rational for using qualitative design	
		5. Description of theoretical background	
		6. Description of methodology	
		7. Methodology appropriate for research question or objectives	
	Methods	8. Description of methods	
		9. Methods appropriate for research question or objectives	
	Sampling strategy	10. Rational for sampling strategy explained	
		11. Selection criteria described	
		12. Thickness of description likely to be achieved from sampling	
	Data collection	13. Description of data collection	
		14. Data collection strategy appropriate to capture complexity of events and highlight context	
	Analysis	15. Analytical approach explicit	
		16. Analytical approach appropriate for methodology	
		17. Analysis grounded in the data	
		18. Evidence of participants' involvement in analysis	

		19. Saturation addressed	
Interpretation	Clear audit trail given	20. Demonstration of thorough interpretive pathway and 'decision trail'	
	Description of context	21. Description of social, physical and interpersonal contexts of data collection	
	Interpretation grounded in the data	22. Extensive use of field notes entries/verbatim interview quotes in discussion of findings	
		23. Provides new insights and increases understanding	
Discussion	Contextualization with literature	24. Findings compared and contrasted with other literature	
	Relevance and transferability	25. Interpretation interwoven with existing theories and other relevant literature drawn from similar settings	
		26. Discussion of how explanatory proposition/emergent theory may fit other contexts	
		27. Limitations and weaknesses of study clearly outlined	
		28. Significance for current policy and practice outlined	
		29. Outlines further directions for investigation	
Reflexivity	Researcher reflexivity demonstrated	30. Discussion of relationship between research and participants during fieldwork	
		31. Discussion about how issues/complications met were dealt with	
Ethical dimensions	Ethical committee approval	32. Evidence of ethical approval and following ethical procedures	
	Sensitivity to ethical concerns	33. Documentation of how autonomy, consent, confidentiality, anonymity were managed	
		Total	

Appendix E

	Study	Country	Study aims	Participants, setting	Study design, data collection, analysis	Quality
1	(Andrews, 2004)	United Kingdom	To explore women's experiences of home birth	8 women who had planned a home birth in the six months before the study South Wales	Qualitative study Semi-structured interviews using open-ended questions Thematic analysis using a phenomenological approach	M
2	(Bedwell, et al., 2011)	United Kingdom	To explore expectant fathers' views of birth setting	37 expectant fathers, 19 of which were interviewed North West of England	Qualitative interpretive approach Semi-structured interviews in women's 34 th week of pregnancy Thematic analysis	M
3	(Bernhard, et al., 2014)	United States of America	To explore why women choose home birth and their perceptions of their birth experiences	20 women who had a hospital birth and subsequently chose a home birth Not stated	Qualitative description study Five focus groups conducted with participants Qualitative content analysis	M
4	(Catling, et al., 2014)	Australia	To explore what influences women who chose a publicly-funded home birth in one state in Australia	17 women who chose a publicly-funded home birth Suburbs of Sydney, Australia	Qualitative study using a constructivist grounded theory approach Semi-structured interviews were conducted with participants Analysis method not stated	M
5	(Catling-Paull, et al., 2010)	Australia	To explore the reasons why multiparous women feel confident to have a home birth within a publicly-funded model of care in Australia.	10 multiparous women who chose to have a home birth within a publicly funded care model in Australia.	Qualitative study Postnatal semi-structured interviews using open-ended questions Thematic analysis	M
6	(Cheung, 2002)	United Kingdom	To provide insights into how women's birth experiences can be improved	10 Scottish and 10 Chinese pregnant women Scotland	Four semi-structured interviews (antenatal and postnatal) with the 20 expectant mothers Thematic analysis filtered through participant observation	H

7	(Coxon, et al., 2014)	United Kingdom	To examine the extent to which approaches to risk can enhance understandings about birthplace decision-making	41 women who access maternity services Two inner-city area and one semi-rural area in the United Kingdom	Longitudinal narrative study Three interviews with all participants Thematic narrative analysis	H
8	(Coxon, et al., 2015)	United Kingdom	To explore the influence of pregnancy and birth experiences on women's current and future place of birth decisions	41 women who access maternity services Two inner-city area and one semi-rural area in the United Kingdom	Prospective, longitudinal narrative study Three interviews with all participants Thematic and structural narrative analysis	M
9	(Dahlen, et al., 2008)	Australia	To explore the experiences of first-time mothers who gave birth either at home or in the hospital in Australia	19 first-time mothers Not stated	Qualitative study using a grounded theory approach In-depth interviews were conducted with participants 6 weeks after they had given birth Grounded theory analysis procedure using open, axial and selective coding	M
10	(DiFilippo, 2015)	Canada	To examine women's learning when choosing to give birth at home with a midwife using a critical feminist approach	7 women who planned a midwife-attended home birth in the two years prior Ontario, Canada	Qualitative study Semi-structured interviews were conducted with each of the 7 participants Close textual analysis in order to identify themes	M
11	(Feeley & Thomson, 2016)	United Kingdom	To explore what influences women's decisions to free birth within the United Kingdom	10 women planning to freebirth Not stated	Qualitative study using an interpretive phenomenological approach Narratives (n=9) and in-depth interviews (n=10) were conducted with participants Analysis guide by Heidegger and Gadamer's interpretive phenomenological concepts	H
12	(Grigg, et al., 2014)	New Zealand	To explore and report what influences women's decision-making about place of birth in New Zealand	37 women from the larger study cohort (n=702) Christchurch, New Zealand	Mixed methods study Qualitative data generated from focus groups conducted in Christchurch Inductive content analysis	M
13	(Grigg, et al., 2015)	New Zealand	To explore women's birthplace decision-making	37 women from the larger study cohort (n=702) Christchurch, New Zealand	Mixed methods prospective cohort study Eight focus groups were conducted Thematic analysis	M

			To identify what enables a woman to plan giving birth in freestanding midwifery-led unit rather than an obstetric unit			
14	(Happel-Parkins & Azim, 2016)	United States of America	To explore and contextualise the experiences of first-time mothers who planned a natural birth (e.g. No medical intervention)	6 first time mothers Midsouthern region of the United States	Narrative inquiry study Semi-structured, life-story interviews were conducted Thematic analysis	H
15	(Jimenez, et al., 2010)	Canada	To explore women's birth experience in the context of the changes that have occurred in perinatal care since the 1970s To examine how acquired information and knowledge about birth and pregnancy influence women's birth experiences	36 pregnant women (26 from Montreal, 10 from Vancouver) Montreal and Vancouver, Canada	Qualitative study using semi-structured interviews Two semi-structured interviews at 4-6 weeks before birth and 6-8 weeks after birth were conducted with participants Thematic analysis	M
16	(Lagan, et al., 2011)	Australia, Canada, New Zealand, United Kingdom and United States of America	To build on previous quantitative studies on women's internet usage for pregnancy-related information To explore women's experiences and perceptions of using the Internet for pregnancy-related information and its influence on their decision-making	92 women from five countries Online, specific regions not stated	Global study drawing on interpretative qualitative traditions 13 asynchronous online focus groups Inductive thematic analysis using Ritchie and Spencer's framework	M
17	(Lally, et al., 2014)	United Kingdom	To explore how women can be better supported when preparing for and making decisions about pain management during pregnancy and labour	32 pregnant women North east region of England	Qualitative study Semi-structured interviews conducted when women were 28-36 weeks pregnant and six weeks after they gave birth Thematic analysis	M

18	(Lee, et al., 2016)	United Kingdom	To examine the decisions about place of birth among women with high-risk pregnancies, who were planning either home or hospital births	26 women with high-risk pregnancies, who were at least 32 weeks gestation Not stated	Qualitative study Semi-structured interviews Inductive thematic analysis	H
19	(Levy, 1999)	United Kingdom	To explore the processes involved when women make informed choices during pregnancy	17 pregnant women receiving care in different maternity settings East Midlands, England	Qualitative study using grounded theory approach Observation during booking appointments of 12 women, with follow-up interviews Five interviews and one observation with women who were 32-38 weeks pregnant to aid theory construction Thematic analysis using a grounded theory approach	M
20	(Lothian, 2013)	United States of America	To explore women's experiences of planning, preparing for and having a home birth in the United States	13 pregnant women who were planning a home birth in the United States Not stated	Ethnography Informal interviews and participant observation during participants' pregnancies and after the births of their babies Thematic analysis following Lincoln and Guba's guidelines	M
21	(Madi, 2001)	United Kingdom	To explore pregnant women's decisions about place of birth and what influences their preferences	33 pregnant women (20 planning a hospital birth, 13 planning a home birth) Not stated	Qualitative study Semi-structured interviews were conducted with all participants Thematic analysis	H
22	(Malacrida, 2015)	Canada	To examine how women learn about birth and make choices using a critical feminist perspective	40 expectant and new mothers Red Deer and Lethbridge, Alberta, Canada	Qualitative study Qualitative, semi-structured interviews were conducted with 40 expectant and new mothers Thematic analysis using Atlas-ti software	M
23	(Mander & Melender, 2009)	Scotland, Finland and New Zealand	To examine if choices and decision-making could be enhanced for pregnant women in Scotland	4 women who use the maternity services Not stated	Qualitative study using a hermeneutic phenomenological approach In-depth, semi-structured conversations	H

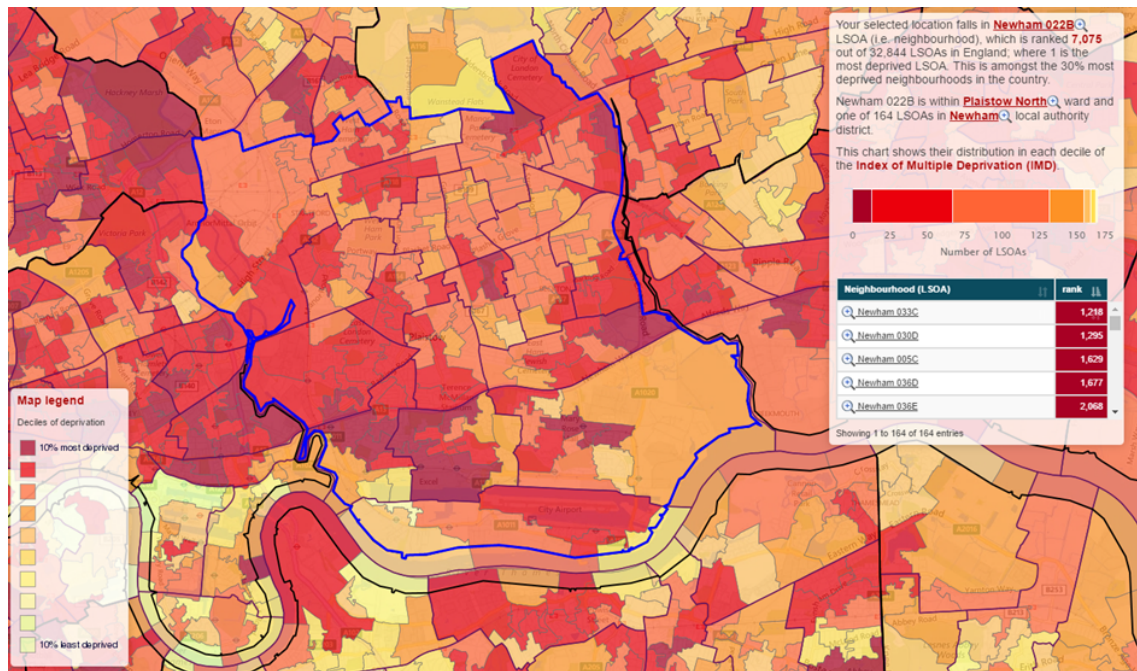
			To inform the organisation of Scottish maternity services		Modification of Colaizzi's analysis procedure for phenomenological research	
24	(Miller & Shriver, 2012)	United States of America	To explore women's perceptions and decision-making regarding birth in an American context	135 women who chose either a home birth with a midwife, an unassisted home birth or a hospital birth Southeastern region of the United States	Three phase qualitative and ethnographic study Phase one involved interviews with 60 women, phase two involved in-depth interviews with 21 interviews supplemented by a dataset of 127 birth stories and phase three was an ethnography of birth in an American obstetric unit Line-by-line coding analysis of interview transcripts and database birth stories Contextual analysis of field notes	H
25	(Murray-Davis, et al., 2012)	Canada	To increase understanding of why women decide to have a home birth To describe what influences women's decision to plan a home birth	34 women (16 from Ontario, 18 from British Columbia) who were either pregnant and planning a home birth or who had planned a home birth in the last two years Ontario and British Columbia, Canada	Qualitative study using a grounded theory approach Semi-structured interviews Thematic analysis	M
26	(Pitchforth, et al., 2009)	United Kingdom	To explore women's experiences of choice of birthplace in remote and rural area where different models of maternity services	70 women who had given birth in the prior 7 years Remote and rural areas of North Scotland	Qualitative study 12 focus groups at eight study sites Analysis using an inductive thematic approach	H
27	(Regan, et al., 2013)	United States of America	To examine the factors that influence women's decisions about birth and how this affects caesarean section use	49 first-time mothers between the ages of 21 to 36, who were in their 28-36 th week of pregnancy Not stated	Mixed methods study Focus groups and structured postpartum interviews with all participants Analysis using the Consensual Qualitative Research method	H

28	(Stapleton, et al., 2002)	United Kingdom	To examine how evidence-based leaflets about informed choice are used in maternity services	Pregnant women were recruited from maternity units Cohort size not reported Not stated	Randomised controlled trial using qualitative methods 886 non-participant observations of antenatal consultations and 173 in-depth, semi-structured interviews (85 antenatal, 78 postnatal) Not stated	M
29	(Song, et al., 2012)	United States of America	To explore how white women use the Internet during their experiences of conception, pregnancy and birth To examine the extent to which this usage aids in making meaningful choices and shapes their patient identities	32 women who identified as Caucasian Southeastern region of the United States	Qualitative study using grounded theory approach Interviews were conducted with each of the 32 participants Thematic analysis using the inductive approach of grounded theory	M
30	(Viisainen, 2001)	Finland	To explore how cultural models of birth and current practical choices influence parents' understanding of home birth To examine women's reasons for and experience of planning a home birth	21 women and 12 men who had planned to give birth at home within the prior three years	Qualitative study Unstructured interviews with open-ended questions were conducted with 12 couple and 9 mothers alone Narrative structuring used for analysis	M

Appendix F

Newham

A map of the Borough of Newham with the Indices of Multiple Deprivation scores overlaid.



Index of Multiple Deprivation, [DCLG 2015](#)

Newham average ranking* in England (out of 326 areas)	
2010	2015
2	8

* 1 being the most deprived.

Main Languages spoken by Newham residents

(Top 10) (aged 3+), Census 2011

English	58.6%	Tamil	2.3%
Bengali	7.4%	Polish	2.0%
Urdu	4.4%	Punjabi	1.8%
Gujarati	3.3%	Romanian	1.6%
Lithuanian	2.7%	Portuguese	1.4%

Births, [Birth summary tables - ONS](#)

2012	2013	2014	2015
6,426	6,267	6,023	6,226

Proficiency in English (aged 16+), [Census 2011](#)

Population by ethnic group*, [GLA Ethnic Group](#)

[Projections](#)

White	26.8%
<i>British</i>	13.5%
<i>Other</i>	12.6%
<i>Irish</i>	0.7%
Asian/Asian British	46.1%
<i>Indian</i>	15.0%
<i>Pakistani</i>	10.4%
<i>Bangladeshi</i>	12.4%
<i>Chinese</i>	1.4%
<i>Other Asian</i>	6.6%
Black/Black British	18.3%
<i>African</i>	11.2%
<i>Caribbean</i>	4.4%
<i>Other Black</i>	2.6%
Mixed/multiple ethnic groups	4.9%
Other Ethnic Group (including Arab)	3.9%

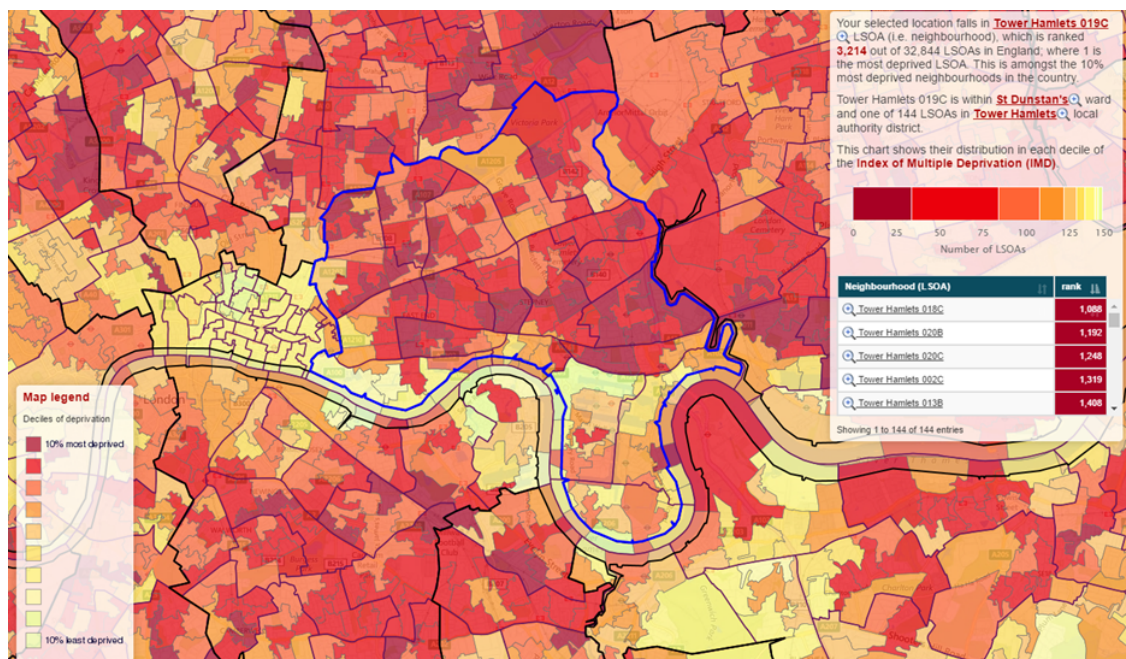
Residents whose main language was not English but can speak English:	Newham	London
Very/well	78.9%	81.5%
Cannot speak English well	17.9%	15.7%
Cannot speak English	3.2%	2.8%

Religion, [Census 2011](#)

Christian	40.0%	Religion not stated	6.4%
Muslim	32.0%	Sikh	2.1%
No Religion	9.5%	Buddhist	0.8%
Hindu	8.8%		

Tower Hamlets

A map of the Borough of Tower Hamlets with the Indices of Multiple Deprivation scores overlaid.



Index of Multiple Deprivation, [DCLG 2015](#)

Tower Hamlets average* ranking in England (out of 326 areas)	
2010	2015
3	6

* 1 being the most deprived.

Main languages spoken by Tower Hamlets residents (Top 10) (aged 3+), [Census 2011](#)

English	65.8%	Italian	1.1%
Bengali	18.0%	Somali	1.0%
Chinese	1.7%	Polish	0.9%
French	1.4%	Portuguese	0.8%
Spanish	2.2%	German	0.7%

Births, [Birth summary tables – ONS](#)

2012	2013	2014	2015
6,426	6,267	6,023	6,226

Population by ethnic group, [Census 2011](#)

White	45.0%
<i>British</i>	31.0%
<i>Other</i>	12.0%
<i>Irish</i>	2.0%
Asian/Asian British	41.0%
<i>Indian</i>	3.0%
<i>Pakistani</i>	1.0%

Proficiency in English (aged 16+), [Census 2011](#)

Main language is English	65%	
Main language is not English	35%	
Residents whose main language was not English but can speak English:	Tower Hamlets	London
Very/well	75%	81.5%
Cannot speak English well	20%	15.7%
Cannot speak English	5%	2.8%

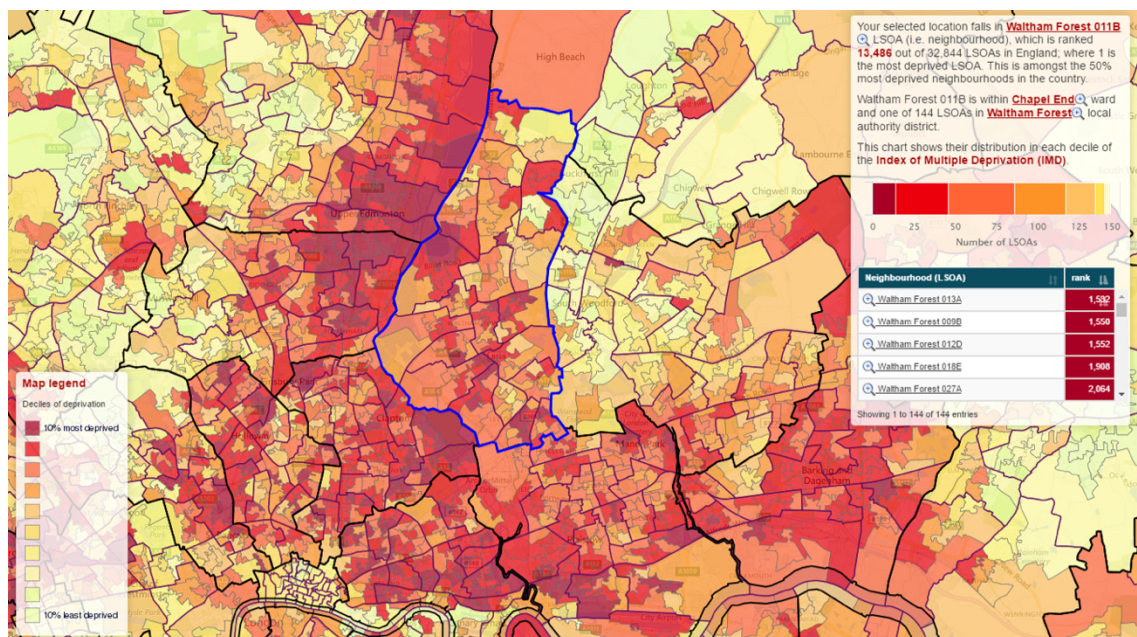
	<i>Bangladeshi</i>	32.0%
	<i>Chinese</i>	3.0%
	<i>Other Asian</i>	2.0%
	Black/Black British	7.0%
	<i>African</i>	4.0%
	<i>Caribbean</i>	2.0%
	<i>Other Black</i>	1.0%
	Mixed/multiple ethnic groups	4.0%
	Other Ethnic Group (including Arab)	2.0%

Religion, [Census 2011](#)

Muslim	38.0%	Hindu	1.8%
Christian	29.8%	Buddhist	1.2%
No Religion	21.0%	Jewish	0.6%
Religion Not Stated	6.9%		

Waltham Forest

A map of the Borough of Waltham Forest with the Indices of Multiple Deprivation scores overlaid.



Index of Multiple Deprivation, [DCLG 2015](#)

Waltham Forest average ranking* in England (out of 326 areas)	
2010	2015
15	35

*1 being the most deprived.

Main languages spoken by residents (Top 10) (aged 3 and over), [Census 2011](#)

English	59.9%	Lithuanian	1.3%
Urdu	3.3%	Punjabi	1.2%
Polish	3.3%	Tamil	1.0%
Romanian	1.6%	Bengali	1.0%

Turkish	1.6%	French	0.9%

Births, [Birth summary tables - ONS](#)

2012	2013	2014	2015
6,426	6,267	6,023	6,226

Percentage of people by ethnic group, [GLA Ethnic Group Projections](#)

White	26.8%
<i>British</i>	13.5%
<i>Other</i>	12.6%
<i>Irish</i>	0.7%
Asian/Asian British	46.1%
<i>Indian</i>	15.0%
<i>Pakistani</i>	10.4%
<i>Bangladeshi</i>	12.4%
<i>Chinese</i>	1.4%
<i>Other Asian</i>	6.6%
Black/Black British	18.3%
<i>African</i>	11.2%
<i>Caribbean</i>	4.4%
<i>Other Black</i>	2.6%
Mixed/multiple ethnic groups	4.9%
Other Ethnic Group (including Arab)	3.9%

Proficiency in English, [Census 2011](#)

Residents whose main language was not English but can speak English:	Newham	London
Very/well	78.9%	81.5%
Cannot speak English well	17.9%	15.7%
Cannot speak English	3.2%	2.8%

Religion, [Census 2011](#)

Christian	40.0%	Sikh	2.1%
Muslim	32.0%	Buddhist	0.8%
Hindu	8.8%	No Religion	9.5%
Religion Not Stated	6.4%		

Appendix G

Community-based study ethics application, study documents, ethics approval and indemnity from City, University of London.

Ethics application

Research Ethics Committee

Application for Approval of Research Involving Human Participants

Please tick the box for which Committee you are submitting your application to

☐	Senate Research Ethics Committee
☐	Cass Business School
☐	Computer Science
☒	School of Health Sciences Research Ethics Committee
☐	Department for Learning Enhancement and Development

For **Senate** applications: return one signed hardcopy of the completed form and all the supporting documentation to Anna Ramberg, Research Governance & Compliance Manager, Research & Enterprise, Northampton Square, London, EC1V 0HB. Please also email an electronic copy as a single document to Anna.Ramberg.1@city.ac.uk (indicating the names of those signing the hard copy).

For **Computer Science** applications: a single copy of the application form and all supporting documents should be emailed to Stephanie Wilson S.M.Wilson@city.ac.uk

For **School of Health Sciences** applications: submit all forms (including the Research Registration form) electronically (in Word format in a single document) to A.Welton@city.ac.uk.

For **Department for Learning Enhancement and Development**: a single copy of the application form and all the supporting documentation should be emailed to Pam Parker (P.M.Parker@city.ac.uk).

Refer to the separate guidelines while completing this form.

PLEASE NOTE THE FOLLOWING:

- Ethical approval **MUST** be obtained before any research involving human participants is undertaken. Failure to do so may result in disciplinary procedures being instigated, and you will not be covered by City's indemnity if you do not have approval in place. It may also result in the degree not being awarded or the data not being published in a peer review journal.
- The Signature Sections **MUST** be completed by the Principal Investigator (the supervisor and the student if it is a student project).

Project Title:
Places of birth: a study of information, choice and outcomes in a maternity context (Exploratory phase)

Short Project Title (no more than 80 characters):
Places of birth: a study of information, choice and outcomes in a maternity context
Name of Principal Investigator(s) (if this is a student project, please note that the Principal Investigator is the supervisor and all correspondence will be with the supervisor):
Professor Christine McCourt
Post Held (including staff/student number):
Professor of Maternal and Child Health
Department(s)/School(s) involved at City:
Centre for Maternal and Child Health Research, School of Health Sciences
If this is part of a degree please specify type of degree:
MPhil/PhD
Date of Submission of Application:
03 February 2016

Tick this box if you do not grant City permission to use your application form for training purposes ☐

1. Applicant Details

This project involves:

(tick as many as apply)

☐	Staff Research	☒	Doctoral Student
☐	Undergraduate	☐	M-level Project
☐	Externally funded	☐	External investigators
☐	Other		
Provide details of external investigators and/or other			

Contact details for the Principal Investigator (including email address and telephone number)

Christine.mccourt1@city.ac.uk, 5863

Other staff members involved

<i>Title, Name & Staff Number</i>	<i>Post</i>	<i>Dept & School</i>	<i>Phone</i>	<i>Email</i>
Lucia Rocca-Ihenacho	Lecturer	Midwifery, School of Health Sciences	5799	Lucia.Rocca-Ihenacho@city.ac.uk

All students involved in carrying out the investigation

<i>Name & Student Number</i>	<i>Course / Year</i>	<i>Dept & School</i>	<i>Email</i>
Cassandra Yuill, 160070521	PhD Health Sciences	Centre for Maternal and Child Health Research, School of Health Sciences	Cassandra.yuill@city.ac.uk

External co-investigators

<i>Title & Name</i>	<i>Post</i>	<i>Institution</i>	<i>Phone</i>	<i>Email</i>
Dr Helen Cheyne	Professor of Midwifery	University of Stirling		h.l.cheyne@stir.ac.uk

Please describe the role(s) of all the investigators, including all student(s)/external co-investigator(s) in the project, especially with regards to interaction with study participants.

The principal investigator, Prof McCourt, and co-investigators, Dr. Rocca-Ihenacho and Prof Cheyne, comprise the supervisory team for the doctoral student, Ms Yuill. They will provide support and feedback on academic and research outputs throughout the study preparation, conduct, completion and dissemination. Ms Yuill is responsible for the study design, liaising with key gatekeepers, obtaining ethics approval, conducting data collection, data analysis and reporting of results, all of which will make up the content for annual progress reviews and sections of the final doctoral thesis.

If external investigators are involved, please provide details of their indemnity cover.

Prof Cheyne is an external supervisor and not directly involved with the research.

Application Details

1.1 Is this application or any part of this research project being submitted to another ethics committee, or has it previously been submitted to an ethics committee? *This includes an NHS local Research Ethics Committee or a City local Research Ethics Committee or any other institutional committee or collaborating partners or research site. (See the guidelines for more information on research involving NHS patients.)*

YES ☐ NO ☒

If yes, please give details and justification for going to separate committees, details of the Secretary of the relevant authority/committee, and, if appropriate, attach correspondence and details of the outcome of the application, including any conditions of approval or reasons for rejection.

Later phases of the work will require subsequent submission to NHS REC.

1.2 If any part of the investigation is being carried out under the auspices of an outside organisation, involves collaboration between institutions or individual external researchers, or

institutions/organisations where interviews/fieldwork will take place please give details and address of organisation(s).

Which? Birth Choice
Social Action for Health (SAfH)

1.3 Has permission to conduct research in, at or through another institution or organisation been obtained? YES ☒ NO ☐

If yes, please provide details and attach the supporting correspondence.

Formal permission will not be needed from Which? Birth Choice, as it is not directly involved in the research.

I have met with SafH and they have confirmed verbally that they are interested in assisting the focus groups. The work is not dependent on this, but as a community-based health organisation, they are in an ideal position to promote the groups. E-mail confirmation of a planning meeting in mid-April is included in the Appendix 4 and a letter of permission has been sent to the Ethics Committee.

Additional permission was sought from SAfH to conduct participant observation during their Maternity Voices events. Support and approval can be found in Appendix 4.

1.4 Duration of Project

Start date: 04/2017

Estimated end date: 07/2018

Funding Details

1.5 Is the project reliant on funding? If no, please go to the next section. YES ☒ NO ☐

If yes, please provide details of the source of financial support (e.g. funding body, charity etc.) for the proposed investigation.

Which? & City, University of London (co-funded studentship)

1.5a Has funding been applied for? YES ☒ NO ☐

1.5b Has funding been approved? YES ☒ NO ☐

If no, please provide details of when the outcome can be expected

International Research

1.6 Is any part of the research taking place outside of England/Wales? (if not go to section 2) YES ☐ NO ☒

If yes, please provide details of where.

2. Project Details

2.1 Provide the background (including the current state of the art in this field), aim(s) and objectives of the proposed research,

The British government has been committed to ensuring that women and their partners have access to a range of choices in maternity services [1]. Importantly, this includes where women decide to give birth, which has implications for birth experiences and outcomes [2]. The NICE Clinical Guideline 190 (2014) and Quality Standard 105 (2015) recommend offering choices between home birth, midwife-led units or obstetric unit, emphasising the importance of health care professionals (HCPs) providing information and advice about all available settings to allow women and their partners to make informed birthplace decisions [3,4].

Moving forward, it is crucial to understand the extent to which providing this information through different sources has an impact on place of birth decision-making. The Which? Birth Choice (<http://www.which.co.uk/birth-choice/>) is a web-based tool that helps families decide where to give birth and understand their maternity options. The site receives over 60,000 unique visits a month, and internal research conducted by Which? reveals that many use the site to confirm pre-existing views on birthplace, while others use it to aid in deciding where they want to give birth. It is still unknown in what ways Which? Birth Choice influences these decisions and how women and their partners feel about their birth options. Research on decision aids in maternity care is inconclusive and indicates that information use is complex, with some forms of information having little influence on informed choice.

Why is place of birth choice so important? Providing choice not only empowers women but also increases the rate of straightforward births and parents' satisfaction with their birth experience and outcome [5]. Even the act of making a birth plan can empower women by expanding knowledge and understanding of maternity care [6]. Moreover, medical interventions are lower and recovery times shorter among those who choose midwifery-led care or home birth, reducing the costs associated with these options [5]. Uptake of hospital birth is still high, but there are indications that it is decreasing, with a 5.2% drop between 2012 and 2015 [7,8]. With the push for the diversification of services and their uptake, place of birth decision-making and what influences it must be considered in order to shape maternity care and information provision.

Such considerations bring forward the issues around informed choice (how to achieve it, augment it and assess it). The concept is most often explored through the development and evaluation of decision-making aids. A review of pregnancy and birth decision aids suggests that decision analysis tools (tools that helps people make decisions when there are several options) significantly influence final choice and final outcome [9]. This signals a need to further investigate to what extent a decision-aid can influence choice and empower women to put birthplace preferences into practice. Exploring the decision pathway to a specific place of birth and subsequent birth outcomes will be key as well as evaluating the differences between the two.

Because place of birth choices are made within an individual's socio-economic [10] and cultural context [11], there is an additional layer of complexity beyond the physical, emotional and experiential aspects of childbirth, and this demands a social science, specifically anthropological, perspective. Such an approach provides a prism through which the complexity of informed choice can be better understood, as the exploration of such intricacies is central to the discipline. Increasing choice, improving knowledge and facilitating informed decision-making are strategies that can empower parents, however, pre-existing views, informal networks of knowledge and support and geographic location can take precedence [12]. With that in mind, this project will also focus on the influence these

information sources have on parents and how that influence can vary from individual to individual and from community to community.

References

1. Department of Health (2016) The NHS Choice Framework: what choices are available to me in the NHS?. 29 April 2016 <https://www.gov.uk/government/publications/the-nhs-choice-framework>
2. Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 343: d7400.
3. NICE (2014) Clinical guideline [CG190]: Intrapartum care for healthy women and babies. December 2014 <https://www.nice.org.uk/guidance/cg190/chapter/1-Recommendations#place-of-birth>
4. NICE (2015) Quality standard [QS105]: Intrapartum care. December 2015 <https://www.nice.org.uk/guidance/qs105>
5. NCT (2009) Location, location, location: making choice of place of birth a reality. NCT 2009.
6. Moore, M & U Hopper (1995) Do birth plans empower women? Evaluation of a hospital birth plan. *Birth* 22: 29-36.
7. NHS (2015) NHS Maternity Statistics – England, 2013-14. 28 January 2015 <http://content.digital.nhs.uk/catalogue/PUB16725/nhs-mate-eng-2013-14-summ-repo-rep.pdf>
8. NHS (2015) NHS Maternity Statistics – England, 2014-15. 25 November 2015 <http://content.digital.nhs.uk/catalogue/PUB19127/nhs-mate-eng-2014-15-summ-repo-rep.pdf>
9. Dugas, M et al (2012) Decision aid tools to support women's decision making in pregnancy and birth: A systematic review and meta-analysis. *Social Science & Medicine* 74(2012): 1968-1978.
10. Davis-Floyd, R (1990) The role of obstetrical rituals in the resolution of cultural anomaly. *Social Science and Medicine* 31(2): 175-189.
11. Donner, H (2003) The place of birth: childbearing and kinship in Calcutta middle-class families. *Medical Anthropology* 22: 303-341.
12. McCourt, C, Rance, S, Rayment, J & Sandall, J (2011) *Birthplace in England Research programme: Organisational Case Studies: How maternity care systems may affect the provision of care in different birth settings. Birthplace in England research programme* (Report No. Final Report 6. NIHR Service Delivery Organisation Programme). London: HMSO.

2.2 Please explain how this project will further existing knowledge.

This research project aims to understand the relationship between information, decision-making processes and subsequent choice outcomes in a maternity context through the lens of anthropological theory. It will explore the different routes of impact an internet-based aid has on women and their partners in a health setting with diverse birthplace options. In order to further existing knowledge on informed choice in maternal health, this study aims to:

- Explore how women and their partners use different information sources to make decisions about place of birth
- Assess the impact of the Which? Birth Choice website on women's birth place choices, experiences and outcomes
- Identify and explore what moderating this impact, such as socio-economic status, ethnic background, accessibility of maternity care and conceptions of choice and control in childbirth

2.3 Provide a summary and brief explanation of the design, methodology and plan for analysis that you propose to use.

This exploratory research will be the initial phase of the larger doctoral research project, the background, rationale and contributions of which are described above. The next research phase will involve a feasibility study, which will be conducted in NHS settings, specifically antenatal clinics within Barts Health NHS Trust. A separate ethics application for this feasibility study will be submitted to the NHS Ethics Committee for review after the completion of the exploratory phase. This initial research phase aims to:

- Explore how women make decisions about where to give birth and how they use different information sources to make these
- Investigate relevant issues about place of birth decision-making not yet incorporated in the scope of the project
- Contextualise parents' experiences and issues in the key
- Inform and refine the design of a larger feasibility study to be conducted with Barts Health Trust

Research design

Three focus groups will be conducted in East London areas served by Barts Health NHS Trust with assistance from from SAfH. Participant groups will be demographically similar to those to be approached later in the feasibility study. I will ask participants about their birthplace plans, what information sources they used and what influenced their decision-making. They will then be given the chance to navigate Which? Birth Choice, after which we will discuss their opinions of the site and whether it affects their birthplace plans. These sessions will also offer an opportunity to receive feedback on data collection tools that will be given to participants during the feasibility study. Ideally, focus groups will have no more than 6-8 individuals and last up to 2 hours. Participants will receive a £5 gift voucher for taking part.

Participant observation will also be undertaken during SAfH's Maternity Voices meet-ups, during which local mothers are invited to discuss any issues relating to maternity health and services. I will observe the meetings and participate in my usual role as a volunteer, noting womens' experiences related to place of birth and care provision in their area.

Eligibility criteria to participate:

- Aged 18 or older
- English proficiency or fluency (Which? Birth Choice content is published in English)

Ineligibility criteria:

- Under the age of 18 at time of recruitment

Focus group sessions will be audio recorded, and the audio will be transcribed for analysis.

Observations will not be recorded, but notes will be made during these times. The notes will be completely anonymous; codes for different participants will not be used. I will, however, differentiate between SAfH associate and parent attendant in any notes taken. Focus group transcriptions and participant observation field notes will be thematically analysed using NVivo.

2.4 Please explain how/if participants will be provided with the findings or outcomes of the project.

Focus group and observation participants will be given the opportunity to receive summaries of the findings and outcomes of the project. They will be given my contact details (City, University of London

e-mail address and phone number) and a point of contact in Social Action for Health who will pass along requests for outcomes to the researcher.

2.5 What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?

All participants must provide informed consent before enrolling into the study.

To ensure informed consent has been obtained for the focus groups, the researcher will provide a study information sheet for individuals to read, explaining orally the study aims and participation activities. Individuals will then be given the opportunity to ask questions about the study to obtain any clarifications they need. Potential focus group participants will be given at least 24 hours to consider taking part in the study, giving them time to discuss the study with their families and ask further questions before deciding whether to participate. Verbal consent will be obtained from any individual taking part during an observation.

Data and personal information protection and safeguarding will be addressed and explained to individuals before they provide consent to participate in the focus groups. The information sheet will detail how participants' contributions will be used in the future and within the context of the larger research project. They will be made aware that they can withdraw from the focus groups at any time without explanation, and that information provided will be confidential. The information sheet will also explain that Data Protection Act 1998 guidelines will be followed when processing, storing, handling and then destroying personal information. Personal information will be kept separately from anonymised data. Participants will be given a study ID number on enrolment, which will be used on all transcripts, during data analysis and in the subsequent write-ups. Information provided that could be used to identify a participant will be anonymised or removed.

Providing compensation for participation is sometimes viewed as potentially unethical, particularly if participants are lower-income. In order to reduce any ethical uncertainty, participants will receive Love2Shop gift vouchers, which can be used at popular High Street shops, as opposed to cash compensation.

2.6 How is the research intended to benefit the participants, third parties and/or the local community? Please consider both direct and long term benefits.

The Committee recognises this does not apply to all research projects.

There is no direct benefit to participants, although women often enjoy giving their views and sharing their experiences. Benefits then may be indirect or long term as women are also enthusiastic to help improve health care services, not just for themselves but for others as well.

2.7 Will invasive procedures (for example medical or surgical) be used?

YES ☐ NO ☒

2.7a If yes, what precautions will you take to minimise any potential harm?

2.8 Will intrusive procedures (for example psychological or social) be used?

YES ☐ NO ☒

2.8a If yes, what precautions will you take to minimise any potential harm?

2.9 In the course of the investigation might pain, discomfort (including psychological discomfort), inconvenience or danger be caused? YES ☐ NO ☒

2.9a If yes, what precautions will you take to minimise any potential harm?

3. Information about Participants

3.1 How many participants will be involved?

The focus groups will recruit no more than 18-24 participants. The number of individuals taking part during an observation may vary, as this depends on the number of parents who attend a Maternity Voices event that day. There will be at least 4 members of SAfH staff who run these meet-ups and will be present during a majority of the observations.

3.1a What is the age group and gender of the participants?

Pregnant women and mothers over 18 years old living in East London will be approached to take part. Volunteers and employees of SAfH will also be asked to take part in the observations.

3.1b Explain how the sample size has been determined. If statistical sampling is relevant to this application, please include details of how the sample size was calculated.

The sample size was determined by the planned number (6-8) of individuals to be included in each of the three focus groups. This is not a fixed number but is recommended as appropriate for focus group studies.

3.1c Please specify inclusion and exclusion criteria. If exclusion of participants is made on the basis of age, gender, ethnicity, race, disability, sexuality, religion or any other factor, please justify this.

The women recruited for the focus groups will be demographically similar to the cohort who will later be invited to participate in the feasibility study, so the inclusion and exclusion criteria will be the same for each.

Eligibility criteria to participate:

- Aged 18 or older
- English proficiency or fluency

Ineligibility criteria:

- Under the age of 18 at time of recruitment

There will be no exclusion based on ethnicity, race, sexuality, disability or religion, however, all adults participating must be able to provide informed consent. This study will not include women under the age of 18 due their incapacity to provide fully informed consent without a parent or guardian.

Similarly, women who are not proficient or fluent in speaking, reading and writing English will not be included in this study, as the Which? Birth Choice content is currently only produced in English.

3.2 How are the participants to be identified, approached and recruited, and by whom?

Individuals will be identified through their participation in or connection with the Social Action for Health (SAfH) maternal health network. I will attend SAfH meetings, during which I will approach women about the study and inquire about their interest and eligibility. I will ask women their age during my approaches, to ensure they are over 18 and can take part. As all of the SAfH parent meetings are conducted in English, the women attending will be proficient or fluent in the language, and therefore eligible to take part in the study. If an individual is interested, then I will explain the study and go through the information sheet with the woman, providing a copy for her to take away. If she is interested in participating, she will then be invited to participate in a focus group discussion.

Individuals who are invited to join the observations will be approached and recruited before the Maternity Voices meetings.

3.3 Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained. Include details of (a) who will obtain the consent, (b) how you are intending to arrange for a copy of the signed consent form to be given to the participants, (c) when they will receive the participant information sheet, and (d) how long the participants have between receiving information about the study and giving consent.

I will obtain consent from individuals interested in taking part. To ensure informed consent has been obtained, I will produce a study information sheet as well as orally explain the study aims and participation activities. Women will receive this information sheet during the initial approach. Individuals will then be given the opportunity to ask questions, which I will answer. If the woman is happy to take part, she will fill out and sign the consent and enrolment forms. I will read each item of the consent form out to the individual, ensuring that the individual initials after each item.

If the woman would like more time to think about taking part in a focus group, I will then ask her to fill out a consent to contact form with her contact details to follow-up then on her interest in taking part. Potential participants will be given at least 24 hours to consider taking part in the study, giving them time to discuss the study with their families and ask further questions. I will contact them after at least 24 hours, and if they are happy to take part, they will be complete a consent form and send it back to me.

If women are taking part in an observation, I will give them an information sheet to read and time to ask me any questions before obtaining verbal consent to observe and record notes on key conversations. I will also place a poster up during the Maternity Voices meet-ups alerting individuals that there is an observation going on and to speak to me about it if they have questions or concerns.

3.4 How will the participant's physical and mental suitability for participation be assessed? Are there any issues related to the ability of participants to give informed consent themselves or are you relying on gatekeepers on their behalf?

There should be no issues with the participants' ability to give informed consent. To ensure this, I will ask potential participants their age before proceeding with the consent and enrolment processes. If participants are under 18, they will not be recruited. All of the SAfH parent meetings where I will be recruiting are conducted in English, so the women attending will be either proficient or fluent in the language and should not have a language barrier to understanding the consent process. I will also rely on the gatekeepers (SAfH staff members) to alert me to any potential participants who might not be able to give full informed consent due to language barriers.

3.5 Are there any special pressures that may make it difficult for participants to refuse to take part in the study? Are any of the potential participants in a dependent relationship with any of the investigators (for instance student, colleague or employee) particularly those involved in recruiting for or conducting the project?

There should be no special pressures on women that would keep them from refusing to take part. None of the potential participants will have any relationship to the researcher.

3.6 Will the participant's doctor be notified?

YES ☐ NO ☒

(If so, provide a sample letter to the subject's GP.)

3.7 What procedures are in place for the appropriate referral of a study participant who discloses an emotional, psychological, health, education or other issue during the course of the research or is identified by the researcher to have such a need?

The topics of the focus group are not sensitive, so this is an unlikely event. Despite this, it will still be addressed if it does occur. I will give out information about the complaint procedure for patients and who to speak to or where to find support if a maternity health concern is disclosed (see Appendix 5). I will talk to the woman individually at the end of the session to advise her to seek support from the SAFH workers, her midwife or other health care professional that she feels comfortable speaking to. The SAFH workers, in particular, will be able to provide a range of support groups and outlets in the local area.

If a sensitive topic or issue is related during an observation, SAFH members will follow the organisation's protocol for handling these cases.

3.8 Is there any risk (emotional, psychological, health or other issues) to the researcher(s)?

There are no emotional, psychological, health or other risks to the researcher. The research does not cover a sensitive topic, and it will take place in a community organisation venue.

3.9 What steps will be taken to safeguard the participants from over-research (i.e. to ensure that the participants are not being used in multiple research projects including those of other researchers)? Please consider all research projects whatever their field, not just those performed by you.

This project will not be going through the NHS, so it will be difficult to know if women are participating in research elsewhere. The enrolment form will ask if women are taking part in any other research and to list the project(s), so I will be aware of any other study participation. As this involves one-off focus groups and not an RCT, there is less commitment, and these are not expected to be burdensome for participants. If the participant is taking part in other studies and feels overburdened, she is can withdraw at any time.

3.10 Where will the research take place?

The research will take place in a community organisation venue that is regularly used by SAFH.

3.11 What health and safety issues, if any, are there to consider?

There are no health and safety issues in this study.

3.12 How have you addressed the health and safety concerns of the participants, researchers and any other people impacted by this study? (This includes research involving going into participants' homes.)

There are no health and safety concerns for the participants, researchers or any other individuals involved in this study.

If a participant changes her birth plans in any way, as a result of the research, after being introduced to the Which? Birth Choice site, then she will be encouraged to discuss these decisions with her midwife.

3.13 It is a requirement that at least an initial assessment of risk be undertaken for all research and if necessary a more detailed risk assessment be carried out. Has a risk assessment been undertaken?*

YES ☒ NO ☐

3.14 Are you offering any incentives or rewards for participating?

YES ☒ NO ☐

If yes please give details

Participants of the focus groups will receive a £5 Love2Shop gift voucher as a 'thank you' for taking part.

3.15 Does the research involve any of the following:

Children under the age of 5 years	YES ☐ NO ☒
Clinical trials / intervention testing?	YES ☐ NO ☒
Over 500 participants?	YES ☐ NO ☒
Are you specifically recruiting pregnant women	YES ☒ NO ☐
Excluding information collected via questionnaires (either paper based or online), is any part of the research taking place outside of the UK?	YES ☐ NO ☒

If you have answered 'yes' to any of the above questions you will need to check that the City's insurance will cover your research. You should do this by submitting this application to insurance@city.ac.uk before applying for ethics approval.

*Note that it is the Committee's prerogative to ask to view risk assessments.

4. Vulnerable Groups

4.1 Will persons from any of the following groups be participating in the study? (If not go to section 5.)

Adults without capacity to consent	☐
Children under the age of 18	☐
Those with learning disabilities	☐
Prisoners	☐
Vulnerable adults	☐
Young offenders (16-21 years)	☐

Those who would be considered to have a particular dependent relationship with the investigator (e.g. those in care homes, students, employees, colleagues)	☐

4.2 Will you be recruiting or have direct contact with any children under the age of 18?

YES ☐ NO ☒

4.4 Will you be recruiting any participants who fall under the Mental Capacity Act 2005?

YES ☐ NO ☒

If so you MUST get approval from an HRA approved committee (see separate guidelines for more information).

5. Data Collection

5.1 Please indicate which of the following you will be using to collect your data

Please tick all that apply

Questionnaire	☐
Interviews	☐
Participant observation	☐
Focus groups	☒
Audio/digital-recording interviewees or events	☒
Video recording	☐
Physiological measurements	☐
Digital/computer data	☐
Other	☐
Please give details if you have ticked other	

5.1b What steps, if any, will be taken to safeguard the confidentiality of the participants (including companies)?

All of the information provided by participants will be kept securely in a locked cabinet and on a password protected computer located at the City, University of London campus. The building area where the cabinet and computer are located is only accessible with card entry. The Data Protection Act 1998 guidelines will be followed when processing, storing, handling and then destroying personal information.

Personal information will be kept separately from anonymised data. Participants will be given a study ID number on enrolment, which will be used on all transcripts, during data analysis and in the subsequent write-ups. Information provided that could be used to identify a participant will be anonymised or removed.

There is a risk that those familiar with maternity work in East London could assume that some comments were made by specific individuals during participant observation. In order to minimise this risk, I will ensure that all taking part in an observation are anonymised and their statements reported in a generic way so that they cannot be identified. Individuals will also be able to withdraw their statements at any time without explanations. Participants will be made aware of this potential risk and opportunity to withdraw on the information sheet that they receive.

If you are using interviews or focus groups, please attach a topic guide. If you are using questionnaire, please attach the questionnaire.

6. Confidentiality and Data Handling

6.1 Will the research involve:

complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification)?	☐
anonymised sample or data (i.e. an <i>irreversible</i> process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates)?	☐
de-identified samples or data (i.e. a <i>reversible</i> process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location)?	☒
subjects being referred to by pseudonym in any publication arising from the research?	☒
any other method of protecting the privacy of participants? (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only)	☒
Please give details of 'any other method of protecting the privacy of participants' is used	
Participant privacy will be maintained during the focus groups through several ground rules that will be used during the all three sessions. I will ask all participants to A) not refer to themselves or others in the focus group by name, B) not use or discuss the names of others outside of the focus group who could be easily connected to the participant C) not to reveal any details about themselves or others that could be used to identify themselves or others Direct quotes will only be used with the permission from the participants, and this is reflected and included in the participant information sheet and consent form.	

6.1a Which of the following methods of assuring confidentiality of data will be implemented?

Please tick all the options that apply

data to be kept in a locked filing cabinet	☒
data and identifiers to be kept in separate, locked filing cabinets	☐
access to computer files to be available by password only	☒
storage at City	☒
stored on an encrypted device (e.g. laptop, hard drive, USB)	☒
stored at other site	☐
If stored at another site, please give details.	

6.1b Will the data be accessed by people other than the named researcher?

YES ☐ NO ☒

If yes, please explain by whom and for what purpose.

6.2 Is the data intended for reuse or to be shared as part of longitudinal research, or a different/wider research project now, or in the future?

YES ☒ NO ☐

If yes, please provide details.

This study is the exploratory phase of a larger doctoral research project, intended to inform the scope of the project and shape the design of the subsequent feasibility study. The anonymised data will be incorporated in the write-up of the doctoral thesis during the final year of study and used for any publications that result from the research.

6.2a If the project is funded, does the funding body (e.g. ESRC) require that the data be stored and made available for reuse/sharing?

YES ☐ NO ☒

6.2b If you have responded yes to any of the questions above, explain how you are intending to obtain explicit consent for the reuse and/or sharing of the data.

Participants will be made aware before enrolment that the information they provided in the focus groups will be anonymised and then used for the larger doctoral project and in future publications.

6.3 Retention and Destruction of Data

6.3a Does the funding body or your professional organisation/affiliation place obligations or recommendations on the retention and destruction of research data?

YES ☒ NO ☐

If yes, what are your affiliations/funding and what are the requirements? (If no, please specify City guidelines on retention.)

City University of London guidelines on retention will be followed.

6.3b How long are you intending to keep the data?

Note that the institutional guidelines on retention state a minimum of 10 years.

The anonymised data will be kept for at least 10 years and archived in accordance with City, University of London guidelines.

6.3c How are you intending to destroy the data after this period?

Please find guidance here.

The hard copies of data will be shredded and the digital files will be deleted in all the locations they are stored on. Anonymised data will be archived in accordance with City, University of London guidelines.

7. Curriculum Vitae

CV OF APPLICANTS (Please duplicate this page for each applicant, including external persons and students involved.)

NAME:	Cassandra Yuill
Title of Post:	PhD Candidate
Department:	Centre for Maternal and Child Health Research, School of Health Sciences
Is your post funded for the duration of this proposal?	Yes
Funding source (if not City)	Which? Birth Choice
Please give a summary of your training/experience that is relevant to this research project	
<u>Education</u> <i>University of Durham</i> MSc in Medical Anthropology, 2012 – 2013 Awarded with distinction <i>Université de Nice</i> Certificat Pratique de Langue Française, 2010 – 2011 <i>University of Maryland, College Park</i> BA in Anthropology, Minor in French Literature and Language, 2008 – 2011 GPA 3.5 (Equivalent to 2:1) <u>Research Experience</u> <i>Research Associate in Parent-Infant Sleep Lab, Department of Anthropology, University of Durham, 01/2015 – 10/2016</i> Project Manager on a study, Let's talk about sleep!, investigating the feasibility and acceptability of a safer infant sleep intervention. This is a collaborative research project involving Durham University, University of Bristol, The Lullaby Trust, UNICEF Baby Friendly, Best Beginnings and City Hospitals Sunderland NHS Foundation Trust. This project was funded by ESRC Impact Acceleration Account and The Lullaby Trust. Responsibilities	

- Liaising with project partners and NHS staff
- Creating project documents and quantitative data collection tools
- Obtaining NHS Ethics approval for research activities
- Coordinating and conducting participant recruitment
- Quantitative and qualitative data collection (surveys, semi-structured interviews and focus groups) and maintenance of databases
- Cleaning data and descriptive analyses
- Producing study reports for funders, NHS Ethics Committee and NHS R&D

Research Assistant in Parent-Infant Sleep Lab, Department of Anthropology, University of Durham, 12/2013 – 01/2015

I worked on two research studies: a study of parent-infant night-time behaviour while using bedside cots and a feasibility study of new technology aiming to detect physiological signals of SIDS in infants.

Responsibilities

- Enrolling participants and ensuring informed consent was obtained
- Responsible for video recording and physiological monitoring equipment and storing all data collected
- Coding behavioural data from video recordings using Observer XT 10

MSc in Medical Anthropology, University of Durham, 10/2012 – 09/2013

My research project focused on physical activity and nutritional knowledge and behaviours of adolescent students in an English secondary school. I investigated the influences of socioeconomic status and school environment on these areas, using a mixed methods approach. I also examined the implications of my findings on school-based childhood obesity prevention programmes.

Achievements

- Fulfilment of programme guidelines for dissertation work and write-up within deadline
- Experience using IBM SPSS Statistics to analyse quantitative data generated by questionnaires accessing levels of physical activity and nutritional knowledge and histories of school meal choices of student participants
- Experience employing a thematic analysis of the qualitative data from focus groups conducted with student participants

Relevant Skills

IBM SPSS Statistics: extensive use for Let's talk about sleep! study & MSc dissertation

Microsoft Office: extensive use of Microsoft Word (dissertation and university assignments), PowerPoint (presentations), and Excel (data entry and cleaning)

Observer XT 10: regular use for collecting, coding and analysing video footage

Training Courses

Developing policy and practice through participatory research (May 2016)

Introduction to SPSS (May 2016)

Data Protection and Resource Management (April 2016)

Good Clinical Practice: Primary Care (July 2015)

Good Clinical Practice: Secondary Care (July 2015)

8.1 Supervisor's statement on the student's skills and ability to carry out the proposed research, as well as the merits of the research topic (up to 500 words)

Cassandra has good background experience and has conducted thorough preparation and literature review that prepares her well for this study. I am happy to support her application.

I confirm that I have discussed the project with the student to my satisfaction.

Supervisor's Signature



Print Name

Christine McCourt

8. Additional documents

You are expected to provide copies of relevant documents including all letters to be sent to participants and other individuals (such as GPs) and organisations involved in the research. Please follow the guidelines and templates which can be found at <http://www.city.ac.uk/research/research-and-enterprise/research-ethics>

Document Checklist

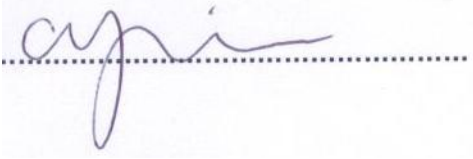
Please place an 'X' in all appropriate spaces for all documents you are submitting

	Attached	Not applicable
Copy of study advertisement (including recruitment emails/letters)		X
Participant information sheet	X	
Participant consent form	X	
Questionnaire(s)		X
Topic guide(s)	X	
Confirmation letter(s) from / correspondence with external organisations		X
Confirmation that insurance is in place		X
Product information		X
GP Letter		X
Other (please provide details)		X

9. Additional Information

10. Declarations by Investigator(s)

- I certify that to the best of my knowledge the information given above, together with any accompanying information, is complete and correct.
- I have read City's guidelines on human research ethics, and accept the responsibility for the conduct of the procedures set out in the attached application.
- I have attempted to identify all risks related to the research that may arise in conducting the project.
- I understand that **no** research work involving human participants or data can commence until **full** ethical approval has been given

	Print Name	Signature
Principal Investigator(s) (student and supervisor if student project)	Cassandra Yuill	
Associate Dean for Research (or equivalent) or authorised signatory	Research Centre Lead and PhD Programme Director	
Date	03 February 2017	

Information sheet for focus groups

Version: 1.1 30 January 2017



Information for Volunteers

Places of birth: a study of information, choice and outcomes in a maternity context (Exploratory phase)

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk

Centre for Maternal and Child Health Research, School of Health Sciences

City, University of London

We are inviting women to take part in a study looking at place of birth and what is important when making decisions about birth location.

What is the study about? This project is looking at: 1) where pregnant women plan to give birth and how they make this decision, 2) what information sources women use to make this choice, and 3) how women use an online birth place information source, Which? Birth Choice.

Who do we need? Women who are pregnant.

What will it involve? If you agree to take part in this study you will be asked to sign a consent form that says you understand what the study is about and fill out a form giving us some basic details about yourself.

You will then take part in a focus group with 5 other pregnant mums that will last up to 2 hours. We will discuss your birth plans and look at the Which? Birth Choice website during this time. All focus groups will be *audio recorded*.

What are the benefits of taking part? You will be helping researchers to understand how and why women make decisions about where they give birth in the United Kingdom. You will help us find out better ways to provide information about birth place and to help women make more informed choices about their maternity care during birth.

What the potential risks of taking part? There are no risks in taking part in this research study.

What if I don't want to be in the study anymore? You do not have to take part in this study, but we hope you will choose to help us. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. You can change your mind at any point and if you decide that you do not wish to continue If you decide to take part you are still free to withdraw at any time and without giving a reason. You will not be able to withdraw any data provided. This is because it will be in a wider conversation with other women and difficult to withdraw it completely.

Confidentiality: Please note that all information we collect will be stored safely and will not be shared with anyone outside the research team. You will be given a code so that your name will not be on any of the data forms and there will be no way of identifying you. In any reports I may write, information will be summarised from several people so you cannot be identified. Any direct quotes used in these reports will be anonymised and no information will be included that could identify you. Approval from City, University of London Ethics Committee has been obtained and the project is covered by City, University of London insurance.

What will happen to the results of this study? The results of this study will be collected, analysed and used in a PhD thesis being completed by Cassandra Yuill. They will also help shape a future study about birth place decisions and information use. I also plan to publish these results and share them with the organisations concerned with maternal health care.

Your identity will be confidential. You may ask for a copy of these reports or a summary of the outcomes.

Who is organising and funding this study? This study has been organised by Cassandra Yuill and staff members of the Centre for Maternal and Child Health Research and is funded by Which? Birth Choice and City, University of London.

What to expect during the consent process: Cassandra will explain the study to you and give you this information sheet. After you have read this sheet, you can ask questions. The researcher will answer all of your questions and give you the consent form. You will read the consent form and sign it if you are willing to take part in this study.

A thank you: As a thank you gift for taking part in this study we will give you £5 in Love2Shop gift vouchers.

What if there is a problem? If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *Places of birth: a study of information, choice and outcomes in a maternity context*.

You can also write to the Secretary at:

Anna Ramberg
Research Governance & Compliance Manager
Research & Enterprise
City, University of London
Northampton Square

London
EC1V 0HB

Email: Anna.Ramberg.1@city.ac.uk

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action

Thank you for reading this information sheet and considering taking part in this study. If you have any questions, please speak to Cassandra Yuill (Cassandra.yuill@city.ac.uk +447840872417).

When completed: 1 for participant; 1 for researcher site file.

Enrolment form for focus groups

Version: 1.1 30 January 2017 Study ID _____



Study Enrolment Form

Places of birth: a study of information, choice and outcomes in a maternity context
(Exploratory phase)

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk

Centre for Maternal and Child Health Research, School of Health Sciences City, University of London

All contact information will be kept in a secure database during the study. This information will be destroyed at the end of the study or if you decide you no longer want to take part.

Date: _____

Enrolment Information

Do you have a 'low-risk' pregnancy? Yes No Not sure

Is this your first baby? Yes No

If you answered 'no' please write below where you gave birth with your previous baby or babies (e.g. labour ward, birth centre, etc.).

Where are you planning to give birth this pregnancy?

Are you part of any other research study? If 'yes' write which one(s). Yes No

Demographic Information

When we write our report from this study we will need to describe the group of people who took part, so we need to collect some information about you. Please circle an option or fill in the blank space below.

Your date of birth:

Marital status: Married / Living with partner / With partner, living apart / Single, no partner

Education: Up to age 16 / 16-18 / Vocational training / A levels / University / Post-graduate

Family Income: Below £10000 / Up to £20000 / Up to £30000 / Up to £40000 / Above £40k

Ethnicity (e.g. White British, British Pakistani, etc.):

When completed: 1 for participant; 1 for researcher site file.

Information sheet for participant observation

Version 1.0 21 September 2017



Information for Participants

Places of birth: a study of information, choice and outcomes in a maternity context (Exploratory phase)

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk

Centre for Maternal and Child Health Research, School of Health Sciences, City, University of London

We are inviting women to take part in a study looking at place of birth and what is important when making decisions about birth location.

What is the study about? This project is looking at: 1) where pregnant women plan to give birth and how they make this decision, 2) what information sources women use to make this choice, and 3) getting a better picture of the local health care services for place of birth from parents' perspective.

Who do we need? Women who are pregnant, mothers from East London and people involved with the Maternity Voices events run by Social Action for Health.

What will it involve? If you are taking part in a Social Action for Health event, you do not have to complete an enrolment form. For this part of the study, I will simply observe and participate in my normal capacity as a volunteer with the organisation. If you decide to be included, I will give you the chance to ask me any questions and ask for your verbal consent. I am interested in place of birth, so I will only be noting conversations about this subject.

I will not audio record the event, but I will put up a poster to let you know that the study is taking place. If you have any questions or concerns, you may ask me them at any time. If you do not want to part in this, you can tell me before or during the Maternity Voices event, and I will not include you.

What are the benefits of taking part? You will be helping researchers to understand how and why women make decisions about where they give birth in the United Kingdom. You will help us find out better ways to provide information about birthplace and to help women make more informed choices about their maternity care during birth.

What the potential risks of taking part? There are no physical risks in taking part in this research study. There is a risk that those familiar with maternity work in East London might assume (accurately or not) that comments were made by specific individuals involved in Social Action for Health. In order to reduce this risk of identification, all conversations and comments noted will be reported anonymously and in a generic format (please see the below Confidentiality section for further information).

What if I don't want to be in the study anymore? You do not have to take part in this study, but I hope you will choose to help me. If you decide to take part, you are still free to withdraw at any time and without giving a reason. You also may request to withdraw your statements made during the observation without giving a reason.

Confidentiality: Please note that all information we collect will be stored safely and will not be shared with anyone outside the research team. You will be given a code so that your name will not be on any of the data forms and there will be no way of identifying you. In any reports I may write, information will be summarised from several people so you cannot be identified. Any direct quotes used in these reports will be anonymised and no information will be included that could identify you. Approval from City, University of London Ethics Committee has been obtained and the project is covered by City, University of London insurance.

What will happen to the results of this study? The results of this study will be collected, analysed and used in a PhD thesis being completed by Cassandra Yuill. They will also help shape a future study about birthplace decisions and information use. I also plan to publish these results and share them with the organisations, like Social Action for Health, concerned with maternal health care. Your identity will be confidential. You may ask for a copy of these reports or a summary of the outcomes.

Who is organising and funding this study? This study has been organised by Cassandra Yuill and staff members of the Centre for Maternal and Child Health Research and is funded by Which? Birth Choice and City, University of London.

What to expect during the consent process: I will explain the study to you and give you this information sheet. After you have read this sheet, you can ask questions. If you decide to take part in the observation, then I will seek verbal consent from you.

What if there is a problem? If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *Places of birth: a study of information, choice and outcomes in a maternity context*.

You can also write to the Secretary at:

Anna Ramberg
Research Governance & Compliance Manager
Research & Enterprise
City, University of London
Northampton Square
London
EC1V 0HB

Email: Anna.Ramberg.1@city.ac.uk

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action

Thank you for reading this information sheet and considering taking part in this study. If you have any questions, please speak to Cassandra Yuill (Cassandra.yuill@city.ac.uk +447840872417).

Consent form

Version: 1.1 30 January 2017 Study ID _____



CONSENT FORM

Places of birth: a study of information, choice and outcomes in a maternity context (Exploratory phase)

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk

Centre for Maternal and Child Health Research, School of Health Sciences

City, University of London

Please initial box

1. I confirm that I have read and taken a copy of the information sheet dated.....for this study and had the chance to consider the information. I have had the chance to ask questions and have had these answered by☐
2. I understand that my participation is voluntary and that I am free to withdraw myself at any time without giving any reason, without my medical care or legal rights being affected.☐
3. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.☐
4. I understand that the information collection about me will be used to support other research in the future and may be shared anonymously with other researchers.☐
5. I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the Data Protection Act 1998.☐
6. I agree and am willing to take part in this study.☐

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

When completed: 1 for participant; 1 for researcher site file.

SAfH partnership and participant safeguarding

Dear Nick,

It was a pleasure talking to you a couple of weeks ago. Further to our discussion, I confirm that Cassandra is volunteering with us and in return for this, we will endeavor to help her as much as possible to speak with women and healthcare providers as part of her PhD research.

I confirm that we will not facilitate the groups ourselves but are happy to promote them through our mailing list and social media and to encourage women to attend the groups. Cassandra will remain entirely responsible for ensuring that appropriate consent has been received from all women or other participants, in line with ethics approval received and usual City University procedures.

I trust the above confirmation is sufficient for your purposes? If you require any further information please do not hesitate to contact me.

Kind regards,

Ceri.

Ceri Durham

Programme Manager – Community research, inc. Maternity Engagement

Please note that I work flexibly, 3.5 days per week

I generally do not work Fridays.



Social Action for Health
Ment House
Unit 1C Mentmore Terrace
London, E8 3DQ

E: cerid@safh.org.uk

T: 020 8510 1970

D: 020 8510 1973



Registered Charity No: 1040496

Company No: 2954744



Ceri Durham <cerid@safh.org.uk>

Tue 9/19, 2:51 PM

UG-Yuill, Cassandra



Reply all



Action Items



Hi Cassandra,

Thank you again for taking the minutes for us this morning. I confirm that I am very happy to support your proposal for the observation. As discussed, would you be able to just add a few words into the 'risks' section which confirms no physical risks, but that there is a theoretical risk that readers of the final study who are familiar with maternity work in this area of East London may make assumptions (accurately or not) that certain comments have been made by specific individuals. In order to mitigate against this, all comments noted through observation will be reported anonymously and in a generic format. In addition, if any participant wishes to retract any comments they may do so at any point prior to publication and without giving a reason.

Thanks Cassandra!

Best wishes,

Ceri.

Ceri Durham
Programme Manager - Maternity
email logo
Ment House
Unit 1C Mentmore Terrace
London, E8 3DQ

E: cerid@safh.org.uk
T: 0208 510 1970

Registered Charity No: 1040496
Company No: 2954744

Signposting for parents

Further resources for parents

If you would like to make a complaint about care in Barts Health or would extra support during and after your pregnancy, please use the following sources to do so.

Making a complaint

On-line at <http://bartshealth.nhs.uk/your-visit/advice-and-support/patient-feedback/making-a-complaint/>

Patient Advice and Liaison Service (PALS) <http://bartshealth.nhs.uk/your-visit/advice-and-support/patient-advice-and-liaison-service/>

Central Complaints Team on 0207 480 4776 or 0207 480 4719. Their opening hours are Monday to Friday, 9am–4.30pm for appointments.

Extra support

Contact your GP or Midwife about extra support you may need. There are many organisations and tools that support parents and babies. Please just a few listed below.

Start 4 Life (<https://www.nhs.uk/start4life/>) – Sign up for regular NHS e-mails during and after your pregnancy

NHS Choices – Pregnancy and baby (<http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/pregnancy-and-baby-care.aspx>)

NCT (<https://www.nct.org.uk/>)

Best Beginnings (<https://www.bestbeginnings.org.uk/parents>)

Positive Birth Movement (<http://www.positivebirthmovement.org/>)

Women's Health & Family Services (<http://whfs.org.uk/>)

Maternity Mates (<http://whfs.org.uk/index.php/what-we-do/maternity-mates>)

Pre and Postnatal Depression Advice and Support (PANDAS) (<http://www.pandasfoundation.org.uk/>)

SaFH Volunteer Agreement & Referral Procedure

Safeguarding

Social Action for Health has a responsibility to promote the welfare and safety of children and vulnerable adults and we are committed to working in a way that protects them. We recognise that all children and vulnerable adults, regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have a right to equal protection from all types of harm or abuse. We also recognise that safeguarding is everyone's responsibility.

1. Background

This policy has been developed in response to and based on the following guidance:

[Charity Commission: Safeguarding children and young people, June 2014](#)

[HM Government: Working together to safeguard children, March 2015](#)

[Department of Health: Statement of government policy on adult safeguarding, March 2013](#)

[NSPCC: Writing a safeguarding policy, June 2015](#)

[HM Government: What to do if you're worried a child is being abused, March 2015](#)

1. Scope of the Policy

2. This policy applies to all staff, volunteers and Trustees, including sessional workers, agency staff, students and anyone else working on behalf of Social Action for Health.

The purpose of this policy is to:

- Protect children and vulnerable adults who receive Social Action for Health services, including the children of adults who receive our services.
- Ensure that all staff and volunteers are clear about their safeguarding responsibilities and the action they should take if they suspect a child or vulnerable adult is being abused.
- Ensure that staff knows the correct steps to take if there is an allegation against a member of staff and who they should report this to.

3. Definitions

4. A child is defined as a person under the age of 18.

A vulnerable adult is defined as a person aged 18 or over who is in receipt of Regulated Activity, defined as healthcare, personal care, and/or social work; assistance with general household matters and/or in the conduct of the adult's own affairs; and/or an adult who is conveyed to, from, or between places, where they receive healthcare, relevant personal care or social work because of their age, illness or disability.

Abuse is a form of maltreatment and may consist of inflicting harm, or failing to protect from harm. Forms of child abuse include emotional abuse, physical abuse, sexual abuse and neglect. In addition to these types of abuse vulnerable adults may also suffer from psychological abuse, domestic abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational abuse and forced marriage.

3. Actions to prevent harm

To protect children and vulnerable adults from the risk of abuse, Social Action for Health will:

- Recruit staff and volunteers safely, ensuring necessary Disclosure and Barring Service (DBS) checks are made
- Manage staff and volunteers effectively, through training, support and supervision
- Keep accurate records of Disclosure and Barring Service (DBS) checks and safeguarding training delivered
- Conduct an annual audit to ensure Disclosure and Barring Service (DBS) checks and safeguarding training are in place
- Have a named Safeguarding Lead and current and accessible Safeguarding Policy

4. Actions to be taken if abuse is suspected

- The signs of abuse may not be obvious. If something seems unusual try to speak to the child or vulnerable adult, alone, if appropriate, to seek further information.
- If a child or vulnerable adult reports that they are being abused or neglected you should listen to them, take their allegation seriously, reassure them that you will take action to keep them safe and explain to them the action that you will take.
- Concerns about a child or vulnerable adult's welfare can vary in terms of their nature and seriousness, how they have been identified and over what duration they have arisen. If you have concerns about a child, you should ask for help from Social Action for Health's named Safeguarding Lead (**Kye Lockwood**). In the case of a child you can also seek advice at any time from the NSPCC helpline.
- If you have concerns about the safety or welfare of a child or vulnerable adult and you feel that they are not being acted upon by the Safeguarding Lead it is your responsibility to take action. You can do this by contacting the local MASH team.
- If you believe that a child may be in need or that a child or vulnerable adult is being harmed or is likely to be, you should refer immediately to the relevant local authority children's or adult social care team. This referral can be made by any member of staff or volunteer.
- If you see further signs of potential abuse and neglect, report and refer again.
- You should record, in writing, all concerns and discussions about a child's welfare, the decisions made and the reasons for those decisions. Make this as true to their word as possible, and do not add any of your own words. You should pass this information, including full name, DOB, address if possible as well as date and time, number of siblings if necessary to the Safeguarding Lead who will store the information securely and contact the relevant bodies.
- If you are not sure if your concern needs reporting you can always contact the local authorities' multi-agency safeguarding hub (MASH) team for advice should you need to. This information can be found on the relevant local authority website.

5. Female Genital Mutilation

On October 31st 2015 female genital mutilation became a **Mandatory Reporting Duty**.

This means that as an organisation working with in the community we have a duty of care for those we work with. If you become aware of female genital mutilation, or have a concern about anyone at risk of female genital mutilation it is your responsibility to report to the Safeguarding Lead, or to the relevant multi-agency safeguarding hub (MASH) team.

Female genital mutilation is the partial or total removal of external female genitalia for non-medical reasons. It is also known as Female circumcision, cutting or sunna.

It is illegal in the UK to subject a girl or woman to female genital mutilation or to assist in female genital mutilation overseas.

6. Prevent – Part of the Government's Counter-Terrorism Strategy.

Under the Counter-Terrorism and Security Act 2015, the Social Action for Health is subject to a statutory duty to have 'due regard to the need to prevent people from being drawn into terrorism.' In respect of safeguarding individuals from radicalisation, Social Action for Health works to the Prevent element of the Government's Counter Terrorism Strategy, and where deemed appropriate, seeks external support for learners through referrals to The Channel Programme. This programme aims to work with the individual to address their specific vulnerabilities, prevent them becoming further radicalised and possibly entering the criminal justice system because of their actions.

Prevent covers all forms of terrorism and extremism and some aspects of non-violent extremism. If you have any concerns please speak with the designated safeguarding lead.

7. Relevant contacts

Social Action for Health Safeguarding Lead: Kye Lockwood: 0208 510 1973

NSPCC Helpline: 0808 800 5000

Hackney Child Safeguarding: 0208 356 5500

Hackney Adult Safeguarding: 0208 356 5782

Tower Hamlets Child Safeguarding: 0207 364 5006

Tower Hamlets Adult Safeguarding: 0207 276 3501

6. Related policies

This policy should be read in conjunction with our Whistle Blowing Policy and Information Governance Policy.

Research registration form

School of Health Sciences Research Ethics Committee

RESEARCH REGISTRATION FORM (formerly EC3)

This form must be completed for all research projects regardless of whether the proposal is going to an NHS, School or other approved research ethics committee. All sections must be completed as indicated; failure to do so will lead to the form being returned to you, and the project remaining unregistered.

Please complete this form and email it to Alison Welton (a.welton@city.ac.uk).

PhD, Master's and other students must ensure that the form is emailed by their supervisor at City, University of London, and contains the following statement "I have read & approved [Name of student]'s submission: [name of project]".

Application date:

0	3	/	0	2	/	2	0	1	7

Short project title: (80 characters)	Places of birth: a study of information, choice and outcomes in a maternity context										
Name of Principal Investigator(s):	Cassandra Yuill										
Research Centre:	Centre for Maternal and Child Health										
Name of Student: (if applicable)	Cassandra Yuill										
Name of Supervisor: (For Students Only)	Professor Christine McCourt										
Course: (For Students Only)	MPhil/PhD in Health Sciences										
Student number: (For Students Only)	160070521										
External organisation(s) involved: (if any)	Which? Birth Choice										
Funding bodies: (if any)	Which? Birth Choice And City, University of London										
Planned completion date:	<table border="1"> <tr> <td>0</td> <td>1</td> <td>/</td> <td>1</td> <td>0</td> <td>/</td> <td>2</td> <td>0</td> <td>1</td> <td>8</td> </tr> </table>	0	1	/	1	0	/	2	0	1	8
0	1	/	1	0	/	2	0	1	8		

A Research Proposal

Full title of research proposal: Places of birth: a study of information, choice and outcomes in a maternity context (Exploratory phase)
Please provide a brief structured lay summary of your proposed research, including: aims, rationale, methodology, and any ethical issues. (<400 words) [PLEASE DO NOT ATTACH YOUR FULL PROJECT PROPOSAL.] <u>Rationale</u> The British government has been committed to ensuring that women and their partners have access to a range of choices in maternity services [1]. Importantly, this includes where women decide to give birth, which has implications for birth experiences and outcomes [2]. This research project aims to understand the relationship between information, choice and outcomes in a maternity context. It will

explore the different routes of impact an internet-based aid, Which? Birth Choice (<http://www.which.co.uk/birth-choice/>) has on families in a health setting with diverse birthplace options.

Aims

This exploratory research will be the initial phase of a larger doctoral research project focusing on informed choice. By conducting focus groups, this phase aims to:

- Explore how women make decisions about where to give birth and how they use different information sources to make these
- Investigate relevant issues about place of birth decision-making not yet incorporated in the scope of the project
- Inform and refine the design a larger feasibility study to be conducted with Barts Health Trust

Research design

Participant observation will be conducted during meetings for local mothers hosted by Social Action for Health (SAfH) which focus on maternal health issues. This observation will provide an opportunity to gain insight into women's perspectives about place of birth and care services in their boroughs. Additionally, three focus groups will be conducted in East London areas served by Barts Health NHS Trust and facilitated by SAfH. Participant groups will be demographically similar to those approached later in the feasibility study. The focus groups will open with participants discussing their birthplace plans, how they arrived at this decision, what information sources they used and what influenced them to choose a certain setting over another. They will then be given the chance to navigate Which? Birth Choice, after which we will discuss their opinions of the site and whether it affects their birthplace plans. These sessions will also offer an opportunity to receive feedback on data collection tool that will be given to participants during the feasibility study. Ideally, focus groups will have no more than 6-8 individuals and last up to 2 hours. Participants will receive a £5 gift voucher for taking part.

Eligibility criteria to participate:

- Aged 18 or older
- Low-risk pregnancy
- English proficiency or fluency (Which? Birth Choice content is published in English)

Ineligibility criteria:

- Under the age of 18 at time of recruitment
- Issues with substance misuse or are a vulnerable adult

Ethical issues

The information sheet will detail how participants' contributions will be used in the future and the nature of the larger research project. They will be made aware that they can withdraw from the focus group at any time without explanation, and that they will be anonymised in any write-up of the focus groups. All personal information provided will be stored securely in a locked cabinet and destroyed at the end of the study.

Providing compensation for participation is sometimes viewed as potentially unethical, particularly if participants are lower-income. In order to reduce any ethical uncertainty, participants will receive Love2Shop gift vouchers, which can be used at popular High Street shops, as opposed to cash compensation.

References

13. Department of Health (2016) The NHS Choice Framework: what choices are available to me in the NHS?. 29 April 2016 <https://www.gov.uk/government/publications/the-nhs-choice-framework>
14. Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 343: d7400.

B Research Ethics Approval

After you have received confirmation of initial registration, you will need to prepare a full application and submit it to **one** approved research ethics committee.

In general, projects involving the participation of patients recruited through the NHS need to go through **NRES** (<http://www.hra.nhs.uk/research-community/before-you-apply/>), as will projects involving non-anonymised patient records. Application can be made through the **IRAS** portal (<https://www.myresearchproject.org.uk/>). You will also need to register such projects with NHS Trust R&D offices and obtain a research passport.

However, some NHS research ethics committees do not require approval for health services research. If you can submit an email or letter from the appropriate R&D office(s) or NRES committee confirming that NRES approval is not required, you may **instead** submit your proposal to a SHS Ethics Committee or Senate Research Ethics Committee.

Please indicate to which one of the following committees you intend to submit a **full research ethics application** (*Please double click to check as appropriate, and see guidance on SHS Research Governance Web pages*)

1. NHS Research Ethics Committee ☐
2. Senate Research Ethics Committee³⁴ ☐
3. SHS Research Ethics Committee³⁵ ☐
4. Proportionate Review ☒

Is this an amendment to a previously approved project?

Yes ☐ No ☒

If yes, please state the reference number of the project,
(*eg MSc/14-15/100*)

- ☐ LCS Proportionate review ☐

(*Please discuss with Prof Lucy Henry lucy.henry.1@city.ac.uk*)

- ☐ Optometry Proportionate Review ☐

(*Please discuss with Prof Ron Douglas R.H.Douglas@city.ac.uk*)

- ☐ Maternal and Child Health Proportionate Review ☒

(*Please discuss with Dr Katherine Curtis Tyler Katherine.CurtisTyler.1@city.ac.uk*)

34 A full application on form EC1 will have to be made to Senate REC for research ethical approval

35 A full application on form EC1 (SHS version) will have to be made to SHS REC for research ethical approval

5. Another research ethics committee (*please give details below*) ☐

6. This project does not require ethical approval (*please give details below*) ☐

- i) It is a service evaluation or audit ☐

- ii) It does not involve human subjects or participants ☐

(*Please check as appropriate and give details of justification below*)

C Research involving staff or Students at City, University of London

Projects which involve the recruitment of School staff or students require approval by the appropriate Associate Dean for Research, undergraduate or postgraduate students. This ensures that the same group of staff/students are not repeatedly contacted to become involved in research projects. Principal investigators should not contact students or staff directly.

If you wish to recruit staff or students into a research project please contact the relevant Associate Dean for approval prior to submitting your application to Alison Welton (a.welton@city.ac.uk).

Does this project involve the recruitment of staff or students at City, University of London:

- 1) This project will recruit staff ☐
2) This project will recruit postgraduate students ☐
3) This project will recruit undergraduate students ☐

(*Please check as appropriate*)

If you have checked one of the above boxes please obtain electronic approval from the appropriate Associate Dean

D Additional information required for University reporting and indemnity

This project is (please check as appropriate)

- Undergraduate ☐
Taught Postgraduate (MSc) ☐
Doctoral Student ☒
Staff ☐

This project involves (please check as appropriate)

- Children aged 5 and over ☐

Children under 5 years of age	☐
Vulnerable adults	☐
Pregnant women	☒
More than 500 participants	☐
Research outside of England or Wales	☐

Please specify country _____

Funding, this project is (please check as appropriate)

Externally funded	☒
Internally funded	☒
Unfunded	☐

For further information and advice on the School research governance system please see the research website at <http://www.city.ac.uk/health/research/research-governance>.

Focus group topic guide

First part of the focus group session: 1 hour to discuss place of birth decisions and the Which? Birth Choice tool

Place of birth decisions and decision-making process

Opener: Is this your first baby? If not, where did you give birth previously?

- Choosing that birth setting and why
- Pros and cons of your place of birth
- Your previous birth experience and its influence on current birth place choice
- Current birth place choice (hospital, birth ward, home, undecided, etc.)
- Why have you decided to give birth in that setting? Discuss most and least important influences
- Length of time it took to make the decision and ideas of birth plans before pregnancy
- What is important to your decision if you are still undecided?
- Place of birth information from your health care professionals – Helpful? Detailed?
- Other sources of information about birth place options – Helpful? Detailed?
- Compare these information sources to information received from HCPs

Navigating the Which? Birth Choice website

Opener: Have you heard of or used the Birth Choice website before?

- Opinions of the website
- What is attractive or interesting to you?
- Opinions about the information/content of the site
 - What is easy to find or understand?
 - What is hard to find or confusing?
 - What would you add to it?
- Further use after session?

COMFORT BREAK: 15 minutes to have tea or coffee and reflect on the Which? Birth Choice

Second part of the focus group session: 45 minutes to place of birth decisions further

Opener: Did Which? Birth Choice make you think about other birth place options?

- Information gained about other birth options
- Contributions to knowledge about your birthplace choice
- Confirming ideas, opinions or feelings about birthplace choice
- Did it help those undecided get closer to making a choice?
- Did anyone reconsider birth place choice? If yes, why?
- Are there other information sources (sites, leaflets, people) that are more important to you when making this decision?
- Compare site to other information sources on place of birth

Community-based study ethics approval and indemnity



School of Health Sciences

Research Office
Northampton Square
London EC1V 0HB

Tel: +44 (0) 20 7040 5704

www.city.ac.uk

Ref: PhD/16-17/09

05 July 2017

Dear Cassandra / Chris

Re: Places of birth: a study of information, choice and outcomes in a maternity context

Thank you for forwarding amendments and clarifications regarding your project. These have now been reviewed **and approved** by the Chair of the School Research Ethics Committee.

Please find attached, details of the full indemnity cover for your study.

Under the School Research Governance guidelines you are requested to contact myself once the project has been completed, and may be asked to complete a brief progress report six months after registering the project with the School.

If you have any queries please do not hesitate to contact me as below.

Yours sincerely

A handwritten signature in black ink that reads 'A Welton'.

Alison Welton
Research Governance Officer

a.welton@city.ac.uk
020 7040 5704

To Whom It May Concern

Our ref: FEHE

15 August, 2016

Zurich Municipal Customer: City University

This is to confirm that City University has in force with this Company until the policy expiry on 31 July 2017 Insurance incorporating the following essential features:

Policy Number: NHE-01CA27-0013

Limit of Indemnity:

Public Liability:	£ 50,000,000	any one event
Products Liability:	£ 50,000,000	for all claims in the
Pollution:		aggregate during
		any one period of
		insurance

Employers' Liability: £ 50,000,000 any one event inclusive of costs

Excess:

Public Liability/Products Liability/Pollution:	£ 250 any one event
Employers' Liability:	£ Nil any one claim

Indemnity to Principals:

Covers include a standard Indemnity to Principals Clause in respect of contractual obligations.

Full Policy:

The policy documents should be referred to for details of full cover.

Yours faithfully

Underwriting Services
Zurich Municipal
Farnborough

Zurich Municipal
Zurich House
2 Gladiator Way
Farnborough
Hampshire
GU14 6GB

Telephone: 0800 335500
E-mail:
claire.purdy@uk.zurich.com

Communications will be
monitored regularly to improve
our service and for security and
regulatory purposes

Zurich Municipal is a trading
name Zurich Insurance plc
A public limited company
incorporated in Ireland
Registration No. 13460

UK Branch registered in England
and Wales Registration No.
BR7985.
UK Branch Head Office: The
Zurich Centre, 3000 Parkway,
Whiteley, Fareham, Hampshire
PO15 7JZ.

Zurich Insurance plc is authorised
by the Central Bank of Ireland
and subject to limited regulation
by the Financial Conduct
Authority. Details about the
extent of our regulation by the
Financial Conduct Authority are
available from us on request.
These details can be checked on
the FCA's Financial Services
Register via their website
www.fca.org.uk or by contacting
them on 0800 111 6768. Our
FCA Firm Reference Number is
203093.

To Whom It May Concern

Our ref: AJ/IND

12 July, 2017

Zurich Municipal Customer: City, University of London

This is to confirm that City, University of London has in force with this Company until the policy expiry on 31 July 2018 Insurance incorporating the following essential features:

Zurich Municipal
Zurich House
1 Gladiator Way
Farnborough
Hampshire
GU14 6GB

Telephone: 0800 335500
E-mail:
claire.cripps@uk.zurich.com

Zurich Municipal is a trading
name Zurich Insurance plc
A public limited company
incorporated in Ireland
Registration No. 13460

Registered Office: Zurich House,
Ballsbridge Park, Dublin 4,
Ireland.
UK Branch registered in England
and Wales Registration No.
BR7985.
UK Branch Head Office: The
Zurich Centre, 3000 Parkway,
Whiteley, Fareham, Hampshire
PO15 7JZ.

Zurich Insurance plc is authorised
by the Central Bank of Ireland
and authorised and subject to
limited regulation by the Financial
Conduct Authority. Details about
the extent of our authorisation by
the Financial Conduct Authority
are available from us on request.
Our FCA Firm Reference Number
is 203093.

Policy Number: NHE-01CA27-0013

Limit of Indemnity:

Public Liability: £ 50,000,000

Products Liability: £ 50,000,000

Pollution:

any one event
for all claims in the
aggregate during
period of
insurance

Employers' Liability: £ 50,000,000

any one event
inclusive of costs

Excess:

Public Liability/Products Liability/Pollution:

Employers' Liability:

£ 250 any one event
Nil any one claim

Indemnity to Principals:

Covers include a standard Indemnity to Principals Clause in respect of
contractual obligations.

Full Policy:

The policy documents should be referred to for details of full cover.

Yours faithfully

Underwriting Services
Zurich Municipal
Farnborough

MSTDNA01

Appendix H

NHS-based study HRA protocol (ethics application), study documents and sponsor letter.

Protocol

Places of birth:

A feasibility study on information, decision-making and choice outcomes in a maternity context

Version 1.1

20 October 2017

IRAS Project ID: 230496

Sponsor: City, University of London, School of Health Sciences

For further information regarding the sponsorship conditions, please contact:

Alison Welton
Research Governance Officer
School of Health Sciences
City, University of London
London EC1V 0HB
Telephone +44 (0)20 7040 5704
A.Welton@city.ac.uk

Funders: City, University of London, Consumers' Association (Which?)



Study Management Group

Chief Investigator
Ms Cassandra Yuill
Centre for Maternal and Child Health Research
School of Health Sciences
City, University of London

Myddelton Building
EC1V 7HD

Academic Supervisors

Professor Christine McCourt
Centre for Maternal and Child Health Research
School of Health Sciences
City, University of London
Myddelton Building
EC1V 7HD
Dr Lucia Rocca-Ihenacho
Centre for Maternal and Child Health Research
School of Health Sciences
City, University of London
Myddelton Building
EC1V 7HD

Lead Principal Investigator

Ms Mary Olusile
Barts Health NHS Trust
The Royal London Hospital
Whitechapel Road
London
EB1 1BB

Local Collaborators

Ms Cathy Falvey-Browne
Barts Health NHS Trust
Newham University Hospital
Glen Road
Plaistow
London
E13 8SL
Mr Felipe Castro Cardona
Barts Health NHS Trust
Whipps Cross University Hospital
Whipps Cross Road
Leytonstone
London
E11 1NR

Glossary of Abbreviations

HCP	Health Care Professional
SAfH	Social Action for Health
NICE	The National Institute for Health and Care Excellence
OU	Obstetric Unit
AMU	Alongside midwifery unit
FMU	Free-standing midwifery unit

Keywords

Abstract

The British government has been committed to ensuring that women and their partners have access to a range of choices in maternity services, including where women decide to give birth. Providing choice not only empowers women but also increases the rate of straightforward births and parents' satisfaction with their birth experience and outcome. With the push for the diversification of services and their uptake, place of birth decision-making and what influences it must be considered in order to shape maternity care and information provision.

This project is co-funded by City, University of London and Which?, and will be developed based on initial research and engagement with local parents and community organisation in the East London area. The feasibility study aims to understand the relationship between information, decision-making and choice outcomes, focusing on what influences the decision-making process of both women and their (birth) partners and to what extent birthplace choices are "informed." Employing two qualitative methods, diaries and interviews, the study will 1) trace the decision-making process during and after pregnancy, 2) explore information use, 3) assess the influence of Which? Birth Choice, an online birth decision-aid, and other information sources on decision-making, 4) measure how informed place of birth choice were and 5) assess the feasibility and acceptability of the study design.

A feasibility trial design will be employed, with eligible women randomised into control and intervention groups after they enrol in the study. The control group will receive usual birthplace information provision from their clinicians, while the intervention will be introduced to and encouraged to use Which? Birth Choice in addition their usual care. If the design looks promising, then plans for further research will to move towards establishing a framework for a randomised trial.

Rationale

The British government has been committed to ensuring that women and their partners have access to a range of choices in maternity services [1]. Importantly, this includes where women decide to give birth, which has implications on birth experiences and outcomes [2]. The NICE Clinical Guideline 190 (2014) and Quality Standard 105 (2015) recommend offering choices between home birth, midwifery units, both alongside midwifery units (AMU) and free-standing midwifery units (FMU), and obstetric units (OU), emphasising the importance of health care professionals (HCPs) providing information and advice about all available settings to allow women and their partners to make informed birthplace decisions [3,4].

Why is place of birth choice so important? Providing choice not only empowers women but also increases the rate of straightforward births and parents' satisfaction with their birth experience and outcome [5]. Even the act of making a birth plan can empower women by expanding knowledge and understanding of maternity care [6]. Moreover, medical interventions are lower and recovery times shorter among those who choose midwifery-led settings, such as a FMU, or home birth, reducing the costs associated with these options [5]. Uptake of hospital birth is still high, but there are indications that it is decreasing, with a 5.2% drop between 2012 and 2015 [7,8]. With the push for the diversification of services and their uptake, place of birth decision-making and what influences it must be considered in order to shape maternity care and information provision.

Such considerations bring forward the issues around informed choice (how to achieve it, augment it and assess it). The concept is most often explored through the development and evaluation of decision-making aids. A review of pregnancy and birth decision aids suggests that decision analysis tools, those that helps people make decisions when there are several options, significantly influence final choice and final outcome [9]. This signals a need to further investigate to what extent a decision-aid can influence choice and empower women to put birthplace preferences into practice. Exploring the decision pathway

to a specific place of birth and subsequent choice outcomes will be key as well as evaluating the differences between the two.

Moving forward, it is crucial to understand the extent to which providing this information through different sources has an impact on the place of birth decision-making. The Which? Birth Choice (<http://www.which.co.uk/birth-choice/>) is a web-based tool that helps families decide where to give birth and understand their maternity options. The site receives over 60,000 unique visits a month, and internal research reveals that many use the site to confirm pre-existing views on birthplace, while others use it to aid in deciding where they want to give birth. It is still unknown in what ways Which? Birth Choice impacts these decisions and how women and their partners feel about their birth options. Research on decision aids in maternity care is inconclusive and indicates that information use is complex, with some forms of information having little influence on informed choice.

Because place of birth choices are made within an individual's socio-economic [10] and cultural context [11], there is an additional layer of complexity beyond the physical, emotional and experiential aspects of childbirth, and this demands a social science, specifically anthropological, perspective. Such an approach provides a prism through which the complexity of informed choice can be better understood, as the exploration of such intricacies is central to the discipline. Increasing choice, improving knowledge and facilitating informed decision-making are strategies that can empower parents, however, pre-existing views, informal networks of knowledge and support and geographic location can take precedence [12].

This research project aims to understand the relationship between information, choice and outcomes in a maternity context through the lens of anthropological theory. It will explore the different routes of impact an internet-based aid has on women and their partners in a health setting with diverse birthplace options. I hope to capture and interpret the richness of experiences related to childbirth through interviews and observational study of resource use and decision-making processes, integrating these data with that generated from quantitative methods. The latter will be directed toward assessing the efficacy of Which? Birth Choice, as research with sufficient power to do so is not widespread [10]. With this mixed methods approach, this project aims to create a more complete picture of informed choice, how it is impacted upon and what moderates it.

Study Aims

In order to better understand the interaction of birthplace information, decision-making and choice outcomes, this research aims to:

- Explore how women and their (birth) partners use different information sources to make decisions about place of birth
- Investigate the impact of the Which? Birth Choice website on women's birth place choices, experiences and outcomes
- Identify and explore the key variables moderating this impact, such as socio-economic status, ethnic background, accessibility of maternity care and conceptions of choice and control in childbirth
- Design and implement a feasibility study to establish a randomised controlled trial framework and measure primary and secondary outcomes of different approaches for supporting informed choice

Public and Participant Involvement

During the preparatory stage of my doctorate, I undertook public engagement activities in order to direct my research focus, shape the research design and revise the data collection tools. The first of these involved attending and observing focus group sessions facilitated by Social Action for Health (SAfH) in areas served by Barts Health. The aim of the session was to obtain feedback about women's maternity care experiences, different information sources they receive about this care and what they want

incorporated into a new online resource. My observations and volunteering activities afforded the opportunity to hear real accounts of maternity care from local women of diverse ages, backgrounds and parity. I was also able to make connections within SAfH, Maternity Mates and Newham NCT and share my research project with key contacts in these organisations.

I also conducted an initial exploratory research phase to investigate decision-aid and information use, running focus groups with facilitation from SAfH. This stage, informed by a literature review, functioned as a sounding board for the design of the subsequent feasibility study. The aims were to refine the focus of the research design, revise data collection tools and take into account relevant issues about decision-making not yet incorporated into the scope of the project. This phase was conducted outside of the NHS setting, and I received ethics approval from the School of Health Sciences, City University of London committee on 5 July 2017.

Study Design and Methods: Overview

This study will involve 60 women, who will be recruited between 8 and 12 weeks into their pregnancies. 30 of these participants will be introduced to the Which? Birth Choice website and encouraged to use it throughout their pregnancy in addition to their usual care and information provision. The second group of 30 will receive their care as usual from their midwives and GPs. Women who consent to take part will be randomly allocated into either the control or intervention group, in order to test procedures for and willingness to be randomised.

Participants will take part from their enrolment until 2 months after they give birth. During this time, they will be asked to complete an online diary (Birth Decisions Diary) about their birthplace decision-making process. This tool also includes a survey about birth knowledge and a photo sharing feature. All those taking part will be invited to give three semi-structure interviews throughout their participation: two during their pregnancies and one postpartum.

Feasibility Study Outcomes

Outcomes for the feasibility study

- Proportion of eligible and demographic diversity of women recruited
- Rates of and reasons for attrition
- Fidelity to the intervention or control arms (e.g. what other information sources do participants use)
- Key outcomes for the full trial and how they could be measured
- Solutions for information provision that is ethical but does not highlight alternative informed choice options

Anticipated Outcomes for Future Trial

Anticipated primary outcome for future trial

- Efficacy of Which? Birth Choice increasing informed birthplace choices and positive birth experiences and choice outcomes among women and their partners
- Anticipated secondary outcomes
- To what extent are key variables moderating the impact of the Which? Birth Choice website
- How and why are women and their partners using other information sources on birthplace
- To what extent is Which? Birth Choice influencing individuals' interactions and relationships with health care professionals

Study Timeline

Month->	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Activities														
Participant recruitment in NU, RL & WX Hospitals														
Participant enrolment & training														
Data collection from participants (antenatal)														
Data collection from participants (postnatal)														
Data analysis														
Report write-up														

Major anticipated milestones

- Commencement of study – October 2017
- Completion of participant recruitment – January 2018
- Completion of data collection – August 2018
- Completion of preliminary data analysis – September 2018
- Completion of final report – December 2018

Study Location

This study will take place in East London, specifically the boroughs of Newham, Tower Hamlets and Waltham Forest. Recruitment will be conducted in the three primary hospitals of Barts Health NHS Trust that provide maternity services: Newham University Hospital, The Royal London Hospital and Whipps Cross University Hospital. The local collaborators for each site are: Cathy Falvey-Browne (Newham), Mary Olusile (The Royal London) and Felipe Castro Cardona (Whipps Cross). Mary Olusile will also be the local Principal Investigator for this study.

Data collection will be conducted online, over the phone and in the participants' homes. Training for the using the decision-making diary and the interviews (See section 6.9) will take place in the participants' homes. The diary will be completed online and all support and prompts will be done either over the phone, by text or on e-mail, depending on the participant's preference.

Recruitment

Women will be recruited when they are between 8 and 12 weeks pregnant. I aim to recruit 20 at each of the three Barts Health hospital sites (Newham University, The Royal London and Whipps Cross University Hospitals), totalling 60 participants in all. There is little guidance on feasibility study sample sizes, even though their justification is a key aspect in the design of trials. This sample size is based on an audit [13], which found that feasibility and pilot trials have on average 30 participants per arm. This is consistent with other recommendations by Browne [14] and Julious [15], who provide minimums for feasibility and pilot trials of 30 participants in total and 12 per group, respectively. A power calculation was not used as the audit suggested that formal calculation of sample sizes may not always be appropriate in these studies. I have doubled the sample size to account for a drop-out rate, which is expected to be 30-50%.

Eligible women will be approached when they come in for their booking appointments at 8-12 weeks. Booking midwives will first identify and recommend eligible women based on the inclusion and exclusion criteria. They will have access to women's patient notes with their medical history and will be able to determine an individual's suitability for the study beforehand, particularly if her pregnancy is considered

low-risk or uncomplicated. Partners or birth partners will also be invited to take part in the study, with the permission of the women being recruited. These partners must also meet the eligibility criteria. During this approach, women (and their partners if they are present and able to participate) will be given a study information sheet and consent to contact form as well as the enrolment and consent forms to take away with them (See Appendices 1-4).

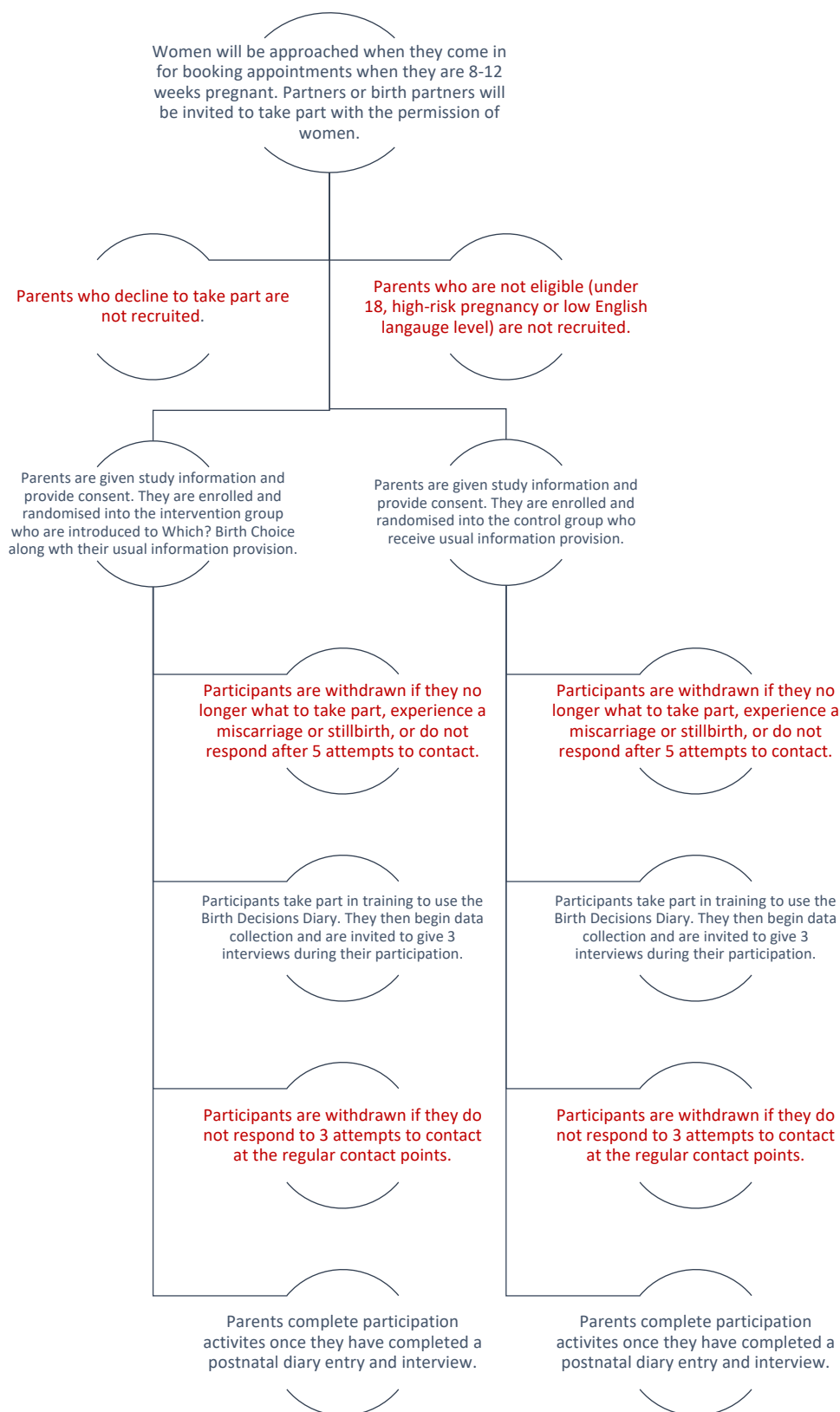


Figure 1: Flow chart depicting participants' recruitment, enrolment and research activities while taking part.

Inclusion criteria

Eligibility criterion for women and their partners participating in this study:

- Aged 18 or older at time of recruitment
- Uncomplicated pregnancy (as defined by the NICE intrapartum guidelines³⁶)
- English proficiency or fluency³⁷

Exclusion criteria

- Ineligibility criterion for women and their partners participating in this study:
- Under the age of 18 at time of recruitment
- High-risk pregnancy
- Issues with substance misuse or are a vulnerable adult

Withdrawal criteria

- Participants will be withdrawn if they:
- Express a desire to withdraw from the study
- Experience a miscarriage or stillbirth
- Do not respond to the researcher following enrolment after five attempts to contact

Drop-out criteria

- Participants will be dropped out if they:
- Do not respond to the researcher at any of the data collection points after three attempts to contact

Consent

Before parents are enrolled into the study, they must provide informed consent and complete the enrolment form. I will be obtaining consent from participants, having completed GCP training for both primary (June 2017) and secondary care (July 2015).

All parents interested in participating will be given an information sheet (See Appendix 1 & 2) as well as enrolment and consent forms (See Appendices 4-7) when I approach them during their booking appointments at one of the three sites. I will explain the project and requirements of participation verbally as well as answer any questions that may arise. I will also ask for initial consent to contact (See Appendix 3) in order to get in touch with parents about enrolment forms and participation in the study. Women will be encouraged to discuss participation with their family members prior to enrolment and may return the enrolment form at via post or e-mail. Potential participants will be given one week after this initial contact to enrol into the study.

Enrolment

Once all participants (mothers and birth partners) have provided informed consent, they will be asked to complete the enrolment form (See Appendices 4 & 5), entered into the study and given a study I.D.

³⁶ NICE guidance defines an uncomplicated pregnancy as “a singleton pregnancy where the mother is healthy and does not require additional care.” Guidelines on indicators and complications that may require additional care can be found here: <https://cks.nice.org.uk/antenatal-care-uncomplicated-pregnancy#!backgroundsub>.

³⁷ Which? Birth Choice is only published in English at this time, so English proficiency or fluency is essential to navigating it and therefore, reflected in the eligibility criteria.

number. A notification letter will be inserted into the women's handheld maternity notes, informing their GPs and Midwives of their participation and what it will entail (See Appendix 8). After completing the enrolment form, participants be asked to fill out a short questionnaire on the diary site in order to complete their profile. The questions will cover where they want to give birth and what kind of role they like to take in when decisions are made about their care (See Appendix 9).

Introduction of Which? Birth Choice

Mothers and their (birth) partners will be randomised into two groups after they enrol into the study. One group of 30 parent participants (10 per site) will receive care as usual from HCPs throughout their pregnancies. The other 30 parents will be allocated into the Which? Birth Choice group and introduced to the decision-aid website. These participants will receive information about and a brief tour of the site during their one-on-one training sessions for using the Birth Decision Diary. They will be given a leaflet produced by Which? Birth Choice to keep with them.

No attempt will be made to prohibit the women in this group from accessing Which? Birth Choice. This is mainly because it could be difficult to control internet activity among participants. If the website was known to be beneficial to women and their birth outcomes, it would be unethical to prohibit the control group from accessing and using it. There is presently no formal evidence on the effects of using such a site on women's choices and outcomes, a gap the future trial aims to address. The participant information sheet (PIS) will also refrain giving detailed information about Which? Birth Choice, in order avoid biasing women's views or encourage those allocated into the control to search for it. As this is a feasibility study aimed at exploring methodological viability and a diverse group of women's experiences, the research design will be less concerned with demographic similarity of the research sites and between the two groups of participants, as would be the case in a pilot for a RCT.

Data Collection

Participants will start data collection soon after they are enrolled into the study. They will first receive a home visit from me to have a short training session for using the Birth Decision Diary, which will cover when and how it should be used, guidelines for the photo sharing feature (Photovoice), and accessing support for any issues they may encounter. Training sessions for online diaries and Photovoice have been conducted by researchers piloting these methods, in an effort to provide support for participants and encourage their engagement in the data collection tools.

After the training session, participants will receive a £5 gift voucher for enrolling and completing the training. Participants will complete data collection from this point up until two months after they have given birth. At the end of their participation, mothers will receive a book of their diary entries and a £5 gift voucher as a 'thank you' for taking part.

Birth Decisions Diary

The Birth Decisions Diary (See Appendix 9) is an interactive data collection tool aimed at tracing the decision-making processes of women during their pregnancies and measuring to what extent their choices about care constitute "informed decision-making." The design of the diary, which is hosted on the Edublog system and supported by City, University of London, is intended to be easy to use for four key features: creating a profile, making diary entries, taking a survey about birth knowledge and sharing photos (see section 6.9.2). Because this is a feasibility study, data on compliance to the diary completion protocol as well as the accuracy and acceptability of the tool will be collected.

Participants will receive training about the using the diary before they begin data collection. Each individual is given a profile to use throughout their participation, which they update once with key information, such as their estimated delivery date.

The diary feature incorporates items that capture data to measure what extent choice were “informed” and what influenced the decision-making process. There will be an antenatal diary entry form will measure the components of making a choice, while a postnatal diary entry form will focus on the consequences of making a choice. The diary entries are semi-structured with text box fields for responses to most of the questions. The antenatal diary will be filled out the throughout the participants’ pregnancies. Women will be asked to fill out the diary whenever they a significant discussion or reflection on a decision about place of birth. The postnatal diary entry will be completed once and will give participants the opportunity to reflect on their care, birthplace decisions and birth experience.

The survey feature will measure knowledge and was created from based on birth information available on the Which? Birth Choice site. Participants will be asked to complete the survey once, and it will be made available on the site for them to fill out towards the end of their pregnancies.

Prompts to complete the data collection will be sent by e-mail or text, depending on the participant’s personal preference, to remind women to complete the Birth Decisions Diary. These prompts will also provide opportunities to offer support for using the diary tool if participants require it.

Photovoice

Photovoice is participatory action research method that allows participants to identify and represent community strengths and concerns and ultimately enhance these communities through photography. The technique encourages individuals to record and reflect on their realities, using the photos to start a dialogue about perceived issues and experiences. This dialogue may be critical in nature, and the outputs are aimed at reaching policymakers [16]. When applied in a women’s health context, it will centre “the relationship among the representation of women’s bodies, lives and, health” [16:186], and is useful for this study as it is focusing on information and decision-making about a health choice that may be situated in the personal, familial socio-cultural and economic experience. Because this method emphasises individual and community and aims to influence policy, there is a possibility for the output have impact at many levels beyond Which? Birth Choice and Barts Health NHS Trust.

The Birth Decisions Diary will adapt and incorporate this method as a feature that participants can use while they are filling out the entries. All those taking part will receive training and guidance (Appendix 10) for the photo sharing feature and receive the themes (e.g. ‘what is important to you when deciding where to give birth?’) that they should focus on when taking a picture. They will be made aware of how the photos they share will be used over the course of the study and after it has finished.

Photos will be taken on mobile phones and uploaded onto the Birth Decisions Diary which will have a comment box so that participants can briefly describe or explain the picture. I will discuss the photos with participants during three interviews (See section for 6.9.3 for more details), which will involve the women selecting and contextualising photos as well as codifying themes and issues, thus aiding in opening deeper discussions about the birthplace decision-making process, what influences it and how it is experienced.

Interviews

All participants will be invited to give two semi-structured interviews during their pregnancies, which will take place in parents’ second and third trimesters. Partners or birth partners will be asked to participate in these interviews, as their perspectives on place of birth decision-making, as well as in wider field of antenatal care, are underrepresented in maternal health research.

Mothers and their (birth) partners will be asked to take part in a final interview after they birth to discuss the experience of taking part in the study and reflect on their decision-making processes and birth place choice outcomes. Transcriptions of the individual's diary data will be printed as a book, which will be used to facilitate discussion during the interview about the key themes explored in the study. The book, as well as a £5 voucher, will 'thank you' gifts to participants for taking part in the study. Appendix 11 contains a topic guide for both the antenatal and postnatal interviews.

Data Analysis

All data from the diaries and interviews will be descriptively analysed, using the Framework Method, which is a type of thematic or qualitative content analysis method. These methods are used to identify similarities and differences in qualitative data, extracting themes and exploring the relationships within and between sections of the data. The Framework Method uses a matrix output of cases, thematic codes and summarised data so that the researcher can systematically reduce data in order to compare and contrast across cases as well as within the cases themselves. This analysis structure ultimately allows the researcher to draw rich, descriptive conclusions centred on each of themes and their intersections [17].

This method of analysis is suitable for qualitative research conducted in a health care setting and is most often used to analyse semi-structured interviews [17], although it can be employed for other types of textual data, including diaries [18]. All interviews and diary transcripts will be thematically analysed using NVivo, a specialist software package for qualitative data.

Regulatory Issues

Ethics Approval

Sponsorship and provisional Indemnity was obtained from City, University of London, School of Health Sciences on 12 July 2017. I am currently seeking HRA approval from the National Social Care Research Ethics Committee and adoption onto the CRN Portfolio as a study connected to a registered project (IRAS ID: 209028; REC: 16/EE/382), 'How can NICE Intrapartum Guidelines recommendations on place of birth for women with uncomplicated pregnancies be implemented in practice', which is ongoing and on the Portfolio.

Confidentiality and Data Protection

I will preserve the confidentiality of participants taking part in the study and will be undertaking a Data Protection training course with City, University of London in order to ensure I follow appropriate protocols to do so.

Two computerised data files will be maintained on a password protected secure server at City, University of London. One will contain anonymised data identifiable only by study ID number. The other will contain identifiable data in terms of names, addresses and dates of birth together with study IDs. This second database is necessary for two reasons: the ability to access contact information for to send diary completion reminders, provide support for participants throughout the study and schedule the interviews. This data will be destroyed at the end of the project, while the anonymized research data will be retained and archived according to City, University of London's data management and archiving policy. Outcome data will be identified by a study code only. It will not be possible for individual patients to be identified in any way.

Indemnity

City, University of London insurance has provided Provisional Indemnity for this research project and will issue full coverage upon receiving confirmation of the Research Ethics Committee's approval of the proposal. See Appendix 12 for the Provisional Indemnity letter.

Sponsor

City, University of London, School of Health Sciences will act as the sponsor for this study (Appendix 12). Contact on behalf of the sponsor:

Alison Welton
Research Governance Officer
School of Health Sciences
City, University of London
London EC1V 0HB
Telephone +44 (0)20 7040 5704
A.Welton@city.ac.uk

Funding

This doctoral research is co-funded by City, University of London and the Consumers' Association, also known as Which? (registered charity No. 296072). Study costs, such as gift vouchers, will be covered by the funders.

Audits and Inspections

The sponsor, City, University of London, School of Health Sciences, reserves the right to audit compliance with the School Research Governance Framework, and has an audit process in place that is conducted by the School Research Ethics Committee.

Publication Policy

It is intended that the results of the study will be reported and disseminated via peer reviewed scientific articles, an internal report, conference presentation and submission to regulatory bodies. Presentations of findings will also be made to local organisations with a focus on maternity care. Participants who wish to receive a summary of the findings at completion of the study may provide their contact details and will be sent a copy.

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Information sheets

Appendix 1: Participant Information Sheet (PIS) for Women

Version: 1.1 27 September 2017

IRAS ID: 230496



Information for Participants

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk

Centre for Maternal and Child Health Research, School of Health Sciences, City, University of London

I am inviting women and their (birth) partners to take part in a study looking at place of birth and what is important when making decisions about birth location.

What is the study about? This project is looking at: 1) where pregnant women plan to give birth and how they make this decision, 2) what information sources women use to make this choice, 3) how women use different information sources, and 4) what influence these information sources have on decision-making.

Why have I been asked to take part? I am inviting women who are booking for maternity care at Barts Health NHS Trust and who do not have medical risk factors in their pregnancy. I am also inviting their (birth) partners to take part too.

What will it involve? If you agree to take part in this study you will be asked to sign a consent form that says you understand what the study is about and fill out a form giving us some basic details about yourself. You will be given a study ID number that will be used on all study-related forms. Your GP and Midwife will be notified about your participation by a letter that I will give you to include in your patient notes.

You will then be allocated randomly (like flipping a coin) to either receive usual care and information about your options, or to receive usual care plus information on a simple tool that I am evaluating. Taking part in this study will last 8-10 months (from when you enrol until 2 months after you have given birth). You will be asked to fill in an online diary throughout your participation about your birthplace decision-making. This diary will also include a short survey and photo-sharing feature. After you enrol, you will receive a short training session on using the diary and photo-sharing guidelines.

I will also invite you and your (birth) partner to take part in three interviews: one midway through your pregnancy, one in later pregnancy, and one after you have given birth. Your (birth) partner's participation is optional and based on whether you want them to take part. We will discuss your birth plans and any other issues or topics related to place of birth. All interviews will be *audio recorded*.

What are the benefits of taking part? You will be helping researchers to understand how and why women make decisions about where they give birth in the United Kingdom. You will help us find out better ways to provide information about birthplace and to help women make more informed choices about their maternity care.

What the potential risks of taking part? There are no risks in taking part in this research study.

What if I don't want to be in the study anymore? You do not have to take part in this study, but I hope you will choose to participate. It is up to you to decide whether to take part. If you do decide to take part, you will be asked to complete an enrolment form and sign a consent form. You can change your mind at any point about taking part. You are free to leave the study at any time and without giving a reason. All information you provided will be removed from the study if you request this.

Confidentiality: Please note that all information I collect will be stored safely and will not be shared with anyone outside the research team. You will be given a code so that your name will not be on any of the data forms and there will be no way of identifying you. In any reports I may write, information will be summarised from several people so you cannot be identified. Any direct quotes used in these reports will be anonymised and no information will be included that could identify you. Approval from National Social Care Research Ethics Committee and Bart Health NHS Trust has been obtained, and the project is covered by City, University of London insurance.

What will happen to the results of this study? The results of this study will be collected, analysed and used in a PhD thesis being completed by Cassandra Yuill. Your identifiable information will be destroyed once you finish the study. Diary entries, photos and interview information will be securely stored for up to 5 year after this study ends. I also plan to publish these results and share them with the organisations concerned with maternal health care. Your identity will be confidential. You may ask for a copy of these reports or a summary of the outcomes.

Who is organising and funding this study? This study has been organised by Cassandra Yuill and staff members of the Centre for Maternal and Child Health Research and is funded by Which? Birth Choice and City, University of London.

What to expect during the consent process: I will explain the study to you and give you this information sheet. After you have read this sheet, you can ask questions. I will answer all your questions and give you the consent form. You will read the consent form and sign it if you are willing to take part in this study.

A thank you: As a thank you gift for taking part in this study, you will receive a book made from your individual posts on the diary and £10 in Love2Shop gift vouchers. The book will be anonymised before it is produced by myself at City, University of London.

What if there is a problem? Please contact me at E: Cassandra.yuill@city.ac.uk / T: 07840872417. You can also speak with Prof Christine McCourt, my PhD supervisor, at E: Christine.mccourt.1@city.ac.uk / T: 020 7040 5863.

If you are unhappy and wish to complain formally, you can do this through City's complaints procedure. Please phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *Places of birth: A feasibility study of information, decision-making and choice outcomes in a maternity context*. You can also write to the Secretary at:

Anna Ramberg
Research Governance & Compliance Manager
Research & Enterprise, City, University of London
Northampton Square
London EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City holds insurance policies, which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action

Thank you for reading this information sheet and considering taking part in this study. If you have any questions, please speak to Cassandra Yuill (Cassandra.yuill@city.ac.uk +447840872417).

Appendix 2: PIS for Partners

Version: 1.0 27 September 2017

IRAS ID: 230496



Information for Participants (Partners)

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk
Centre for Maternal and Child Health Research, School of Health Sciences, City, University of London

I am inviting women's partners or birth partners to take part in a study looking at place of birth and what is important when making decisions about birth location.

What is the study about? This project is looking at: 1) where pregnant women plan to give birth and how they make this decision, 2) what information sources women use to make this choice, 3) how women use different information sources, and 4) what influence these information sources have on decision-making.

Why have I been asked to take part? I am inviting women who are booking for maternity care at Barts Health NHS Trust and who do not have medical risk factors in their pregnancy. I am also inviting their (birth) partners to take part too.

What will it involve? If you agree to take part in this study you will be asked to sign a consent form that says you understand what the study is about and fill out a form giving us some basic details about yourself. You will be given a study ID number that will be used on all study-related forms. I will give you a letter to notify your GP of your participation in the study.

I will invite you to take part in three interviews with your partner: one midway through your partner's pregnancy, one in later pregnancy, and one after your partner has given birth. We will discuss your birth plans and any other issues or topics related to place of birth. All interviews will be *audio recorded*.

What are the benefits of taking part? You will be helping researchers to understand how and why women make decisions about where they give birth in the United Kingdom. You will help us find out better ways to provide information about birthplace and to help women make more informed choices about their maternity care.

What the potential risks of taking part? There are no risks in taking part in this research study.

What if I don't want to be in the study anymore? You do not have to take part in this study, but I hope you will choose to participate. It is up to you to decide whether to take part. If you do decide to take part, you will be asked to complete an enrolment form and sign a consent form. You can change your mind at any point about taking part. You are free to leave the study at any time and without giving a reason. All information you provided will be removed from the study if you request this.

Confidentiality: Please note that all information I collect will be stored safely and will not be shared with anyone outside the research team. You will be given a code so that your name will not be on any of the data forms and there will be no way of identifying you. In any reports I may write, information will be summarised from several people so you cannot be identified. Any direct quotes used in these reports will be anonymised and no information will be included that could identify you. Approval from National Social Care Research Ethics Committee and Bart Health NHS Trust has been obtained, and the project is covered by City, University of London insurance.

What will happen to the results of this study? The results of this study will be collected, analysed and used in a PhD thesis being completed by Cassandra Yuill. Your identifiable information will be destroyed once you finish the study. I will store diary and interview information for up to 5 years after this study ends. I also plan to publish these results and share them with the organisations concerned with maternal health care. Your identity will be confidential. You may ask for a copy of these reports or a summary of the outcomes.

Who is organising and funding this study? This study has been organised by Cassandra Yuill and staff members of the Centre for Maternal and Child Health Research and is funded by Which? Birth Choice and City, University of London.

What to expect during the consent process: I will explain the study to you and give you this information sheet. After you have read this sheet, you can ask questions. I will answer all your questions and give you the consent form. You will read the consent form and sign it if you are willing to take part in this study.

What if there is a problem? Please contact me at E: Cassandra.yuill@city.ac.uk / T: 07840872417. You can also speak with Prof Christine McCourt, my PhD supervisor, at E: Christine.mccourt.1@city.ac.uk / T: 020 7040 5863.

If you are unhappy and wish to complain formally, you can do this through City's complaints procedure. Please phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *Places of birth: A feasibility study of*

information, decision-making and choice outcomes in a maternity context. You can also write to the Secretary at:

Anna Ramberg
Research Governance & Compliance Manager
Research & Enterprise, City, University of London
Northampton Square
London EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City holds insurance policies, which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action

Thank you for reading this information sheet and considering taking part in this study. If you have any questions, please speak to Cassandra Yuill (Cassandra.yuill@city.ac.uk +447840872417).

Consent to contact form

Appendix 3: Consent to Contact Form

Version: 1.1 27 September 2017

IRAS ID: 230496



Consent to contact Form

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk
Centre for Maternal and Child Health Research, School of Health Sciences
City, University of London

If you are interested in taking part, please let Cassandra know by filling this form. All contact information will be kept in a secure are and will be destroyed if you decide not to take part.

Contact information

Full Name:

What is the best way for us to reach you?

- ☐ Phone call
- ☐ E-mail
- ☐ Text
- ☐ Other: _____

What is your phone number or email address?

Please initial the box

☐

I give my consent for Cassandra Yuill to contact me with the information that I have given. I understand that the information that I gave will be used by staff members to contact me and will be kept in a secure database during the study.

Name

Date

Signature

Name of Person taking consent

Date

Signature

Enrolment forms

Appendix 4: Enrolment Form for Women

Version: 1.1 6 October 2017

Study ID _____



Study Enrolment Form

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk
Centre for Maternal and Child Health Research, School of Health Sciences
City, University of London

All contact information will be kept in a secure database during the study. This information will be destroyed at the end of the study or if you decide you no longer want to take part.

Date: _____

Enrolment Information

Name:

Address:

Is this your first baby?

Yes No

If you answered 'no' please write where you gave birth (e.g. labour ward, birth centre, etc.) in your last pregnancy.

Are you part of any other research study? If 'yes' write which one(s).

Yes No

Demographic Information

When we write our report from this study we will need to describe the group of people who took part, so we need to collect some information about you. Please circle an option or fill in the blank space below.

Your date of birth:

Marital status: Married / Living with partner / With partner, living apart / Single, no partner

Education: Up to age 16 / 16-18 / Vocational training / A levels / University / Post-graduate

Family Income: Below £10000 / Up to £20000 / Up to £30000 / Up to £40000 / Above £40k

Ethnicity (e.g. White British, British Pakistani, etc.):

When completed: 1 for participant; 1 for researcher site file.

IRAS ID: 230496

Appendix 5: Enrolment Form for Partners

Version: 1.0 6 October 2017

Study ID _____



Study Enrolment Form for Partners

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk
Centre for Maternal and Child Health Research, School of Health Sciences

All contact information will be kept in a secure database during the study. This information will be destroyed at the end of the study or if you decide you no longer want to take part.

Date: _____

Enrolment Information

Name:

Address:

Is this your first baby? Yes No

If you answered 'no' please write where you gave birth (e.g. labour ward, birth centre, etc.) in your last pregnancy.

Are you part of any other research study? If 'yes' write which one(s). Yes No

Demographic Information

When we write our report from this study we will need to describe the group of people who took part, so we need to collect some information about you. Please circle an option or fill in the blank space below.

Your date of birth:

Marital status: Married / Living with partner / With partner, living apart / Single, no partner

Education: Up to age 16 / 16-18 / Vocational training / A levels / University / Post-graduate

Family Income: Below £10000 / Up to £20000 / Up to £30000 / Up to £40000 / Above £40k

Ethnicity (e.g. White British, British Pakistani, etc.):

When completed: 1 for participant; 1 for researcher site file.

IRAS ID: 230496

Consent forms and notification letter

Appendix 6: Consent Form for Women

Version: 1.1 6 October 2017

Study ID _____



CONSENT FORM

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk
Centre for Maternal and Child Health Research, School of Health Sciences
City, University of London

Please initial box

7. I confirm that I have read and take a copy of the information sheet dated.....for this study and had the chance to consider the information. I have had the chance to ask questions and have had these answered by..... ☐
8. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
9. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. ☐
10. I understand that the information collection about me will be used to support other research in the future and may be shared anonymously with other researchers. Any other research wishing to access data from this study will be subject to approval from the Research Ethics Committee. ☐
11. I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the Data Protection Act 1998. ☐
12. I agree and am willing to take part in this study. ☐

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

When completed: 1 for participant; 1 for researcher site file.

IRAS ID: 230496

Appendix 7: Consent Form for Partners

Version: 1.0 6 October 2017

Study ID _____



Consent Form for Partners

Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context

Project Researcher: Cassandra Yuill, Cassandra.yuill@city.ac.uk
Centre for Maternal and Child Health Research, School of Health Sciences
City, University of London

Please initial box

1. I confirm that I have read and take a copy of the information sheet dated.....for this study and had the chance to consider the information. I have had the chance to ask questions and have had these answered by..... ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. ☐
4. I understand that the information collection about me will be used to support other research in the future and may be shared anonymously with other researchers. Any other research wishing to access data from this study will be subject to approval from the Research Ethics Committee. ☐
5. I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the Data Protection Act 1998. ☐

6. I agree and am willing to take part in this study.



Name of Participant Date Signature

Name of Person taking consent Date Signature

When completed: 1 for participant; 1 for researcher site file.

IRAS ID: 230496

Appendix 8: GP/Midwife Notification Letter



Centre for Maternal & Child Health Research
School of Health Sciences
Myddelton Building
City, University of London
London
EC1V 0HB

Dear [GP or Midwife],

[Patient NAME], has agreed to participate in a research study being conducted by School of Health Sciences and supported by Barts Health NHS Trust. [Patient NAME] will be involved in a feasibility study looking at place of birth decision-making and information use. She may be randomly allocated into a group that is introduced and encourage to use the website, Which? Birth Choice (<http://www.which.co.uk/birth-choice/>).

[Patient NAME] will take part in this study throughout her pregnancy and up until 2 months postpartum. She will be asked to fill in an online diary and participate in three interviews during this time.

If you have any questions or would like more information about the study, please feel free to contact us at Cassandra.yuill@city.ac.uk. Thank you for your time.

Kind regards,

Ms Cassandra Yuill
PhD Candidate
Centre for Maternal & Child Health Research
City, University of London
0784 087 2417

Prof Christine McCourt
Professor of Maternal and Child Health
Centre for Maternal & Child Health
City, University of London
Christine.mccourt.1@city.ac.uk
0207 040 5863

Birth Decisions Diary

Appendix 9: Birth Decisions Diary (Content Guide)

Birth Decisions Diary

Diary for collecting data on the decision making process about where to give birth and measuring informed choice in a maternity health context. Please visit <https://blogs.city.ac.uk/birthdiary/> to view the site.

Creating a profile: Initial questions completed by the participants.

Please enter your study I.D. number:

What is your estimated due date (EDD)?

This diary is about recording decisions about your maternity care during and after your pregnancy. When decisions are made about your care, what kind of role you like to take?

Antenatal diary entry format [Components of making a choice]

Date:

Study I.D.:

How many weeks along are you?

Have you decided where to give birth?

- ☐ Yes
- ☐ No
- ☐ Not sure

Have you made any other decisions about your birth plan? If yes, please state what they are:

Have any of these decisions changed since you became pregnant (or since you last filled out this diary)? If yes, please explain why.

How much information do you feel you've had so far about these birth place?

Please tick what sources gave you any of this information:

- ☐ Midwife
- ☐ GP
- ☐ Antenatal classes
- ☐ Leaflets from health care professionals
- ☐ Website
- ☐ Past experience
- ☐ Family or friends
- ☐ Books or magazines

Which of these information sources influenced your thoughts about what you wanted?

Which of these sources has been to most important or most helpful so far?

How important is it for you to have information about different birth place options at this point?

How do you feel about the information that you've had so far about birth place options?

Have you been able to discuss what you wanted, as much as you wanted when talking to your health care professional about where you are giving birth?

As of now, do you feel like you have had enough information and discussion with your health care professional to make a choice about where to give birth?

Has your health care professional offered you options of where to give birth?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Other

Do you feel you have played an active role in what has happened during your care so far?

Any other thoughts to share? Feel free to share them here.

Postnatal diary entry format [Consequences of making a choice]

Date:

Study I.D.

Where did you give birth?

Did you give birth where you originally planned to? Would you give birth there again?

How satisfied were you with where you gave birth? Think about the care you received, the facilities, etc.

Looking back, what or who was the most helpful source of birthplace information for you?

How important was it for you to have information about different birthplace options during your pregnancy?

How much information do you feel you received about different birthplace options?

How do you feel about the information that you received about where to give birth?

Do you feel you had enough information and discussion with your health care professional to make a choice about where to give birth?

How do you feel about the way decisions were made about where you gave birth?

Do you feel like you had an active role in what happened during your care?

Looking back, is there anything you would like to change about where or how you gave birth?

Any other thoughts to share? Feel free to share them here.

Birth information survey

1. Where can you find information about your local maternity units?
 - a. NHS website
 - b. Local council
 - c. Care Quality Commission (CQC) report
 - d. Midwife or GP

- e. Other source: _____
 - f. I don't know
2. A midwife attends births in the following settings:
- a. Labour ward only
 - b. Birth centre and labour ward
 - c. Birth centre and home birth
 - d. Labour ward, birth centre and home birth
 - e. I don't know
3. Where is the safest place to give birth if you have a low-risk pregnancy?
- a. In a labour ward
 - b. In a birth centre
 - c. At home
 - d. It depends on a number of factors
 - e. I don't know

Please check one response for each sentence.	True	False	I don't know
a. Giving birth in a birth centre is as safe giving birth on the labour ward for first-time mums who have low-risk pregnancies			
b. Giving birth at home is as safe as giving birth in a birth centre or labour ward for first-time mums with low-risk pregnancies			
c. Giving birth at home is as safe as giving birth in a birth centre or labour ward for second-time or subsequent mums with low-risk pregnancies			
d. Women planning to birth at home or in a birth centre were less likely to have an unplanned caesarean during labour than women planning birth in a labour ward			
e. First-time mums planning birth in a birth centre are less likely to transfer to the labour ward in labour than those planning birth at home			
f. Mums planning birth in a birth centre are less likely to have a medical intervention than those giving birth in a labour ward			
g. Mums planning birth in a birth centre outside the hospital are less likely to have a medical intervention than those planning birth in a birth centre attached to a hospital.			
h. It is just as safe to give birth in a birth centre outside the hospital as it is in a centre attached to the hospital.			
i. Giving in a birth centre means all mums will have access to birth pools			
j. Mums with a baby in breech can plan to give birth at a birth centre			
k. The vast majority of homes are suitable for a home birth			

4. Please tick the reasons a mum could be transferred during her home birth:
- a. The mum's labour is slowing down
 - b. The mum can't cope with pain during her labour
 - c. The baby's heartrate begins to drop
 - d. The mum has a cord prolapse (when the umbilical cord is born before baby)
 - e. The mum needs stitches for a minor tear
 - f. The placenta doesn't come out after birth
5. What is the difference between an **alongside** and **freestanding** midwifery-led units?
6. How many second time or subsequent mums transferred from a freestanding midwifery unit (birth centre)?

- a. 9%
 - b. 12%
 - c. 13%
 - d. 40%
 - e. I don't know
7. How many women are typically giving birth on a labour ward every day?
- a. 1 – 5 depending on the size of the unit
 - b. 5 – 20 depending on the size of the unit
 - c. More than 20 depending on the size of the unit
 - d. I don't know
8. How many first-time mums have a **straightforward birth** in the labour ward?
- a. 46%
 - b. 63%
 - c. 69%
 - d. 71%
 - e. I don't know
9. The following pain relievers are **only** available in the labour ward:
- a. Gas and air
 - b. Pethidine, diamorphine or other opioid drug
 - c. TENS Machine
 - d. Birth pool
 - e. Epidural
 - f. Natural methods (e.g. massage and hypnosis)
 - g. I don't know

Photo upload feature

Do you have a photo of something related to planning your birth or deciding where to have your baby?

What does this picture show and why is it important to you?

Photovoice guidelines

Appendix 10: Photo Sharing (Photovoice) Guidelines

Version 1.0 12 July 2017



Guide for using photo-sharing feature on the Birth Decisions Diary

Places of birth: a study of information, decision-making and choice outcomes in a maternity context

Study Researcher: Cassandra Yuill

This is a guide about using the photo-sharing feature on the Birth Decisions Diary. You should keep this sheet with you throughout participating in the study to use as a reference.

What are the main guidelines for using photo-sharing?

- Share a photo of objects, spaces or actions that were important when you were thinking about where you are going to give birth.
- Do not share photos of people's faces (including yours!), especially those of children or strangers.
- Be sure to leave a short comment explaining the photo you shared.
- Please be sure share photos relating to these questions:
 1. What is important when you are thinking about where to give birth?
 2. What types of information are important to you?
 3. How does information about or discussion of birthplace make you feel?
 4. What or who affects your experiences or feelings about birthplace?
- Remember that it's ok if you don't feel like sharing any photos while you are taking part in this study. You can share your thoughts on the diary entry form online instead.
- If you ever have any questions, feel free to contact me at Cassandra.yuill@city.ac.uk or 07840872417, Monday-Friday, 9am-5pm. You can also submit a comment/question form online through the Birth Decisions Diary.

Interview topic guide

Appendix 11: Interview Guide

Version 1.1 18 October 2017



Topic Guide (Interviews)

Places of birth: a study of information, decision-making and choice outcomes in a maternity context
Study Researcher: Cassandra Yuill

Guide for a 1 hour semi-structured to discuss place of birth, decision-making and influences on it, patient experiences, and information use

Place of birth decisions and decision-making process

Opener: How is your pregnancy going so far? Is this your first baby? If not, where did you give birth previously?

- Choosing that birth setting and why
- Describe your 'ideal' birth setting – Where is it? Who is there? What is the atmosphere like? What steps have you taken to achieve this ideal setting?
- Pros and cons of your place of birth

- Your previous birth experience and its influence on current birth place choice
- Current birth place choice (hospital, birth ward, home, undecided, etc.)
- Why have you decided to give birth in that setting? Discuss most and least important influences
- Length of time it took to make the decision and ideas of birth plans before pregnancy

Influences on the decision-making process & making a choice

Opener: What is important to your decision about where you give birth?

- Role of health care professionals in decision-making
- Role of family and friends in decision-making
- Perceived barriers to making a decision, perceived support for decision
- Health care professional, family and friends' roles in offering choices
- Role of the media and internet in decision-making
- Participants role in decision-making and experiences interacting with and balancing other influences

Information use

Opener: What type of information resources about birthplace have you used so far?

- Place of birth information from your health care professionals
- Place of birth information for your health care professionals – Helpful? Detailed?
- Other sources of information about birth place options – Helpful? Detailed?
- Compare these information sources to information received from HCPs
- Accessing sources and conflicting sources – patient experiences
 - Amount of information – do you feel you've received enough?
 - Do any information sources conflict?
- Sources you have used the most and why
- Sources you like or dislike and why

Using the Which? Birth Choice website or other information source

Opener: Why do you like this specific information source?

- Opinions of the information compared to other sources
- What is attractive or interesting to you?

- Opinions about the information/content
 - What is easy to find or understand?
 - What is hard to find or confusing?
 - What would you add to it?
- Further use after this interview?
- Information gained about other birth options
- Contributions to knowledge about your birthplace choice
- Confirming ideas, opinions or feelings about birthplace choice
- Did it help those undecided get closer to making a choice?
- Did this make you reconsider birth place choice? If yes, why?

Postnatal interview topics

This interview will focus on participants' birth experiences and give them an opportunity to reflect on their decision-making during pregnancy, while also covering many of the topics listed above.

Satisfaction with birthplace decision

- Level of satisfaction with the decision about where to give birth
- What aspects contributed to your level of satisfaction
- Pros or cons of birthing in that setting
- Would you give birth in this setting again?

Information use

- Do you feel like you had enough information to make a choice about where you gave birth?
- Retrospectively, what was the most helpful for you in making a decision?
- What pieces of information were the most important to you? This can include leaflets from midwives, websites or others' birth stories.
- Is there any information you wish you had more of during your pregnancy?

Decision-making

- Thinking back to your decision-making about birthplace, what influenced it the most or the least?
- What specific sources of information influenced your decision about where to give birth?

Sponsor letter



**School of Health
Sciences**

Research Office
Northampton Square
London EC1V 0HB

Tel: +44 (0) 20 7040 5704

www.city.ac.uk

Ref: PhD/17-18/03

12 July 2017

Dear Cassandra and Christine

Re: Places of birth: a feasibility study on informed decision-making

Thank you for returning the Research Registration Form. This letter offers you Provisional indemnity. You will NOT be FULLY covered against negligence until you forward written confirmation from the Research Ethics Committee relevant to your proposal (MREC/LREC or City University), that it has given a favourable decision regarding your project. Once we receive this, you will be issued a final letter of indemnity that will cover you fully against negligence.

I can confirm that City University London, School of Health Sciences is willing to act as sponsor for the above named project.

As a condition of the sponsorship, the School reserves the right to audit compliance with the School Research Governance Framework. Further information on the audit process is available from the Chair of the School Research Ethics Committee.

You must also inform the School Research Office if:

- a) Your research terminates before the end date specified on the ethics form.
- b) You intend to extend the timescales for your research. Indemnity and sponsorship only apply to the duration of the research stated in the research ethics application form. Failure to notify the office of an extension may result in no indemnity or sponsorship cover for the extension period. Ethical approval for the extension period **must** be obtained.
- c) Similarly, any changes to the protocol must be notified to the School Research Office. Ethical approval for substantial amendments **must** be obtained.
- d) There are staff changes on the project. This is important as indemnity only applies to staff named on the original research ethics application.
- e) The principal investigator relocates to another organisation during the study period.

Details of any changes must be sent to Alison Welton, Research Governance Officer, at the above address or via e-mail at a.welton@city.ac.uk

Under the School Research Governance Framework you are requested to contact Alison Welton once the project has been completed, and will be asked to complete a brief progress report 6 months/1 year after registering the project with the School.

Yours sincerely

A handwritten signature in black ink, appearing to read 'A Welton', with a stylized, cursive script.

pp. Professor Chris Hull
Associate Dean for Research

Appendix J

NHS-base study indemnity from City, University of London.



School of Health Sciences

Research Office
Northampton Square
London EC1V 0HB

Tel: +44 (0) 20 7040 5704

www.city.ac.uk

Ref: PhD/17-18/03

09 November 2017

Dear Cassandra and Christine

Re: Places of birth: a feasibility study on informed decision-making

Thank you for confirming that you have received HRA ethical approval for your proposed project.

Please find attached, details of the full indemnity cover for your study.

Under the School Research Governance guidelines you are requested to contact myself once the project has been completed, and may be asked to complete a brief progress report six months after registering the project with the School.

If you have any queries please do not hesitate to contact me as below.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'A Welton'.

Alison Welton
Research Governance Officer

a.welton@city.ac.uk

Appendix K

HRA ethics approval and R&D approvals from Barts Health NHS Trust.



Ms Cassandra Yuill
Student
City, University of London
School of Health Sciences, City, University of London
Myddelton Building, 1 Myddelton St
London
EC1R 1UW

Email: hra.approval@nhs.net

15 November 2017

Dear Cassandra Yuill

Letter of HRA Approval

Study title:	Places of birth: A feasibility study on information, decision-making and choice outcomes in a maternity context
IRAS project ID:	230496
REC reference:	17/LO/1510
Sponsor	City, University of London, School of Health Sciences

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the [HRA website](#).

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](#), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](#).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through [IRAS](#).

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	230496

procedure. If you wish to make your views known please use the feedback form available on the [HRA website](#).

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the [HRA website](#).

Your IRAS project ID is **230496**. Please quote this on all correspondence.

Yours sincerely

Rekha Keshvara
Senior Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Alison Welton, City, University of London (Sponsor contact)*
Mr Pushpsen Joshi, Barts Health NHS Trust (R&D contact)

Appendix L

Example of the framework used for the thematic analysis of the ethnographic data.

Case	Performing good motherhood	Uncertainty	Embodied experience	Temporal dimension
Faith	<u>I looked into how it's safe</u> and how you're in your own environment. On the first appointment I didn't get much information about place of birth. <u>It took me actively going out and finding the information.</u> Lots of friend and family I asked, some colleagues, just anyone really that wanted to tell their story. Then, looking online, on Facebook I joined some groups. There are some parenting groups and I asked people there what their experiences were giving birth and what was it like. <u>Once I had heard about the home birth, I joined the actual home birth groups as well and asked some people how their experience was. Reading other people's advice and stories, questions and answers.</u>	I kind of like the fact that you're around own germs as well. There's no other random bugs about. <u>Because going to hospital, you have a risk of getting an infection in the hospital, too. You can wash your hands a million times. It's just that fact you're in the hospital building that there's always going to be a chance.</u>	<u>I knew just being in hospital, you - even if you're the strongest person - the minute you walk in, you're in somebody else's, you're in the hospital environment, you're no longer...that kinda of independent person.</u> <u>First of all, you're in your own environment, so you have everything where you want it to be. You're relaxed. You can go up the stairs, you can go down the stairs, you can stand up and sit down.</u> There's no machines. It's just like being at home, basically. <u>You can move, do what you like.</u> I really wanted to feel comfortable as well, and feel confident, empowered...I felt like the most likely place I could achieve that, if I wasn't able to use the birth centre, was at home. I thought that I'll be really comfortable a home.	<u>My initial appointment was about 12 weeks, saw the midwife. Birth choices weren't discussed around that time, it more information about me.</u> It wasn't so much about the birth choices. I just assumed really that it was just the hospital there, I knew people who had given birth in hospital... <u>It was definitely in the third trimester, somewhere around 30+ weeks definitely. Actually, I only just discovered the Barkantine was there around that time in my pregnancy.</u> I didn't actually realise that we had a stand-alone birth centre.
Case	Performing good motherhood	Uncertainty	Embodied experience	Temporal dimension

Charlotte	Yeah that's sort of when we decided and then just all the way through <u>we've just sort of had this caveat of you know if we're given strong evidence that suggests that we shouldn't have it at home, or I come up with anything that's high risk, if the baby's breech or I go over and they want to induce, then I'll end up going in.</u> I think that sometimes I found that [home birth groups] does go like a bit too far for me because I guess my I feel like we're gonna have a home birth but we will take all the advice of medical professionals. <u>That's why I have these caveats, so if I have an appointment next week and they're like - I don't know what would happen - they found something in my urine or blood test and they're like, 'oh you're risking something we wouldn't advise a home birth' then we definitely wouldn't.</u> And obviously that's down to an individual to decide whether or not they have risk, but some of it feels quite pressurised and a bit culty.	Maybe that's why I've been avoiding groups [online] because I think that is I hadn't realised like – <u>at first I was like, 'oh it's really early.'</u> Obviously <u>we don't what's gonna happen, if it's gonna be okay. There's definitely an element of superstition but I don't have to like count my chickens.</u> It's the only thing we do too much, and I guess it's like the last couple of weeks, I think like I feel that we should probably get a bit organised now...	<u>[My husband] said that he noticed as new people came in, like I wasn't really aware, but he said when people came in, the contractions would slow down. And when the midwife went to get the doctor, the contractions also slowed down.</u> The other thing that is weird is that I had, <u>before labour, my main anxiety was something happening to the baby during labour, but when I was in it, I just had this overwhelming feeling...I was like, 'the baby is fine.'</u> I knew he was fine, and you know, I was like, 'I don't, we didn't need this belt on, like can we get rid of the belt?'	<u>I'm only just starting to like ramp up midwife appointments. I had one at 13 weeks and then 16 weeks and 24 weeks to get 24 weeks and then I just have my 28th week one, but they haven't mentioned it, like they haven't brought it up in my notes. It says it's discussed at like 32 or 34 weeks, so last time I did ask when they do the home assessment because my friends who had home birth said they had theirs quite early and then the midwife left a bag of stuff at their house from about 35 weeks.</u> <u>Actually I found like with the generation thing is that I think like for the grandparent generation, it's much more common that, to have babies at home. They've been like, 'Oh, cool. That's normal,' and then I think like maybe in the 70s and 80s it was much more medicalised again, so parents' and aunts' and uncles' generation seem to be a lot more surprised.</u>

Appendix M

Glossary of terms

Alongside midwifery unit (AMU)

“A NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair” (NPEU Birthplace in England).

Booking or Booking clinic

Women are encouraged to register for antenatal care early in pregnancy, ideally by 12 weeks gestation. This appointment is an initial consultation with a midwife that lasts about an hour and includes referral for ongoing antenatal care.

Continuity of carer

“The provision of care by a known midwife throughout the pregnancy, labour, birth and postnatal period” (RCM).

Elective caesarean section

A caesarean section that is pre-planned before the onset of labour, rather than occurring in response to an obstetric emergency.

Free birth	A planned birth that is unassisted by and/or not under the guidance of a skilled clinician ³⁸ .
Freestanding midwifery unit (FMU)	“A NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General Practitioners may also be involved in care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance” (NPEU Birthplace in England).
Full caseloading model	“Whereby each midwife is allocated a certain number of women (the caseload) and arranges their working life around the needs of the caseload. The backup is provided by a core midwifery team whom the woman is unlikely to have met” (Maternity Transformation Programme, 2017b, p. 4).
‘High risk’ or Complex pregnancy	When pregnant people have, or develop, any of the risk indications listed in the NICE intrapartum care guidelines. In these circumstances, practitioners recommend a planned birth at an OU.

³⁸ This should not be confused with a Born before arrival (BBA), which is an unplanned, unassisted birth, in which a baby is born before clinicians can attend the mother.

Induction of labour	“When labour is started artificially, through the administration of hormones to the cervix, or rupture of the membranes” (Coxon, 2011, p. 373).
‘Low risk’ or Straightforward pregnancy	When pregnant people do not have any history of the medical or obstetric risk indications listed in the NICE intrapartum care guidelines, and they do not develop any of the risk indication during pregnancy. In these circumstances, practitioners recommend all birthplace options available.
Maternity Voices Partnerships (MVPs)	“A NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care” (National Maternity Voices). MVPs replaced Maternity Service Liaison Committees (MSLCs) in 2018. Establishing MVPs in Local Maternity Systems is part of the co-production section (Chapter 4) of <i>Implementing Better Births: A resource pack for Local Maternity Systems</i> , and service user chairs of MVPs represent parents at the Local Maternity System level.
Meconium	The dark green or brown substance from a newborn infant’s bowel. Meconium stained liquor (amniotic fluid) is associated with foetal distress and an indication that continuous electronic monitoring during labour may be needed. In the case of thick or lumpy meconium in amniotic fluid, midwives will advise a transfer to an OU.

Multiparous	A woman who has given birth to one or more children.
NHS trust	A hospital or group of hospitals, within which the NHS has self-governing status.
Primiparous	A woman who is expecting her first child.
Obstetric unit (OU)	“A NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care are available on site, 24 hours a day” (NPEU Birthplace in England).
Parity	A medical term denoting the number of live births a woman has experienced.
Physiological or ‘Normal’ birth	“Spontaneous labour (no induction) and vaginal birth without instrumental assistance, episiotomy or epidural, spinal or general anaesthesia” (Maternity Care Working Party).
Postpartum Haemorrhage (PPH)	The most common form of major obstetric haemorrhage, which is traditionally defined as the loss of 500 ml or more of blood from the genital tract within 24 hours of giving birth (RCOG).

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ⁱ Which? Birth Choice closed operation in Autumn 2019, as a strategic streamlining of the services offered by the Which? organisation. The site was absorbed into the general Which? website (which.co.uk), and the Birth Choice tool, which features prominently in this research, was migrated over and updated. The tool continues to provide expectant parents with tailored guidance on the best birth setting for them, based on their needs and preferences; however, it no longer offers localised results for specific hospitals and midwifery units, instead directing parents towards relevant NHS information and sources. The free pregnancy and birth advice from Which? Birth Choice was moved to sit alongside existing infant product reviews, buying guides, safety alerts and advice concerning pregnancy and new parenthood on which.co.uk. The maternity unit pages were retired, along with the remainder of the Which? Birth Choice website. Many researchers and stakeholders, including myself, were made aware of the changes in late August 2019. Given that this thesis was in the final editing stages before submission, it was not rewritten to incorporate the closure of the website, or to reflect the changes to the content and Birth Choice tool. I will be sending a report of relevant findings to Which? in October 2019, which will take in account the closure and changes when written and edited.