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Title: Women's decision-making about birthplace choices: Booking for birth centre, hospital or home birth in the North of England.

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Key words: Women, decision-making, birthplace choice, influence. pregnancy

Abstract:

Aim This paper presents findings from an Interpretive Phenomenological study that illuminates unique characteristics of the different social representations of antenatal primigravida and multigravida women who book to birth their babies in a birth centre, hospital, or at home.

Methods Semi-structured interviews were conducted with 19 women and analysed by interpretive phenomenological analysis.

Findings Analysis revealed different social representations independent of each other, that illustrate how these social groups, determined by women's collective voices, are uniquely characterised by group views, beliefs, misinterpretations and preconceptions and establishes what influences women in decision-making about choice of birthplace.

Conclusion Women make decisions about what they want for themselves in this birthing experience. These decisions are made long before this impending experience. Recognising the different social representations of women in pregnancy, reveals deeper insight into the complexities of women's decision-making about birth choices, and highlights why some women might opt for certain choices. Knowing that some women may make decisions based on little or misrepresented information, confirms midwives are best placed in their interactions with women to provide positive influences, empowering them to make decisions based upon what they want for themselves. This affirms the woman and her midwife should remain partners in the decision-making process.

Introduction

Cultural differences determine certain choices that are available to women about birthing options, influencing the care they receive or the services accessible to them. Some systems advocate choice in services (Murray-Davis, McDonald, Rietsma, Coubrough, & Hutton, 2014; Youngson, 2015) upholding principles that view pregnancy and childbirth fundamentally as a physiological process (van Haaren-ten Haken et al., 2015) where policy recommends midwife-led women centred care (Y. Fontein-Kuipers et al., 2015). Others continue to make improvements and reforms within their maternity system that enhances consumer involvement and choice (Parker, McKinnon, & Kruske, 2014), yet for many women, whose care is situated in a system that undermines midwifery-led care (Hadjigeorgiou, Kouta, Papastavrou, Papadopoulos, & Martensson, 2012), women have much less chance of receiving choice, respect and compassion in birth (Bastos, 2015). Regardless of the cultural differences, pregnancy and birth are profound events for women, the concept of choice, when linked to choice and compassion is naturally relevant, for all women accessing services in maternity systems and models of care locally, nationally and internationally and those integral to the maternity experience must fully appreciate the choice concept.

For women giving birth in the United Kingdom (UK), maternity policy advocates the importance of flexible individualised services that fit with the needs of women, promising national choice of where and how to give birth (Department of Health, 2004; NHS England, 2016). Embedded in this is the promise that the views, beliefs and values of women will be sought and respected (National Institute for Health and Clinical Excellence, 2008a). Despite policy recommendations, many women are still not being offered real choices in the services they can access and rather than being given information in which to make their own decisions they are often told what to do (Department of Health, 2007; Hollowell, Li, Malouf, & Buchanan, 2016). For women that access maternity care in the UK, this positions them as valued consumers of services and active decision-makers about their care. Despite this, little is known

or understood about the processes women undertake in their decision-making that informs the choices they make.

Choice is the end-result of a process of decision-making and begins for women before they become pregnant. As women make choices, they navigate a complex journey, learning from their experiences is fundamental to understanding this journey so that it may inform future policy and practice. This paper presents the findings from a study that sought to understand the everyday decision-making process women make about birth choices. Determined by women's collective voice, this paper illustrates different social representations independent of each other that are representative of antenatal primigravida and multigravida women who book to birth their babies in a birth centre, at home or in hospital. Furthermore, findings illustrate how these social groups are uniquely characterised by different group views, beliefs, misinterpretations and preconceptions that establishes what influences women in decision-making about choice of birthplace.

Background

As individuals we are socially organised beings living within social contexts. A social context encompasses "the immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact" (Barnett & Casper, 2001 p465). These contexts influence us, who we are, what we do, what we believe, how we perceive things and the decisions we make in how we choose to live our lives. The choices we make are dependent upon the social norms of the social group in which we live and have been nurtured. Such norms are the foundations of what may be perceived as 'normal' within our social group and these can very often be dependent upon what resources are available; incorporate components of the social environment including social and economic processes; health services; social inequalities and cultural practices. Social groups are characterized as a collection of people bound together by some common purpose, or who are interrelated in a micro-social structure or interact with one another (Brown, 2000 p4). Women are individual social beings and in the event of becoming pregnant they join a cohesive social group of

pregnant women. Within this micro-social structure, they will interact with other group members, other women, service providers, healthcare professionals, including midwives, midwifery supervisors, paediatricians, GP's consultant obstetricians and user representatives. Once pregnant, women represent a certain social group of beings, their collective voice offers deeper insight into the characteristics of women in pregnancy and how they socially represent as primigravida and multigravida women who book to birth in different environments of birth centre, hospital and home.

Setting

The study was conducted in an NHS trust in the North of England. At the time of recruitment, December 2010 until July 2011, women had choice of giving birth in the obstetric hospital, at home or in a stand-alone midwife-led birth centre. The birth centre facility closed in July 2011 following rumours and speculation of closure. At the time the study was underway all women still had the option to book for birth within these environments and all interviews were completed before the birth centre facility closed. In terms of experience, the significance of this was that women who booked to the birth centre had the uncertainty of whether this facility would still be a realistic option and the threat of closure was a lived concern for these women, having a direct impact for some on their decision-making and related experience.

Method

The inquiry used hermeneutic interpretive phenomenology and adopted a Heideggerian interpretive perspective (Fleming, Gaidys, & Robb, 2003) to allow focus on women's *lived experience* as they are experienced, understood and consequently socially constructed by childbearing women. Grounded in a feminist perspective to promote women's voices, antenatal women were asked about their experiences, perceptions and choices in the context of their maternity care. Semi-structured interviews were conducted with 19 women receiving antenatal care, recruited following their 36th week appointment when their final decisions about birthplace had been made. Recruited were English speaking primigravida or multigravida

women over the age of 16 years and attending from 27-36 weeks pregnant, regardless of health/pregnancy risk factors and booking for hospital, birth centre or home confinement. All women had given informed consent to participate. Anonymity, confidentiality, and security of all information in records and data were undertaken in line with ethical approval requirements. NHS Ethics (Rec Ref 10/H1304/16) and trust governance approval were sought and granted prior to the study commencing. All participants were assigned a pseudonym.

Purposeful sampling was used to recruit women from two geographically distinct clinics within one city and whilst consideration of different variables between the two was not the purpose, both areas incurred similar journey times for women to both the maternity hospital and birthing centre, albeit by different routes. Recruitment was undertaken by clinic midwives through the distribution of information sheets. Interviews were transcribed verbatim.

Analysis

Interpretive Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) was used as an underpinning approach for analysing data. IPA concerns itself with the relationship dynamics of the parts within the whole process at a progression of levels (Smith et al., 2009). What developed was a sophisticated cycle in response to the data from the earliest stages of engagement and began as a consequence of interactions between women's narratives and the researcher's construction of meaning. Analysis began line-by-line, identified themes emerged initially from single contextual cases, and then across several cases that led to a more interpretive account. Table 1 & 2 illustrates the process from two contextual cases from the individual narrative texts of Julie and Louisa. Themes were noted and explanatory comments made. The Theme of Self and the different aspects of self are exemplified in these cases. Over all cases a total of thirty aspects relating to self emerged these are illustrated with working definitions (COED11, n.d.,n.p.) in Table 3. This framework of analysis made possible an observational frame that enabled exploration of women's constructed discourses. As particular texts were methodically analysed one by one, distinctive aspects of an individual phenomenon were highlighted and connections between characteristics of individuals became

evident encompassing characteristic views, beliefs, misinterpretations and preconceptions. These characteristics determined unique constructs that became representational of individual social groups of primigravida and multigravida women, booking to birth in these different environments, and facilitated the beginning of understanding about how these women made sense of their experiences.

Figure 1 illustrates the five representative social groups (SR), determined by where they had made the decision to book for birth.

Findings

Due to the confines of this paper the following provides a snapshot of the characteristic views, beliefs, misinterpretations and preconceptions held by each group. Expressed through individual narrative, collectively these unique social groups provide insight into the influences and experiences about birthplace decision-making, illustrating how the women who make up these social representative groups are uniquely different from one another. Moreover, it is not within the confines of this paper to theorize or define the meaning of *self* but merely acknowledge this exists as part of a much larger question of self-identity (Budgeon, 2003).

Hospital Primigravida (SR1)

Birth was recognized as risky, and pregnancy problematic and traumatising process that just had to be accepted. Participants portrayed vivid anxiety in not having complete control over what 'you want for yourself'; this is a nervous first-time experience with unknown expectations:

> *"Just worrying all the time about whether things are going to be okay" [Tricia].*

> *"I am quite naturally ...a worrier, and would want to err on the side of caution, the fact that the birthing centre...can be half an hour travel if something happens, you haven't got a NICU on the doorstep." [Susie].*

To allay anxieties experienced, women looked for support information and confirmation from professionals:

"When it was confirmed I was pregnant... the only thing that I remember initially feeling was 'I wish I had more support'… I desperately wanted confirmation from the medical profession that I was pregnant, even though I'd done probably six pregnancy tests." [Alex].

It was 'others' that influenced these women during this experience and in asking permission they lacked self-determination:

"They all want to give you their advice...I did take that with a pinch of salt, it did influence my decision a little bit... it's ridiculous, it's not the health professionals because I'm low risk, so I could… go anywhere... but my option to go to hospital, where I would imagine higher risk patients should be, is based on what other people have said." [Fi].

They considered themselves in control of their own life, spoke about faith in their bodies and perceived themselves as open minded but this was not conveyed in their narrative rather they believed that professionals would give them the information necessary to deal with their experience:

"I've got full faith in the medical profession…I know I'll be in safe hands…I'll just have to be open minded and trust my body really…a girl I play hockey with focused on it, 'Mother nature knows what she's doing try and relax… listen to your midwife and just really have faith that your body knows'.." [Alex].

Pain was a fear and thoughts were mostly about this and relieving it. They displayed no signs of being self-assured or self-determined to manage pain and described themselves as not being good with pain, this concept, and the availability of medical intervention justified choice of environment. Knowledge of themselves and their preconceptions of birth justified their reasoning:

"I'm not too good with pain, so I thought I'd be best off where I can get offered as much pain relief as I want." [Anne].

Influential for these women therefore was risk, control, pain and the influence of others. They had no first-hand experience and used the experiences of others to achieve what they believed they wanted for themselves. The ideal was a natural birth and this was their ideology. Not having a birthing plan was connected to having an open mind, however, they did not recognise the role they could play in actively promoting this. They were self-aware of their limitations and acknowledged that 'knowing' reduces fear. Though they did not perceive this as a negative necessarily, they readily self-surrendered to professionals and were conscious of being compliant. As worriers, they had a negative view of birth and a high perception of risk, these feelings underpin the reason they book to birth in hospital.

Birth centre primigravida (SR2)

These women held the environment and what it signified as the most important factor. They were explicitly more independent and self-reliant with an element of self-stoicism and self-expectation:

"For me it's not an option, I will breastfeed, so whether I struggle or not, you know, it's not something I would give up on." [Lorraine].

They booked to the birth centre for birthing and postnatal support, perceived as an important aspect of control during birth and supportive of their desire for a natural birth with no intervention. In knowing what they wanted for their experience they self-determined to put themselves in an environment that could facilitate this:

"It's one to one midwifery care, … knowing that support is… available to help you do it, and carry on, …I don't think you…get that at [the hospital], ...I want...my preferences taken into account, I don't know how much I would get that at the [hospital]." [Rosie].

Decisions were for a natural birth but not at home. These women lacked knowledge about home birthing, but they had self-recognition that the fundamentals of birth are the same anywhere, this re-enforced their belief and gave them confidence to be self-assured to home birth next time:

> *"I do believe every birth is different… you know yourself what your body's going to go through because you've done it once, even though it's a different birth experience, it's still giving birth, ...a few people have said with their second they'd quite like a home birth, … maybe they realised it was quite a nice experience, that it can be done at home, …the more people that share their experiences and views on it, you know, the more acceptable it becomes." [Lorraine].*

They had conscious awareness of the risks surrounding birth, weighing them up against birth as being a natural process that can be achieved. Being aware that the birthing process is naturally unpredictable they put this into perspective, believing adversity is small in reality:

> *"We all have different levels of...awareness's of dangers and challenges, … I don't think a risk is a risk to everybody, loads of things… can go wrong even if it's a very straight forward pregnancy, ... the baby...can get distressed; … it can poo inside; … the cord can get stuck round it's neck; or it can be back to front; or the mother can have a big bleed and the placenta can come away, there's huge risks, but again it's the most natural thing in the world..." [Rosie].*

The focus was not on pain but wanting the minimum pain relief during their birth experience. The narratives illustrated women were tempted to use pharmacological pain relief. This was one of the reasons why women book to birth in a facility where generally pharmacological pain relief is not possible:

> *"If I'm at the [birth centre], the only thing I'm really saying no to is an epidural, ... I've always known... that unless it was really necessary it's not something I've wanted to do,*

at the [birth centre] I know I just can't, it's just not an option, … but if I need to go to [the hospital], I think there's more chance of me having an epidural, I don't know whether it's pressure as such, it's just that it's much more available, … I think it's more within yourself if you know that something's available, will you automatically be more willing to take it, or, ... less willing to stick with something else for longer." [Mandy].

This group had awareness of a social culture, which supports and promotes epidural use and suggest there is too much choice in this regard which should not be offered too easily. An 'opting in' approach to epidural could be a way of changing people's outlook and these women suggest that a different system might be needed. They perceived that other women just conform when they have not weighed the options:

"A lot of people make up their mind they want an epidural… before they're even… 20 weeks pregnant, … if you decide you want an epidural before you've even started your labour, then [this] should actually be discussed, ...'why do you feel you want an epidural?' … that level of choices needs to be explained a bit more in depth and looked at a bit differently, … if it [birth centre] was all in one site, then you just booked in and had an initial assessment when you got there, and you'd already spoken to your midwives about… 'I might want, or I might not want an epidural." [Rosie].

Birth centre care was perceived as a different philosophy of practice. Its closure for them would mean they would have to conform; feeling coerced and pressured to go to hospital as their only other choice. Despite high self-awareness, they were not aware of the information and understanding required to make an informed decision about home birthing. Mandy felt her only option would be to book to the hospital, consequently she self-surrendered to the external influences of the birth centre closure. Her behaviour is changed because of a real pressure to go to hospital and she conforms:

"I think I probably would go to [hospital] and try to have a natural birth as possible." [Mandy].

Birth centre primigravida women remained self-determined to have the desired experience and to have their preferences considered, which is something they are concerned will not necessarily be possible at the hospital. This actively underpins their decision to opt out of a medical approach that they believe would result in diminished choice. They try to keep an open mind in the event of possible closure; in this context, they are aware of a need to remain even more self-determined to achieve their desired birth experience. While they see this as a removal of choice, they would all self-surrender to a hospital birth and to medical authority as the only other option.

Hospital multips (SR3)

These women acknowledged their previous pregnancy selves as young, scared, naive, weak and not strong enough to voice themselves. They considered themselves differently, and felt more assertive because of experience, knowledge and maturity. Knowledge from previous experience made them more prepared, more self-assured and confident in what they wanted this time:

> *"This time I have had a talk to my midwife and said 'I really don't want that to be the case this time if I can help it… I'd rather things happen naturally', … I felt like things were taken out of my hands a little bit, … I think if I had been stronger, I would have probably said 'Can we wait and just see and just monitor it more'..." [Jose].*

A good experience in the end, whatever the journey to achieve it, was perceived as a good result and their previous negative experiences did not influence their decision-making to change birthplace environment to avoid such experiences again. They reflected on the environment in which birth occurs, not the experience of birth. The hospital environment is perceived as the professional's domain, and these women referred to 'asking permission' and 'being allowed'. They perceived it as the best place for them, a safer option due to the available facilities that are believed to reduce intervention. The hospital environment was perceived as

the best option and professionals knew best and so were happy to follow professional recommendations:

"I'd put my trust in the doctors, …you do obviously, consultants; doctors; midwives, who are a hell of a lot more clued up than you are on birthing, … they see it every day, …I'd just put my trust in them, … I'd just go with what they say really, because obviously they're the professionals and they know what's best for you and your baby." [Nicola].

The availability of expertise and facilities just in case things go wrong and to ensure baby is safe, underpins their decision-making about where to birth. Hospital professionals are to be trusted and self-preparation stops at the hospital when others take over. Anywhere other than hospital is perceived as putting yourself at risk:

"You always have a possible risk, it's whether…it's going … or … isn't going to happen, … this is why I see a hospital as... you've got everything there, you don't have to do that travelling, … that's why I'm totally against anywhere else or home births, ... I think of 'What if?'… even if I had a perfect birth, I think I'd still like to be there, … if anything happened I'm there, I'm with the people that can do the jobs, ... I wouldn't like to be in that position where you're thinking...'What if it's going to do this, and what if that's going to happen', … you just want to get the baby out." [Becky].

Relationship development was attributed to women and midwives, not women and doctors. Doctors are the hierarchy and they looked up to these professionals. They were not comfortable in challenging professionals, despite describing themselves as different and more self-confident in this pregnancy. They compared themselves to these professionals, continuing the belief that 'professionals know best', passing over the responsibility to them and avoiding self-blame in the event of something going wrong. Furthered by fear or pain, they are compliant and can be too trusting which at times is acknowledged as happening within a context of coercion. The extent of coercion and self-surrendering can occur at different points in the birthing process:

“There’s so much pressure that’s on your body, ... you’ve not just got yourself to look after, you’ve got this life inside that’s depending on everything that you do from one day to the next, …to be honest, I just went with whatever they was telling me, because obviously, I didn’t have a clue about it and they were the professionals… I just went with it ... they asked if it was okay, obviously, I was just... ‘Get her out if you need to’ as long as she’s safe that was the main [thing].” [Nicola].

For Jose this was in relation to epidural anaesthesia and not being able to have a choice if or when she wanted it:

“At the time, I was told by the midwife I had to decide, ... I don’t know how many centimetres I was dilated, and I was coping okay, I’d tried gas and air and didn’t get on with it, ... I was told by the midwife if ‘I wanted an epidural I had to decide there and then because the anaesthetist was going into surgery and would be in surgery for about 2 hours and the baby would be born before then’...so I had to decide quite early on.” [Jose].

On one hand they wanted the ‘other’ to have control due to the perception of risk acknowledging they self-surrender, but at the same time *self* was perceived as having little or no control. Despite this being undesired at times, overall these women remained unquestioning:

“The first-time round I let everybody do it for me which… I shouldn’t have done really, but I was more nervous and... I trusted people more than myself the first time, … they advised me the best thing to do, and I remember saying ‘Just do whatever’, because I didn’t feel I wanted to be in control, I just wanted them to get the baby out cos I was in pain and I didn’t care what was happening at the time, ... obviously now, …I wish I was more in control.” [Becky].

They considered someone else to be in charge, seeing themselves only as a product in the process and understanding this experience as secondary. The primary concern was the safety

of the baby, and consequently self-surrendering was without question to those seen as an advocate.

Birth centre multips (SR4)

These women knew what they wanted before seeing a health professional. Previous experience, and in wanting a full and positive experience in which they are central was their focus this time. Previous negative experiences such as being rushed; lack of information; self-doubt with breast-feeding and no support were reasons for wanting a different experience:

> *"I felt happier being in the birth centre without… doctors and all the other things on hand, knowing I had somebody there fulltime, ... I felt like I was safer." [Linda].*

They acknowledged that problems can happen to anyone, at any time, and had confidence in the midwives to perform the necessary tasks in an emergency. They acknowledged risk as normal, and were conscious of a culture of risk 'as waiting to happen'. Despite the birth centre being perceived as safe, some women were aware of the common perception that the birth centre was not safe or a riskier option:

> *"I think very much the view of the [birth centre], they see it as a risk, because people automatically see it as there's no medical staff there." [Louisa].*

For these women, negative past experiences changed their self-awareness, self-assurance and determination to make different decisions this time*:*

> *"The more...I've experienced, I've seen my sister and friends who've had their experiences, and, the more I've come to realise that...'Your frame of mind and attitude… affects how your labour goes'… obviously that kind of frame of mind I was in, didn't feel ready, absolutely terrified strapped to [the] monitor, ... then I was on the drip, … I couldn't walk around, … couldn't move, ... I felt like I was trapped and I couldn't do anything, so it was very, very negative." [Julie].*

Support was paramount and expressions of ‘try to do it normally’ conveyed elements of self-doubt. This illustrated that these women were not completely self-assured due to self-perceptions created by previous experience of not having birthed completely independently. Anxieties were still experienced because of ‘knowing what to expect’, and in remembering their previous negative experiences. Negative experiences changes ideas and perceptions, and for Louisa this was experienced because of the midwife giving her what she had asked for, but failed to provide further dialogue with discussion or alternative solutions:

> *“I think at that time...I was in that mind set - I was in all this pain, and it had all just happened, … I had no idea what to expect as far as the pain was concerned… looking back on it, I think if someone had said ‘Look this is meant to be happening, this is a thing you know your body’s working properly’, if they’d examined me and said, ‘You’re however many centimetres, do you want to try the other stages first?’...I would have gone with it.” [Louisa].*

Further, for these women, labour just happened and they could not play any part in managing it:

> *“You’re never really 100% in control because it’s your body in control, ...your mind doesn’t run it, does it? … yes, you can relax and do your breathing exercises, and you can [sit] on a ball to help you, … but your body does what it needs to do… at the time.” [Mary].*

Control was understood as ‘doing it naturally’ and everything other than natural is not being in control. Not having control in birthing was the reason for their previous negative experience. Angela expresses her thoughts on an epidural:

> *“I know it sounds daft but I didn’t like the...procedure that came with it, … not being mobile, ... you have the catheter, … there’s a lot of down sides to it, … some of my*

friends have had it and have suffered with... their legs, or their back, and I didn't want any of that, and I just wanted to do it for myself." [Angela].

Control was not just having what is desired, but how it is individually experienced:

"I suppose of how you do it, of how you have your baby, and where, ... control is like letting your body do it naturally, and giving your body the control to do it, and not handing it over to someone else." [Louisa].

Negative relationships with professionals' results in negative experiences. Visiting her midwife in early labour, June began to think about changing birthing units to facilitate the epidural option because of what the midwife was saying to her:

"She sort of turned round to me and said, 'It was only going to get worse', and you just think 'Oh', that's the worst thing you want to hear." [June].

Decision-making was previously taken out of their hands, and therefore these women assume in a hospital setting that it is generally someone else who makes the decisions for them. Decisions to birth at the birth centre were made based on the following negative experiences: previous feelings of being unable to voice themselves; being trapped and powerless and viewing doctors as superior in the hierarchy. Consequently, these women self-surrendered under the doctors' influence:

"I didn't know what cholestasis was, and just told 'Right that's it we're admitting you', …I didn't know what...was happening, I was very scared so I just went along with what the experts told me to do... I went to [hospital] the consultant had printed…off some information from a medical website and just gave me the paper to read...nobody actually sat down and said to me 'This is what it is, this is why we need to induce you', … I was terrified, I didn't know what was going on, ... really scared, but I was just going along with what I was told, what the medical experts were telling me to do...because I didn't know any better." [Julie].

These women took a more self-determined approach in e.g. seeking out information, and they had self-realisations which was resultant of their communication with others. There was awareness that women trust professionals unquestioningly, and professionals (as sources of information), are in a position of power. Professionals' language significantly affected women. Yet these same professionals are not always aware of the impact of their language and how certain comments can be construed yet, at the same time, create an environment of compliance:

> *"Where else do you get your sources of information from, … if you don't have any experience of giving birth, being pregnant, you don't have any source of information apart from these people, so they sort of don't realise how much of a position of power they're in, ... I don't think they realise... that they say things, and how much it does have an impact, …you know just these kind of throw away comments like 'Right I think it's better if you do this, or you really should', and... it sort of sticks with people I think." [Julie].*

Home birthing multips (SR5)

These women tended to be laid back due to having had different experiences to draw upon and a self-realisation of how they deal with birth. They had a positive focus on pain and described themselves as not being very good with pain relief, and putting self-expectation of managing it central in their minds. This outlook meant they were self-reliant in managing it. Anna knew managing the pain herself was her only option, that underpinned the need to be self-reliant:

> *"The contractions were getting quite strong, ...I rang [birth centre] and said, 'They're... lasting this long, they are quite strong... but I can manage pain quite well', …she said, 'Oh well you sound okay,… have a bath, two paracetamol,… but just to let you know, we have got two in, when they're five minutes apart ...ring us back and hopefully… one*

might have finished,…but if not, you will have to go to the hospital', that really did put a downer on me, I thought, I don't want to go there, so I thought I'll hang on." [Anna].

Experience means they do not feel out of their depth or frightened of pain because they are more self-assured, self-determined, self-informed and independent. This self-concept informed by previous births makes them desire a different experience this time:

"I do feel like I was sort of controlled, told what to do, … also confidence because I was young, whereas this time round, I know what I want, I'm not frightened to say what I want, … got a lot more confidence and I think people pick up on that." [Anna].

Control is in the hands of nature in relation to what their bodies 'told them' and they surrender to nature and to what baby requires. In this, mind and body are perceived differently because 'self-identity', who they *are,* has no choice in the matter. Their bodies are focused and as the body takes over and is in control, the woman becomes separate from her physical self. This is viewed as being in control. The act of self-surrendering to nature is expressed by Anna:

"Being sat in the bath having contractions was horrific, ...I didn't enjoy it, but just the idea of having an epidural takes away your natural body's instinct, …I haven't had one, but from what I've heard you don't feel when you need to push, and you don't feel this and that, …and your body just takes over, I mean my body just took over, I didn't plan to go on all fours, it's what my body told me, it was just that was it, I didn't have any choice in the matter." [Anna].

This group considered the relationship between themselves and their midwives as mutual respect which supported self-assured decision-making.

Janet illustrates her decision to have her baby at home, even willing herself into labour that night so she could have the midwife she wanted to complete her experience:

"I had the back up of having known a couple of people who had done it, even though it wasn't in this area, …because I knew the midwives so well… for so long, ... I'd had that trust in them, whether I'd have felt differently, you know, if there's a whole new bunch of midwives, but then you've got nearly 10 months to get to know them, haven't you? …because we were at home, and the atmosphere, and the fact that it was [her midwife], that made a big difference, that was just lovely for me, … I've known her for such a long time now that to get her, the chances of actually getting her here, I think my brain had gone, '[midwife's] on call tonight'..." [Janet].

These women do not look to the environment set-up, but to the skills of their midwives. Midwives are perceived positively, but women were aware of a difference in attitude and engagement in professional knowledge, in how they would pass on their knowledge to women, and awareness that what they were told might not always be correct. While, some midwives would pick up on what women would say exploratively, others would not. A chance encounter with a particular midwife meant Anna who had been booked for a hospital birth realised her experience could have been very different:

"I said that I was getting acupuncture and was doing this and doing that, … she said… 'Well it sounds like you'd be better off going to the birth centre'. Yeah… 'I wanted to' ... I said what the other midwife had said, …'I don't think that's right' she said, ... rang through to the birth centre, ...and told them,... then I got a letter... saying they'd looked over my notes from my first pregnancy and… I'm welcome to register there, …if I hadn't had that chance conversation, ...I was a bit annoyed but I realised that it was just that one midwife." [Anna].

Experience is seen as shared with midwives and women have faith in midwives. Experience and being laid back illustrates a sense of change in self-identity that develops during pregnancy due to knowing oneself, one's own limitations and an ability to become self-reliant. They have a self-expectation of being able to effectively manage the process and know their

physiological capabilities due to intuition and a reflexive element. Anna felt birth changed her forever, the extent of how profound this was, is expressed:

> *"When I look back at my second [birth], just amazed, totally in awe...at what your body can do, how it just takes over, …I didn't think of anything… just was focused on giving birth, …medical intervention has become too much, ...has taken over, ...I look back on it and I'm really happy, …even though it [the birth] was totally unplanned I felt great afterwards, …whereas when I look at my first, I do feel guilt at how I didn't have as much of a say, and I didn't have the connection, and the whole ventouse thing, …how it was taken out of my hands, …I didn't really have much of a relationship with the midwife. It makes me feel guilty to my first one that he didn't, that I didn't have that birth with him, …it still affects me now, the birth I went through, and people say, …'Oh, I'll just go to the hospital', …they don't realise that you think about that day… and it can have an effect on you for years ahead." [Anna].*

Fear is not a focus for these women. They have no preconceptions about it but consider it a predetermined realisation. It is important to train themselves into not thinking negative thoughts, but to 'empty the head' and think about keeping a positive outlook, and maintaining a firm belief that there are always options. These women essentially look to themselves to find the answers:

> *"… 'Why would anything go wrong?', ...I always think if there is a risk you know by the time you're going into labour, …I know there are risks that happen once you're in labour, but because you've got options …of moving, ...even if it was rushing into [hospital] and having a caesarean, it's still an option, isn't it? … you need to look at each individual woman and say, 'What kind of person are you, ...how do you feel about pain, ...how do you feel about childbirth, what is it to you, what information have you got', and give them the right information, …then let them decide on how they feel about everything, …not*

every woman could give birth at home, and not every woman wants to give birth in hospital." [Janet].

Environment was not the concern but the type of birth desired. Their decision-making aimed to ensure that they would put themselves in an environment that would provide the optimal chances of getting the desired experience. It was perceived as doing it right for themselves rather than as something dangerous or risky. The potential of risks did not result in a questioning of the environment even in experiencing previous risk situations. Janet puts risk awareness into context:

"It can be risky, but… you have to look at the figures, …the number of natural births and the number of successful births against the number of… complications and what the complications are, …you've got all that information, and the figures to back them up, because, if somebody said, 'Ooh birth is really risky, you could die giving birth', and then somebody said, 'Yeah but there's a 1 in 6 million chance if you die giving birth', that may sway your decision." [Janet].

These women support their decisions with contingency plans. These are different to birth plans as they acknowledge there could be changes in the progression of events, whereas a birth plan concerns what the process will involve. Janet self-prepares a contingency plan, as she does not know how events might unfold:

"It's alright having a plan, and you also have to have a backup plan because you don't know how your birth's going to go, so you know they kind of guide you into... having a birthing plan, but if… people ask me about what did you do, I said, 'I had a vague plan', but in the back of my head, all the time was this, 'might not go to plan have a contingency plan'..." [Janet].

They recognised that home birth was not for them in their previous pregnancies; they would not have felt comfortable. The definitive factor for these women in this current pregnancy, was

a removal of choice. Choice, due to the birth centre being full portrayed previously in Anna's narratives or for Janet in its closure:

> *"Just booked into [birth centre], …because it was... easier, going to the [birth centre] ... having a pool there ready, than faffing about at home, and then they closed it, …and so when they closed [it] we thought, 'Right fine, we'll just get a pool and we'll have a water birth at home instead'..." [Janet].*

Discussion

For both primigravida groups the birth environment was important for divergent reasons. Birth centre primigravida articulated culture as being the greatest importance, ultimately it is about the experience and being centred in the process. Maximising the potential to achieve what they wanted. Perceiving a longer-term view of the *'needs of self'*, they looked to ensure support in labour and in the early postnatal period as the transition to motherhood begins. Research has demonstrated (Hofmeyr, Nikodem, Wolman, Chalmers, & Kramer, 1991) that clinical environments may undermine women's feelings of competence, and self-confidence in adapting to parenthood and in the initiation of successful breastfeeding. This supports the opinions presented by the primigravida in their birthplace choices. This was a different vision to the hospital primigravida group who visualised themselves in a process, the process of a healthy outcome for the baby being the primary concern and themselves being the secondary concern. All women had made decisions of where to birth before having any contact with a health professional. For the birth centre group this decision would always be their choice and only if the decision was made for medical reasons during pregnancy would their birthplace decision change. The chosen place of birth for the hospital group would also remain constant despite information and knowledge gained since making their initial decision, and supports similar findings regarding preference for care in a hospital setting (Hollowell et al., 2016). Health professionals did not have any influence on birthplace for either of these groups.

Risk and pain were not a focus for women booking to the birth centre. The experience to be had within this environment, and in having the knowledge about coping with pain, rather than pain relief on offer, was the central focus. Attitudes were divergent in the hospital group where the underlying focus was getting the baby out at whatever cost, and in knowing how to manage the pain with the available relief on offer. Women who booked to the birth centre did not consider home birthing, this was due to a lack of knowledge in the fundamentals of planning it. Believing adverse risk is small, this did not affect their decision-making about choice of birthplace, but the influence of what they want from the experience took priority.

Differences in control was evident between groups. For the birth centre group, it was important for the *self* to be in control, whereas it was viewed by hospital primigravida as being the responsibility of the professionals. Both groups were convergent in awareness of risk, in the same types of risks concerning birth, yet differed in how they focused this awareness. This was a determining factor with how they dealt with risk. Birth centre women appeared to continually risk-assess throughout the process, which facilitated control of the experience and themselves as central to it. Conversely, the hospital group handed over the risk processing to the professionals. How primigravida women perceive risk and pain is a key influencing factor on decision-making about where to birth. Moreover, how they perceive themselves, their self-assurance and self-determination to accomplish birth is also key. Findings coincide with others who have explored the concept of control in childbirth, having a sense of control in one's own behaviour and in deciding if and when to hand over control is a major factor for psychological health and satisfaction in women's birth experience (Green & Baston, 2003; Jomeen, 2006; Jomeen, 2010)

Previous birth experience has been found to be central to multigravida women (Nilsson & Lundgren, 2009). Hospital multips did not necessarily expect choice, were not bothered about it and would not have made any other choice even if they were given all available choices. Choices are personal preferences and women be 'empowered' to make them. Though it was not their intention to have negative perceptions, these women focused intensively on things

going wrong. These perceptions were divergent to the birth centre group, whose emphasis was on the experience to be had, much like the home birthing women, rather than a means to an end in whatever that good result took to happen philosophy, of the hospital group.

There is concurrence across the groups regarding their awareness of birth risks, but divergence in how they view these risks personally when considering previous negative experiences. Negative experiences of the hospital women did not result in a change in birthplace situation to avoid this again, and there was acceptance of these negative experiences as the norm. The negative experiences of the birth centre women directly caused them to change their birthplace context and situation this subsequent time. Fear of risk, and/or of pain appear to be the factors contributing to this unchanged birthplace choice of the hospital women. Whereas for the birth centre women, the experience of being controlled, not having control or self-surrendering to control by a dominant other, had a psychological impact that meant active decision-making to avoid these experiences reoccurring, and psychological impact related to control has previously been acknowledged in this paper in the work of Jomeen (2006; 2010) and Green et al (2003). For the home birthing women, their positive, realistic understanding about birth risk meant they understood that there is no more risk with home birth any more than any other environment, this concurs with findings from the Birthplace study (Brocklehurst et al., 2011) that these women are at no more risk of experiencing negative perinatal outcomes. In this context this knowledge should be shared with women in their decision-making process and in reaffirming their choices.

All multigravida women converged in their compliance with professional advice, but were divergent in how this occurred. Birth centre and home birth women comply by an altruistic mode, in self-sacrificing their own desired experience, without question, for the sake of their unborn baby. The hospital women did not acknowledge the experience to be had, and would comply unquestioningly at the beginning of the process for the sake of the baby.

Expressions within their narratives, highlight how the home birth women perceived the birthing experience, and presented themselves as self-determined, questioning individuals in a

situation where choice was reduced. They searched for other options and did not just accept given alternatives. These women, despite being interviewed postnatally, and rather than considering this might have simply been because birth worked out well in the end, illustrated characteristics of a sense of *self* that demonstrated their strength of *self*. What this exemplifies, is the supporting and empowering relationships midwives can have with women, that enable liberated decision-making in choosing what is right for them (Freeman & Griew, 2007; B. Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008; Kirkham, 2010; Lundgren & Berg, 2007).

For more than thirty years birth plans have been advocated, and used in increasingly medicalised environments (Lothian, 2006) as a way for women to become more informed about available choices (Moore & Hopper, 1995). Nevertheless, women have always planned for their birth (Kitzinger, 2011). Historically, as birth has moved in to the hospital domain, birth plans seem prescript of choice and agreement (Moore & Hopper, 1995) with a focus around what women will do, who will support them, and what they will need from these supportive others (Lothian, 2006). All this considered, how can women truly know what it is they want or need from an experience they are yet to experience? The home birthing women spoke of having contingency plans, and as their options looked like changing, or did change, there was an obvious weighing up of options by them that occurred after pursuit of information. Contingency plans put women at the centre of their lived experience as they are experiencing it, and allows for negotiating change and choice in a supportive and shared decision-making partnership with their midwives.

They asked questions, questioned assumptions and followed up on any doubts. In turn, they questioned professionals, and voiced themselves until they had satisfaction with what they were being told. These home birthing women present a comparative *self* in relation to others, and in how others view them. Regarded by their peers, as being brave, in light of birth pain, and risk, this was not their own understanding. They had self-confidence that they knew their own bodies, had instinct about the birth process, and although they trust in midwives, they had

self-assurance to trust in themselves, and they used their instinctive behaviours to ensure a more comfortable labour. They were aware that they could aid the natural birthing process through the decisions they make, and have a proactive determination in light of options being taken away from them.

In respect of facilities for risk management the environment is not what these home birthing women look to, but focus on this only for being able to achieve what they want for themselves. It is reasonable to suggest this is due to a *changed self-identity (Budgeon, 2003)* the individual qualities and characteristics these women have, and their *self-concept*, the mental picture they have of themselves because of previous experience. They also tended to be liberated, having attributes of emancipation in decision-making (Wittmann-Price, 2004). They base their decision-making on a shared influence, transmitted between them and the group of experts and in having a support network of others who they view as important. Emancipation it appears, transpires because of confidence in others, self-assurance and self-reliance is down to the 'lived through' experience that changes their qualities and characteristics and the mental picture they have of themselves. Their self-identity, the particular characteristics that these women have in determining their essential being, that distinguishes them from others, meant they had a reflexive understanding, they have the knowledge and do not need the actual experience to 'know'. For example, in water birth, they do not need to have had this experience to know how they will feel in labour or what labour pain will be like. This is related to their prior birthing experience even though they have no experience of giving birth in water, like pain, it is an understanding that one must go through it to know it and once experienced in principle, when parallel pain experiences occur, these can add to the overall knowing of the experience.

What these findings demonstrate, is how decision-making is highly complex, critical and delicate for women and concurs with the findings of others who write authoritatively within this arena (Anderson, 2004; Edwards & Murphy-Lawless, 2006; Edwards, 2010; Jomeen, 2010; Kirkham, 2004; Kirkham, 2010; Smythe, 1998; Smythe, 2003; Thomson, Dykes, & Downe, 2011) Additionally, these findings demonstrate how *self* is critical to this process. What is

apparent is how influence causes both positive and negative experiences for women that can have long-term effects for them. Decision-making does not occur in a vacuum but is a result of social influences women are exposed to in their everyday lives (Budgeon, 2003). What is at the core, are the responses to previous knowledge, learning, understanding practitioner interaction and the support of a significant other. Women take on other's thoughts and feelings and what midwives believe profoundly affects how they view women and their experience (Edwards, 2005). It is imperative that midwives have awareness of these factors and how their interactions with women potentially influence the birth experience positively or negatively. Women come into pregnancy with their own philosophies and understandings on which they base their choices. This is but a 'moment' in a woman's birthing journey, the problem with this is that decisions are often made based on misconceptions and are not fully informed. This is where the midwife has the potential to assert a positive influence. The relationships midwives and women have, is at the foundation of care (Hunter, 2008; Leap, 2010) and, in this exclusive position, midwives can effectively support the experiences women encounter (Fontein-Kuipers, Jacoba Adriana Cornelia Antonia, 2016). Tinkler and Quinney (1998) explored women's maternity care experiences, and considered how the midwife-woman relationship influenced experiences and perceptions of care, acknowledging this relationship as an important aspect of women's satisfaction. However, in Barber, Rogers and Marsh's study (2006), though midwives were found to have the greatest influence over women with regard choice of birthplaces, they did not use their influence effectively to ensure that all women were aware of all the options so that informed choices could be made.

Social representations illustrate how decision-making in pregnancy can be viewed as a continuum, with decision-making behaviour at opposing ends. Hospital primigravida are influenced by others because they have no first-hand experience and use the experiences of others to make decisions about what they want for themselves. For home birthing women who are more liberated decision-makers, more positive experiences override previous negative experiences. This is due to information, self-understanding, self-determination and self-

assurance which render these women unafraid of the labour and birth experience and poles apart from hospital primigravida and hospital multips whose fear of risk and pain indicates they cannot overcome this fear.

What these collective images identify are clear differences that reveal how women are profoundly influenced in their birth options; what the influencing factors are and how women deal with these. Women are seen to opt-in or opt-out of certain choices. If these choices were not made available to them then they choose what they perceive to be a similar option. Understanding social representations of pregnancy is paramount so midwives essentially gain understanding of what influences women in their decision-making.

Expanding practitioner knowledge can highlight birthing philosophy amongst women that leads to new understanding about the influences women experience in their everyday decision-making about birth choices. This can be achieved by practitioners having an understanding and a conscious awareness about the decisions women make; what the reasons for these decisions might be; and in being aware of the impact of influence practitioners have on an individual's behaviour, feelings and beliefs.

Limitations and strengths

Due to the nature and unpredictability of birth the home birth group evolved quite by chance. There is no right time from which to gain perfect perspective and a woman's experience will be recounted differently after her birth (Smythe, 2011). The position that both these women were interviewed postnatally despite being recruited in the antenatal period does not weaken the analysis, the experiences these women shared strengthen and add to the sample overall. It is naturally a limitation that no home birthing primigravida came forward to represent complete group representation. The fact that this social representation is non-existent from the recruiting phase was illustrative of a limited pool of primigravida booking to birth at home. This demonstrates as clearly evidenced elsewhere, that these women are in a minority (Office of National Statistics, 2017), profoundly so that no primigravida woman were booked for home

birthing within the sampled geographical areas. Furthermore, there were at the time of recruitment, no primigravida booked for home birthing from the trust locality. The reasons for this cannot be made clear but may corroborate findings from Barber et al (2006) who report primigravida women are least likely to be offered a home birth. Findings may only be specific to these groups and therefore cannot be generalizable to other pregnant women experiencing pregnancy and birth decision-making accessing other services within different systems of care. Though this was not the intension of the study, IPA and the unique hermeneutical framework that developed was undoubtedly fundamental in illuminating these findings to uncover how women are profoundly influenced in their birth options. IPA was pivotal in an attempt to understand women's *lived experiences* in relation to social influences upon decision-making about birthplace choices. Moreover, how these are perceived and understood by women and what consequence this might have on them in being truly liberated to make choices freely.

Conclusion

International perspectives identified how cultural differences determine certain choices about birthing options that can influence the care women receive, or the services accessible to them. The current climate of midwifery care advocates choice (Department of Health, 2007), however, women are still not being offered real choice and are often told what to do (NHS England, 2016). Difficulties and barriers to choice have been well documented (Beech, 2003; Edwards, 2005; Hollins Martin, 2007a; Jomeen, 2007; Jomeen, 2012; Kightley, 2007; Kirkham, 2004; Mander, 2001).

A climate where policy states women should have choice, yet all available birthplace choices are not made available to them, then women have no choice but to comply with the choices available. Women navigate a complex journey as the make decisions about birthplace choices and learning from their experiences is fundamental to understanding the choices they make.

This paper shares findings from antenatal participant women from a study that explored how women may be socially influenced in their decision-making about where to birth. It has aimed to identify the essence of human experience, described by the women themselves in understanding their personal experiences and perceptions based on their 'life world' descriptions. Their collective voice reveals images of women that are characteristic of their life worlds and presents socially constructed representations of antenatal women within the current climate of maternity care.

How these women appear in real terms, within this current climate, provides some understanding about the processes women undertake in the decision-making that informs the choices they make. This affords new insight regarding the choices women might make about where to birth, and why they opt-out of certain options to avoid some of the choices available to them. This raises debate on how choices can be best addressed utilising the experiences of women as a basis for change.

Table 1. Aspects of Self emerging from individual narratives: Julie

Aspects of self within the narrative text of Julie	
Original transcript	Dominant themes within the narrative and explanatory comments
Julie: 31.30 and I was never sort of told [pause] try your best to stay up right cos gravity helps and I was never told change position I was just laid on the bed and nobody said anything different to me	Self. Information/communication. Professional/practitioner. She didn't feel informed.
Julie: 32.2 erm I haven't no one's said it to me it's just experiences I've gleamed from other people and watching 'one born every minute' [laughs] where the midwives there do keep people upright and they have said it's it helps so I would like to be more upright and I would like [pause] so I think I would definitely be more assertive and I you know things like I feel like now I will say to them please can you leave the room I want to be on my own please can you turn the lights off [pause] please you know and I do feel like I will be saying that now if I have to be at the hospital erm [pause]	Self-awareness. Self-identity. Self-reliance. Self-determined. She learns from these external influences what she wants for herself. Self-reliant to speak out.
Julie: 2.12 erm well I've gone through everything with my husband and he knows the kind of labour I want erm [pause] and I would just like to think [pause 5 seconds] that he would be able to say you know to people 'just leave her alone' cos I just want to be left alone	Self. Self-confidence in husband to aid her decisions.
Julie: 32.16 when I'm in the throes of labour [smiling] erm who knows who knows I would like to think so but [pause] you know it might come out less polite than though please can you leave me alone [laughs] but cos I would like to think that I would say that before labour becomes really established and I will	Self. Self-determined. Self-reliance. She wants to remain these in the throes of labour. States her position clearly before the situation gets that far.

Table 2 Aspects of Self emerging from individual narratives: Louisa

Aspects of self: interview transcript of Louisa	
Original transcript	Dominant themes within the narrative and explanatory comments
Louisa: 59.15 and I thought thank god I didn't have to tell her and now I can hide it and then she came a few weeks after that and she was like [pause] I was like oh I'm sorry I'm sorry that the house is a mess [pause] then she was like oh and she goes oh I'd rather it be a mess you know and if it was tidy I'd be worried that there'd be something wrong with you	Self-doubt. Information/communication. Professional/practitioner. She was worried about being judged.
Louisa: 59.20 so then in the back of my mind I was like right make sure it's a mess every time cos then they're not going to worry	Self-changes. She could cover the tracks of how she really was feeling.
Louisa: 60.6 yeah I remember thinking I need him I need I need a bit of him back in me to kind of feel connected and I'd lay there for and I did erm through work [pause] you know a year and a half ago a mental health first aid 3 day course and they touched on postnatal depression and like things like this and [pause] like them bizarre little things that I was doing I didn't even realise that they were kind of weird things to do I just thought presumed they were normal things to do so it was only a couple of years ago that I realised god that was a bit bizarre that I did that	Self-awareness. Self-changes. She needed her baby. Her bizarre behaviour. She describes as weird to herself. She judges herself by doing this.
Louisa: 60.21 [pause] I was like I'm just you know unhappy I'm just everything seems a struggle and I think a lot of it then at that point was just my life	Self-changes. Self-regret. Self-awareness. Self-concept. When she was pregnant initially she was worried about being a single parent.

Table 3. Aspects of Self emerging within narratives of 19 antenatal women	
Term related to self	Definition
Self	A person's essential being that distinguishes them from others, especially considered as the object of introspection or reflexive action. A person's particular nature or personality
Identity	The fact of being whom or what a person or thing is. The characteristic determining this.
Self-concept	An idea or mental picture of self, formed by combining all their aspects
Self-awareness	Conscious knowledge of one's own character, feelings motives and desires
Self-assurance	Confidence in one's own abilities or character
Self-determination	The process by which person controls their own life
Self-regret	Feeling of sorrow, disappointment or sadness over something
Self-regard	Consideration for oneself
Self-surrenders (submit)	The surrender of oneself or one's will to an external influence, an emotion etc.
Self-reliance	Reliance on one's own powers and resources rather than those of others
Self-confidence	Belief that we can have faith in or rely on someone or something. A positive feeling arising from an appreciation of one's own abilities.
Self-doubt	Lack of confidence in oneself and one's abilities.
Self-sacrifice	The giving up of one's own interests or wishes in order to help others or advance a cause.
Self-changes (changing self)	The action of changing. The instance of becoming different.
Self-less	Concerned more with the needs and wishes of others than one's own.
Self-blame	Assigns responsibility for fault or wrong to self.
Self-realisation	The attitude or practice of accepting a situation as it is and dealing with it accordingly
Independent self	Capable of acting or thinking for oneself
Fulfilled self	Gain happiness or satisfaction by fully achieving ones potential
Self-assumption	A thing that is assumed as true
Comparative self	Managed or judged by comparison, relative.
Self-preparation	The action or process of preparing or being prepared
Inquisitive self	Interesting in learning about things, curious
Self-expectation	A strong belief something will happen or be the case
Situated self	In a particular context
Self as pragmatist	Practical self, dealing with things in a way that is based on practical rather than theoretical consideration
Intuitive self	Based on what one feels to be true even without conscious reasoning
Self-justification	Justifying something to oneself, proving to be right or reasonable
Self-expression	Expressing something, conveying in words, gestures and conduct
Self-detachment	Detaching self, separating oneself
Self as advocate	A person who pleads the case on someone else's behalf or publicly supports or recommends a particular cause.

Table 4 Participant Characteristics									
	Order	Name	Age	Booked place of birth	Parity	Occupation	Relationship mentioned	Medical history	Birth place outcome
A/N	1	Alex	32	Hp	P	Lecturer in children's services	Married	N/A	Hp
A/N	2	Tricia		Hp	P	Occupational Therapist	Husband	N/A	Hp
A/N	3	Julie	27	BC	M	Receptionist	Boyfriend	N/A	Bc
A/N	4	Janet	39	Hm	M	Emergency services	Married	N/A	Hm
A/N	5	Mandy	31	Bc	P	Working in accounting	Married	Transferred in labour	Hp
A/N	6	Jose	39	Hp	M	Works in the NHS	Married	GB Strep	Hp
A/N	7	Louisa		Bc	M	Working	Partner	Factor V Leiden-APC Resistance	Hp
A/N	8	Susie		Hp	P	Full time in a hospital	Husband	On long term steroids-Rheumatology	Hp
A/N	9	Fi		Hp	P	Educational rehabilitator community	Married	N/A	Hp
A/N	10	Lorraine	26	Bc	P	Primary school Teacher	Married	Postpartum haemorrhage	Bc
A/N	11	June		Bc	M	Full time mum	Married	N/A	Bc
A/N	12	Mary		Bc	M	Teacher	Married	N/A	Bc
A/N	13	Rosie		Bc	P	Works for the NHS/ giving up work	Husband	N/A	Bc
A/N	14	Angela		Bc	M	Receptionist	Boyfriend	Low platelets last pregnancy	Bc
A/N	15	Nicola		Hp	M		Partner	Cholestasis: previous pregnancy	Hp
A/N	16	Anne	39	Hp	P	Works full time	Partner	N/A	Hp
A/N	17	Anna	27	Bc	M	Beautician	Husband	N/A	BBA
A/N	18	Becky	22	Hp	M	Hairdresser/beautician	Partner	Migraines	Hp
A/N	19	Linda		Bc	M	Full time mum	Husband	Low platelets but able to book to birth centre	Hp (Bc closed)

Figure 1. Representative social groups (SR) illustrating narrative compilation of experiences dependent on where women booked to birth

SR1	Five primigravida women who booked to the hospital. Two of the women had a professional identity within healthcare
SR2	Three primigravida women who booked to the birth centre
SR3	Three multigravida women booked for consultant led care. Each woman had a previous or current condition such as cholestasis; Group B Streptococcus and slightly raised Blood Pressure in labour; or suffered migraines since puberty. Not all had seen consultants in this pregnancy for these conditions. All had care by midwives.
SR4	Six multigravida women booking to the birth centre. Despite these women experiencing their 2nd or 3rd pregnancies they still remained unaware of birthplace choices.
SR5	Two women, recruited as antenatal participants but due to the nature and unpredictability of birth both gave birth ahead of the planned interview date and were interviewed following the birth of their babies. Their narratives represent a woman booked to birth at home and a woman booked to birth at the birth centre whose baby was expectantly born at home.

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