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Exploring decision making to create an active offer of planned home birth

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Exploring decision making to create an active offer of planned home birth

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Abstract

Background:

Historically, the focus of the UK and international research exploring planned home birth decision making has been largely focused on understanding the experiences of women who decide to birth at home. As a result of high-profile research that suggests that non-OU birth locations are safe for low risk women, there has been a recent shift in focus resulting in research studies that aim to increase the rates of planned home birth, or more often the rates of all non-obstetric unit birth within the UK. However, despite this increased level of attention, the rate of home birth remains stubbornly low. Whilst there is some research to indicate why this might be the case, research that sheds a new light on the issue, and that develops an evidence base for new interventions is required. This thesis illuminates the factors that need to be considered in order to increase women's abilities to make an informed decision about planned birth.

Methodology:

A pragmatic approach, using mixed methods, was used to explore the current way that we offer planned home birth to maternity service users, and to ultimately make suggestions about how this could be improved.

The following studies have been undertaken:

Study 1: Initial exploratory study:

The case notes of one hundred and sixty nine women, from one health board and who had planned to birth at home, were audited.

Non-participant observation of birth planning meetings at thirty-six weeks gestation were undertaken with seven community midwife and low-risk women dyads. These were followed by individual semi-structured interviews with the participants.

Study 2: Scoping review:

Qualitative and quantitative research, and non-research based literature, were analysed to produce a qualitative review of planned home birth decision making.

Study 3: Active offer of planned home birth concept analysis

The findings of the initial exploratory study and the scoping review, in addition to active offer literature that is predominantly applied to support the provision of services within minority official languages, were used to create an active offer of planned home birth.

Study 4: Workshop study testing the findings of the concept analysis

Narrative based exercises were used to explore the concept analysis findings with twenty previous service users who had birthed at home, nine previous service users who had chosen an institutional birth, and fourteen community midwives.

Findings:

Women will either take a 'passive' or 'active' approach to the offer of planned home birth, with a passive approach likely where no motivation for an active approach has been provided.

Where a woman takes a passive approach, her ability to make an informed decision about planned home birth will depend on an active offer being made by her midwife. This will be most effective when it is supported by a midwife's employing organisation.

The findings of this thesis suggest that a two stage active offer of planned home birth (AOPHB) process, consisting of 'Creating the conditions' and 'Positive reinforcement' stages, can be used to underpin the offer of planned home birth.

Discussion:

There has previously been minimal understanding of how to facilitate the home birth decision making process, and a passive offer is routinely provided to women in the UK.

The proposed two-stage AOPHB process provides a structured way for midwives to underpin their offer to women, in order that an increased percentage of women are able to make an informed decision about home birth and/or decide to birth at home. Where midwives apply the AOPHB, women who may take a passive approach could be 'activated' to engage in home birth decision making.

A pilot intervention has been drafted to implement the AOPHB within clinical practice. The intervention provides support for the implementation of the two-stage AOPHB process through the use of individual components focused on midwives and their employing organisation; student midwives; and women, and their significant others.

Implications:

This thesis has contributed to the developing knowledge base about planned home birth decision making. The application of active offer theory to the offer of planned home birth has been undertaken for the first time, and this has generated a new and useful perspective on this area of midwifery practice.

The resultant two-stage AOPHB process has the potential for developing midwifery practice in terms of supporting midwives to understand and facilitate women's decision making around home birth, providing a flexible tool that can be used in clinical practice. This is the first approach that has been developed with the aim of increasing the ability of women to make an informed decision about whether they wish to birth at home.

Additionally, the pilot AOPHB intervention has implications around the understanding of how employing organisations can best support midwives in this aspect of their role, and developing how student midwives are educated about offering home birth to women.

Acknowledgements

I don’t feel it to be an exaggeration to say that my PhD journey has been a fairly turbulent one for many reasons, but I know I have been extremely fortunate to have been accompanied along it by some wonderful people.

Firstly my family – I know I have taken a rather long time to complete my PhD, and that the last three years have been pretty full on, to say the least. Thank you so much, on top of all that we have been through together, for being so understanding and supportive of my need to keep working on this thesis.

Secondly to my supervisors, Professor Jo Rycroft-Malone and Professor Chris Burton, who gave me this opportunity and have been constant sources of ideas, feedback and encouragement all the way through. I am very thankful to have been supervised by you both, and am enormously grateful for all that you have helped me to achieve.

And then to my colleagues and friends that have been on the PhD roadside with me - comradery in room 15 and a ½; ‘riding the Heulog’ with Lucy; and more recently the mutual support and encouragement of our department’s staff PhD support group, and my lecturing colleagues.

Finally, thank you to the women and midwives who took part in this research and generously shared their thoughts and experiences with me. This study would not have been possible without you.

Chapter One: Introduction

This PhD thesis advances the knowledge and understanding of planned home birth decision making and develops the knowledge base around how to more effectively offer the option of planned home birth to women. The intention of this introductory chapter is to provide sufficient consideration of policy and practice so as to set the context of the thesis for the reader. The prominence of birth place options within maternity policy will be outlined, followed by a discussion of the position of planned home birth within the context of the UK maternity service. Lastly, a discussion about the use of the concepts of choice, informed choice and informed decision making is included, before concluding with an overview of the contents of the thesis.

The position of birth place options within UK maternity policy:

The prominence of birth place options within UK maternity policy has altered greatly throughout the last century. It is difficult to access statistics that accurately state the rates of birth taking place within the different birth locations, but figures suggest that prior to the 1960s approximately thirty-three percent of births took place at home (Office of National Statistics [ONS] 2014). It is feasible to assert that the vast majority of the remaining birth would have at that point taken place within Obstetric Units [OUs], although Free Standing Midwife Led Units [FSMLUs] – perhaps also called 'cottage hospitals' would also have been in operation across the UK at this time (National Archives, 2017; Dodwell, 2013).

Unlike the current clinical guidance that advises low women in birthing in midwife led settings (National Institute for Health and Care Excellence [NICE], 2014), the position of birth place location was historically more focused towards ensuring that women birthed in an OU location. This was achieved via the use of maternity policy, such as the now infamous Peel Report (Ministry of Health, 1970), which advised that one hundred percent of births took place in an obstetric labour ward for reasons of safety. This policy was successful in its intentions – leading to a home birth rate of nought point nine percent between the years 1985-1988 (ONS, 2014). However, a shift in the positioning occurred again within maternity policy in 1993 with the publication of 'Changing Childbirth' (Department of Health [DoH], 1993). This reversed the official policy that an OU birth was always the safest location for birth, and additionally recommended that women were facilitated to regain the choice,

control and continuity of carer that had previously been a feature of maternity care provision.

There are currently four types of birth locations referred to within clinical guidelines (NICE, 2014). These are a woman's home, FSMLU, alongside midwife led unit [AMLU], and OU. As suggested above, birth in an OU is no longer expected to occur by default, and instead guidance states that the four available options should be discussed during a woman's pregnancy to allow a choice to be made. In addition, recent research findings have meant that the current guidance (NICE, 2014) states that in addition to informing all low risk women that they may choose to birth in any setting and supporting their decisions, maternity professionals should:

"Advise low risk multiparous women that planning to give birth at home or in a midwifery-led unit (free standing or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit birth" (p 1.1.2)

and:

"Advise low risk nulliparous women that planning to give birth in a midwifery-led unit (free standing or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit birth. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby" (p 1.1.2)

Further detail that midwives can use during their discussions with women is also available via the NICE guidance (NICE, 2014). Additionally, an information leaflet has also been developed and is available for women to support their decision making (Coxon, 2014a).

This guidance represents a shift in the evidence base to support birth place decision making. The previous NICE Intrapartum Care guideline (NICE, 2007) had only stated that women should be offered the choice of planning birth at home, in a MLU or an OU; and that birth was generally very safe for women and babies. This lack of clear guidance resulted because the available information on planning place of birth was not of good quality (NICE, 2007). The Birth Place in England cohort study (Birthplace in England Collaborative Group, 2011), led through the National Perinatal Epidemiology Unit, was undertaken with the aim of

generating evidence of sufficient quality on which to base clinical guidance on birth place decision making. Evidence from this study was used to underpin the updated guidance (NICE, 2014). The undertaking of this large study, with the aim of updating clinical guidelines, demonstrates an increased interest in birth location amongst maternity care professionals and policy makers. However it is possible that the aim was to increase the rates of any non-OU births, rather than to specifically ensure that each of the three midwife led care locations (home, AMLU and FSMLU) were adequately promoted and offered to women. It is difficult to obtain statistics that demonstrate the impact that the updated NICE guidelines have made on birth place decision making across the four UK countries. However, a recent report documents that the number of AMLU births has risen dramatically (NMPA project team, 2017), while the planned home birth rate for England and Wales during 2015 is reported to have remained unchanged at two point three percent (ONS, 2016).

Planned home birth within UK maternity policy:

In this section the way in which planned home birth is included within the maternity policy for each of the four UK countries is considered.

The maternity care system in Northern Ireland does not currently routinely provide access to planned home births. The 'Strategy for maternity care in Northern Ireland 2012-18' (Department of Health, 2012. p.6.26) reflects this and an intention to alter their approach in line with current clinical guidelines when it states that there will be a move within Northern Irish maternity care provision towards providing home birth and MLU birth 'for those women for whom such care is appropriate'.

Within Wales, England and Scotland maternity policies reflect an existing commitment to ensuring that planned home birth is available as one of the four birth place choices. A brief overview of the individual policies is given below:

In Wales a policy to achieve a planned home birth rate of ten percent was published in 2002 (Welsh Assembly Government, 2002). While the home birth rates did increase during the policy timeframe between the years 2002 and 2007, in advance of any increase in rates within England and Scotland, this target was not achieved. The Welsh Government policy, 'A strategic vision for maternity services in Wales' (2011, p.8) now states the commitment to

ensure sufficient capacity to 'enable women to give birth at home, in a birth centre or midwife led unit where that is their choice'.

In Scotland, the Scottish Government's (Scottish Government [SG], 2017, p.7) policy 'The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland' states that women should have an 'appropriate level of choice in relation to place of birth' and that home birth, along with the option of MLU and OU birth 'should be available to all women in Scotland'.

In England, 'Better Births' (NHS England, 2016, p4.11) states that there has been a 'longstanding expectations that women should be given a full choice of place of birth: home birth, midwifery unit and obstetric unit'. The policy requires that Clinical Commissioning Groups must ensure that women are cared for by maternity services who offer them the choice of birth at home, in an MLU or OU.

Therefore, each of the four UK countries makes reference to home birth as a possible birth location for women. However, all include a range of midwife led care options, rather than making specific reference to home birth alone in the way that was seen within Wales in 2002 (Welsh Assembly Government, 2002).

Choice and decision making:

All of the four UK countries recognise, within their maternity policies, the role of maternity professionals and the maternity services in facilitating choice and providing the offer of home birth. In contrast to midwife led units, in relation to home birth where the maternity service does not need to provide the birth premises, this involves providing appropriately trained staff to attend the birth.

Within England, the publication 'Better Births' (NHS England, 2016, p.8) makes the recommendations that women should have a 'genuine choice, informed by unbiased information' that enables them to be able to be 'fully involved in the decision making' about whether they prefer to give birth at home, in a midwifery unit or in an obstetric unit. Within Wales, the Strategic Plan for the Maternity Services (Welsh Government, 2011) intends that women are supported to make an 'informed choice' about the care that they receive; and this premise is also advocated within Scotland, where the maternity policy (Scottish Government, 2017) refers to women making decisions regarding care and birth preferences.

In Northern Ireland (Department of Health, 2012, p 6.14) the policy states that 'as with any other procedure, risks and benefits of place of birth must be explained to women (antenatally) to allow them to make an informed clinically appropriate choice about place of birth'.

However, despite the policy intentions, it is also increasingly being acknowledged within policy documents that support for the birth place decision making process for women is not always well facilitated. The 'Foreword' to the Better Births report (NHS England, 2016) states that 'We heard that many women are not being offered real choice in the services they can access, and are too often being told what to do, rather than being given information to make their own decisions', with specific reference being given to choice in place of birth. This sentiment is echoed within Scottish policy (Scottish Government, 2017, p.61) where reference is made to the fact that 'at present, very few NHS Boards actively promote home birth as a realistic choice'.

Why study planned home birth decision making?

While it is not possible to be categorical about the current home birth rate within all four UK countries, the most recent available figures show that the rate within England and Wales was two point three percent in 2015 (ONS, 2016), Scotland had a home birth rate of just over one percent (NCT, 2010), and Northern Ireland had a rate of naught point three percent in 2012 (Quigley et al., 2016). To set these figures within an international context, the USA is reported to have had a home birth rate of naught point eight nine percent in 2012 (MacDorman, Declercq, & Matthews, 2013), while in the Netherlands an approximate home birth rate of twenty percent was reported by de Jonge et al (2014).

The policies outlined above all highlight the importance of women making an informed choice around all four birth place options. However, policy makers are acknowledging that this is not always being achieved, and this is also being discussed within clinical practice and research. Research demonstrates that a higher percentage of women in the UK would like to give birth at home than currently do so (Bourke, 2013; Plotkin, 2017), and that maternity professionals are also aware that within their practice environments best practice in this area is not being achieved (RCM, 2011).

The thesis aim and objectives:

As a result of the clear clinical guidelines advising that low risk multiparous women choose to birth at home or in an MLU, and clear policy support within the four UK countries for the option of home birth being available for primiparous and multiparous women to choose from, this thesis aims to generate knowledge about how to ensure that women are offered the option of planned home birth in an effective manner. Justification for focusing on planned home birth, rather than including the other midwife led care locations is that the rates of births taking place in MLU locations are increasing, in contrast to home birth rates.

The thesis structure:

Chapter 1

Chapter 1 has provided the background to this study, and has broadly set out the study's aims and objectives.

Chapter 2

Chapter 2 presents the methodological approach that has been applied within this thesis. Justification for using a mixed methods approach with a pragmatic stance has been provided, along with an overview of how the chosen study methods enabled the research aims and objectives to be achieved.

Chapter 3

Chapter 3 presents the initial exploratory study that was undertaken within one local health board with the aim of exploring the ways in which planned home births were offered to low risk women, particularly in relation to the birth planning visit at thirty-six weeks gestation. Seven low-risk women and community midwife dyads were recruit to this study, and non-participant observation and semi-structured interviews were used as data collection methods. A case note audit of home births planned within the health board was also undertaken.

Chapter 4

Chapter 4 presents a scoping review of planned home birth decision making that aimed to explore factors that influence women's decision making experiences. An inclusive approach was adopted with the result that the included sources of published literature included both research and non-research based publication, from the UK and internationally.

Chapter 5

Chapter 5 presents a concept analysis of an active offer of home birth, using Walker and Avant's stepped approach (2011). This was undertaken in order to provide understanding of how an active offer of planned home birth [AOPHB] could be made to women accessing midwifery care. The published literature that outlines the way in which the process of active offer is applied within minority language services is explored and applied to the context surrounding the offer of planned home birth. The findings of the analysis are presented, including the resultant model, borderline and contrary cases.

Chapter 6

Chapter 6 presents the way in which the findings of the concept analysis were explored with relevant stakeholder groups during workshop sessions. The groups were previous service users who had planned to birth at home, previous service users who had not planned to birth at home, and community midwives who offer and attend planned home births. The aim of the study was assess the degree of 'fit' of the concept analysis findings with the participant experiences either in receiving or providing the offer of planned home birth. The findings of the study are presented, alongside the refined concept analysis and a resultant two-stage AOPHB process.

Chapter 7

Chapter 7 concludes this thesis by providing a discussion of the findings across the elements of the thesis. The original contributions arising from this thesis are provided, and a draft pilot intervention for an active offer of planned home birth presented. A reflexive account of the process that was undertaken throughout the PhD process is provided, before the presentation of a number of implications for research, practice and policy are outlined.

Conclusion:

To conclude, this thesis provides a report of how several interlinked studies have generated sufficient new knowledge and understanding of the planned home birth decision making process to enable the creation of a two-stage active offer for planned home birth (AOPHB) process that now needs to be further tested in order for it to be effectively used to support planned home birth decision making in practice.

Chapter Two - Methodology

Introduction:

As described in Chapter 1, NHS policy and UK maternity policy states women should have choice in place of birth, and that for low risk women the choice of planned home birth should be offered alongside the options of any Obstetric Unit and Midwifery Led Units, both Alongside and Freestanding, that are available in their local area (Department of Health [DoH], 2010; NICE, 2015). Low risk multiparous women are now to be 'recommended' to choose to give birth in an MLU or at home (NICE, 2015). Rates of MLU births are increasing in the UK (NMPA project team, 2017), but rates of home birth are remaining static (ONS, 2016).

All birth choices are viewed equally, with the choice of planned home birth viewed neutrally within the guidance in terms of discussion around options (Cairoli, 2010). The only exception to a neutral approach to planned home birth within policy documents is seen within a Welsh Assembly Government maternity policy document which states that low risk women should be 'encouraged' to consider planned home birth as a birth place option, in the aim of increasing the Welsh planned home birth rate to ten percent (Welsh Government, 2002).

This chapter explores where the studies within my thesis have developed from, before moving to describe the methodological considerations that I made, and to provide justification for my use of a pragmatic approach and multi-phase mixed methods study design, in order to achieve my overall aim to develop an active offer of planned home birth. In doing so, an overview of the main research paradigms is provided, before outlining the decision making process to reject these in favour of a mixed methodological approach. The chapter then moves to provide an overview of the constituent study methods, justifying the chosen methods of data collection and analysis within the thesis.

The development of the thesis:

The thesis has its roots in my personal and professional interest in planned home birth, and the result that the Welsh Government did not attain their policy objective of a ten percent home birth rate by the year 2007 (WAG, 2002). In exploring this, the initial exploratory study that is reported in chapter 3 of this thesis was originally conceived as stand-alone mixed

methods study. This was then re-conceptualised as the initial phase of the multi-phase project that is reported within this thesis as a whole, with the subsequent sequential studies developed from the findings of the initial exploratory study [Chapter 3], and reported in chapters 4, 5 and 6.

Methodological considerations:

Any discussion of a study's methodological perspectives requires consideration of the nature of knowledge, and how researchers go about finding what it is they think that they can know. Within healthcare research, and specifically within the sphere of maternity research, this includes personal beliefs regarding aspects of maternity care, philosophical opinions regarding the nature of reality and the nature of knowledge and the type of research question being explored. These considerations have required researchers to design and conduct studies that uphold wide ranging values on these broad philosophical areas (Gray, 2009). The decision to create a mixed methods study for the initial exploratory study was initially underpinned by my reluctance to apply a purist stance (Green & Hall, 2010), in regard to the use of a single research paradigm, such as positivist or constructivist, in my aim of exploring the research areas that I wished to pursue. This decision is discussed in more detail below with reference to the positivist position, and several positions within the constructivist paradigm - interpretivist, social constructionist, and critical theory perspectives.

Positivist perspective:

Historically, scientific investigations have been conducted using a positivist worldview. A researcher who upholds a positivist philosophy would describe the scientific process as being a methodical observation with the aim of identifying casual relationships (Gray, 2009). According to Gray (2009), conducting research from this perspective requires a material or physical ontological position that holds that there is one 'truth' or reality that can be known about or found, and the adherence to an objective epistemological perspective that states that this reality exists aside from any interaction that the participants or researcher may have with it. The use of experimental conditions aims to reduce, as far as is possible, the

influence of confounding variables to ensure the objective observation of the effect of an independent variable upon the dependant variable in question. This aims to ensure the internal validity of the experiment, and so allows the researcher to come to know the objective reality of the phenomenon in question (Bork, Jarski, & Florister, 2016). Although it is possible to question an individual researcher's or research team's neutrality in terms of any research question that they are investigating, conducting clinical trials according to the standards prescribed by the use of a positivist lens is accepted by most researchers as being the most appropriate methodological stance (Ryan, Hill, Prictor, & McKenzie, 2013).

Within research into planned home birth decision making I argue that there are two main points regarding the application of the positivist worldview that make it unsuitable for my research. Firstly, the positivist lens' epistemological position would not enable me to fully address the aims of my research question as it would require the observation of a single objective reality, rather than my understanding about the existence of multiple realities. In terms of this research this would require the knowledge that my participants provided as isolated, and external to their experiences as maternity service users and members of UK society. This requirement renders impossible the consideration of the impact of the well documented medicalisation of birth upon the general society of the UK (Johanson, Newburn & Macfarlane, 2002), and how this process may impact upon how a woman's social networks and the maternity service providing maternity care influence her view of birth and of planned home birth (Schwandt, 2000). This epistemological position would also require me, in my role as researcher, to claim a position of neutrality in terms of data gathering, analysis and reporting. I am cognisant that in my professional and personal life my opinion is that the UK maternity services do not always ensure that maternity service users make informed choices about planned home birth, and that the option of planned home birth is a positive birth place that women should be encouraged, alongside other options, to consider. Positivist researchers aim to eliminate this potential for confounders through the separation of researcher and participants (Ryan et al., 2013). The way in which these important considerations have been addressed within this thesis is discussed in greater detail within the section on reflexivity in the final discussion chapter [Chapter 7, p. 285].

Secondly, the discussion of whether positivist ontology can be applied to the complex subject matter explored within the social sciences is ongoing within methodological

literature (Polit & Beck, 2009). In terms of this thesis, I would argue that employing a positivist lens to the truth of how decision making around planned home birth needs to be facilitated, is inappropriate for two reasons, but that the current Intrapartum Care Guidance published by NICE implies that the use of this perspective is acceptable (NICE, 2015). This is seen through the suggestion that a single discussion about place of birth is sufficient for women to make an informed birth place decision about planned home birth, and also in the ideological sense where the ontological 'truth' that is supported through a neglect to challenge the culture of institutional birth that exists in the UK ultimately supports, rather than challenges our society's medical model of birth (NICE, 2015; Teijlingen, 2005). The medicalisation of birth within the UK has become synonymous with the positivist worldview, and so I felt that this approach would be inappropriate within a study that aimed to highlight, and ultimately challenge the practical impact of the medicalisation of birth upon current maternity care provision, for example, through the low percentage of home births.

Constructivist and interpretivist positions:

The interpretivist position, as a standalone worldview, is difficult to define (Weber, 2004). Additionally, the approach that some commentators have taken is to describe worldviews, such as social constructionism and feminist, within the broad category of 'Interpretivist Paradigms' (Denzin & Lincoln, 2000), and this lack of clear distinction appears to transfer into research studies (Catling, 2013).

Schwandt appears to critique this approach, as while he accepts that the qualitative movement as a whole has developed as a reformative movement that served to question the use of traditional positivist approaches in social science, he acknowledges that significant differences exist between the perspectives taken by the scholars of the differing approaches (Schwandt, 2000). In relation to the interpretivist and constructionist worldviews (which he states includes the 'social constructionism' worldview), he claims that while both share the intention of understanding human inquiry, the way in which they answer questions on the purpose and aim of human interactions, and how we can know about this is different (Schwandt, 1998).

Interpretivist

Schwandt (2000, p.189) describes interpretivism as 'the interpretivist theory of human action and meaning' and that 'to understand a social action, the interpreter must grasp the meanings that constitute the action' and that 'what an action means can only be understood in terms of the system of meanings to which it belongs'.

I was unconvinced that the interpretive worldview would provide new insights into how to effectively offer planned home birth. It is possible that interpreting birth place choices, therefore the meaning behind the action, would demonstrate similar rational for all maternity service users – their choice reflects where they feel to be the most appropriate place, for example in terms of safety or birth experience, for their baby to be born. It may not explain why that was, for example, in terms of understanding how their sociocultural backgrounds, and current contexts created this meaning.

Additionally, undertaking research within the interpretative worldview requires the researcher to understand the subjective meaning of an action, in an objective manner (Schwandt, 2000). In my position of researcher within discussions with maternity service users and Community Midwives this requirement would be impossible to adhere to as I continually reflect upon my own experiences as a service user and as a midwife during the research process.

Social constructionism

Social constructivists reject the idea that the world can be known about through positivist approaches (Christensen, 2005), refuting statements regarding the ability of positivist science to operate aside from the process of social construction, and that the yielded results of positivist research actually access the searched for objective and singular 'truth'. Therefore, social constructivists do not regard science as a process of objective discovery and empirical verification (Christensen, 2005). Instead, the scientific process is one that discovers 'subjective and socially contingent' truths (Rowland 1995, in Christensen, 2005). For researchers using a social constructionist perspective, the purpose of conducting research is to make contact with, and learn from the 'meaningful reality that is contingent upon human practices, being constructed in and out of interaction between human beings

and their world' (Crotty, 1998, p.42). It is this subjective meaning that social constructivists aim to access.

Social constructionists build upon the constructionist position that knowing is not passive but actually an active process when one considers how our minds generate and test concepts and ideas as we seek to make sense of our experiences (Schwandt, 2000). Social constructionists add in to this process the grounding of our experiences in our historical and sociocultural backdrop of shared understandings and practices (Schwandt, 2000). This is supported by Stake's (1995, p.100) illustration that 'infants, children and adults construct their understanding from experience and from being told what the world is, not by discovering it whirling there untouched by experience'. Therefore, within this worldview, it is reasonable to imagine that maternity service users being offered the opportunity to consider or choose a planned home birth can be expected to be using their prior knowledge about birth, and about planned home birth to assist them with their decision making. Using this worldview, we can understand that maternity service users who have not given birth, or witnessed a birth before can already have knowledge about birth that they have learnt from those around them.

Godman and Blanchard (2015, p.3.1) write that 'epistemologists often speak of epistemic "sources"' in terms of the way that 'we can get knowledge or justified belief'. This statement refers to the application of appropriate research methods, and to the quality of participant selection affecting the ability of a study design to achieve reputable findings. This thesis has applied these principles by viewing the primary source of knowledge of how an effective offer of planned home birth could be made as being maternity service users who have been involved in making a decision about where to give birth, and secondly Community Midwives who are employed to offer and attend planned home births. By virtue of their social or historical positioning these two groups of participants have 'epistemological privileges' as a result of their experiences and their 'knowledge' should be accorded value above those who do not inhabit this group in society (Devin, 1997). This epistemological 'privilege' is differentiated from 'epistemological authority', which is currently bestowed upon those involved in policy making (Janack, 1997).

However, while social constructionism may provide a beneficial approach to underpin this research, difficulty in applying a social constructionism worldview within this thesis exists.

The perspective proposes that it is through language that we are able to learn from each other about the world, and it is through this process that social constructionist research employs while knowledge collecting (Taylor, 1995). While this thesis uses multiple narrative methods to access the language used by my participants – interviews, observation, workshops, it also employed numerical methods for data collection and analysis in the form of an audit of maternity case notes, and during participant observation. This therefore creates a degree of disconnect between the social constructivist worldview, and the methods that are employed within the thesis.

Critical theory

Proponents of the critical theory worldview feel that it contrasts beneficially with that of other viewpoints, such as that of social constructionism, in that 'because of its inherent reformative fervour, it goes beyond mere recording observations, and strives to reform for a better world' (Asghar, 2013, p.3121). This makes critical theory particularly suitable for use in research exploring power relations, and the issues around numerous subjects including race, gender, economy, religion (Asghar, 2013). In consideration of whether this worldview could be applied to my work, Cohen and Crabtree (2006, p.5) write that research employing critical theory should have 'social import' and that this could include 'how people see the world'. I would argue that assisting maternity service users to make informed choices about planned home birth as a result of facilitating their reconsideration of birth has social import; as does assisting Community Midwives who currently operate under the belief that the current approach to offering planned home birth is effective at ensuring that maternity service users make informed choices around birth place location that include planned home birth. Additionally, the relativist ontology proposed by critical theory provides a fitting explanation to the fact that while maternity service users and community midwives operate under the assumption of a reality of birth that may feel 'real' to them, that this is actually the product of the social and historical, and political backgrounds to which they have been exposed (Cohen & Crabtree, 2006).

An area of incompatibility for me in terms of applying the critical theory worldview is that I did not intend to encourage maternity service users to 'take charge' of the maternity services to create change themselves. Rather the aim was to use the input from this

transient population of maternity service users to potentially help design a more effective offer of planned home birth that may benefit future service users. However, it is possible that participating in this research process may cause Community Midwife participants to reconsider their own concepts of the reality of how maternity service users should be offered planned home birth, therefore un-legitimising their current approach to offering home birth, and that this may result in them employing a different ideological perspective to their clinical interactions in future (Comstock, 1994).

A further reason I perceive that this research does not fit within a critical theory worldview is the central requirement that maternity service users are being denied the ability to make informed choices about planned home birth because maternity professionals, such as the obstetric profession, wish to exert power over them (Bastalich, 2015). While this is a view that has been discussed in some literature about maternity service users' lack of choice of planned home birth, understanding the power base of health care providers was not a research aim or objective.

Using the requirements of the application of critical theory to a research study that Comstock (1994) outlines, it would be possible to outline how the option and choice about planned home birth has become side-lined in place of the option and choice of institutional birth location in both policy and practice. It would also be possible to show how the current position of adopting a position of objectivism and neutrality within maternity policy actually serves, despite a policy that appears to support maternity service users' choice of planned home birth, to ensure that other institutional birth place options continue to be the dominant choices. This feels important, as to date no published studies have been undertaken where maternity service users have been asked to discuss how they feel an offer of planned home birth would have been most effectively made to them, and so it could be suggested that at present the current NICE guidance (2014) privileges other sources of knowledge above that of the service user. Therefore, in some ways, this research would fit well into the parameters of critical theory worldview. However, because it was not designed with a 'fervour for reform' (Asghar, 2013) of how the maternity services offer planned home birth to service users I did not align myself to it, although it is where the research could naturally lead.

Therefore, in the way outlined above, I recognised fundamental components of the various paradigms, such as their fixed ontological or epistemological positions in relation to planned home birth, as being unsuitable for use within my thesis, while recognising that a range of data collections methods and analysis methods that would traditionally be considered as aligning with opposing paradigms, would be beneficial to my research. Therefore, mixed methodology research was felt to be an instinctual 'fit' for my thesis. This, along with my decision to adopt a pragmatic stance, is discussed in more detail below.

The methodology of mixed research:

Teddlie and Tashakkori (2010, p. 5) define the methodology of mixed research as 'the broad inquiry logic that guides the selection of specific methods and that is informed by conceptual positions common to mixed methods practitioners'. The authors state that the most significant variation among practitioners arises in relation to the approach taken by those who are conceptually or philosophically orientated, and those who are methods orientated, and that therefore, with the aim of supporting all practitioners within the field, the methodology of mixed methods can be viewed as being the 'mediator between conceptual and method issues within the field, or as the point of integration between the two' (2010, p. 16).

In considering conceptual positions and the way this impacts on the subsequent research design, Teddlie and Tashakkori (2010, p. 13-15) explain that the way that paradigms, such as those discussed above, are viewed within mixed methods research has developed over the past years, moving from a perspective that views them as 'monolithic interlocking sets of philosophical assumptions towards a more practical orientation'. Six conceptual stances have been noted in the mixed methods research by groups of scholars adopting a mixed methods approach, differing on the ways that paradigmatic positions are viewed as important. These range from the a-paradigmatic stance that proposes that within the real world, 'paradigms and conceptual stances are unimportant'; a substantive theory stance that privileges theory above philosophical paradigms; a stance proposing the use of complementary strengths, where researchers adopt an approach that attempts to conserve the different methods so as to conserve the strengths of their different assumed paradigmatic positions; the multiple paradigm stance where researchers believe that

depending on the design of your study, a researcher may adopt the relevant most appropriate paradigm position; a dialectal stance which advocates the use of multiple paradigms within a single study on the understanding that each different paradigm will provide a different understanding of the research area, and that in combining these perspective, a greater level of understanding will be achieved; and a single paradigm stance that proposes that, in the same way as was proposed within studies that employed solely quantitative or qualitative methods, in applying a mixed methods approach that an 'alternative paradigm' provides the philosophical underpinnings for this approach. Within the alternative paradigm, which therefore can be said to position mixed methodology as the '3rd paradigm' (Teddlie & Tashakkori, 2010, p. 318), several stances are currently included, of which pragmatism is stated to be the most popular.

Despite these philosophical differences, a key binding principle across all researchers who adopt a mixed methods approach, is the belief in 'methodological eclecticism', which is defined as the 'rejection of the either-or principle' or the 'incompatibility thesis' at all levels of the research process, in the way that is practiced within either the quantitative or qualitative approach (Teddlie and Tashakkori, 2010, p. 5). This results in researchers selecting and integrating the most appropriate techniques to investigate their area of interest.

Mixing methods with a pragmatic stance:

In discussing the use of a pragmatic stance within mixed methods research, continued discussion exists amongst researchers regarding the exact definition and application of the pragmatic stance (Biesta, 2010). Drawing upon an everyday pragmatic position, Johnson and Onwuegbuzie (2004) state that a pragmatic approach enables the researcher to select the combination of methods that is most effective in answering the research questions. However, the importance of recognising the philosophical underpinnings of pragmatism, rather than merely applying 'everyday pragmatism' that permits an 'anything goes approach' within research design, is required by Biesta (2010, p. 131), and supported by Green and Hall (2010, p. 131) who suggest that researchers should not adopt a pragmatic approach as a

'mindless mantra' and should instead understand and adhere to what they view as its key characteristics. These are considered to be a rejection of the mind and matter dualism, a view of knowledge as both constructed and as a function of the organism-environmental transactions, recognition that knowledge is fallible as we can never be certain that our current knowledge will be appropriate for future enquiry, holding the belief that truth comes from experiences, support for a problem solving, action focused inquiry process, to understand that warranted assumptions are those that arise from a particular context and can therefore only be warranted in that context, and commitment to the values of democracy, freedom, equality and progress. While it would be perhaps simpler to state that my thesis has employed an 'everyday' approach (Biesta, 2010) in its use of the pragmatic stance, I believe that several of these key characteristics underpin the research approach that I have taken.

***The reality of experience*:**

Within this research, 'truth' and knowledge is viewed as arising from the participant experiences. Maternity service users and their significant others all hold real experiences of planned home birth decision making, whether they decided to give birth at home or within an institutional setting; and all Community Midwives hold their own knowledge, based on their own experiences, of the process of offering planned home birth to maternity service users. As each participant's truth will be based upon their own personal experience, they will therefore be expected to differ from each other. However, within this, I acknowledge that I have accorded the maternity service users a greater degree of epistemological privilege, than the Community Midwives - based upon suggestions within research publications that many women who do not choose to give birth at home may have made this choice with insufficient midwifery input, and because many of the service users who would prefer to birth at home face obstacles and difficulties making this choice or enforcing this choice (Royal College of Midwives, 2011; Shaw & Kitzinger, 2005; Lavender & Chapple, 2005).

Knowledge as fallible:

I acknowledge in the conclusion of this thesis, and within the empirical chapters where I have conducted primary research [Chapter 3 & 6] that the findings, or warranted assertions

that arise from the studies within the thesis should be viewed as being context dependent. Therefore, while some suggestions with regard to the way that the findings could be used within future research are made, this is to be understood as taking place with this in mind.

Commitment to the values of democracy, freedom, equality and progress*:*

This research, in exploring the subject of planned home birth decision making, is intended to provide support for progress within clinical practice, and has attempted to consider and include the perspectives of the of maternity service users who do not appear to be accessing planned home birth services within the UK.

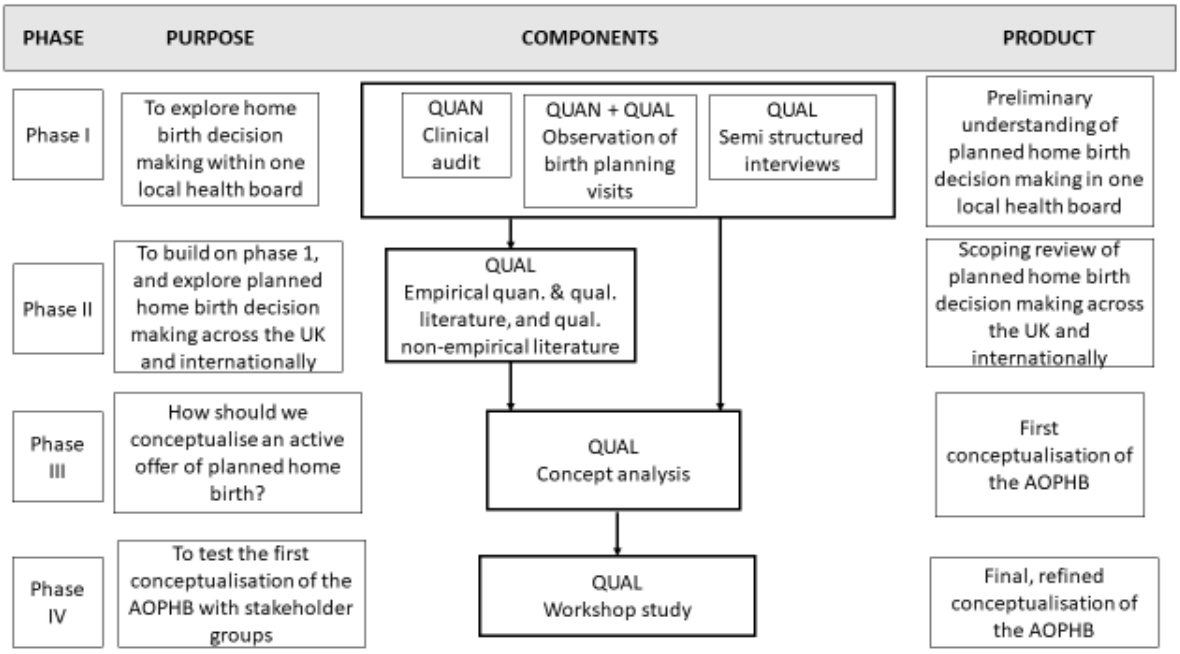
Having justified my use of a pragmatic stance within this research, I will now move to discuss how this has been taken forward within my study design.

Methods:

The thesis reports the findings of a multi-phase research study, using mixed methods for data collection and data analysis. The overview of the methods used within these studies will be briefly discussed for the remainder of the chapter.

In accordance with the chosen pragmatic stance, the study methods were chosen as they were felt to provide the most effective approach to answer the research questions (Johnson & Onwuegbuzie, 2004). Figure 1 below illustrates where methods that result in quantitative data (QUAN) being obtained, and where qualitative data (QUAL) was obtained:

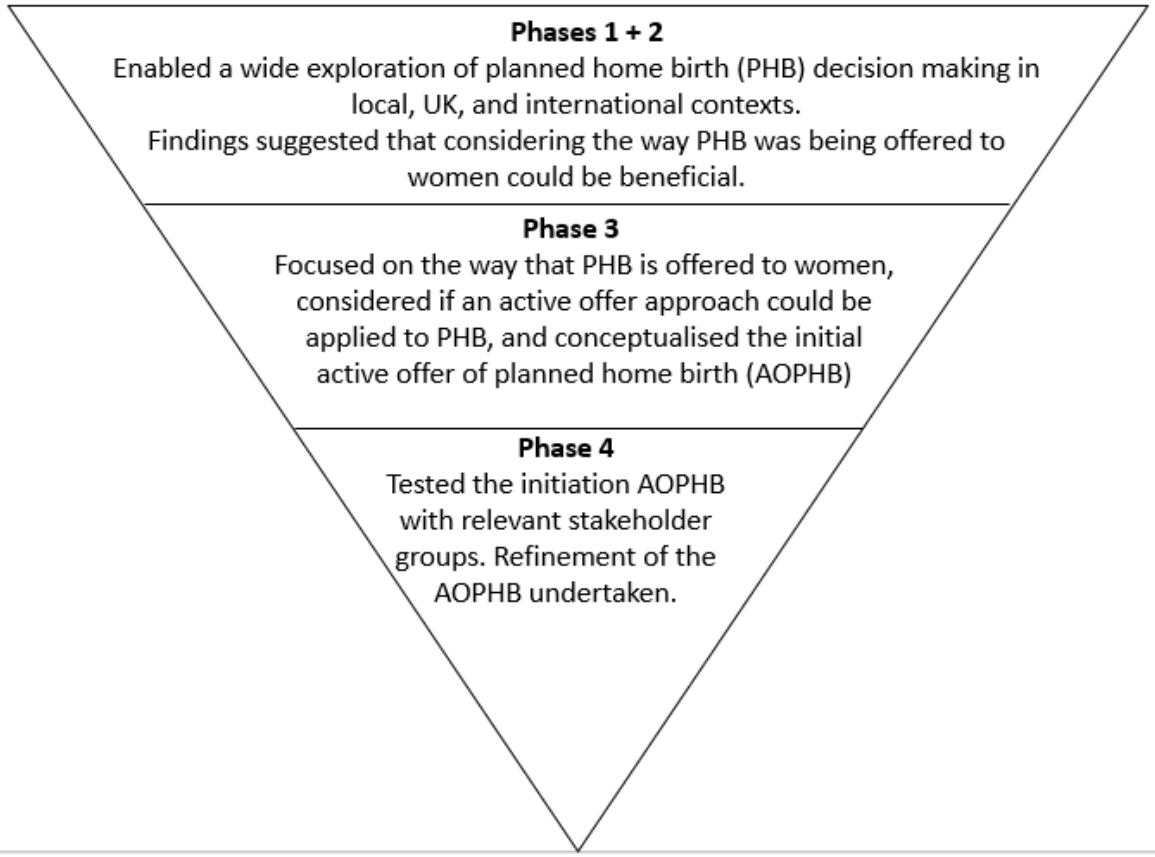
Figure 1. Illustration of the multi-phase research project that is reported in this thesis



***The focus of the programme of work*:**

The figure also illustrates the way that the subsequent studies were undertaken sequentially, with the subsequent research phases being developed pragmatically according to the findings of the previous studies. The columns labelled 'Purpose' and 'Product' demonstrate this process, with phases one and two providing the opportunity to take an exploratory approach within the subject of home birth decision making locally [Chapter 3], and then UK wide and internationally [Chapter 4]. Findings of the respective exploratory study and scoping review led to the consideration that consideration of a more effective way of offering planned home birth within midwifery practice may be possible and beneficial to maternity service users and midwives. Phase three [Chapter 5] considered how this process could be conceptualised, assessing the possibility of applying an 'active offer ' approach within planned home birth decision making and creating the initial conceptualisation of the Active Offer for Planned Home Birth [AOPHB]. Phase four [Chapter 6] then provided the opportunity to test the first AOPHB conceptualisation with relevant stakeholder groups. In this way, the methods employed within this thesis have enabled the research process to move from a wide exploration of the subject area, to a more specific assessment of one area of clinical practice. This is illustrated below:

Figure 2. Illustration of the way study commenced with a wide focus, and moved towards a more narrow focus



***The way the study methods facilitated the programme of work*:**

The chosen study methods enabled the necessary focus of the studies to be achieved. The following section provides some brief discussion about the rationale for the data collection and data analysis methods that were employed. Additional detail about each of the studies is provided in the relevant chapters.

Chapter 3 – The initial exploratory study:

This study is a mixed methods study using a concurrent triangulation design (Teddlie & Tashakkori, 2010). Non-participant observation, semi-structured interviews, and clinical audit were the three data collection methods employed within this study. As a result, the study collected both quantitative and qualitative data [Figure 1], and this was analysed using descriptive statistics, and thematic analysis respectively, with the quantitative data integrated within the final qualitative thematic analysis.

As noted in figure 1, this chapter came to provide one element of an initial broad exploration of planned home birth decision making, after its original conception as a stand-alone mixed methods study exploring planned home birth decision making in one local area. The use of clinical audit, employed to capture the documented midwifery care of all women who had planned to birth at home within the health board's catchment area within 2010, supported this aim. The use of non-participant observation, followed by individual semi-structured interviews with each participant provided additional detail in a way that is not felt to have been achievable via the use of any other research methods. The use of semi-structured interviews following the observation allowed some flexibility to respond to the individual context of the observation (Rees, 2011). Additionally, and of particular importance, was the opportunity for the triangulation of the data that was provided by taking this approach, enabling me to explore confirming and disconfirming findings that were collected through the different methods - for example between the interview and observation data, and between the clinical audit findings (Rees, 2011). The clinical audit could have provided a more useful component to the thesis if data from women who had not decided to birth at home had also been included. This is viewed as a weakness in the study design, rather than a weakness of the chosen study method and has been noted as such as a study limitation.

The following table details the research aims, and the data collection and analysis methods that were used to achieve them:

Table 1. Chapter 3 research aims and methods

Study type	Research aims	Data collection methods	Data analysis methods
Mixed methods study using a concurrent triangulation design	To ascertain greater detail on home birth rates in one region	Audit – quantitative data	Descriptive statistics
		Observation – qual. and quan. data	Descriptive statistics Thematic analysis
		Interview – qualitative data	Thematic analysis
		Audit – quantitative data	Descriptive statistics

	To investigate birth planning decisions between midwives and women in a sample of low-risk pregnancies	Observation – qual. and quan. data	Descriptive statistics Thematic analysis
		Interview – qualitative data	Thematic analysis
	To investigate the facilitators of and barriers to increasing the proportion of planned home births across one maternity service	Audit – quantitative data	Descriptive statistics
		Observation – qual. and quan. data	Descriptive statistics Thematic analysis
		Interview – qualitative data collection	Thematic analysis

Chapter 4 – Scoping review exploring decision making for planned home birth:

This chapter reports how the scoping review to broadly explore planned home birth decision making in the UK and internationally was conducted. The three research aims are stated in table 2 below, alongside the approaches taken regarding data collection and analysis:

Table 2. Chapter 4 research aims and methods

Study type	Research aims	Data collection methods	Data analysis
Scoping review of published literature	To broadly explore the published literature surrounding women's decisions to plan a home birth.	Inclusion of empirical sources – qualitative and quantitative	Thematic analysis
		Inclusion of non-empirical sources – qualitative	
	To highlight any gaps in the existing literature	Inclusion of empirical sources – qualitative and quantitative	Thematic analysis

	Suggest directions for future research into the process of women's home birth decision making	Inclusion of empirical sources – qualitative and quantitative	Thematic analysis
		Inclusion of non-empirical sources – qualitative	

In line with scoping review methodology (Levac, Colquhoun & O'Brien, 2010) empirical publications, including qualitative, quantitative and mixed methods publications, and non-empirical publications. The inclusion of non-empirical publications, especially those written by service users about their maternity care experiences were afforded epistemological privilege (Janack, 1997) in the light of their experiences in home birth decision making.

A thematic analysis was undertaken, with coding undertaken to enable the narrative findings of the quantitative research to be integrated with those of the qualitative research publications, and non-empirical publications. International and UK based sources were included in the review as, in line with the first aim of the review, this enabled a broad overview of the multiple contextual factors that may be considered to influence or relate to planned home birth decision making.

In response to the second and third aims of the review, the review findings, in combination with the findings of the initial exploratory study suggested that consideration around how to improve the way that planned home birth is offered to women may be possible and beneficial to women and midwives. My awareness of an active offer approach being used in Wales (WAG, 2012), in relation to publicly funded services being provided in minority official languages, suggested than this approach may be applied to the offer of planned home birth.

Chapter 5 – Concept analysis for an Active Offer of Planned Home Birth [AOPHB]:

Walker and Avant's (2005) concept analysis approach was used to explore what the defining attributes of an active offer of planned home birth may be. The location of this study within the thesis enabled the previously broad perspective of home birth decision making that had been taken during the previous phases, to be focused more narrowly on the process of conceptualising the active offer.

While the philosophical underpinnings of Walker and Avant's (2005) approach, in addition to other popular concept analysis approaches that have been used within healthcare and in particular nursing research, have been criticised as a result of their misunderstood philosophical underpinnings (Risjord, 2009), the decision to use this method of concept analysis was a pragmatic one. Alternative approaches, such as Rogers' (1989) emphasises the importance of maintaining the context of healthcare within their approach, denying the use of wider sources within the analysis, and it was of central importance to this conceptual analysis that input pertaining to the active offer approach within minority language provision was included.

Table 3. Chapter 5 research aims and methods

Study type	Research aims	Data collection and analysis methods
Concept analysis	To define the concept of 'an active offer of planned home birth'	A mixture of quantitative and qualitative data analysed as per Walker and Avant (2005)

Chapter 6 – Workshop study:

This chapter employed a workshop approach to test the initial conceptualisation of the AOPHB with relevant stakeholder groups. As stated above, epistemological privileges were afforded to the previous services users and Community Midwives, in line with a constructivist approach, which aligns with the pragmatic stance of viewing experience as knowledge (Biesta, 2010; Green & Hall, 2010).

Table 4. Chapter 6 research aims and methods

Study type	Research questions	Data collection methods	Data analysis methods

Workshop study	Test the findings of the AOPHB concept analysis with three relevant stakeholder groups.	Workshop data – qualitative Verbal, oral and written data	Framework analysis
	Refine the conceptualisation of the AOPHB by exploring participants' experiences	Workshop data – qualitative Verbal, oral and written data	Framework analysis

The decision to invite the previous service users [PSUs] who had planned to birth at home [PHB PSUs], and those who had not planned to birth at home [Non-PHB PSUs], and Community Midwives to attend workshops where members were solely of the same participant group provided the opportunity to observe for confirming and disconfirming data across the group perspectives (Teddlie & Tashkkori, 2010).

The workshop approach, in contrast to other possible data collection methods, such as a questionnaire, that could perhaps have been adopted, provided a flexible approach that enabled me to interact with the participants, exploring and clarifying their experiences (Rees, 2011).

Conclusion:

This chapter has outlined the decision making process that has led to my employing a mixed methods approach with a pragmatic stance, and justified the methods for data collection and analysis that were made.

The subsequent chapters detail how the research process was undertaken within each study in my aim to understand the component parts that would create an effective offer for planned home birth.

Chapter Three - Initial exploratory study

Introduction:

This study was conducted in one Welsh local health board four years after the Welsh Assembly Government target (Welsh Assembly Government, 2002) to achieve a rate of ten percent of planned home births by 2007 was not achieved. In Wales during 2010 the home birth rate was three point four percent and within this local health board the achieved home birth rate was approximately two point one percent (BirthChoice UK, 2012). According to statistics published by BirthChoice UK (2012) within the catchment areas of the three district general hospitals staffed by the health board, the home birth rates differed between approximately four point three percent and one percent. The comparative rate of planned home birth across the UK was two point four percent (BirthChoice UK, 2012). The study arose from a professional and personal interest in planned home birth, and an awareness that this policy target was not being achieved across Wales, including in the local health board.

Funding was secured that initially enabled me to conduct the study, however, during the study period the opportunity to undertake a PhD arose, and so this study then developed into the initial exploratory study within this thesis.

The study gave me the opportunity to explore the way that planned home birth is provided within the local health board, using observation of birth planning meeting, and subsequent interviews with the participants as 'windows' in to the way that home birth was discussed and offered as a birth place option by midwives, and the decision making process that women and their significant others engaged in. Research studies conducted in England at around this time suggested a range of approaches to supporting women in their birth place decision making were being taken by midwives. Some studies suggested that women were not being encouraged to consider the option of planned home birth (Madi, 2001, Houghton et al., 2008) and other researchers finding that some areas were employing innovative methods to this area of clinical practice (Kemp & Sandall, 2010). One piece of published research had been conducted elsewhere in Wales, and this suggested that improvements could be made to the way in which home birth was discussed with women making this choice (Andrews, 2004b). However, no research had been undertaken to explore this with

women who were not necessarily planning to birth at home, or within the local health board. Therefore, it was felt that undertaking a study to explore the way in which planned home birth was offered to low risk women within one local health board may provide an opportunity to understand current practice, and further ascertain women's views about home birth decision making.

Methods:

The aims of this study were to:

1. To ascertain greater detail on home birth rates in one region

2. To investigate birth planning decisions between midwives and women in a sample of low-risk pregnancies

3. To investigate the facilitators of and barriers to increasing the proportion of planned home births across one maternity service

The study used a mixed methods design, using three data collection methods within two distinct phases:

In line with a mixed methods study using a pragmatic approach, in this study quantitative and qualitative data were collected using audit, observations and interviews as data collection methods. The use of these varied approaches to data collection were envisaged to provide the opportunity to the required data.

A retrospective audit of all of the case notes where women had intended or achieved a home birth whilst being cared for within the local health board during 2010 were accessed.

Birth planning meetings between midwives and mothers at thirty-six weeks gestation were observed.

Separate semi-structured interviews were then conducted with midwives and mothers to investigate perceptions about their prior interactions, the birth planning meeting and how future interactions would proceed.

This is illustrated in the following table [Table 5]:

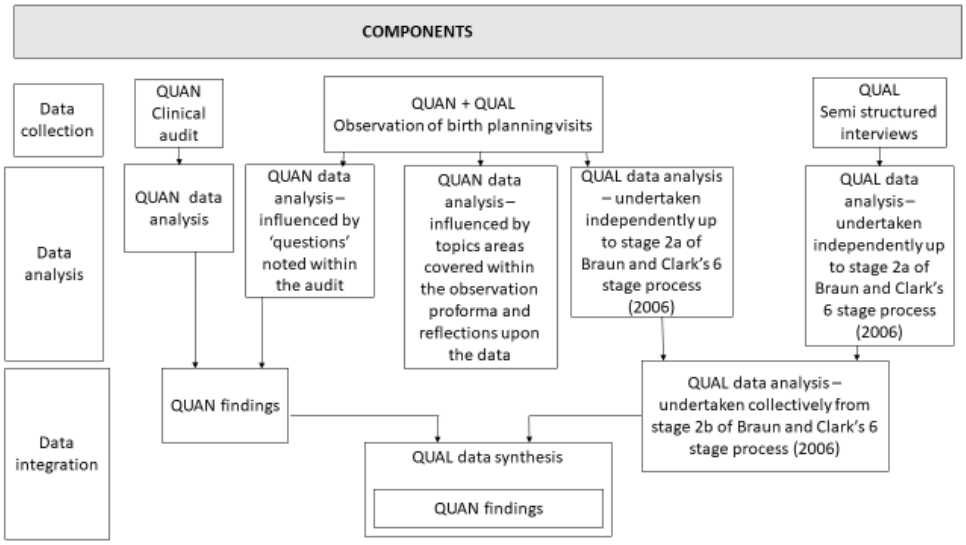
Table 5. Rational for the study data collection methods

Study aim	Data collection approach	Rational for this approach
To ascertain greater detail on home birth rates in one region	Audit	Opportunity to note care components, and documentation relating to home birth for one cohort of women planning home births within the Health Board, and to consider the implications in relation to home birth rates
	Observation	Ability to observe how birth planning discussions are undertaken at several points across the Health Board, and to consider the implications in relation to home birth rates
	Interview	Opportunity to discuss with women and midwives about their individual experiences of how way home birth is integrated into care provision, and to consider the implications in relation to home birth rates
To investigate birth planning decisions between midwives and women in a sample of low-risk pregnancies	Audit	Opportunity to note documentation about how home birth decision making in the cohort's case notes
	Observation	Ability to directly observe how decision making about home birth was approached within the woman-midwife dyad
	Interview	Opportunity to discuss individually with women and midwives about their individual experiences of home birth decision is undertaken within their dyad, and for the midwives in terms of their routine practices
To investigate the facilitators of and barriers	Audit	Opportunity to note care components, and documentation relating to home birth for one cohort of women planning home births within the Health Board,

to increasing the proportion of planned home births across one maternity service		and to consider the implications in relation to barriers and facilitators to increasing the home birth rate
	Observation	Ability to observe how birth planning discussions are undertaken at several points across the Health Board, and to consider the implications in relation to barriers and facilitators to increasing the home birth rates
	Interview	Opportunity to discuss individually with women and midwives about their individual experiences of home birth decision is undertaken within their dyad, and for the midwives in terms of their routine practices, and to consider this in relation to barriers and facilitators to increasing the home birth rate

The way in which the data were collected and analysed is presented below in figure 3. This figure provides a more detailed view of the approach that was taken, building on the broader overview of this study location within the overall thesis that is provided within the methodology chapter [Figure 1].

Figure 3. Figure to illustrate the approaches to data collection, data analysis and data integration within this study



As discussed above in table 5, figure 3 above illustrates that three data collection methods were used within this study, with the audit undertaken independently of the observation and interviews, which were conducted as part of the same stage of the study.

The audit data which was entirely quantitative, and the quantitative observation data was analysed separately. The figure illustrates that within the quantitative observation data reference was made to questions contained within the audit, and also topics contained within the observation proforma [Appendix 1]. After being analysed separately, the findings were then embedded within the qualitative observation and interview findings.

The qualitative observation data, and the interview data which was entirely qualitative, were analysed separately during the initial stages of the thematic analysis (Braun and Clarke, 2006) to the point where codes were created, and then categories from both data sources were created, and then combined to complete the thematic analysis.

Within the study reporting, while the focus adopted within the reporting of the study findings has been given to the findings from the qualitative data analysis, the integration of the findings from the quantitative data has been used to provide a complementary, explanatory framework (Howe, 2012; Mertens & Hesse-Biber, 2012).

Ethical approval:

Ethical Approval was received from the local NHS Research Ethics Committee on 21st of April 2011 [Appendix 2], and governance approvals granted by the Research and Development Department at the health board on the 18th April 2011 [Appendix 3]. The key ethical issues attended to in the study design and conduct related to preventing coercion through a transparent recruitment strategy and ensuring informed consent of study participants, and maintaining confidentiality and anonymity. As I am a Registered Midwife, professional responsibility required attention to the possibility of the observation of harm or poor practice during the birth planning meetings. A protocol was agreed through which any concerns could be raised and escalated if appropriate. Harm or poor practice of concern was not observed.

Ethical approval was not required for the case note audit, but appropriate governance approval was granted from the Health Board, and the audit registered with the relevant departments. Ethical principles adhered to included ensuring the confidentiality of data obtained, and anonymity through appropriate data protection processes.

Component study designs:

Case note audit:

The case note was undertaken in order to set the context for this study. It was anticipated that the audit would provide detailed information about the care provision that was documented in relation to the cohort women in the Health Board who had decided to plan a home birth within 2010. While smaller audits had been undertaken in relation to aspects of home birth provision, such as the provision of home birth information leaflets, an audit of this scope had not been undertaken before in the Health Board.

Sample:

All of the case notes where women who had intended or achieved a home birth whilst being cared for within the local health board during 2010 were accessed.

Observation and interview study:

The observation and interview components of this study were undertaken for the reasons discussed in table 5. Observation does not appear to have been used widely within research exploring home birth decision making, and so this combination of data collection tools is felt to provide a strength of this study.

Sample:

Participants who volunteered for this study were participants in both the observation and interviews aspects of this study. Therefore, the sampling will be discussed jointly.

Sampling was dyadic, in that each data collection opportunity included both:

Community Midwives – any Community Midwife employed by the health board.

Pregnant Women – inclusion criteria were that the woman was aged over 18 years, fluent in English or Welsh, over 24 weeks into her pregnancy, experiencing a low risk pregnancy - as defined by NICE (2007), and cared for by a participating Community Midwife.

Over the period of the study, the aim was to recruit 15 Community Midwife and woman dyads, as this was expected to balance the available funding and project timescales with the richness of data to support a credible analysis.

Identification of participants:

Community Midwives – The names and practice addresses of all the Community Midwives employed by the health board were obtained from the Health Board.

Pregnant Women – Eligible women were identified by participating Community Midwives from their caseloads.

Approaching participants and obtaining consent:

All Community Midwives employed by the health board were sent Midwives Study Invitation Packs [Appendix 5] containing English and Welsh Midwives Study Information Sheets, and Midwives Consent Forms; and a stamped addressed envelope. Community Midwives were asked to contact me stating that they did not wish to take part in the study, or that they gave their consent to take part in the study. Two weeks after the initial invitation to participate Reminder Study Invitation Packs [Appendix 6] were sent to all of the Community Midwives who had not contacted me yet. This pack informed them that I would be not be sending any further reminders.

Community Midwives who wished to participate were sent approximately 25 Women's Study Information Packs [Appendix 7] and asked to offer them to all the women in their caseload who met the study inclusion criteria. An enclosed letter recapped the study inclusion and exclusion criteria for the Community Midwives.

The Women's Study Information Pack contained English and Welsh language Women's Study Information Sheets and Women's Study Consent forms; and a stamped addressed envelope. The women were asked to return their completed Consent Form to me if they wished to take part. Participating Community Midwives were informed of women who consented to participate in their caseload, and were asked to inform the researcher of the date of their planned 36 week birth planning meeting with each woman, or if a situation arose that meant that they felt would it was no longer appropriate for me to attend a scheduled birth planning meeting.

Where I had a previous relationship with the Community Midwife I travelled independently to the location of the birth planning meeting, and met them and the woman there. Where I did not have a previous relationship with the Community Midwife I met her beforehand to introduce myself and then awaited the arrival of the woman, or then travelled to the

woman's house in my own car. A colleague was informed of my location and expected time of return from each appointment, in line with the University's lone working policy.

Data collection:

Audit data collection:

An audit proforma [Appendix 4] was created to collect data on the numbers of intended and achieved planned home births, and also the documentation within the women's handheld notes in terms of frequency of when references to home birth was documented by a midwife, and the sources of information that were listed as being provided as part of the birth plan.

Observation data collection:

Observations of the 36 week birth planning visits were undertaken and digitally recorded with the consent of all participants. An observation checklist [Appendix 1] was also completed during each of the meetings. The checklist was developed following consideration of Kemp and Sandal's (2010) research findings about the process of undertaking birth planning meetings in a way that aimed to uphold the philosophy of physiological birth. The content was also aligned with the topics that were included within the birth plan in All Wales handheld maternity notes. Note was also made of the way in which the verbal and non-verbal interactions were made within the midwife-woman and partner relationship.

Two of the meetings were undertaken using the Welsh language; therefore a Welsh Language Research Support Officer was present, with the consent of the participants, to complete the checklist.

Interview data collection:

Independent, semi-structured interviews were undertaken in the English language by the researcher, the participating women [Appendix 8], and in some case their birth partners; and then the Community Midwives [Appendix 9]. Three of the women had their birth partners present with them during their interviews and they all participated in our conversations.

Three of the Community Midwives had Student Midwives present with them during their interviews, in an observational capacity, and with their consent. This is illustrated in Table 6.

The interviews were digitally recorded with the consent of the participants.

Data protection:

Participants were assigned codes, and their names removed. Pseudonyms have now been awarded to each midwife-woman dyad. All of the transcribed documentation was saved to University password protected computers. These were only accessible to me. Recordings were deleted once they were transcribed. Original documents were stored within locked cabinets.

Data analysis:

Audit Data Analysis:

Data from the completed audit proforma were uploaded into SPSS.14 (IBM, 2017).
Descriptive statistics were used to note:

The gravida and parity of the women who had intended to birth at home

The relationship status of the women who had intended to birth at home

The type of the most recent birth that the women who had intended to birth at home had experienced

The location of the recent birth that the women who had intended to birth at home had experienced

The location of the first contact between woman and midwife

The number of midwives documenting in the handheld notes

The frequency of planned home births being intended and also achieved

The frequency and timing of any references to home birth within the women's handheld notes that was documented by a midwife

The recorded location of the birth plan visit

The sources of information that were listed as being provided by the midwife as part of the woman's birth planning meeting

Observation data analysis:

Both quantitative and qualitative data analysis was undertaken with the observation data. This is discussed below, commencing with presentation of the quantitative analysis process.

Quantitative analysis of the observation data:

The observation recordings were listened to.

The time spent by in relation to the following subject areas was noted:

The time spent within the birth planning meeting discussing each topic that had been listed within the observation pro-forma

The time that each of the participants in the birth planning meeting spent talking

The time spent discussing topics that align with the Maternity Working Party (2007) definition of normal birth

Points one and two were subject areas that related to the case note audit subject question areas. Point three is an additional line of enquiry that arose as part of the observational process.

The data was then tabulated, and descriptive statistical analysis undertaken.

Qualitative analysis of the observation data:

The thematic analysis of the observations, and the semi structured interview data, was undertaken according to Braun and Clark's (2006) six phased approach, with an adaption required at the point where the initial codes that had been created within each data source (stage 2a) were integrated and categories created (2b). Categories allowed the opportunity for the consideration of confirming and disconfirming data arising from the observation and interview process. This is suggested to be a strength of this study.

Braun and Clark's (2006) approach is listed below:

1. Familiarising yourself with the data

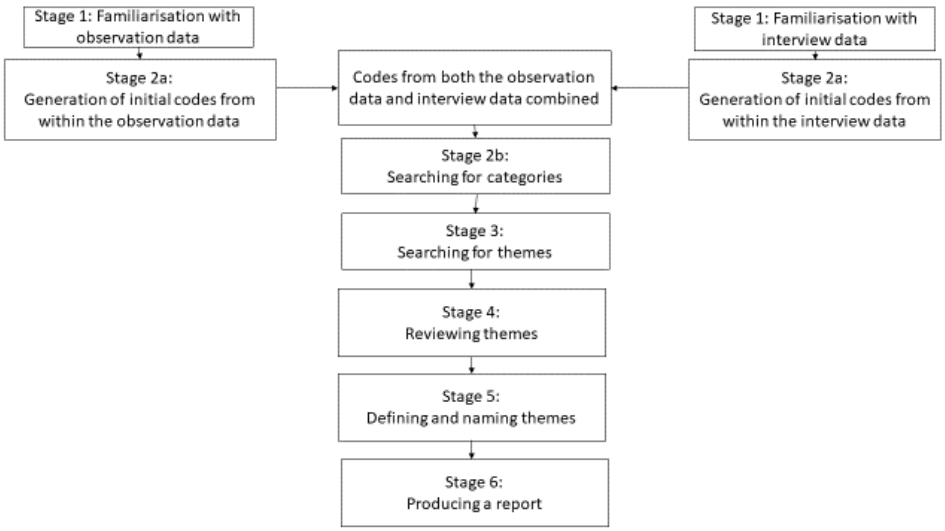
(2a) Generating initial codes

(2b) Creating categories

3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report of your findings

As illustrated above in figure 3, the observation data was analysed separately during stages 1 and 2a of this approach, and at stage 2b the codes that had been generated were combined to create categories. From this point onwards the analysis process was combined for both aspects of this study. This is illustrated below:

Figure 4. Study qualitative data collection and analysis process



Combining two sources of data could be considered a variation in Braun and Clark's (2006) approach, however, they do state that approaching your analysis in a pragmatic manner is permissible within their approach. Therefore, this process of initial analysis from the two data sources, and the resultant combination of the two sources from stage 2b onwards could be considered the product of appropriate 'analytic sensibility' (Braun & Clark 2013, p.7). The combination of data from the two data collection methods is also permissible within the multiple methods approach, with consideration given to the process of data integration (Teddlie & Tashkkori, 2010).

The analysis process for the observation data will therefore be discussed below up to stage 2b:

Stage 1 - Familiarising yourself with the data

All of the observations were anonymised and fully transcribed by myself in to WORD documents with the exception of the two Welsh language observations which were translated into English by the Welsh Language Research Support Officer who had been present at the meeting.

The transcripts provided a verbatim reproduction of the data collection episode, and also contained non-verbal utterances [Appendix 10]. A recognised method of transcription was not used, but I ensured that the scripts were formatted in same way.

Braun and Clarke (2013) note that the transcription phase was a highly beneficial process as it results in a good level of knowledge of the data being obtained, prior to any formal re-reading being undertaken. A process of reading and re-reading each of the data sources was then undertaken until familiarity with the content was achieved. Each of the data sources was read at least once before the active process of analysis started. In addition, initial blocks in the coding process were generated during this stage of analysis (Braun and Clarke, 2013). This related to the apparent disparity between the approach to the discussion and promotion of home birth that was observed within several of the birth planning meetings, in comparison to the level of professional experience and commitment to home birth that I had experienced within my own professional interactions with these midwives.

Stage 2a – Generating initial codes

During the subsequent episodes of reading the transcripts, meaningful units for analysis relating to the research questions, were identified within the transcripts. These varied in size from a few words to small paragraphs. The codes were either descriptive in nature – mostly reflecting the topics that were covered within the observation proforma, or made reference to a 'sense' that had been gained within this element of the data. Therefore, both data-derived codes, such as descriptions, and researcher-derived codes, such as relating to concepts or theory, were created (Braun and Clarke, 2013).

In the initial stages I printed out the WORD documents and wrote on the transcripts to highlight the unit for analysis and the accompanying code. I then started to collate each of

the relevant quotations within handwritten documents for each of the codes that I had generated. Later I moved to using the 'copy and paste' function within WORD and Excel to create tables for each of the codes that I had identified - across all of the data sources, and across each participant dyad by copying the highlighted sections of text. I did try to use Nvivo (QSR International, 2017) but rejected this in favour of manual analysis as I preferred the feeling of being closely connected to the data.

The following codes were noted within the observation data:

Table 7. Codes that were derived from the observation data

Codes generated from the proforma check-list	Codes generated from the analysis process
Place of birth	Attitude to birth interventions
Type of birth	Pressure on interaction
Antenatal classes	Midwife wants to feel a relationship has developed between her and her client(s)
Pain in labour	Understanding of decisions and thoughts
Induction of labour	Assumption of hospital birth
Signs of labour	Myths and stereotypes of home birth being supported
Who to contact in labour	Atmosphere
Routine AN check	Location of care during pregnancy
Woman already written anything in her birth plan?	Continuity of care
Use of props	Power over interactions
Birth plan discussion	Involvement
Place of birth discussed	Offer of home birth
Interventions during labour	Brief discussion of topics
Normality focus	Health literacy impacting on interactions

Woman's autonomy	Tailoring of the approach
	Feels like a conversation
	Feels rushed and skimmed over
	Home birth is a difficult topic
	Some topics 'safer' than others
	Priorities
	Choice sounds real
	Decision making
	Social norms
	Midwife protecting woman
	Discussion of considered birth location impacts on ability to discuss home birth

Reflective notes were also made after each individual observation episode, and after the entire process of data collection has been undertaken. These are listed below:

More talk of home birth when use of an MLU is possible/ likely? Why?

See what fits into 'normal labour' definition of what is being suggested - 'without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery' as all affects perceived possibility of ability to give birth at home?

Idea of continued conversation throughout pregnancy – relate to interviews re opinions of care provision and what is provided

Actual discussion of birth itself – is there any?

Midwives seem to be disempowered – maybe because in this model of care, care is fragmented and all important discussions take place in AN class? Their role is to provide routine AN checks

There is an issue of how visible home birth is to women going on – what makes up visibility? We need to think about within maternity care and also outside of their care

What situation drives what? Chicken and egg situation?

Interview data analysis:

The woman's and midwives' interviews were analysed concurrently, and as discussed above were analysed along with the observation data from stage 2b onwards [Figure 3]. The decision to analyse the midwives and woman's interviews together, rather than individually, was felt to be the most appropriate approach as the sources of data were considered to be interlinked. As the observations had been undertaken within dyads, to separate them felt to create an artificial distinction between them. On reflection, it may have been useful to consider the two sources individually, and to then collate the codes from each source as this may have provided a clearer picture of the ways in which the two groups of participants experienced the birth planning meeting and birth planning in general.

Therefore, as per Braun and Clark's (2006) description of their six phased approach, thematic analysis of the semi-structured interviews was undertaken, and will be described below up to the conclusion of stage 2a:

Stage 1 - Familiarising yourself with the data

All of the interviews were anonymised and fully transcribed by myself in to WORD documents.

The transcripts provided a verbatim reproduction of the data collection episode, and also contained non-verbal utterances [Appendix 10].

Braun and Clarke (2013) note that the transcription phase was a highly beneficial process as it resulted in a good level of knowledge of the data being obtained, prior to any formal re-reading being undertaken. A process of reading and re-reading each of the data sources was then undertaken until familiarity with the content was achieved. Each of the data sources was read at least once before the active process of analysis started.

Phase 2a – Generating initial codes

During the subsequent episodes of reading the transcripts, codes were given to each data segment. Complete coding was undertaken, with the creation of both data-derived codes and researcher-derived codes. As with the observation analysis detailed above, in the initial stages I printed out the WORD documents and wrote on the transcripts to highlight the unit for analysis and the accompanying code. I then started to collate each of the relevant quotations within handwritten documents for each of the codes that I had generated. Later I moved to using the 'copy and paste' function within WORD and Excel to create tables for each of the codes that I had identified - across all of the data sources, and across each participant dyad by copying the highlighted sections of text.

Table 8. Codes derived from the interview data

Data derived descriptive codes	Researcher derived codes
Experience of offering	Continuity in relation to the offer of home birth
Attitude to birth	Benefit of partner involvement
Attitude to home birth	Influence of partner on decision making
Maternity service factors	Influence of social network on decision making
Continuity of carer	The visibility of home birth in our society
View of community midwifery role	Home birth as a priority
Impact of possible locations	Home birth offer is led by women not midwives
Community midwifery influence on decision making	Concern about how to offer
Confidence in community midwife	Assumption that an unwelcome offer of home birth is viewed as pressuring a woman
Information provision	Offer everyone the same – is that a good way to approach this?

Knowledge of home birth	Vibes influence how an offer is made
Welsh Assembly Government policy	Information provision is all that is needed
Community midwifery support to provide home births	Trying to offer
Attitude to other birth locations (OU, AMLU, FSMLU)	Decision making is done before birth planning meeting
Community midwife's attitude to home birth	Takes place outside of maternity care
	Passive approach that 'just happens' sometimes
	Sources of info via the media
	The impact of expectations
	Preconceptions are powerful but may not be acknowledged
	Guidelines
	Midwife feels she has discussed home birth a lot during this woman's care
	Women have known for a long time if they want a home birth, do not make this decision during pregnancy

Qualitative data analysis continued – observation and interview data:

Stage 2b – generating categories

In stage 2b the combined codes from the qualitative observation and interview data were considered to generate categories. This enabled confirming and disconfirming data to be considered. Disconfirming data was most commonly noted in relation to a woman's perception of the care she had received, and the care her community midwife reported that had been provided; and between the way that a community midwife provided care, and the

way that she then described her care provision, or the aims of her care provision during her interview with the researcher. Examples are illustrated in the table below:

Table 9. Examples of disconfirming or differing perspectives within dyads

Configuration	Data sources	Example codes
Woman + Community Midwife	Interviews	Midwife feels she has discussed home birth a lot during this woman's care, but women seem to hold a different view
Community Midwife + Researcher	Observation + Interview	Myths and stereotypes of home birth being supported but this is not acknowledged Home birth offer is led by women not midwives , but this is not discussed

Stage 3 – Searching for themes

The third stage of the data analysis required categories to be collated into themes, generated to illustrate important aspects of my data, in relation to the three research questions (Braun and Clark, 2006).

Initially six key areas of participant experiences were revealed as potential themes.

Table 10. The initial themes and categories

Theme		Categories
1	The participants personal backgrounds in relation to home birth	The women's pre-pregnancy experiences
		The Community Midwives' personal and pre-midwifery experiences
2	Observed birth planning meetings	Location of the birth plan meetings
		Content of the birth plan meetings
		Division of conversation time between Community Midwife and Woman, and her birth partner if present

		Resources and demonstrations used during the birth planning meetings
3	Making an informed choice about home birth	The opportunity to make an informed choice about home birth
		Varying priorities to making an informed choice about home birth
		Clarification - the constituting elements of an informed choice about home birth
4	Antenatal discussion of home birth	Consensus of discussion at the start of pregnancy
		Mixed perceptions and experiences of continued home birth discussion during pregnancy
		A dyad's further discussion about home birth is influenced by their initial interactions
		Home birth discussions, and birth discussions during the birth planning meetings
5	The visibility of home birth	Within maternity care Outside of maternity care provision
6	The position of home birth within the Health Board	Community Midwife opinion about home birth Support for home birth by Health Board management

As quantitative data analysis was being undertaken alongside the qualitative analysis, I expected that theme 2 'Observed birth planning meetings' would be extensively supplemented with findings from the audit.

Stage 4 - Reviewing themes

During this stage the themes were refined further, and four themes were decided upon that provided a more appropriate explanation of the data.

These are listed below in table 11. The associated codes from both the observation and interview data analysis, and categories, are included to demonstrate the extent to which the themes are grounded in data from both data collection methods.

Table 11. The resultant study themes, categories and codes

Theme	Categories (from both data sets)	Codes from observation data	Codes from interview data
Fragmented care provision – living the dream	Continuity of care in the antenatal period	Continuity of care	Continuity in relation to the offer of home birth
	Conversations about birth and about birth place choices that include planned home birth are conducted during the antenatal period between woman and community midwife	Midwife wants to feel a relationship has developed between her and her client(s)	Decision making is done before birth planning meeting
	Perceptions about the community role	AN classes	Continuity of carer
	Location of discussion about PHB during pregnancy		Community midwifery influence on decision making
			View of community midwifery role
			Confidence in community midwife
			Community midwifery support to provide home births
Informed choice in place of birth	Information provision and discussion	Tailoring of the approach	Information provision
	Sources of information	Importance of informed decision making	Attitude to home birth

	Clarification of thoughts and plans during birth planning meeting	Choice sounds real	Assumption that an unwelcome offer of home birth is viewed as pressuring a woman
	Achieved informed choice or decision?	Offer of home birth	Home birth offer is led by women not midwives
		Assumption of hospital birth	Power over interactions
		Myths and stereotypes of home birth being supported	Information provision is all that is needed
		Understanding of decisions and thoughts	Passive approach that 'just happens' sometimes
		Decision making	Offer everyone the same – is that a good way to approach this?
			Trying to offer
			Experience of offering
			Concern about how to offer
			Women have known for a long time if they want a home birth, do not make this decision during pregnancy
			Vibes influence how an offer is made
			Feels like a conversation
			Home birth as a priority
Planned home birth visibility	PHB within their social world	Location of care during pregnancy	The visibility of home birth in our society

	The visibility of professional support for home birth	Some topics 'safer' than others	Influence of social network on decision making
	PHB by 36/40	Home birth is a difficult topic	Decision making takes place outside of maternity care
	Planned home birth within antenatal care provision	Social norms	Sources of info via the media
		Place of birth discussed	Welsh Assembly Government policy
			Knowledge of home birth
			Impact of possible locations
			Maternity service factors
			Social norms
			Midwife feels she has discussed home birth a lot during this woman's care
			Benefit of partner involvement
			Influence of partner on decision making
			Priorities
			Community midwife's attitude to home birth
			Pressure on interaction
Chicken and the egg	Thoughts about birth – social influences	Interventions during labour	Attitude to birth
	Birth and intervention	Normality focus	Attitude to other birth locations (OU, AMLU, FSMLU)

	The influence of the community midwives on the women's thoughts about birth	Induction of labour	Preconceptions are powerful but may not be acknowledged
		Pain in labour	The impact of expectations
		Attitude to birth interventions	Feels rushed and skimmed over
		Discussion of considered birth location impacts on ability to discuss home birth	Brief discussion of topics
		Midwife protecting woman	
		Place of birth	
		Type of birth	
		Signs of labour	
		Birth plan discussion	

Braun and Clark (2006) state that at this stage the researcher should assess both the internal and external homogeneity of their data analysis. Internal homogeneity refers to the extent to which the codes that are collated under each of the themes creates an accurate and distinctive picture of the intended focus of each theme. My assessment of each of my four resultant themes, and the categories and codes that are aligned within them is that this has been achieved. External homogeneity refers to the extent to which the four themes, when considered as the whole product of this study, accurately reflected the meaning of the entire data set. My assessment of the way that this has been achieved rests upon the way that each of my four themes addresses a distinct aspect of my data, and allows me to tell the 'story' that is contained within the original data that my participants provided (Braun and Clark 2006).

Stage 5 - Defining and naming themes

Braun and Clark (2006) suggest that at this point in the data analysis process that data is re-read to ensure that the most appropriate elements of the data are used to illustrate the meaning of each theme. I also returned to my list of quotations contained within my coding documents to highlight which quotations best illustrated the aspects of the themes that I wished to highlight in my findings.

Phase 6 - Producing the report of your findings

The findings from the qualitative analysis process follow as the substantive content of this chapter, with the addition of the quantitative data that was obtained from the case note audit and the observations (Howe, 2012). Therefore, the findings from all data collection approaches were combined in order to write the final findings section, with the quantitative data integrated within the qualitative themes. This is illustrated below:

Table 12. Table to illustrate the ways that the sources of data have been integrated within the qualitative themes

Finding		Data source			
Demographic findings		Audit data	Observation and interview participant data		
Thematic findings		Quantitative data		Qualitative data	
		Audit data	Observation data	Observation data	Interview data
	Fragmented care provision – living the dream	✓	✓	✓	✓
	Informed choice in place of birth	✓		✓	✓

	Planned home birth visibility	✓		✓	✓
	Chicken and the egg		✓	✓	✓

Before the themes are discussed, my personal reflections, and the initial findings of a demographic nature in the case note audit, and demographic information of participants in the observation and interviews will be provided first. Where data relates to the overall thematic analysis this is discussed later in the chapter.

Personal reflection:

My observations of the birth planning meetings were supplemented by the fact that I trained and worked within the same health board locality as many of the Community Midwife participants (Mw Davina, Emma, Fern and Grace) so I therefore had prior knowledge of the way in which they practiced midwifery and of their underlying birth philosophies. I had previously been part of conversations with these Community Midwives talking about their belief in the benefits of home birth, and attending home births with one of them, so already knew about the commitment that they had for this aspect of their work.

The first birth planning observations that I undertook for this study were with Community Midwives (Mw Anna and Carole) that I had not already met. As a result, my observations were not grounded in the same context of the background knowledge I had of Mw Davina, Emma, Fern and Grace. However, after observing birth planning meetings with the Community Midwives with whom I did already have a professional relationship I started to develop a fuller understanding about the complexities that Community Midwives encounter when they try to offer and discuss home birth. I believe that without this prior knowledge I would not have had a reason to question or consider the women participants lack of clarity around their Community Midwives' positivity towards home birth, or their perceptions that home birth had not been discussed with them.

Initial results:

Case note audit:

Planned home births across the jurisdiction of the three health board areas during 2010:

A total of 177 women planned home births within the health board jurisdiction during 2010. This equates to approximately two point two percent of all births taking place under the health board jurisdiction being planned to take place at home [Table 13].

The health board operates three broad areas, based on the geography of its three DGHs, and within these different jurisdictions the rates of planned home birth varied from four point three in area 1; naught point nine percent in area 2, and one point nine percent in area 3.

Table 13. Demographic detail of the number of case notes accessed, in relation to health board area

Area	Birth rate 2010	Complete Notes viewed	Maternity Notes incomplete in Medical Notes – therefore data incomplete	Notes location unknown/ location known but unavailable at time	Total
1	Approx. 2077	65	12	13	90
2	Approx. 2191	21	0	0	21
3	Approx. 3443	66	0	0	66
TOTAL	7711	152	12	13	177

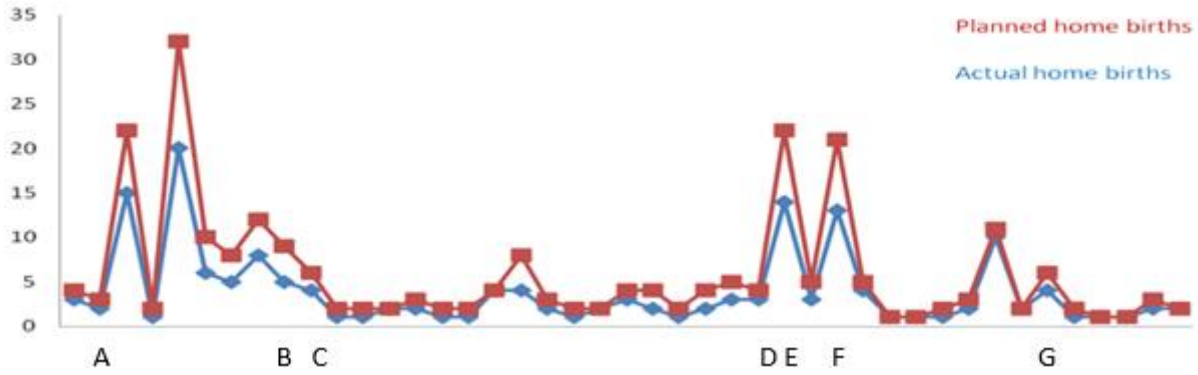
The frequency of planned home births being intended and also achieved:

Further variation occurred within the three DGH areas as the rates of PHB differed across postcode areas. The data showed that approximately twenty-five postcode areas, out of a total of sixty-eight across the health board jurisdiction, did not have any home births planned within them during 2010. In the remaining postcode areas twenty-eight had between one and five home births planned in them during 2010, eleven had between six and

nineteen home birth planned during this time period, and four had more than twenty. From the data collected as part of this audit, it is not possible for me to provide this data in terms of percentages [Table 13].

The majority of the postcodes areas had less achieved planned home births than were planned, as in only seven postcodes areas had all of the women who had planned a home birth been able to achieve this aim.

Figure 5. Graph to illustrate the numbers of planned and achieved home birth rates within the health board postcode areas in 2010. Where no home births were planned or achieved the postcode is absent (N = approximately 25). Letters A-G illustrate the location of the participant dyads across the health board



The seven observed birth planning meetings took place in seven different postcode areas, and these have been marked on the graph with the letter that corresponds to their participant pseudonyms. Each area had at least one home birth planned within this postcode region during 2010 – although this does not necessarily coincide with the local community midwifery team case load area.

The gravida and parity of the women who had intended to birth at home:

The audit data showed that the most common gravida and parity for the women who planned home births within the health board was gravida three para two. However, the range of the gravida status was from gravida one to gravida twelve, and the range of the women's parity was from para naught to para nine.

The majority of the women were multiparous, with only thirty-one women planning home births with their first pregnancy.

The relationship status of the women who had intended to birth at home:

Ninety-eight of the 161 women who planned a home birth were married, and a further five were reported to be cohabiting. Forty-four women were reported to be single. For a further twenty women the data was incomplete.

The type of the most recent birth that the women who had intended to birth at home had experienced:

With the exception of the women who were planning a home birth with their first pregnancy, all of the women planning home births had given birth vaginally in their most recent birth.

With consideration given to the definition of normal birth (Maternity Working Party, 2007), it was possible to note that seventy-five women had experienced normal births, eighteen had experienced spontaneous vaginal births and in the case of a further thirty women it was not possible from their notes to establish if they had experienced either a normal birth or spontaneous vaginal birth. A further thirteen women had experienced instrumental births – seven experiencing a ventouse birth, and four a forceps birth.

The location of the recent birth that the women who had intended to birth at home had experienced:

At the time of the audit there was no Alongside MLU available within the health board, but there were Freestanding MLUs available in areas 1 and 2. Ninety of the 138 multiparous women had given birth in an Obstetric Unit during their most recent birth, and forty-three of the women had most recently given birth at home. No women had birthed in a FSMLU in their most recent pregnancy.

The location of the first contact between a woman and her midwife:

The audit data demonstrates that the majority of first contacts were made in a primary care setting – 113 women were booked for their maternity care here, and thirty-four women were booked at home. There were twenty-two sets of missing data.

The number of midwives documenting care provision within the handheld notes:

Fourteen women who planned a home birth within the health board during 2010 received antenatal care from only one midwife. The thirty-six and thirty-five women respectively received care from three or four midwives, with eleven women receiving care from five midwives, and a further eleven from six midwives. Five women received care from seven midwives, and one woman was cared for by eight different midwives.

The frequency and timing of any references to home birth within the women's handheld notes that was documented by a midwife:

The audit data showed that on average women were documented to have discussed home birth with their midwife three times during their pregnancy, although this ranged from once to seven times.

The first time that a discussion was first documented was most commonly noted by fifteen weeks of gestation, although this ranged from six weeks to thirty-eight weeks.

The last time of discussion for most women was documented at around thirty-seven weeks gestation, although this ranged from ten weeks to forty-two weeks.

The recorded location of the 36 week birth plan visit:

Most birth plan visits for this cohort of women occurred at home. Ninety- six women had a home visit, and thirty-four women had their birth plan completed in a primary care facility. In thirty-nine cases the data was missing.

The sources of information that were listed as being provided by the midwife as part of the woman's birth planning meeting:

Ninety-five of the women's birth plans were completed in full with their handheld notes, and twelve were partially completed. A further twenty-two birth plans were blank within the notes, and in thirty cases the ability to record this information was missing.

In 129 cases the All Wales 'Your pathway through normal labour' leaflet (WAG, 2004) was documented as being provided during the birth plan visit. No other source of information or resources were documented as being used.

The following table states the findings arising from the descriptive statistical analysis of the case note audit data:

Table 14. Table to display the findings of the descriptive data analysis of the case note audit

Documented details	All planned home births (N=169)
Pregnancy demographics:	
Gravida (Median, range)	3 (1-12)
Parity (Median, range)	2 (0-9)
Place of recent birth experience:	
Home (No. births, %)	43 (25)
CLU (No. births, %)	91 (54)
No previous birth (No. births, %)	31 (18)
Missing data (No. births, %)	4 (2)
Type of most recent birth experienced:	
Normal birth	75
Spontaneous Vaginal Birth	18
Unknown NB or SVB	30
Ventouse	7
Forceps	4
No previous birth	31
Missing data	4

Marital status:	
Married	98
Cohabiting	5
Single	44
Other	2
Missing data	20
Location of booking / first contact	
Home	34
Primary care setting	113
Missing data	22
Number of midwives documenting in the notes	
1	14
2	0
3	36
4	35
5	11
6	5
7	5
8	1
Location of birth plan visit	
Home	96
Primary care setting	34
Missing data	39

Place of birth discussed: (median, range) Weeks gestation at first discussion Weeks gestation at last discussion No of times place of birth discussion documented	 15 (6-38) 37 (10-42) 3 (1-7)
Birth plan: Completed in full In part Blank Missing data	 95 12 22 30
Resources used during birth planning meeting: Normal Labour Pathway Leaflet Photographs Other	 129 0 0

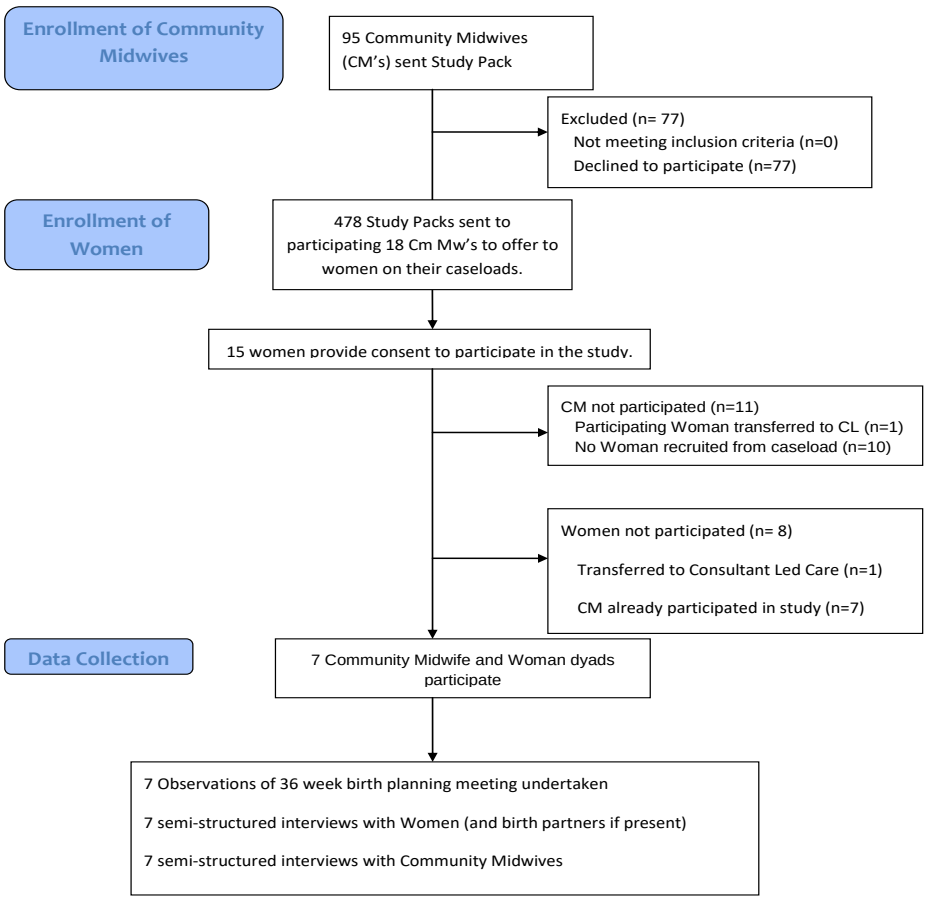
Observation and interviews:

Recruitment:

Eighteen of the health board's ninety-five community midwives consented to participate in the study, and they recruited fifteen women to the study.

Ultimately, as the result of one of the women being transferred to consultant led care, and a further seven women not being able to participate as their community midwife had already been observed providing care and interviewed for the study, seven community midwife and woman dyads participated. This process is outlined in figure 6:

Figure 6. The recruitment process for community midwife and women participants



Participant details:

Community midwife participants:

The area of practice for the community midwives encompassed the three areas of the health board.

All had extensive years of experience within community midwifery, as all had been in the role of community midwife for at least twenty years with the exception of one who had been in the role for nineteen years.

Six of the seven community midwives had attended more than five home births in the previous year, and one had not.

Woman participants:

Five of the women were experiencing their first pregnancy at gravida one para naught; and two women were multiparous at gravida two para one, and gravida three para two.

The ages of the women varied from twenty-two to forty-three, and all were married or cohabiting with the exception of one woman who was single.

Both of the multiparous women had experienced planned home births with their most recent births.

The women were mostly at 36/40 gestation, with the exception of one woman who was at 37/40+ 4.

Table 6. Participant demographics and observation details

Dyad Ref.	Woman					Community Midwife			Location of care and birth planning meeting	Others present during observation. (In addition to Cm Mw and Researcher)	Duration of observation	Interview with Woman, location as per Observation	Interview with Community Midwife, location at workplace
	G & P	Age	Marital Status	Prev. home birth	Gest.	Area of	Years in Community Midwife role	No. of home births in the year					
A	G1 P0	31	Married	/	37+4	3	27	<5	Home	Nil	43 mins	✓	✓
B	G1 P0	35	Cohab.	/	36	2	28	>5	MLU	Partner, WLSO	47 mins	✓	✓
C	G1 P0	26	Cohab.	/	36	3		>5	Home	Nil	34 mins	✓	✓
D	G1 P0	20	Cohab.	/	36+	1	>20	>5	Home	Partner and Student Midwife	48 mins	✓	✓
E	G2 P1	43	Cohab.	Yes	36	1	19	>5	Home	Student Midwife	47 mins	✓	✓
F	G3 P2	26	Single	Yes	36	1	22	>5	Home	Mother and Student Midwife, WSPO	30mins	✓	✓
G	G1 P0	22	Cohab.	/	36	1	23	>5	Clinic	Nil	15 mins	✓	✓

Observation – quantitative findings:

As stated above, the initial quantitative analysis of the birth planning observations was prompted by relevant questions asked of the audit data. These are presented below in a narrative form.

The location of the birth plan meetings:

For the two women planning home births, their birth planning meeting was conducted in their homes. This was also the case for women Ava, Chloe, and Daisy. Woman Gina had her birth plan conducted in her Community Midwife's clinic. The woman (Wm Briony) who was planning to use a FSMLU had her meeting held in the Unit as she and her partner had not seen there before. For most of the women this was the first occasion that a Community

Midwife had visited their houses, with the exception of those who had had home births previously (Wm Erica and Faye).

The birth plans were all conducted in similar environments. Where they took place in the woman's home (Wm Ava, Chloe, Daisy, Erica and Faye) both Community Midwife and woman sat on sofas in the lounge of the house. Where they took place in a health service setting (Wm Briony and Gina) Community Midwife and woman, and partner sat opposite each other on chairs.

Resources used within birth planning meetings:

Birth plans were completed within the handheld notes for all of the women who were not planning home births. In all cases the Community Midwives held the notes and in all but one occasion wrote in them – Mw Emma just used the note as a guide to their discussion, and advised Wm Erica to write a birth plan using the handheld notes proforma afterwards.

On four occasions a Community Midwife made reference to the leaflet 'Normal Pathway through Labour' to support their discussion about the process of labour (WAG, 2004).

One Community Midwife (Mw Bethan) completed a Health Board checklist to document that a full discussion of the potential risks of community birth (FSMLU and home) had been explained, when the Woman was planning birth in the FSMLU.

On one occasion a Community Midwife (Mw Davina) demonstrated how it is beneficial to stand up for the second stage of labour rather than lie semi-recumbent by explaining the comparative dimensions of the female pelvis in these two positions. This Community Midwife also used a set of three small balls to demonstrate the size of a newborn's stomach at three different points of age, and a doll to demonstrate recommended positions for breastfeeding. No other non-written props or discussion aides were evident in any of the birth planning visits although the Community Midwife (Mw Bethan) conducting the birth plan in the FSMLU briefly made reference to pieces of furniture in the room, and ascertained that the woman's antenatal class midwife had discussed use of a rocking chair and birth ball during the classes that the woman had attended.

Further quantitative analysis was undertaken in response to the topics addressed within the observation proforma:

Interaction style during birth planning meeting:

The proforma required observation of the way in which the dyad interacted during their discussions. The following table [15] illustrates as a percentage the amount of time that the service user participants were talking during the birth planning visit, versus the time that the community midwife was speaking.

The five nulliparous women all spoke for less than twenty-five percent of their birth planning visit, and the multiparous women spoke for between forty-five and fifty-five percent of the time.

The women who were planning to birth at home spoke for between forty-five and fifty-five percent of the time, and those who were planning to birth in a health board setting all spoke for less than twenty-five percent of the time.

Table 15. Time spent talking by the participants during the birth planning meetings

		% of time of birth planning meeting talking	
Dyad	Duration of birth plan observation	Woman (& partner)	Community Midwife
A	43 minutes	13%	87%
B	37 minutes	23%	77%
C	34 minutes	8%	92%
D	48 minutes	16%	84%
E	47 minutes	45%	55%
F	30 minutes	55%	45%
G	15 minutes	8%	92%

Subjects discussed:

The observation proforma also generated quantitative data around the topics that were discussed as part of the birth planning meeting. Consideration was given to the definition for normal labour provided within by the Maternity Care Working Party (2007) and the data analysed in terms of no birth intervention being discussed at this time, an intervention considered compatible with normal birth being considered, and an intervention not considered to be compatible with normal birth being discussed.

The following table [16] illustrates this a percentage the amount of time spent during the birth planning visits:

Table 16. Table to illustrate the content of the observed birth planning meeting discussions by intended birth location, as a percentage of the total time. Interventions as per the Maternity Care Working Party (2007)

	% of birth planning meeting discussing:		
Planned birth place	No intervention	'Normal' intervention	'Non-normal' intervention
Home	92	8	0
All MLUs	85	12	3
OU	80	11	9
Community (Home & FSMLU)	87	12	1
All DGH (AMLU & OU)	81	11	8

Birth planning meetings in this sample were more 'normality' focused amongst this sample of low risk women, when birth was planned to occur at home and within a community setting.

Thematic findings:

The chapter now moves to discuss the key study findings that have arisen from the thematic analysis of the observation and interview data. During the presentation, reference will be made to the quantitative findings from the case note audit and the birth planning meeting observations in the way that is highlighted in table 12.

While similarities could be drawn between many aspects of the seven women's experiences of antenatal care and their birth planning visit, all of their experiences in terms of their own prior exposures to home birth, their interactions with their Community Midwife during pregnancy, and the impact of their birth planning visit were unique to them. This supports Coxon's statement (2012) that the factors influencing a woman's birth place choice are complex and multi-faceted.

As discussed above, the following inter-related themes emerged during data analysis:

Fragmented antenatal care provision

Informed choice around home birth and place of birth

The visibility of planned home birth

Normal birth and planned home birth – a chicken and egg situation?

Fragmented antenatal care provision:

This theme considers the potential impact on the ability of a woman to give birth at home in relation to several factors related to her antenatal care. These include continuity of care, and the way that conversations about birth and about birth place choices that include planned home birth were conducted during the antenatal period between woman and community midwife; and the way that antenatal classes were used within routine antenatal care provision to provide information and discussion opportunities about birth and place of birth including planned home birth.

Continuity of care in the antenatal period:

All of the women participants in this study had received high levels of antenatal continuity of care in terms of care provision during their routine antenatal appointments from their named Community Midwives. Only a few appointments had been conducted by other

Community Midwives, and these were all reported to have been by members of their own particular community teams.

Continuity of care appeared to be an important aspect of care provision for the community midwives, as all spoke positively about providing high levels of antenatal care to the women in their caseload:

> 'Continuity of care is still happening for the women in [name of town]…at least for the time being' (Mw Grace - interview)

The case notes audit found that the majority of the women who had planned home birth within the health board has seen three or more midwives during their antenatal care, so this sample of women were receiving care that is more in-line with the aims of current maternity policy than the women included within the audit.

Conversations about birth and about birth place choices that include planned home birth conducted during the antenatal period between woman and Community Midwife:

However, despite this being achieved and recognised positively by the women participants who welcomed the fact that aspects of their care requirements did not need to be retold at their antenatal appointments, this level of continuity did not appear to have translated into frequent discussions about planned home birth, or labour and birth in general. This was acknowledged by many of the Community Midwives, who noted that antenatal classes served to provide this input to women:

> '…it's not like we talk about that all the time - they've been to antenatal classes' (Mw Carole - interview).

This perspective was supported by several of the women:

> 'Wm Daisy: … like we said, this our first time [birth planning visit] we've actually specifically spoken about labour or birth with Mw Davina, so…
>
> Partner Daniel: over the many times we've seen her it's check-ups and general talks about, we haven't talked about labour and what's going to happen' (Wm and Partner D – interview)

Therefore, although a level of discussion around topics aside from the physical and medical aspects of a woman's developing pregnancy, such as brief discussions about the demands of

their day to day lives at work or study, and at home was present within the routine care, little discussion about possible birth planning or birth place choices had occurred between the dyads who were not intending to birth at home throughout the antenatal period.

Perceptions of the Community Midwifery role:

When discussing the role that their community midwife had undertaken throughout their pregnancies, the women frequently referred to components of the routine antenatal check:

> '…obviously we haven't gone through the birth plan before, but the rest of it in terms of blood pressure and feeling my stomach are quite normal' (Woman Ava – interview)
>
> 'No, I mean, when you go to the clinic it's just clinic and you're in and out and you've heard baby' (Woman Chloe – interview)
>
> '…over the many times we've seen her it's check-ups and general talks about, we haven't talked about labour and what's going to happen' (Partner Daniel – interview)

However, the women planning home births both volunteered their confidence in their Community Midwife's ability to care for them in labour, and this was also stated by Woman Briony in terms of how her Community Midwife had demonstrated her clinical competence during her antenatal care. It is interesting to note that it was within Dyad B's birth planning meeting that the Community Midwife most discussed her, and her team's training and experience in intrapartum care provision.

The possible result of this is illustrated below:

> 'She's very good at putting me at my ease and giving me confidence…the level of care she's given me has given me a lot of faith in her'(Wm Briony - interview)

Location of discussion of PHB during pregnancy:

Amongst the women not planning home births, antenatal classes were recalled to have been the venue where most had engaged in the majority of their home birth related discussion and information provision:

> ‘It’s been the same amount of time has been dedicated to home birth during the classes as any other option’ (Wm Briony - interview)
>
> ‘The first one [AN class] was teaching your child to bring it up bilingually so something, and then I can’t remember much of it (laughs), and the Labour Ward one I remember, because we got shown round’ (Wm Gina – interview)
>
> ‘…it [planned home birth] wasn’t a big part or anything in depth, it was more just touched on’ (Wm Ava - interview).

However, as can be noted from the above quotations, the extent of this discussion varied depending on the class that the women attended. During the antenatal period, the two processes (routine appointments, and antenatal classes) had seemed to be viewed as separate processes by both members of the dyad as neither recalled discussing the content of classes within their antenatal appointments. Additionally, as occurred in this example, this was also not always clarified during the later birth planning meeting:

> ‘Mw Anna: … So we’ll just go through all these things and I’m sure, like you say that they’ve gone through everything in ***, but we’ll just make sure….So, we know we’re going to hospital to have the baby, don’t we, yeah?’ (Mw Anna – observation)

Therefore, this situation appeared to result in the strictly clinical tasks of monitoring a woman’s pregnancy being undertaken within their Dyads, and meant that if the class facilitated it, the more personal learning and discussion about birth took place outside of this relationship:

> ‘…when I see [Mw Bethan], it’s purely a medical thing, it’s not really to discuss, or I didn’t feel like I need to discuss, well if I have questions I ask her’ (Wm Briony – interview)

As illustrated above, this was not reported to have been experienced negatively by the women participants, as they felt satisfied that enough information about labour and birth had been included in the antenatal classes that they had attended, although this may reflect the lack of expectation that the women participants held. However, an impact of this model of care provision was that birth place decisions were finalised within the dyad when this had not been the forum for such discussions throughout pregnancy. This is illustrated by the

following quote where the community midwife aims to qualify that a woman has been suitably prepared for making her decision:

> ‘Mw Davina: …and what are your thoughts about where to have your baby?
>
> Wm Daisy: Hospital
>
> Mw Davina: Yeah, definite? Have you read the information about the choices? Because you’ve been low risk all the way through the choice would be to have your baby at home or to have your baby in hospital. [Taking blood pressure]
>
> Wm Daisy: Yeah, hospital.’ (Dyad D – observation)

From the position of an observer, the non-home birth planning dyads style of communication was shallow. As seen in the above observation quotations, the Community Midwife would often raise a topic, suggest that the woman already had sufficient knowledge or talk quickly about it, and then move on to the next topic. As a consequent, often no in-depth conversation about birth had taken place between the dyad by the completion of the birth planning meeting:

> ‘And then you’ve got your signs of labour….you’re OK with that? Yeah?’ (Mw Anna - observation)

In contrast, the care that the multiparous women planning home birth (Wm Erica and Faye) received appeared to have been less fragmented. Neither of the women were attending antenatal classes and so their Community Midwives were providing all of the information about birth, and planned home birth that they required personally:

> ‘Wm Erica ‘I am feeling quite a lot tightenings’
>
> Mw Emma ‘That’s a good thing, that’s your body preparing the cervix, so yes, you look as though you are doing everything right’ (Dyad E – observation)

In particular, this observation alluded to the ongoing process of birth planning within this Dyad, as reference was made to previous conversations and experiences, and future conversations. Within the birth planning visits with these women there appeared to be less pressure placed on the Community Midwives to ‘cover everything’ and the interactions seemed more a continuation of a longitudinal experience:

> Mw Emma 'With water birth we like a meter of clearance right around so we access you from any position, so we've discussed that you are going to make sure there is space all the way around' (Dyad E – observation)

> Mw Fern: We'll sort directions out afterwards; so would you be planning, it's the back room that you'll usually in, isn't it, so that's what you're planning, on being in the back room again?
>
> Wm Faye: Not the same sofa but yeah (laughs) (Dyad F – observation)

The impact, and therefore potential importance, of the contrasting experiences of fragmented or non-fragmented antenatal care provision was seen in the quantitative observation data concerning the way in which the pattern of interaction occurred between the seven different Dyads [Table 15]. The findings suggest that the two women planning home births experienced a more natural conversation style during their birth planning meetings than did those women who were not planning home births as they both shared approximately half of the conversation time with their Community Midwives.

In their interviews, as reflected in an earlier quotation (Mw Carole – interview), the Community Midwives did not appear to reflect upon this model of care provision as having any possible detrimental impact on the effectiveness of the birth planning visits, and appeared positive about the role of the birth planning visit within antenatal care provision:

> Res: So what do you feel the purpose of the birth plan visit is?
>
> Mw Davina: For me, it's to find out what the women wants, if she's looked at all her options, if she's clear about what they are, if she knows about the evidence behind it as well, and that she's happy with her choice and comfortable with her choice; it's her birth and that she does it somewhere that she feels is right for her, and safe for her… (Mw Davina – interview)

Additionally, other than by Mw Grace who stated that she knew she did not promote home birth as effectively as she could do, there was little acknowledgement about opportunities to improve the way that women were currently being asked to make birth place choices and

decisions about the option of home birth. This will be discussed later in the theme considering the 'visibility' of planned home birth.

To conclude, it appears that the aspiration of providing continuity of antenatal care, in terms of the building of a midwife-woman relationship that will provide support to her during her forthcoming labour and birth experience was not being fulfilled in this sample. Amongst many of the dyads in this sample, a relationship of emotional trust and comfort does not seem to have been developed and it was not possible for this atmosphere to instantly be created. I felt that a few of the Community Midwives were conscious of this fact and hoped to be able to go some way to generating this atmosphere, but I did not feel that they were ultimately successful as little discussion of any depth took place. Instead, as the above quotes suggests, where women were not planning home births their routine antenatal care appears to have been absent of birth related discussions, and their birth plan discussions appeared to be a one-off opportunity to cover a range of birth related eventualities. This seemed to result in a few of the Community Midwives appearing to find the demands of covering every birth situation listed within the pro-forma birth plan difficult to include within the available time frame.

One of the women's partners stated to me:

> 'It's not that we weren't listening to [Mw Davina], it's just that we already knew what she was telling us from attending the antenatal classes' (Pt Daniel - interview)

It may be that facilitating greater discussion of birth and home birth to occur within a Community Midwife-woman dyad could help to better facilitate women's consideration of planned home birth.

Informed choice about planned home birth:

This theme is concerned with how the women had made their decision on if they wished to give birth at home, or elsewhere. It involves consideration of the discussions that were held during their pregnancy, and the information that was given to them or available to them.

Information provision and discussion:

The women often reported that the option of home birth had been made to them at the start of their pregnancies:

> 'I think she talked about it and gave us all the options…not in depth, but more like 'If it's a low risk, you can have a home birth' (Wm Davina - interview)

However, this was not always the case as one woman could not recall home birth ever being discussed within their dyad:

> 'We've talked about where initially, obviously in terms of which hospital…' (Wm Ava – interview)

And a second recalled it being mentioned once she reached 34 weeks of pregnancy:

> '…about 2 weeks ago, she went through it' (Wm Gina – interview)

For the women planning home birth, they recalled discussing this within their dyads at the start of their pregnancies:

> 'When she came just before the dating scan, after you confirm with the doctor that you're pregnant, she comes a couple of days later and it's then she asks 'What are you planning to do?' and I say 'The same as before – home birth' (Wm Faye – interview)

Sources of information:

As discussed above in the theme exploring 'fragmentation of care', for the majority of women the main source of health professional provided information about home birth had been received via their antenatal classes, but that this had not appeared to have been integrated into their antenatal appointments. Therefore, for the women not planning home births, their birth planning meetings appeared to be the first time that the opportunity for information provision from their named midwives occurred since the start of pregnancy.

Reference to prior discussion about home birth at the start of pregnancy was made in several of the birth planning visits:

> '… you've had one of these at the beginning haven't you, do you remember (shows leaflet)….somewhere in your pack' (Mw Carole – observation)

It was interesting to note that leaflets were viewed by midwives as providing useful information to women, but from a woman's perspective this may not be the case:

> 'I wasn't sure, I'd heard about the home from home in *** but I'd never been spoken to about it, so I thought it was for specific people' (Wm Chloe – interview)

During their interviews, the Community Midwives discussed the way in which they would routinely discuss home birth, stating that it was their common practice to briefly raise the possibility of choosing home birth with low risk women during their initial consultation when they were about 12 weeks pregnant, and then to mention this choice again at their birth planning meetings between 34 and 36 weeks gestation:

> '…and then around 34-36 weeks, before 36 weeks really, we get them, 'What are your thoughts now, about where you'd like to have your baby?' (Mw Emma - interview)

At this point the women could be provided with Health Board leaflets about home birth:

> '…maybe later on in the pregnancy if things are going well I mention it again, and then offer to give them the 'Thinking About Home Birth', or, if they are fairly certain the 'Having a Home Birth' leaflet…' (Mw Fern - interview).

Mw Davina also stated that she encourages women to take an active part in the decision making process:

> '…read up about it, look at the evidence, see what you think' (Mw Davina – interview)

Most of the women did talk about the way that they had sourced information themselves during pregnancy – although aside from Wm Erica planning a home birth, this was not specifically related to home birth:

> 'I have been reading some baby books, I think I've been reading on the internet, reading up what other mums have written I suppose to see what it's like in real life, rather than specialist books. I'm feeling prepared' (Wm Briony – interview)

> 'I've spoken to my Mum' (Wm Gina – interview)

> 'I haven't read so this much this time, just going over favourite paragraphs in this book' (Wm Erica – interview)

Clarification of thoughts and plans during birth planning meetings:

After the birth planning meetings when the interviews were conducted, numerous gaps still existed in many of the participants knowledge of planned home birth, as several of the women felt or made apparent that they lacked knowledge about routine planned home birth care such as analgesia availability, equipment use and provision, birth location, and the exact details about which professionals would provide care to them:

> Wm Ava: 'I presume you would need to go in if you wanted an epidural, but other than that, I don't know… I did think, 'Well if you were at home, would they bring a bed or what would happen (laughs)?' Or where would you be?' I don't know. So no, I haven't got a clue." (Wm Ava – interview)

> 'Res: So no-one has gone through with you how a home birth is undertaken then?
>
> Wm Chloe: No. I only know from what I've seen on the TV' (Wm Chloe – interview)

As illustrated above, during the observed birth planning visits, the way in which the midwives clarified the women's rational for their intended birth place did not always clarify the reasons why they were not planning to birth at home, and on one occasion appeared to support the myths of home birth being unsafe…

> 'Is that because it's [OU] safer [than home birth]? (Mw Davina - observation)

And going to potentially cause damage to their rental accommodation:

> 'You don't want mess the carpet up!' (Mw Davina – observation)

This comment on the one hand served to reassure the couple that their Community Midwife understood that they did not wish to consider a home birth, but her later attempts to ascertain that the woman has actually made a choice based upon evidence, were in contrast with this reference to the stereotypical view of birth at home. While research findings were referred to, this was done in a way that did not invite or expect to create further discussion.

However, clarification of birth place rational that included home birth was seen within Dyad B when the Community Midwife, whilst discussing the routine home visit in early labour that staff covering the FSMLU provide, checked with the couple that:

> ‘You know everything you can have here [at the FSMLU] you can have at home?’ (Mw Bethan - observation)

This woman (Wm Briony) talked with her Community Midwife about her preference for the FSMLU, which centred on the benefits of its accommodation in terms of bathing and location of the bathroom, over that of her own home, and preference to have space from her dogs and her family. The birth planning meeting also contained discussion of the specific resuscitation equipment that the Community Midwives bring to a home and the FSMLU, and the community management and treatment of specific obstetric emergencies and related intrapartum and neonatal reasons for transfer to the OU:

> ‘We have training drills all the time to deal with that. It’s that same machine as they use in [name of DGH], just that it’s stuck in the wall and you can see it, we’ve just got a little one. So we set all that up here just in case every time, and the same kit goes home if you want to stay at home’ (Mw Bethan – observation)

The Community Midwife followed the NICE Intrapartum Care guidance (NICE, 2007) in terms of informing the couple that the distance to OU may cause an outcome to be less positive than if it occurred in an OU, but also placed this into the context of the FSMLU saying that the complications are less frequent because of the way the FSMLU surroundings support normal labour and birth:

> ‘ Like I said it doesn’t happen that often, but it happens more in the hospital because more women give birth on their backs, and it happens more often if it’s a forceps delivery because they have to pull the head out and the shoulders don’t get time to turn’ (Mw Bethan – observation)

This style of clarification was present within the discussions of Dyads E and F, who also discussed the process of care during a pool birth in the event of obstetric emergency:

> ‘It rarely happens but it’s nice that we’ve discussed it beforehand, that you know that you might need to come out on some occasions. If we think there’s a lot of blood or something… and when the baby comes, when the head appears, if the body doesn’t come out with the next contraction, again we’ll ask you to come out of the water. It rarely happens but just letting you know it can happen’ (Mw Emma – observation)

Achieved informed choice or decision?

> Researcher: “Do you feel that you have made an informed choice about planned home birth?”
>
> Wm Ava: “No, I don’t think I’ve made an informed choice.” (Wm Ava – interview)

As this quotation illustrates, the application of the concept of informed choice in terms of birth place decision was not always achieved amongst this sample of women. Despite the importance placed on it by current maternity policy, it was mostly absent in the observed and reported experiences of the women participants who were planning to give birth away from their homes. Only women Erica and Faye who were planning home births, and woman Briony who was planning birth in an FSMLU appeared to have consciously considered the choice of PHB alongside the other locations that they had available to them, and made informed choices based upon their own experiential and social knowledge bases and the knowledge that they had obtained during pregnancy from their community midwifery team. For woman Briony, while she had decided to plan her birth in the FSMLU it was apparent from their birth planning discussions that the option of home birth, in addition to hospital options, remained open to her:

> ‘…when you go into labour it’s still up to where you want to be, and that means you can change your mind if you decide to stay at home, it’s fine to do that’ (Mw Bethan – observation)

The other women (Wm Ava, Chloe, Daisy and Gina) had not reached a point in their decision making experiences where they had felt that their home was a potential birth location that needed to be considered to the extent that they wished to discuss this with their community midwife. Woman Daisy was knowledgeable in terms of the findings of the Birthplace in England study (Birthplace in England Collaborative Group, 2011) about the safety reasons in terms of transfer and neonatal outcome. However, despite the fact that it had been suggested to her that home births were undertaken in an professional manner, the fact that during her interview she said ‘I guess they don’t turn up and ask if you’ve got ‘such and such’ in your kitchen’ (Wm Daisy - interview) belied her underlying view that home birth was not a serious location for her to consider. Woman Chloe had not considered home birth because her partner would not support this option, and this was also briefly referred to during her birth planning meeting:

Mw Carole: 'How does [partner] feel about things, have you had a chat with him?

Wm Chloe: As long as it doesn't happen at home it's fine (laughs).

Mw Carole: (Laughs) He's not keen on it happening at home.

Wm Chloe: I think he just feels safer at hospital. So, I think he would more opt for the midwifery unit… (Dyad C – observation)

While, although briefly, the reasons that women Chloe and Daisy were not choosing to birth at home were stated, the other women planning institutional births (OU or AMLU) were less likely to discuss their reasons with their Community Midwife. Reasoning was not raised at all during the birth planning discussions for women Ava and Gina. Woman Ava later reported in her interview that she had not considered a home birth at all and had always thought she would give birth in hospital. Woman Gina told me that she had chosen a DGH birth based on her belief that this was safer for a first birth and the possible need to transfer in labour.

Other than within Dyad B's meeting to plan a community birth no Health Board documentation was completed to confirm that the risks and benefits of chosen birth locations had been discussed. However, Community Midwife Davina, in her interview with me, spoke about how the Health Board was introducing the completion of risk forms when a woman chooses a community birth location (home or FSMLU) into practice across the whole Health Board. She commented that low risk women were not asked to sign that they have been informed of their increased risk of caesarean section by attending an OU setting.

This approach ties in with the attitude to informed choice that was given by Community Midwife Carole:

'…if anybody wants one, I'll always support them, so long as they know all the benefits and risks and everything then that's up to them to make that decision...' (Mw Carole - interview)

This statement, while it contains reference to the Community Midwife's belief in the benefits as well as risks to home birth, could be interpreted to rely on a woman to have become interested in having a home birth, and that a midwife's role is then to clarify her knowledge about her chosen option. This approach was also illustrated by Midwife Grace when she stated:

> '…the ladies that say 'I would like the baby to be born at home' at that point, I actively support, so I hold my hands up and say I don't actively encourage everyone to have a home birth…' (Mw Grace – interview)

These Community Midwives were aware that their approaches are not examples of best practice, and Community Midwife Carole suggested that further discussion about home birth was tailored according to the initial response to home birth that a woman made at her booking visit:

> 'I don't know maybe I shouldn't say that, but I think you've got an idea – like sometimes, when you book them you give them the choices of where they'll be able to deliver, and sometimes you'll get vibes of 'Ohh, gosh no', and sometimes they'll say 'Ohh yeah, I hadn't thought about that' (Mw Carole - interview)

This honest account of a Community Midwives practice could potentially result in a woman's knowledge of home birth remaining on a minimal level throughout her pregnancy if she did not reacted positively towards the reference to home birth. However, despite this lack of informed decision making, each of the women had been content with their experience of birth place decision making. No participant mentioned that they felt that had wished for a greater input about planned home birth within their antenatal care, or that they had expected to make a decision about place of birth that included planned home birth – although woman Ava, after discussing home birth during her interview stated:

> '…maybe if I'd have thought about it a bit earlier on to get my head round it and think about it a bit more, than it might have been more that I'd have, it might have influenced it a bit more… The practicalities of how it would actually work, I think that would make me decide more how I felt about it' (Wm Ava – interview)

The observation and interviewing process allowed consideration of how confident and effective community midwives are at ensuring that women are aware of their option to birth at home. This was illustrated by a disparity in the way that Community Midwife Anna stated that:

> 'Everyone is singing from the same hymn sheet, pushing for home births'. (Cm Mw Anna - interview)

Whilst the differing viewpoint on her experience of how home birth had been included within her antenatal care was provided by woman Ava:

> 'I haven't really discussed it with [Mw Anna] or the other midwife [AN class midwife] that we saw to know what their feelings would be….the midwife who did the class…I think she spoke in a positive way about it, how it can be positive, so maybe she's for them, I don't know. But I haven't had a conversation with anybody else' (Wm Ava – interview)

This point was also illustrated by Community Midwife Bethan in her interview where she discussed the way that a new midwife had recently joined her team:

> 'We've had a new member of staff that's come from another team, and that caseload's community birth rate has gone down and I did bring that up with her in her PDR, and she was saying 'I do promote it', and I've heard her promote it, but it's more than just saying 'This is your choice', it's about drip feeding all the time, about, you don't have to try and persuade them, because that's what her view was 'I don't want to try and badger them' (Mw Bethan – interview)

To conclude this theme, several of the Community Midwives in this study were unsuccessful in demonstrating to women the importance of making an informed decision about the choice of a home birth. This served to retain the status quo seen within the audit figures [Figure 5] in terms of the number of women cared for within the Health Board that decide to birth in institutional locations. This includes MLUs (AMLU and FSMLU), in addition to OUs, as in this study, where the women had the option of planning an MLU birth (either AMLU or FSMLU) this option was being chosen (Wm Briony and Chloe). Findings suggest that for some midwives, a lack of clarity about how to effectively offer home birth may be impacting on the way women in their caseloads are able to make informed choices about birthing at home.

Visibility

This theme considers the extent to which home birth was visible to the women participants, and how the way in which this birth place option was visible to them appeared to affect the way that they were able to consider home birth for themselves.

Planned home birth within their social world:

For each woman in this study, the way that home birth was visible to them at the start of them pregnancy was individual to them, and differed from that of the other participants as a result of their own previous birth experiences, and the experiences and information provision of members of their social networks.

Prior to their current pregnancy, the women who were choosing to give birth at home had already experienced their own home births (Wm Erica and Faye) – fitting with the audit findings that approximately one quarter of the women who gave birth during 2010 had given birth to their previous child at home. Additionally, one (Wm Erica) was aware of many other successful home births in her area, and this appeared to have been a powerful and beneficial experience for her:

> 'The more that you talk about it with people, the more you learn how many people do it now; it's so good to hear. I know a girl through work and we started talking about how we gave birth, and she's on her fourth pregnancy now, and all the previous three were born at home and kids were there, and those type of stories give you heart I think' (Woman Erica – interview)

Of the other women, two of them (Wm Ava and Briony) mentioned that they knew of one other couple who had had a home birth, but it was apparent that one woman felt that she did not know enough detail about the birth for it to encourage her to choose a home birth:

> '…I didn't know them at the time they had the baby' (Wm Ava - interview).

For the other woman, the individual circumstances around the home birth she had heard of did not match her own situation, and therefore did not influence to choose home birth:

> '...[it] was with her third child, and I think she said she felt more confident' (Wm Briony - interview).

The remaining women did not know of anyone who had had a planned home birth and assumed that was because they were not being chosen locally and only occur unplanned:

> 'I've not heard of many home births but whether it's because it's not a big thing around here I don't know…I've heard of it happening but only because they couldn't get to the hospital on time' (Wm Chloe - interview)

None of the women had heard of government targets to increase the home birth rate in Wales (Welsh Assembly Government, 2002), although one was aware of the WAG target to increase breastfeeding rates (Wm Briony). This may be because of the different ways in which these two policies have been publicised across Wales.

A general lack of awareness about home birth amongst maternity service users was referred to by Partner Daniel and Wm Daisy, who saw this as the reason for the overt focus on home birth within their antenatal classes:

> Partner Daniel: 'They did put a big focus on it to try and influence people to think about it more, rather than thinking straight for hospital…'
>
> Woman Daisy: 'I think most people just think automatically hospital don't they, they have to push the home birth side to get you to think about, whereas they don't have to push the hospital side' (Dyad D – interview)

However, this approach was not felt by the couple to have been beneficial to aiding their decision making:

> 'I'd rather just be given all the information and make the decision myself' (Wm Daisy – interview)

Planned home birth within antenatal care provision:

The Community Midwives also often shared their view that home birth as an option is less well known to women than other birth place options. Where this was acknowledged, they also made reference to the way that they aimed to address this within their practice:

> '…a lot of women don't realise if it's a first pregnancy that the option is actually there, so I usually just let them know that the option is there' (Mw Fern – interview)
>
> 'We talk about the positive home births that we've had, and they always know if we've been at a home birth because we're late, or 'Sorry I'm really tired, I've been at a home birth, beautiful baby', you know try and give a bit of normality to it as well' (Mw Davina – interview)

However, despite the intention to assist women to consider home birth as an option, this approach does not appear to have been successful within the dyads where the women were not planning to birth at home, because, as noted earlier in this chapter, many reported that

their antenatal appointments had not included reference to home births. Therefore, in relation to encouraging women to consider home birth for themselves, this finding suggests that this approach may need to be combined with additional approaches in order to achieve this aim.

The visibility of professional support for home birth:

All of the community midwives in this study stated that they felt positive and supportive of home births. However, two of them (Mw Carole and Grace), as noted above, acknowledge that they do not 'actively encourage' women to birth at home – but that their practice was to support women in their choice if they independently decide to birth at home. This may provide some explanation for the fact that woman Gina responded that she did not have 'any idea' of her midwife's view of home birth, and that woman Chloe stated:

> 'I don't know… I think the one you choose they then discuss to you, I think that's all it is really' (Wm Chloe – interview)

Conversely, when asked about her perception of how her community midwife had felt about home birth, woman Erica responded that her positive feelings, and visible demonstration of professional support had given her, and her partner the strength to support her wish to give birth at home:

> '…positive…straight from the word go….without the positive attitude and the support then I would have gone down the same path as everyone else I think' (Wm Erica - interview).

This mirrors with this midwife's description of home birth as the:

> '…icing on the cake' (Mw Emma – interview)

For this woman, who had experienced a Community Midwife that she did not know attending her first birth, it was also beneficial to feel the support of her own Community Midwife's colleagues:

> 'it's so good having a team of midwives who don't see it as a weird thing to do…their attitude to giving birth at home is fabulous' (Wm Erica - interview)

However, as I note in my personal reflection [pg. 51], and from the interviews that were conducted with the midwives where this was expressed, the enthusiasm and experience that

several of the community midwife participants to have does not appear to have been apparent to the women they were caring for. While the women reported that they felt that they would be, or were, supported in choosing a home birth, this appeared to be a reflection of professional requirement rather than professional interest and commitment:

> 'I think particularly [Mw Davina], she never really, she encourages you to do whatever…' (Wm Daisy – interview)

> 'I think she goes by your notes and things, and your feelings, and just the person herself; if they think that everything's, if you feel comfortable, then she's not going to turn around and say…' (Wm Faye – interview)

My personal experience was supported within the midwives' interviews where Community Midwife Davina stated that 'home births are the best part of the job' and she and her team are always 'delighted if somebody chooses to have a home birth', and Community Midwife Fern when she shared her and her colleagues' commitment to attending home births:

> 'I think we all love doing home births, and you know, in an ideal world all Community Midwives would love, but we're all different characters, some of us are more nervous than others' (Mw Fern – interview)

A disparity was also generated within Dyad B during the data collection process. As illustrated with the quotations throughout the chapter, woman B's birth planning meeting had contained detailed reference to the option of home birth in addition to the care provision in the FSMLU, and this is reflected in the following quotes:

> 'Wm Briony: I don't think I've got any vibes really. P Bill: I think [AN Class Mw], and [Mw Bethan] from what I've seen today, have been quite open about that as an option haven't they? (Woman indicates yes). Quite happy for it to be an option for us. Wm Briony: I don't feel like it would a massive inconvenience for them, I don't get that impression at all, I feel quite confident that they'll support me if I do want a home birth' (Woman and Partner B – interview)

However, in her interview Community Midwife Bethan described her commitment to community birth and the way that it led her to set up the FSMLU where her team were based, and the importance she places on ensuring that all women being able to make informed choices and decisions about where they give birth:

> ‘I tell all women about their choices of home birth. I give everybody the leaflet (indicates place of birth choices leaflet) and tell them, and then say, if the woman is a previous section, I say ‘This is what is on offer, but in your case I would advise you to go to hospital because that’s the safest place’, but I tell them, absolutely, same as everybody’ (Mw Bethan – interview)

Despite an understanding of the influence of societal birthing norms and being positive about home births, many of the Community Midwives discussed their practice of only providing home birth information leaflets to women who demonstrated their interest in their option. However, this was questioned by several (Mw Davina, Emma and Fern) during their interviews as perhaps limiting a woman’s ability to consider home birth, although this approach was supported by the then NICE Guidance (NICE, 2007).

Additionally, it was accepted by the Community Midwives that any formal discussion of home birth was only routinely included at booking, and then the birth planning meeting – leaving a duration of twenty-two weeks where no reference to home birth occurred. In the case note audit, home birth discussions were documented by midwives caring for the women planning home births an average of three times, which suggests the benefit of more frequent discussions throughout pregnancy. The fact that the Health Board did not appear to be concerned with working to increase the rates of planned home birth was reflected upon by two of the Community Midwives, and so this gap in prescribed discussion points is not questioned in clinical practice:

> ‘…I don’t think management are for it [PHB] either, they talk the talk and say ‘This is what we need to do’, but you need to get midwives to do it.’ (Mw Bethan – interview)

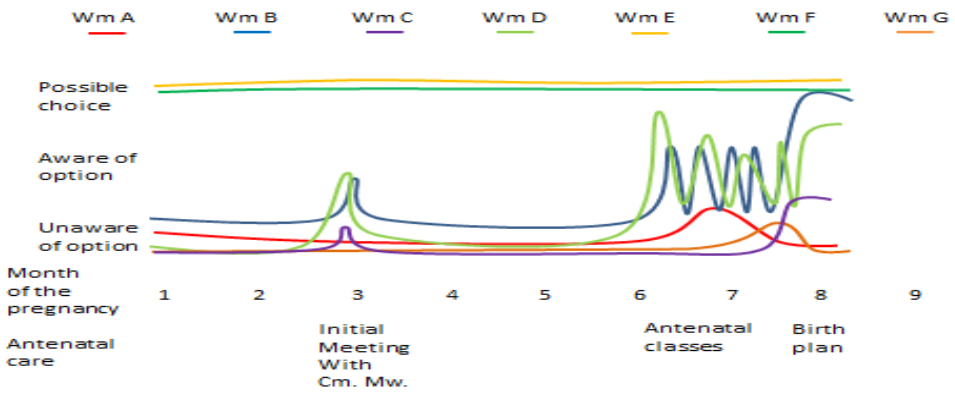
> ‘it’s heart breaking to tell these women one thing and then turn up on the day and say ‘look I’m sorry, there’s no staff’, to tell someone you haven’t got time to sit with them, it is tragic really. And there was another one following that as well, when we couldn’t scramble enough staff to do it’ (Mw Grace – interview)

Planned home birth by 36/40:

The illustration below [Figure 7] demonstrates how for most of the women (Wm Ava, Briony, Chloe, Daisy and Grace), my analysis of their perception of care was that planned home birth

visibility was raised slightly at their booking visit, and that they did not then receive any input that increased the visibility of planned home birth during their second trimester of pregnancy. The responsibility of education about home birth appears to have been left to them, without the clear suggestion that this is an important part of their antenatal decision making, and within their individual social contexts that possibly would not support this learning.

Figure 7. Illustration of the levels of home birth visibility experienced by the women participants



Attendance at antenatal classes did increase the visibility of planned home birth, but does not, with the exception of woman Briony, appear to have done so sufficiently enough for them to have made informed choices about this option as the topic was often discussed minimally and did not initiate discussion about home birth outside of the classroom. The observed birth plan meetings continued the same level of visibility for these women; with the exception of woman Briony whose plan to give birth in the FSMLU appeared to facilitate further detailed discussion of routine PHB care. The use of the term 'high levels of home birth visibility' within this analysis is not, therefore synonymous with the belief that the offer of home birth would never be declined once a woman has an adequate level of visibility. Instead, it suggests that giving attention to the level of home birth visibility within antenatal care means that women with a sufficiently high level of home birth visibility could then decline home birth from a fully informed position.

Discussions with the women during their interviews indicate that it may be more beneficial to ensure that home birth visibility is increased prior to the third trimester of pregnancy in order to allow women to re-evaluate their view of birth, and the possibility of choosing to give birth at home:

> ‘I think now, at this stage, I’d probably just stick with going in to hospital. Maybe if I’d thought about it a bit earlier to get my head round it…’ (Wm Ava - interview)

In conclusion, even where a midwife felt that she was providing reference to home birth on frequent occasions, these were not registered by the women participants. This analysis also demonstrates that where women have had home birth suggested by their Community Midwives, in addition to their support, the continued requirement or benefit of support from the social network for the option of home birth is also important. Woman Faye in this study had the strong support of her mother and also lived in a postcode area that was shown within the home birth audit to have one of the highest home birth rates in the Health Board. The Community Midwives caring for woman Faye in her previous pregnancy had increased the visibility of home birth by discussing in such a way as to make it appear to be a viable option for her to choose – in particular with reference to her precipitate labour. The need to consider visibility within home birth decision making compared to other birth locations is potentially greater because of home births social positioning as an alternative birth location and the associated negative stereotypical positioning of home birth within the media. In this study, the visibility of potential negative consequences of home birth was high for the women planning birth in DGH facilities, and the visibility of any benefits seemed low.

In relation to home birth visibility, it could be considered that midwives clearly discussing their professional opinions on the benefits and positive aspects of home birth with women might be beneficial – regardless of where a woman is considering or planning to give birth.

Normal birth and planned home birth – a chicken and egg situation:

This theme considers the relationship between a woman’s knowledge and belief in her body’s ability to birth her baby safely, with her ability to consider planned home birth as an option.

Thoughts about birth – social influences:

Several of the women (Wm Briony, Daisy, and Gina; and Wm Emma at the time of her first pregnancy) referred to the influence of their mothers, sisters, cousins and sister-in-law’s

birth positive and negative experiences of birth on their own information gathering, and their resultant decision making:

> '…everyone that I speak to that hasn't had a water birth all they say is how painful it is, but my Mum said, 'yeah, it was painful, but while I was in the bath it was relaxing', so I just think that's got to help if you're relaxed' (Wm Daisy – interview)

> 'Res '…and what information was your Mum giving you?'
>
> Wm Gina: Pretty much what she went through, so I know what's going to happen so, I'm pretty clued up I think (laughs)' (Woman Gina – interview)

Additionally, woman Faye's mother was clearly a strong influence on her daughter's view of birth:

> 'I wanted a home birth when I was pregnant with her but it was 'No chance – hospital', that was all they thought of was getting you to hospital, but now, they don't want you to go into hospital until your contractions are 5 minutes apart…' (Mother of woman Faye – interview)

However, the only references to family members' birth experiences, to a minimal extent, within the birth planning meetings of the other nulliparous women were observed in the Dyad D:

> 'Wm Daisy - Elli was 8 centimetres when she got to hospital wasn't she. They were like, are you in labour and she was like 'I don't know'.
>
> Partner Daniel: She didn't realise she was in labour' (Woman and Partner D – observation)

The comment above was not discussed further within the observed birth planning meeting.

Birth and intervention:

Brief references to resources, such as information leaflets and relaxation CDs, and approaches to assisting the normal birth process by using upright birthing positions were used by Mw's Bethan and Davina during the birth planning meetings:

> ‘There’s a fantastic relaxation CD I’ve just learnt about and it’s never too late to do relaxation…I listened to it last week and I thought what a wonderful tool to have for labour, to switch off and relax, so that’s something you could look at’ (Mw Davina – observation)

However, as was discussed in relation to the quantitative analysis of the observation data, the observed birth planning visits differed in terms of the percentage of time spent discussing the physiological birth process, birth requiring interventions that are classified as ‘normal’ within the parameters defined by the Maternity care Working Party (2007), and birth interventions that fall outside of these parameters. The birth planning meetings for the women not planning to birth at home, particularly when planning hospital birth locations (OU and AMLU), contained a greater proportion of references to obstetric interventions, than where birth was planned at home or in a community setting.

> Mw Anna: ‘This is it, to avoid the induction, so you know, once they can get you to Labour Ward they’ll break your waters and get you on a drip with the drug in to get things going for you, is that alright yeah?’
>
> Wm Ava: ‘Yeah.’ (Dyad A – observation)

However, despite this, two of the Community Midwives (Mw Davina and Mw Grace) seemed to acknowledge the way in which a DGH environment tends to have a medicalising effect on a low risk woman’s labour, and tried to create support mechanisms to assist a woman’s desire for a water birth in an OU setting, and to protect a woman from potentially unnecessary fetal monitoring:

> ‘Water birth please’ (Writing on the top of birth plan in capital letters) (Mw Davina - observation)
>
> ‘…say ‘Excuse me, why am I on this [CTG]?’, and they might say that baby’s heart wasn’t quite right when you came in which is fair enough, or they might say ‘Sorry, sorry’ and then you can come off and wiggle and jiggle around again’ (Mw Grace - observation)

The observed birth planning meetings for women Erica and Faye suggested a different style of discussion, with most of the content supporting the expectations of woman and midwife that birth will take at home with minimal intervention:

> ‘Excellent, it appears that you’re like a text book [name Wm Erica]. The back, from what we heard from the heart beat, is on your right side, head is engaged, exactly where we like them to be and it should make labour easier’ (Mw Emma – observation)
>
> Wm Faye ‘I only want gas and air, and plenty of it’ (Wm Faye – observation)

While Community Midwife Davina did not discuss this with me as a concern, she did state her opinion that:

> ‘I think women have become disempowered to the degree in that they’ve lost faith in their own bodies to be able to birth, there’s a lot of things on tele that scare people, I don’t think ‘One born every minute’ (Channel 4, 2017) did anybody justice, women or midwives really, and I think we have to keep tapping away and just keep inspiring women and being honest about labour (Mw Davina - interview)

Confidence that you can give birth safely with nil or only minimal intervention may serve to increase a woman’s confidence to consider or plan birth at home. The audit finding that a large majority of the women who planned home birth had given birth vaginally to their previous baby supports this assertion.

The influence of the community midwives on the women’s thoughts about birth:

Community Midwife Davina discussed the need for midwives to facilitate women to feel positive about their ability to birth, and this was mentioned by other midwives as possible approaches to encouraging women to consider home birth:

> ‘You can instil that confidence into them and explain why home birth is an option’ (Mw Fern - interview)
>
> ‘…you could say ‘Hospital or home’ and they’d say ‘Hospital’, and then you could say ‘Did you have trouble last time? Have you thought about it?’, and you could send them away to think about it’ (Mw Grace - interview)

However, most of the women (Wm Ava, Briony, Chloe, Daisy, Faye and Gina) did not feel their Community Midwives had influenced their views on birth – appearing to linked this

their perception that they had not discussed birth, or place of birth with them throughout their pregnancies:

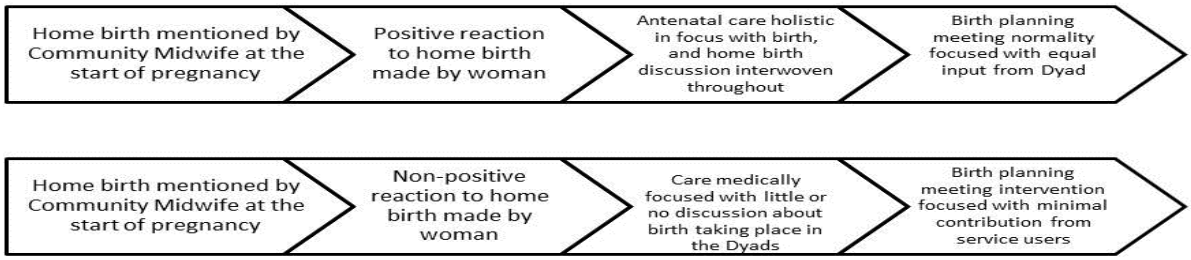
> 'I don't know whether any conversations I've had with [name Mw Anna] would have changed how I feel about it, I've always felt supported, so if I've had queries or anything, just explaining if I've ever gone to [name Mw Anna] with a query about a pain, or I've had this or I've had that, she's always given me quite a medicalised answer of what's happening with my body, changes and helping me understand why that might be the case. So it's more been conversations like that really' (Wm Ava – interview)

> 'She hasn't changed my views in any way, because we haven't been discussing my options as such, it's just been about health, and stuff like that, but she's definitely given me confidence that everything's fine, that everything's on track and care as well, the level of care that she's given me given me a lot of faith in her' (Wm Briony – interview)

This situation contrasts with the way that Wm Erica explains how influential Mw Emma had been for her and her partner is included above.

There appeared to be reflexivity between the birth location that a woman had been considering throughout her pregnancy, with the care that she had received as a result of her considering this particular location, and the way in which discussion about the birth process was framed during her birth planning meeting. Where home birth or FSMLU birth was not being planned, and the woman had not provided a prior reason for home birth or indeed 'normal' birth to be discussed in detail, the majority of Community Midwives, in addition to not spending much time clarifying the level of knowledge that the women held about labour and birth, followed a birth plan that resulted in a large percentage of time being spent discussing obstetric interventions [Table 16]. This may further serve to reduce the inclination for women to consider planned home births as discussions about induction, caesarean section and epidural may reinforce the belief that birth needs to take place in, or near, an obstetric unit.

Figure 8. Illustration of how the Dyads' initial interactions and their resultant subsequent interactions appeared to then impact on the birth planning visits



In conclusion, even though several of the Community Midwives discussed the importance of birth being discussed in a way that generates confidence in their ability to birth, much of the content of many of the observed birth plans related to obstetric interventions – in particular where women were planning to birth in a DGH setting (OU or AMLU). The women did not perceive that their Community Midwives had discussed birth with them in such a way to alter their personal thoughts about birth, and the social influences that the women felt had influenced their views were not discussed within their antenatal care provision.

Study strengths and limitations:

Strengths:

The study provided an opportunity for detailed exploration of the 36 week birth planning visit for low risk women, within one local health board.

The rigour of the study is provided by the use of appropriate data collection methods, accurate transcriptions, and adoption of a recognised approach within the qualitative data analysis.

Use of non-participant observation is infrequent within birth place decision making research, so this study is unusual in its access to this form of data. Use of semi-structured interviews is a more frequently taken approach.

Use of the non-participant observation proforma and semi-structured interview approach resulted in data that was easily comparable for each participant dyad, whilst also facilitating flexibility to allow individual experiences and thoughts to be recorded.

The methodological decision to conduct the semi-structured interviews after the observations is felt to have provided the participants with the ability to speak freely during

their individual time with the researcher, and also allowed the researcher to refer to the content and approach taken within the observed birth plan during the interview.

The opportunity to pay attention to confirming and disconfirming was provided within the study design.

Alongside the seven women participants, several of the women were accompanied by their partners. This was an unintended benefit which enabled their experiences and thoughts to be recorded.

Involvement of a Welsh speaking Research Officer during the birth planning visit for two women enabled care provision and participation in the study to be provided in their language of choice.

The use of the case note audit provided an additional source of data with which to further contextualise the findings of the observation and interview study.

Limitations:

The study did not recruit a range of women to provide diversity regarding parity and birth place – all the primiparous women were not choosing to birth at home, and all the multiparous women were planning a home birth.

The study was conducted prior to the publication of the NICE Intrapartum Care (2014) guidelines around place of birth. It is possible that this publication may alter the way in which contemporary birth planning visits are conducted.

While the decision to analyse the midwives and woman's interviews together, rather than individually, was considered to be the most appropriate approach at the time of data analysis, it may have been useful to consider the two sources individually, and to then collate the codes from each source. This may have provided a clearer and beneficial picture of the ways in which the two groups of participants experienced the birth planning meeting and birth planning in general.

The study only recruited midwives who stated that they felt positive about the offer and provision of planned home births. It would have been beneficial to have recruited some midwives who did not feel positive in order to explore their experiences and thoughts.

However as the data shows, a positive attitude to home birth translates variously into practice.

The sample was small, and data were only collected from within one local health board therefore no national perspective on barriers and facilitators to planned home birth decision making is possible. Consideration of the findings in the context of wider literature, and in relation to the thesis of the whole, will enhance the transferability of these findings.

Inclusion within the audit of case notes where women did not plan to birth at home would have provided comparison with the documentation where a hospital birth was being planned.

Implications:

This study was successful in its aim of investigating the birth planning discussions of seven low risk Community Midwife and woman dyads, and in investigating the facilitators and barriers to increasing planned home births across one local health board's maternity service. The study found four main themes within the data in terms of the ways in that clinical care provision may have been impacting on a woman's ability to birth at home. These were - fragmented antenatal care provision; informed choice around home birth and place of birth; the visibility of planned home birth; and normal birth and planned home birth – a chicken and egg situation? These factors will be briefly concluded below in terms of how these findings could be applied to antenatal care provision.

For the women participants who were experiencing their first pregnancy, and were not planning to give birth at home, the fragmentation of discussion about their forthcoming birth experiences appears to have been a missed opportunity to discuss labour and birth informally during routine care provision. Continuity of care provision was viewed as beneficial in many ways by the women and community midwives, but did not ensure that a relationship that facilitated birth related discussions was created. If these relationships had served to create a relationship of trust and support between the dyad based on an encouraged period of reflection and open discussion between them than that could have potentially provided a stronger platform for discussion about birth, and planned home birth. Therefore, an implication of this study may be that Community Midwives could be

supported to create opportunities within routine antenatal care provision to discuss a woman's feelings towards her forthcoming labour and birth, and relate these to the option of planned home birth. Reference to the antenatal classes that women have been attending could also help to unite these two aspects of care provision more effectively.

Findings of this study suggest that to enable more women to make informed birth place choices, it may be useful to explore the way in which midwives discuss and offer home birth to women. This study demonstrates that for many women, discussion and the offer of home birth ceases once a woman has not responded positively when it is first mentioned to her. An anecdotal reference by one of the Community Midwife participants suggests that midwives find the promotion of home birth difficult. Additionally, for many women the opportunity to access evidence-based discussion and information about home birth will only ever be provided by their maternity care providers as women often do not have members of their social network who tell them about home birth. In terms of how home birth should be discussed, it appears that women could benefit from more aspects of home birth provision being categorically explained, rather than referred to implicitly. Potentially relevant factors in terms of all of these elements being used in combination so that a woman is being informed categorically that her home is one of her birth place options, how care would be provided, that home birth will be brought up again by the Community Midwife in subsequent antenatal appointments, and that her Community Midwife is encouraging her, from a professional perspective, to fully consider home birth and make a decision about this option. This study found that despite several of the Community Midwives being extremely positive about women having access to the option of home birth, and caring for women during home births, this professional perspective was often not seen by the women they were caring for. This may be because once an offer of home birth is declined, Community Midwives may feel unable to discuss the option further – meaning that only women who are planning home births are exposed to this, or that they can only mention it with women planning to birth in other locations when they have recently attended home births.

The study findings also suggest that consideration of how to increase the visibility of planned home birth throughout the duration of a woman's pregnancy may be useful where a maternity service wishes to increase the rates of service users considering and choosing to give birth at home. It seems that a certain level of visibility in terms of an understanding of

the risks and benefits as they relate personally to her is needed before a woman translates an awareness of home birth into a realistic option for herself. In order to achieve this, Community Midwives may need to work to address the balance of the high level of visibility around the negative aspects of planned home birth, such as are reported in the media or discussed amongst individuals without access to current evidence based information that women are more commonly familiar with. Additionally, Community Midwives discussing their professional opinions on the benefits and positive aspects of a woman's personal suitability for planned home birth might be beneficial – regardless of where they are considering or planning to give birth.

Within this sample of women where the offer of a planned home birth had been responded to positively at the start of pregnancy the content of their routine antenatal care appointments appear to have contained more references to labour and birth, and planned home birth than did the equivalent care experiences received by those who were not. It is suggested that this (the chicken), then affects the content and style of the birth planning visit that the woman experiences (the egg), and in turn affects the way in which a woman may even at that point be assisted to consider or choose a planned home birth because of how birth has been portrayed to them (the chicken). Therefore, in the way that was discussed above in relation to increasing birth relate discussions within the Dyad, rather than fragmenting these conversations across care providers, this study suggests that assisting women to view birth positively may facilitate their ability to personally consider to birth at home.

A limitation of this study was that only Community Midwives who feel positive about home births, and who are, in terms of their years of qualification and experience, senior Community Midwives were recruited. However, this factor is interesting in terms of allowing consideration that despite this, some areas where clinical practice could be developed to promote home birth more effectively were still been found. Therefore, it is possible that amongst Community Midwives who do not feel positively towards planned home birth, a greater range of practice development may be required in addition to that suggested above.

Conclusion:

As was stated earlier, the experiences and influences on women as they make decisions about birth location are complex and multi-faceted. Therefore, it is not possible to have total clarity about the best way to interpret and consider the findings in terms of the best way to enable more women to make informed decisions about home birth. However, as a result of conducting this study, it appears possible to categorise pregnant women in to two main groups in terms of the Community Midwife input that is required for an informed choice or declination of home birth to be made:

Enabling a woman who commences her pregnancy with no interest or little knowledge about home birth to feel that an offer of home birth has been made to her, to know that an active choice in birth location needs to be made, and to gain sufficient knowledge and support to make a fully informed choice about this birth place location

Enabling a woman who commences her pregnancy with the hope of planning a home birth to feel that an offer of home birth has been made to her, and to ensure that she feels supported in her decision making and has sufficient knowledge to make an informed choice about birth place location

The findings of this study suggest that in both of these scenarios the woman requires communication that both provides factual and more holistic aspects that facilitate her consideration and informed decision making around home birth. However, as acknowledged, this study was only conducted within one local health board with a small sample. Therefore, it was felt to be useful to contextualise these findings by conducting a scoping review to explore the published UK and international literature on planned home birth decision making. The scoping review is reported in the next chapter.

Chapter Four – Scoping review of planned home birth decision making

Introduction:

This chapter leads on from the initial exploratory study which found that varying approaches to the way that home birth was discussed and offered to women may have resulted in several low risk women not making a fully informed decision about whether they wished to birth at home. Conversely, some midwifery practices appeared to relate positively to women making informed decisions about the option of home birth. Findings showed that four ways that clinical care provision may have been impacting on a woman's ability to birth at home. These were - fragmented antenatal care provision; informed choice around home birth and place of birth; the visibility of planned home birth; and normal birth and planned home birth – a chicken and egg situation?

This scoping review was undertaken to enable a wider review of the factors that may influence women during their home birth decision making process, in order to gain a more in-depth understanding of the issues. The review enabled consideration of national and international factors and it was anticipated that this additional information would be beneficial in the further consideration of this aspect of maternity care provision. In line with the pragmatic approach taken within this thesis, it was anticipated that the results of this review would be useful in determining the next stage of the research process.

Methods:

The aims of this scoping review were to:

1. To broadly explore the published literature surrounding women's decisions to plan a home birth.

2. To highlight any gaps in the existing literature

3. Suggest directions for future research in to the process of women's home birth decision making.

Rationale for conducting a scoping review:

The development of rigorous methods within literature reviewing has developed as a result of the need for health professionals to be providing clinical care based upon the best available healthcare evidence. Several different review approaches are available, with selection of review type made according to the aims of the review and the available resources. Arksey and O'Malley (2005) placed the scoping review methodology in the middle ground between systematic and narrative reviews processes, and state that this review is one review type among many that can be used to review literature. Moher et al (2015), while acknowledging that all of the following reviews are undertaken using scientific and systematic principles, summarise possible review types within the systematic review 'family': systematic reviews are used to answer questions about the effectiveness of possible interventions; rapid reviews are used when time is of the essence; that an evidence map provides a visual representation of the published studies; that a realist review is useful in terms of understanding how and why complex social interventions may be effective; and that scoping reviews are useful when a researcher wishes to gain an overview of a broad subject area. This is in line with Colquhoun et al (2014, p.2) who define a scoping review as 'a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge'. Additional detail is provided by Moher et al (2015), who state that scoping reviews can be undertaken in order to summarise and disseminate research findings, to identify research gaps, make recommendations for future research or to map a body of literature in relation to a specific attribute, such as time, location, source or origin. Therefore, in terms of the initial two aims of this literature review, and for the possible future application of the results of this review, it was felt to be an appropriate decision to use a scoping review approach.

In terms of the extent of the published literature about home birth decision making, following an initial search for published work it was unclear as to what the extent and breadth of research studies relating to decision making was, both in the UK and internationally, and so the process of mapping the literature and acknowledging any gaps in the literature, was felt to be beneficial (Frith et al., 2014). Secondly, in order to gain as full a

picture as possible of how the relevant parties - service users and service providers - viewed influential aspects around home birth, it was felt beneficial to be able to include a wide range of literature types – qualitative, quantitative, and mixed methods research studies; along with non-research articles written by maternity professionals, service users, midwife academics; and other relevant academics that were published within relevant professional journals (Edge, 2006). The inclusion of a wide range of evidence is accepted within scoping review methodology (Arksey and O'Malley, 2005), and this also aligns with the mixed methods approach that is used within the thesis as a whole.

Thirdly, in comparison to traditional narrative reviews, adopting a systematic approach to the finding, and inclusion and exclusion of articles whilst retaining the wide variety of sources of information was felt to add to the rigour, and potential usefulness of the review (Levac, Colquhoun & O'Brien, 2010).

The use of scoping reviews within health care has increased over the past two decades (Levac, Colquhoun & O'Brien, 2010), and in maternity care, during the last fifteen years scoping reviews have been conducted by researchers exploring varied aspects of care provision. These include an exploration of the organisational culture in maternity care (Frith et al., 2014), the policy and provision of perinatal healthcare in prisons (Edge, 2006), and the consideration of healthcare support workers within the nursing and midwifery workforce (Griffiths & Robinson, 2010). However there has not been a scoping review undertaken to explore planned home birth decision making.

Design:

The first attempt to define scoping review methodology was undertaken by Arksey and O'Malley (2005). Prior to this, various types of review 'animal' were being used, but without consistent definitions being applied. It is acknowledge and discussed in terms of the proposed strengths and limitations of this review at end of the chapter, that scoping review methodology has developed significantly since 2010 and that were this review to be conducted now in 2018, that some additional considerations may be applied (Cacchione, 2016; Peters et al, 2017). However, because this review was initially conducted in 2013 prior to the publications that disseminated recent approaches to scoping reviews, this review follows the six stepped scoping review framework that was initially developed by Arksey and

O'Malley (2005), and then advanced further by Levac, Colquhoun and O'Brien (2010). The six stages proposed by Levac, Colquhoun and O'Brien (2010) are:

Stage 1: clarifying and linking the purpose and research question

Stage 2: balancing feasibility with breadth and comprehensiveness of the scoping process

Stage 3: using an iterative team approach to selecting studies

Stage 4: data extraction extracting data

Stage 5: incorporating a numerical summary and qualitative thematic analysis, reporting results, and considering the implications of study findings to policy, practice, or research

Stage 6: incorporating consultation with stakeholders as a required knowledge translation component of scoping study methodology

Within this chapter, stages one to five are discussed and reported. Stage six was not undertaken as the next stages of the research process evolved to include the input of stakeholders in another way.

Criteria for study inclusion:

Sources published between 1993 and mid-2015 were included within this scoping review. Initially, the intention of the review process was to retrieve solely empirical studies – either using qualitative, quantitative, or mixed methods. However, after starting the review and becoming aware of the nature of the ideas and information that this limitation was excluding, this limiter was then widened to include non-research based, peer reviewed sources. A recognised strength of the scoping review methodology is that it permits access to a breadth, depth and comprehensiveness of evidence that can be included from a given field of enquiry in a way that other review methods may not (Levac, Colquhoun & O'Brien, 2010), and this was embraced and achieved within this review.

To be included the non-empirical sources needed to be informed by a relevant professional perspective or experience, or by a service user who has a relevant personal perspective or experience – this would include also wider family members such partners and children, in addition to women themselves. The benefit of including such a range of sources was that it would allow a wider and perhaps more holistic perspective on home birth decision making than only including solely empirical studies.

The decision was made to include sources from outside of the UK if the maternity service provision included access to aspects of community care provision or decision making opportunities that were considered broadly similar to that found within the UK. This was because the review aimed to explore aspects of maternity provision that the commentators or study participants found beneficial or difficult in terms of home birth decision making. It was not necessary for all of the included maternity services to provide all of the features of care proposed or provided by the maternity services in the UK.

Search strategy and screening methods:

The scoping review search strategy is included in Appendix 11. As noted, the review employed broad search terms in order to ensure all relevant articles were captured during the retrieval process.

The initial start date of 1993 was chosen as this was prominent in the development of UK maternity policy in terms of support for women's choices in birth place, and the re-emergence of discussion of home birth as a suitable location for women to choose (Department of Health, 1993). Language choice was determined by the fact that this PhD is being conducted in Wales, a bilingual country where English and Welsh are both official languages and where access to a Welsh translation service is free. The lack of funds as part of the PhD studentship for the translation of articles that were not published in Welsh or English resulted in the exclusion of articles not published in English or Welsh. The decision to include research and comment from comparative countries was made from a lack of knowledge about the extent of research findings generated from with the UK, and a desire to obtain professional opinion and research findings from as wide a relevant knowledge base as possible.

The search was initially conducted in 2013 and so included publications between the years 1993 and 2013, and a search was conducted in September 2015 to update the evidence base from 2013 - 2015.

Study selection:

Levac, Colquhoun and O'Brien (2010) recommend a team approach to study selection, however, in this review study selection was undertaken mostly by me, although my

supervisory team were also involved where there was uncertainty. It is increasingly acknowledged within scoping review methodology that this stage of the review process should be undertaken by two reviewers independently of each other (Peters et al, 2017) and so this has been noted as a limitation of this review.

Retrieved articles were screened for relevance initially by reading the titles, and then at the abstract level. It was a frequent occurrence that non-empirical titles such as 'My lovely c-section' (Taylor, 2010) needed to be read at abstract level in order to ascertain if they met the inclusion criteria for the review.

A number of further articles [n=36] were also obtained by a snowball process by reading the reference lists of included articles.

Quality assessment:

In accordance with scoping review methodology, no quality appraisal of the included sources was undertaken. This decision was made in 2013 at the time that the initial scoping review search was conducted, and was not reviewed when the decision to revisit the search was made in September 2015. While recent literature regarding scoping review methodology continues to support this approach (Peters et al, 2015), it is acknowledged that a formal assessment of methodological quality of the included empirical publications could have been undertaken using the relevant CASP tools (CASP UK, 2018). This may then have enhanced the review findings by ensuring that they could be assessed against the quality of the sources that generated them. This approach was taken within Coxon et al's (2017) recent review. A lack of quality appraisal has been included as a potential limitation of the review to acknowledge that this process would have added to the validity of the findings, creating greater confidence and trustworthiness of the findings.

Data extraction and synthesis:

Data extraction forms were designed and used [Appendix 12]. This is a recognised approach within recent scoping review approaches (Peters et al, 2017).

The aim of data extraction was to illuminate factors that may influence women during their home birth decision making process, and so data was initially gathered in relation to two broad questions:

What is reported or perceived to have helped women to choose a planned home birth?

What is reported or perceived to have hindered or prevented women choosing planned home birth?

Thirdly, in order to scope the way in which studies had been conducted to increase the rates of home birth worldwide, data in relation to the question 'What research has been undertaken with the aim of increasing planned home birth rates?' was also gathered.

Levac, Colquhoun and O'Brien (2010) again recommend a team approach for this stage of the scoping review process, but as the majority of this process was undertaken individually this has again been noted as a limitation of this review.

The analysis followed a thematic analysis approach, consistent with Braun and Clarke (2006). The included sources were printed, and read several times to gain a broad understanding of their content. During this process the text was highlighted manually using different coloured highlighter pens to note areas of text addressing each of the three broad questions. This information was then uploaded to the data collection forms.

After highlighting the key areas of text, the sources were then re-read and codes noted alongside each area of text that related to the content of the section [Appendix 13]. The codes were then collated under the questions relating to what is reported to help women plan to birth at home, or that which is reported or perceived to hinder or prevent women from birthing at home - with the related quote or summary from each of the sources noted beneath the code as a heading [Appendix 14]. These codes were then used to create the four broad themes.

During the supplementary stage of the review in September 2015, the sources were again highlighted according to the three questions, and the data coded alongside the previously recognised thematic areas.

Many of the publications were found to provide data appropriate to several of the resultant review themes and this is illustrated in Appendix 15.

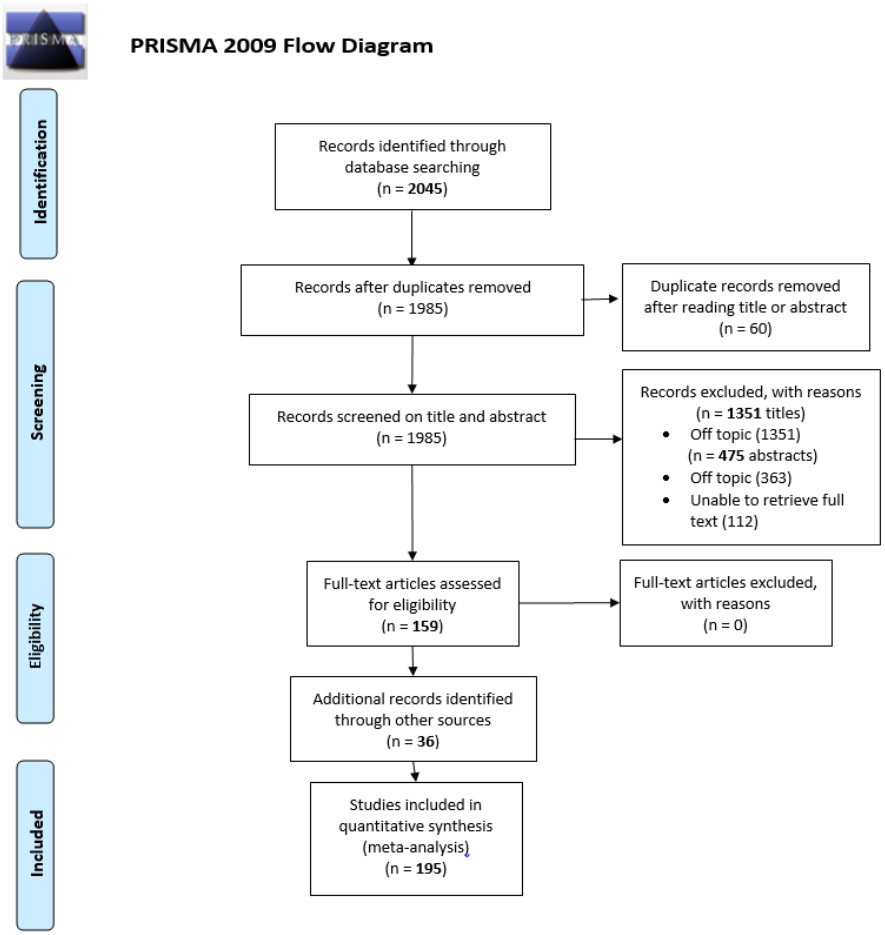
Initial results:

Levac, Colquhoun and O'Brien (2010) recommend a three step process within stage five of the scoping review process – analysing data, reporting results and applying meaning to the results. It is their opinion that stage five is required to be the most extensive stage of the review process, and that it is within this stage that the framework outlined by Arksey and O'Malley (2005) required greater development.

Search results:

Out of 2045 records that were screened and checked, 195 full text articles were included in this review [Figure 9].

Figure 9. PRISMA diagram to illustrate the review process



The PRIMSA diagram shows that 1351 sources were excluded from the review where the inclusion criteria were not met. Sources were considered to be off topic where the maternity service provided a was significantly different context to that in the UK context, for example concerning the decision to birth at home in a developing country; or where the focus of a source was on the clinical outcomes of planned home birth rather than the decision making

process. It was not possible to retrieve 112 of the 2045 identified sources because the University did not have a subscription to these journals, and there were no additional financial resources to complete the review – in particular Midwifery Matters (Midwifery Matters, 2016).

Description of included sources:

A summary of the 195 included sources is provided in Appendix 15.

In total, 195 sources from four continents were included in this scoping review. The majority of the sources originate in Europe, with the majority of evidence originating from the UK.

The rate of published articles about planned home birth decision making has increased since 1993. It appears to have peaked between the years 2008-2012. This coincides with the publication of the Birthplace in England results (Birthplace in England Collaborative Group, 2011).

The review contains both research (n=119) and non-research based sources (n=76). The most commonly used data collection method used within the included research articles was interviews, and the most common data collection method within the non-research based group of articles was professional discussion, defined as being where an individual has provided a professional perspective to an aspect of planned home birth decision making.

The review has included the voice of a wide range of relevant individuals. In approximate numbers, this includes 741,300 women maternity service users, including 5570 women who were planning or who had birthed at home; seventy male partners, including thirty-nine partners of women who were planning home births; four wider family members including grandparents and children; 3,600 midwives; an additional 630 members of the wider maternity multi-disciplinary team, and twenty professionals from other disciplines.

Study quality:

No assessment of quality was made of the 119 empirical sources.

Thematic findings:

There are five main themes from this review – that a woman's individual social context profoundly influences her ability to consider or plan a home birth; that how a woman views

birth influences her ability to consider or plan a home birth; that the midwifery care that a woman receives can either enhance or reduce her ability to consider or plan a home birth; that the context of the maternity service care provision can influence the ability for women to decide to birth at home, and how intervention studies have been implemented to increase the planned home birth rate. These are presented below.

Table 17. Table to illustrate the review themes

Theme	Sub-theme
The influence of social context	Partners Family Friends Individual socio-demographic characteristics The wider social context
Women's views of birth	Previous birth experiences Expectations for birth Birth preferences
The influence of midwifery care	Care that enhances or reduces a woman's ability to consider or plan home birth
The context of the maternity service	The influence of other healthcare providers Home birth amongst other available birth settings The prioritisation of planned home birth within individual maternity services Midwifery leadership The impact of poor staffing levels
Intervention studies to increase planned home birth rates	Components of intervention studies

Theme 1: The influence of social context

A woman's individual social context profoundly influences her ability to consider or plan a home birth. This is explained by Arcia (2015, p.13), who states that 'normative choices are the backdrop against which the mother's expectations and decision occur'.

Therefore, members of a woman's social network, that could include her partner, family and friends, can facilitate or reduce her ability to consider or choose to birth at home. Additionally, within the published literature, certain favourable socio-demographic characteristics are seen to reoccur in the profiles of the women who plan to birth at home, and the birth culture of her wider society may also influence decision making – particularly where a medicalised birth culture is dominant and her individual social network does not counter this approach.

Partner support:

Rogers et al (2005) found that women place their partners, in combination with their own views, as the most influential factor in their birth place decision making. Partners can 'generally dissuade' women during pregnancy before they come to 'a firm decision' on whether to plan to give birth at home (Dagustun, 2009; Lavender & Chapple, 2005). Male partners often state that they did not have a significant influence over their partner's decision making, and that they would support their partners in a home birth if that is what she wished for (Coxon, 2012, Houghton et al., 2008, Bedwell et al., 2011). However, Edwards states that women do not wish to challenge the person that they ultimately need to rely on, especially if they do not feel overly confident themselves (Lavender & Chapple, 2005, Edwards, 2008b, Bourke, 2013).

Partners are noted to be important support mechanisms for women who plan home births, and reports of planned home births almost always include the presence of a supportive partner (Rogers et al., 2005, Houghton et al., 2008, Andrews, 2004a, Andrews, 2004b, Dagustun, 2009, Lavender & Chapple, 2005, Madi, 2001, Madi & Crow, 2003, Ng & Sinclair, 2002, Ogden et al., 1997b, Shaw & Kitzinger, 2005, Bourke, 2013, Green, 2015, Jervis, 2014, Johnson & Davis-Floyd, 2006, Jowitt, 2014, Budin, 2013, Sinnhuber-Giles, 2008, Walsh et al., 2011, Bailes & Jackson, 2000, Vries, 2010, Taylor, 2010, Viisainen, 2001, Lindgren et al.,

2006, Sjöblom et al., 2006, Morison et al., 1998, Magri, 2012, Kontoyannis & Katsetos, 2008, Goldstein, 2012, Catling-Paull et al., 2011).

The influence of a supportive partner was protective in terms of women being able to counter the negative responses they experienced during interactions with family or friends (Viisainen, 2001; Jouhki, 2012).

Sometimes a partner is noted to have been supportive of home birth from the start of his partner's pregnancy (Johnson & Davis-Floyd, 2006, Lindgren et al., 2006, Morison et al., 1998, Lindgren & Erlandsson, 2011, Viisainen, 2001, Bailes & Jackson, 2000, Magri, 2012, Mottram, 2008). However, it is more common in the literature to observe that women participants wishing to plan a home birth had been conscious of their partners' need to 'come to terms' with the idea, with the acceptance that their role was to help them during this process (Goldstein, 2012, Kontoyannis & Katsetos, 2008, Lindgren & Erlandsson, 2011, Lindgren et al., 2006, Lundgren, 2010, Morison et al., 1998, Taylor, 2010, Vries, 2010, Walsh et al., 2011, Welch, 2001, Andrews, 2004a, Madi, 2001, Halton, 2006, Ng & Sinclair, 2002, Edwards, 2005, Shaw & Kitzinger, 2005, Ashley & Weaver, 2012a). There are very few references within the home birth decision making literature of a male partner suggesting to his pregnant partner that their baby's birth should take place at home. Examples of this are only seen in two studies, with three partners (Ogden et al., 1997b, Coxon, 2012).

Factors suggested to assist a partner to support a choice of planned home birth are confidence from knowing his partner or wife has already had a normal birth, and in the system providing maternity care (Catling-Paull et al., 2011), being surrounded by people who were positive about home birth (Morison et al., 1998; Vries, 2010, Magri, 2012), and the support of a midwife for a woman's choice (Kontoyannis & Katsetos, 2008).

There is evidence to suggest that amongst couples who do not intend to plan a home birth, a process of silent decision making takes place (Bedwell et al., 2011). In this situation no importance is placed on clarifying the reasons why both parties prefer not to give birth at home, either amongst themselves, or with a midwife (Madi, 2001, Houghton et al., 2008, Bedwell et al., 2011)

Family that is knowledgeable, experienced and supportive of planned home birth:

Amongst the women in the published literature who decided to plan a home birth, numerous qualitative articles refer to family members as mostly providing support for their choice (Ashley & Weaver, 2012a, Dagustun, 2009, McCourt, Rance, Rayment & Sandall, 2011, Ng & Sinclair, 2002, Ogden et al., 1997b, Shaw & Kitzinger, 2005, Grace, 2014, Kornelsen, 2005, Vries, 2010, Catling-Paull et al., 2011, Wiegers et al., 1998). In addition to these research articles, the vast majority of all of the non-research based published literature written by women service users and professional service providers provides evidence that most of the women who plan a home birth had either learned about home birth through their families and were therefore influenced by their families to consider this choice (Morison et al., 1998, Murray-Davis et al., 2012, Parratt & Fahy, 2004), or they went on to receive support from their families for this choice (Dobson, 2009, Gannon, 2005, Richley, 2011).

Family members holding a positive birth philosophy (Angha & Scaer, 2008, Lothian, 2002), discussion of positive birth experiences (Dahlen et al., 2008, Lothian, 2010) or birth place choices (Lothian, 2010; Lothian, 2013; Magri, 2012; Angha & Scaer, 2008; DiFilippo, 2015; Gibbons, 2015) are viewed as supportive to women.

The influence of a woman's mother on her choice to give birth at home may be strong, as mothers of several of the participants in the cited research studies had also give birth at home (Ogden et al., 1997b; Dobson, 2009; Gannon, 2005; Richley, 2011). Dagustun also found that many of her participants planning home birth had same generation relatives, such as sisters who had had planned home births (Dagustun, 2009), as did McCourt, Rance, Rayment & Sandall, (2011), and this is supported within the international literature (Taylor, 2010; Dahlen et al., 2008; Sluijs et al., 2015). The way in which knowledge of planned home birth is transmitted within families, where a member is planning, or has had a successful planned home birth is illustrated in a number of sources (Lowden, 2012; Stephens, 2008; Richley, 2011).

A transitional process is referred to, possibly similar to that undergone by some partners, of family members becoming supportive of a relative choosing to give birth at home, after initially holding a negative view of this option (Edwards, 2005). However, family support is not always essential as some women have described how their family members did not ever

become supportive of their choice to give birth at home (Andrews, 2004a; Ashley & Weaver, 2012a; Lavender & Chapple, 2005; Noble, 2015).

Amongst women in this body of literature who did not plan to give birth at home, it is evident that for many their families were more positive towards hospital being the planned birth place (Dahlen et al., 2008; Arcia, 2015; Lavender & Chapple, 2005; Coxon, 2012; Sluijs et al., 2015). Alternatively, for some women there was a lack of discussion about birth place options within the family when a hospital birth was being planned (Kornelsen, 2005).

Friends that are knowledgeable, experienced, and supportive of planned home birth:

Friends are common sources of information for women seeking all forms of birth information (Catling-Paull et al., 2011; McCourt, Rance, Rayment & Sandall, 2011; Jouhki, 2012; Soltani et al., 2015).

Much of the international home birth decision making literature illustrates that in the majority of cases women experienced positive reactions about home birth from their friends (Catling-Paull et al., 2011; Jouhki, 2012; Lindgren & Erlandsson, 2010; Lothian, 2010; Lothian, 2013; Lundgren, 2010; Morison et al., 1998; Murray-Davis et al., 2012; Taylor, 2010; Walsh et al., 2011; Wiegers et al., 1998), and that on occasion their friends were present to support them during their labours at home (Budin, 2009; Budin, 2013; Johnson & Davis-Floyd, 2006; Kornelsen, 2005; Murray-Davis et al., 2012; Walsh et al., 2011; Welch, 2001).

The process by which knowledge and awareness of planned home birth is transmitted by women who have had a planned home birth amongst their female friends, and on occasion by their partners to other partners, is illustrated within anecdotal and research based sources (Andrews, 2004b; Craig, 2010; Davis, 2011; Dobson, 2009; Dagustun, 2009; Halton, 2006; Lowden, 2012; Madi, 2001; Ng & Sinclair, 2002; Richley, 2011; Dahlen et al., 2008; Magri, 2012).

Members of home birth support groups can function as a micro social network for women, including for women who did not have friends who were knowledgeable about home birth prior to joining the group (Grace, 2014; Jervis, 2014).

References to negative reactions to planned home birth were reported in a number of sources, where friends tried to convince women to birth in hospital (Sjöblom et al., 2012; Viisainen, 2001). Anticipating negative reactions, and actively avoiding discussions with

selected people was referred to as a coping strategy in several articles (Morison et al., 1998; Lothian, 2010; Lothian, 2013; Catling-Paull et al., 2011).

Amongst women who did not plan a birth at home, the literature suggests that these women do not talk about planned home birth with any friends (Dagustun, 2009; Madi, 2001; Houghton et al., 2008).

Individual socio-demographic characteristics:

Women who birth at home in the UK were mostly, but not exclusively, noted to be born in the United Kingdom, or living in the UK but born in developed countries, aged around 30 years of age, in the higher socio-economic bracket, living with their husbands or partners, and having had a elements of higher education (Ashley and Weaver, 2012a; Brintworth & Sandall, 2013; Edwards, 2005; Madi, 2001; Madi & Crow, 2003; McCutcheon & Brown, 2012; Munday, 2003b; Ogden et al., 1997a; Mastroianni, 2012; Craig, 2010; Carter, 2012; Dobson, 2009; Green, 2015; Jervis, 2014; Jowitt, 2014; Soltani et al., 2015; Nove, Berrington and Mathews., 2008).

This socio-demographic profile aligns with the 'privileged identity' that is discussed by Coxon as a woman who is 'white, native born and speaks 'received' English, graduate, relatively affluent, married or in a long-term relationship, of an appropriate age to have children, and with a moderate-sized family' (Coxon, 2012, p.133). Possessing some or all of these privileged characteristics may actually enable women to access birth place choices to a greater extent than women who do not have these characteristics (Coxon, 2012; Law et al., 2009; McCourt, Rance, Rayment & Sandall, 2011; Thomas, 2006).

Women from black or minority ethnic groups, women who were single and those who were deprived were less likely to feel that they had been offered a home birth than women from other socio-demographic groups (Redshaw et al., 2007, Redshaw & Heikkila, 2010), along with women with lower levels of educational attainment and those living in deprived areas (Redshaw & Heikkila, 2010). Women who are least likely to achieve a home birth are those who were born in Bangladesh, India and Pakistan (Nove, Berrington and Mathews., 2008).

However, exceptions to this situation exist. Midwives, often members of home birth teams, refer to the fact that they support women from a variety of socio-demographic characteristics such as varied age ranges, marital status, race, and education (Davis, 2011;

Richley, 2011; Carter, 2012 Collins & Kingdon, 2014; Rogers, 2009). However, McCourt, Rance, Rayment & Sandall, (2011) report how, despite the aim to provide case loading services and the associated choice of home birth to women from a lower socio-economic groups, it was often women from more affluent areas who requested to be cared for by these teams, generating a perceived inequality in care provision.

The wider social context:

Much of the literature suggests that the national birth culture of the UK (Ashley & Weaver, 2012b; Coxon et al., 2015; Dagustun, 2011; Edwards, 2008c; Gifford, 2003; Ng & Sinclair, 2002), and of the majority of Western countries (Arcia, 2015; Ball, 2014; DiFilippo, 2015; Kontoyannis & Katsetos, 2008; Viisainen, 2001; Sluijs et al., 2015) has been influenced by the medicalised approach to childbirth. McCourt, Rance, Rayment & Sandall, (2011) conclude their discussions around birth place choice by noting that most of their interviews reflected the fact that out of hospital birth is no longer the norm. The media is frequently referred to as a potential source of fuel for the medicalisation process (DiFilippo, 2015; Walton et al., 2014).

Theme 2: Women's views of birth

The evidence shows that the way in which a woman views birth will influence her ability to consider or plan a home birth. Factors such as previous birth experiences, expectations for birth and birth preferences all appear to impact on planned home birth decision making.

The influence of previous birth experiences:

After giving birth once, women consider their own experiential knowledge as a key source for subsequent birth place decisions (Dagustun, 2009). Positive previous experiences, such as having had a normal birth either at home or hospital (Walsh et al., 2011; Catling-Paull et al., 2011; Cheyney, 2011; Viisainen, 2001; Lundgren, 2010; Lindgren et al., 2005; Ashley & Weaver, 2012b; Madden, 2005), and having had a previous successful home birth (Chamberlain et al., 1999; Thomas, 2003; Rogers, 2009; Reed, 2008; Jouhki, 2012; Morison et al., 1998; Lundgren, 2010; O'Boyle, 2013; Sluijs et al., 2015) were both reasons that many women gave for their decision to plan a home birth in subsequent pregnancies.

Previous negative experiences of hospital births are also referred to by women as being a reason for them to subsequently plan a home birth (Bailes & Jackson, 2000; Jackson et al., 2012; Johnson & Davis-Floyd; 2006, Jouhki, 2012; Lindgren et al., 2010; Merg & Carmoney, 2012; Boucher et al., 2009; Chadwick & Foster, 2013; Kontoyannis & Katsetos, 2008; Kornelsen, 2005; Viisainen, 2001; Ferreira Lessa et al., 2014; DiFilippo, 2015; Bernhard et al., 2014; Goldstein, 2015; Dagustun, 2009; Edwards, 2009; Fraser, 2013; Halton, 2006; Ogden et al., 1997a; Shaw & Kitzinger, 2005; Andrews, 2004a; Ashley & Weaver, 2012a; Ng & Sinclair, 2002).

The previous birth experiences of other women, especially births at home or in an MLU, can also be influential to any woman's decision making process (Gannon, 2005; Coxon, 2012; Houghton et al., 2008; Coxon et al., 2013; Madi, 2001 Soltani et al., 2015) in particular those of mothers or sisters (Angha & Scaer, 2008; Dahlen et al., 2008; Goldstein, 2012; Taylor, 2010).

Where women give birth in hospital, most will decide to return to an institutional setting to have their subsequent babies (Ogden et al., 1997b; Chamberlain et al., 1999; Coxon, 2012; Madi, 2001) or anticipate making this choice in the future (Houghton et al., 2008; Coxon, 2012). The 'notion that women become less risk averse in second or subsequent births, even after straightforward vaginal births in OU settings' is not supported in the literature (Coxon et al., 2015, p.145). Additionally, although a woman may believe that 'childbirth is natural' and that interventions are used unnecessarily at points, if they feel that intervention was justified during their own previous labour then they may believe that there is the potential for it be necessary for subsequent labours (Bogdan-Lovis & Vries, 2013;Murray-Davis et al., 2014).

Expectations for birth:

Women who plan a home birth do not always arrive at pregnancy with these expectations or preferences, but may gain the confidence to choose a planned home birth throughout their pregnancy by 'un-learning' misconceptions (DiFilippo, 2015; Hollowell et al., 2015). Johnson & Davis-Floyd (2006) also describe how a process of un-learning may take place in the interval between birth and a subsequent pregnancy. Women continuously re-validate their decision to have home birth during their pregnancy (Catling et al., 2014).

Belief in the safety of birth at home appears to stem from a fundamental expectation that birth would take place without complications for women and their newborns (Ashley & Weaver, 2012a; Ng & Sinclair, 2002; Lavender & Chapple, 2005; Jimenez et al., 2010; Lindgren et al., 2005; Catling-Paull et al., 2011; Cheyney, 2011; Dahlen et al., 2008; Lothian, 2013; Morison et al., 1998; Regan & McElroy, 2013; Sjöblom et al., 2006; Viisainen, 2001; Catling et al., 2014). Additionally, rather than merely minimising risks by birthing at home, women also embrace the possibility of their birth being a very positive experience for them (Chadwick & Foster, 2014; DiFilippo, 2015; Ball, 2014).

Where women felt confident about their body's ability to give birth, immediate recourse to obstetric interventions was unwarranted, and potentially damaging to the birth process (Bailes & Jackson, 2000; Dahlen et al., 2008; Green, 2016; Hildingsson et al., 2003; Jackson et al., 2012; Lindgren et al., 2010; Merg & Carmoney, 2012; Morison et al., 1999; Murray-Davis et al., 2012; Janssen et al., 2009; Kontoyannis & Katsetos, 2008; Kornelsen, 2005; Lothian, 2013; Shaw & Kitzinger, 2005; Redshaw et al., 2007; McCutcheon & Brown, 2012). Home, as a location, is viewed as making birth easier and safer, and improving the birth experience (Ng & Sinclair, 2002; Andrews, 2004a; Longworth et al., 2001; McCutcheon & Brown, 2012, Ashley & Weaver, 2012b; Hollowell et al., 2015). Women planning home births felt confident that they could cope with the physiological pain of labour and that they did not require pharmacological pain relief (Hildingsson et al., 2003; Sinnhuber-Giles, 2008; Lindgren et al., 2005).

The literature suggests that women planning hospital births anticipate a less positive birth experience than those who plan home births (Christiaens et al., 2008; Hildingsson et al., 2010; McCourt, Rance, Rayment & Sandall, 2011). Where women expect difficulties or danger for either themselves or their babies, they tend to plan institutional births (Coxon, 2012; Coxon et al., 2014; Hollowell et al., 2015; Goldstein, 2015). Birth may be conceptualised as risky or unpleasant or embarrassing (Dagustun, 2009; Houghton et al., 2008; Coxon, 2012; Lavender & Chapple, 2005), with hospitals providing the skills and equipment to protect mother and baby from death (Houghton et al., 2008; Coxon, 2012). Women may choose to birth in a MLU if they feel that better support services are available there (Watts et al., 2003).

Birth preferences:

Preferences for labour and birth found in the literature relate to the availability of resources in different birth locations, and women's control of their chosen environment in terms of decision making about the care they receive and the birth location atmosphere. Differences in the preferences of women who planned home births can be seen when viewed against those women who did not. Holloway et al (2015) state that policy makers need to be aware that women's views and preferences are not necessarily fixed.

Amongst women who plan home births:

Three main areas of preferences around resources were noted. Women who preferred or planned home births did not feel they needed access to epidural facilities (Longworth et al., 2001; Coxon et al., 2014) and often held a 'resistance' towards the use of birth technology (Ball, 2014; Murray-Davis et al., 2014; Neuhaus et al., 2002; Kornelsen, 2005; Coxon, 2014; Redshaw et al., 2007). However, women planning home births do not shun medical technology in all instances (Chadwick & Foster, 2014); and gain reassurance from knowing that midwives are fully integrated into back-up services of a local obstetric unit (Janssen et al., 2009; Catling-Paull et al., 2011; Lothian, 2013; Catling et al., 2014).

The second birth preference concerns 'control'. Women who birth at home are suggested to want to be 'in control' of their experience (Boucher et al., 2009; Watts et al., 2003; Kornelsen, 2005; Godfrey, 2010). Control is further defined in terms of the women themselves (Ashley & Weaver, 2012a), their environment (Redshaw et al., 2007; Coxon et al., 2013; Ashley & Weaver, 2012b; Andrews, 2004a; Redshaw et al., 2007; Coxon et al., 2015; Hollowell et al., 2015; Cheyney, 2011; Morison et al., 1998; Murray-Davis et al., 2012; Chadwick & Foster, 2013; Kontoyannis & Katsetos, 2008; Regan & McElroy, 2013; Ball, 2014; Cheyney, 2016; van Haaren-ten Haken et al., 2014; Arcia, 2015; Sluijs et al., 2015) and decision making (Ogden et al., 1997b,;Shaw & Kitzinger, 2005; Longworth et al., 2001; McCutcheon & Brown, 2012; Ashley & Weaver, 2012b; Bailes & Jackson, 2000; Jouhki, 2012; Lindgren & Erlandsson, 2010; Murray-Davis et al., 2012; Sjöblom et al., 2006; Chadwick & Foster, 2013; Janssen et al., 2009; Regan & McElroy, 2013; Catling et al., 2014; Bernhard et al., 2014; van Haaren-ten Haken et al., 2014; Ball, 2014). Birthing outside of their own environment is felt to potentially render women vulnerable to negative influences (Ashley & Weaver, 2012a).

Thirdly, women may prefer to not need to leave their family by giving birth in an OU or an MLU (Silverton, 2012; Ogden et al., 1997b; Watts et al., 2003; Hildingsson et al., 2003; Murray-Davis et al., 2012; Sjöblom et al., 2006; Bernhard et al., 2014; Catling et al., 2014).

Amongst women who do not plan home births:

Women who preferred or planned hospital births [including AMLUs] preferred this option because of access to an epidural service (Murray-Davis et al., 2014; van Haaren-ten Haken et al., 2014; Hollowell et al., 2015; Soltani et al., 2015; Pavlova et al., 2009), and because the use of birth technology and obstetric interventions was both accepted and expected (Kornelsen, 2005; Regan & McElroy, 2013; Arcia, 2015). Women who preferred an MLU may wish to have definite access to a birthing pool and Entonox (Saunders et al., 2000; Rogers et al., 2011; Longworth et al., 2001). Women who preferred an OU setting also appeared to prefer birth equipment being visible in a birth room (Houghton et al., 2008). Frequently, women, and their partners, who planned hospital births wished to know that emergency resources, such as medics and a SCUBU, were available to them immediately without transfer (Lavender & Chapple, 2005; Hollowell et al., 2015; McCourt, Rance, Rayment & Sandall, 2011; Soltani et al., 2015).

Preference for control, in the ways discussed above in relation to home birth choosing women, is not common in the discussions of preferences mentioned by those not planning home births, although Coxon (2014) does discuss women's concerns for loss of control over their bodily functions or feminine identity amongst women who choose hospital birth locations. Women planning hospital births often do not expect to be able to influence their births, and actually want their caregivers to take responsibility and provide direction (Longworth et al., 2001; Houghton et al., 2008), although planning for an operative birth has been suggested to provide control for women who make this choice (Chadwick & Foster, 2013). Additionally, where women did not want to birth at home, they preferred a different environment because of fear of mess arising from a home birth or because they felt they would be more comfortable in hospital (Murray-Davis et al., 2014), because they felt there would be peace during a hospital birth for the reason of no telephone calls or children around, or because they felt their home was not suited to a home birth (Sluijs et al., 2015). AMLUs are discussed as the best of both worlds (Stephens, 2008) in terms of providing a pleasant atmosphere without high levels of medicalisation by women making choices across

the full range of birth place options (McCourt, Rance, Rayment & Sandall, 2011; Murray-Davis et al., 2014; Arcia, 2015; van Haaren-ten Haken et al., 2014).

Theme 3: The influence of midwifery care:

The literature suggests that midwifery care may be an important factor in decision making about home birth, either enhancing or limiting women's abilities to being informed or make this choice.

Relationships between women and midwives:

Women who planned home births appeared to be strongly influenced by the positive relationship that they have, or hoped to have, with their midwife (Johnson & Davis-Floyd, 2006; Thomas, 2003; McCutcheon & Brown, 2012; Ashley & Weaver, 2012a; Dahlen et al., 2011; Jimenez et al., 2010; Neuhaus et al., 2002; Janssen et al., 2009; Kornelsen, 2005; Murray-Davis et al., 2012; Ball, 2014).Where women planning hospital births had been unable to form a trusting relationship with a particular midwife they were found to have turned towards placing their trust in particular NHS Trusts, or particular institutional locations of maternity care (Coxon, 2012).

Building relationships is also seen to be facilitative of women's decisions to birth at home as it enables them to know who will attend them in their labours (Carter, 2012; Griffiths, 2015a; Johnson & Davis-Floyd, 2006). Continuity of carer appears to be a positive feature of the care that the women who planned a home birth received (Bliss, 2010; Craig, 2010; Furlong-Davies & McAleese, 2008; Ogden et al., 1997b; Ashley & Weaver, 2012b; Ashley & Weaver, 2012a; Longworth et al., 2001; Lindgren et al., 2010; Hildingsson et al., 2010; Dahlen et al., 2011; Ball, 2014; Munday, 2003; Lothian, 2010; Goldstein, 2012; Gibbons, 2015; Bernhard et al., 2014). Quantitative studies and evaluative reports of maternity services suggest that increased rates of continuity of care are associated with higher rates of planned home birth (Benjamin, Walsh & Taub, 2001; Fleming et al., 2007; Brintworth & Sandall, 2013).

Positive relationships were built when midwives took time to talk with women, and to listen to them (Cheyney, 2011; Merg & Carmoney, 2012; Murray-Davis et al., 2012). When midwives have developed a relationship with a woman in their care they feel more involved

and responsible for her care and therefore more inclined to spend time discussing options with her (Rogers et al., 2005; Davis, 2011; Davies Floyd & Davies, 1996; Fleming et al., 2007; Kemp & Sandall, 2010; Brodie, 2012; Edwards, 2009; Carter, 2012; Hosein, 1998; McLean, 2016). Positive mutual support and understanding is created when midwives are able to develop relationships with women (Mander, 2015; Coxon, 2014; Dancy & Fullerton, 1995).

For women not guaranteed to have continuity of care during labour, there appears to be merit in the woman meeting other members of the team (Jennings, 2005). Some women chose to plan a home birth because thought they might receive an increased level of continuity of care by doing so (Ashley & Weaver, 2012a). However, concern over the lack of knowledge about whether their attending midwife would be positive towards their home birth plan have been voiced in these instances (Jennings, 2005).

Women's confidence with the clinical provision of planned home births:

It is possible that in developing a supportive relationship with their midwife, women become instilled with confidence (Bliss, 2010; Furlong-Davies & McAleese; 2008, Jennings, 2005).

Confidence was created with the midwife's belief that birth was a natural process (Morison et al., 1998, Kontoyannis & Katsetos, 2008; Jouhki, 2012,;Morison et al., 1999; DiFilippo, 2015; Murray-Davis et al., 2014), and their belief that the individual women they are caring for are capable of giving birth naturally (Lindgren & Erlandsson, 2010; Viisainen, 2001; Catling et al., 2014). The notion of empowerment was also used to describe this process within several sources (Dahlen et al., 2011; Lindgren & Erlandsson, 2010; Merg & Carmoney, 2012).

Women who understand their midwife's clinical role, and have confidence that their midwives can manage certain emergency situations such as neonatal resuscitation, are more likely to consider birthing at home (Catling-Paull et al., 2011; Janssen et al., 2009; Johnson & Davis-Floyd, 2006; Lindgren et al., 2010; Lothian, 2010; Lothian, 2013; Murray-Davis et al., 2012; Regan & McElroy, 2013; Sinnhuber-Giles, 2008; Sjöblom et al., 2006; Viisainen, 2001; Walsh et al., 2011; Lindgren et al., 2005; Catling et al., 2014,;Ball, 2014; Goldstein, 2015; Hollowell et al., 2015).

Women's confidence in home birth also increases where there is a co-ordinated back up service in case transfer to obstetric services is necessary (Catling-Paull et al., 2011; Johnson

& Davis-Floyd, 2006; Lothian, 2010; Lothian, 2013; Murray-Davis et al., 2012; Dahlen et al., 2011).

Women who do not plan home births appear to perceive a midwife's clinical role as being to assist the doctor, and that they therefore may not have confidence in their ability to deal with emergency scenarios (Lavender & Chapple, 2005). Additionally, midwives who work in hospital environments were viewed with more confidence because of the greater use of technology in this setting (Lavender & Chapple, 2005; Arcia, 2015). Particular concern in relation to the safety of home birth for the neonate may resonate from a lack of confidence in a midwife's clinical skills (Murray-Davis et al., 2014).

Midwifery confidence with home birth:

Midwives having a belief that women can give birth safely is very important in terms of their ability to discuss and promote home birth effectively (Davies Floyd & Davies, 1996; Green, 2015; Jervis, 2014; Walton, 2015; Gifford, 2003; Newburn, 2012; Perkins, 2009).Continuous support appears to potentially assist midwives to feel confident to attend home births, and where this is not currently facilitated, several sources discussed this as being a potentially positive service development (Mills Shaw, 2009; Floyd, 1995; McLaughlin, 2006; Bick, 2012). McCourt, Rance, Rayment and Sandall (2011) found that where midwives were not proactive in their promotion of home birth with women, this stemmed not from a lack of support for home birth, but from their own lack of confidence in this aspect of care provision. This finding is also noted in other literature (Edwards, 2008b; Floyd, 1995; Chamberlain et al., 1999; Rogers et al., 2005; Madden, 2005).

Exposure to home birth during training and in clinical practice helps a midwife to feel positive about offering and providing home birth (Janssen et al., 2009; Vedam et al., 2009). Student midwives are facilitated to become familiar with home birth during their training, in order to increase their confidence in this aspect of midwifery care (Brodie, 2012; Carter, 2012; Finigan & Chadderton, 2015). A lack of clinical exposure to home birth results in less positive feelings to home birth during a midwife's time in clinical practice (Vedam et al., 2009; Vedam et al., 2010; Vedam et al., 2012).

Midwives need sufficient training, so that they can feel confident and supportive of home births (Madden, 2005; Rogers et al., 2015; Noble, 2015; Jervis, 2014; Hollowell et al., 2015;

Griffiths, 2015b). There is concern that the way in which student midwives are educated (Milner-Smith, 2010; Green, 2015), and how individual maternity services operate, result in midwives being constrained and deskilled in these practices (Geneviev, 2014; Walton, 2015). Where midwives do not have a belief that women can give birth normally this will negatively affect their ability to discuss and promote home birth effectively (Davies Floyd & Davies, 1996; Gifford, 2003; Reed, 2008; Rogers et al., 2012 Hagelskamp et al., 2003).

Information provision about home birth:

A percentage of women who plan a home birth will learn about this option through their interactions with their midwife (Dagustun, 2009; Watts et al., 2003; Andrews, 2004a; Ashley & Weaver, 2012a; Catling et al., 2014; Kontoyannis & Katsetos, 2008; Munday, 2003a; DiFilippo, 2015; Chadwick & Foster, 2014).

Where a midwife holds a strong belief in the ability, and the importance of women making informed choices about their care, home birth as one of the possible birth locations for her to choose from is more likely to be offered (Davies Floyd & Davies, 1996; Fleming et al., 2007; Kemp & Sandall, 2010; Brintworth & Sandall, 2013; McLaughlin, 2006; Richley, 2011; Davis, 2011; Geneviev, 2014; Green, 2015; Jervis, 2014; Hoang et al., 2013; Bailes & Jackson, 2000). The process should become one of shared decision making, based on respect for each party (Bogdan-Lovis & Vries, 2013; Dancy & Fullerton, 1995) with support also given to partners during the information and decision making process (Howe, 2013).

Midwives stimulating positive discussion about home birth, and performing actions that facilitate the consideration of home birth during a woman's pregnancy could also influence her to choose home birth, or serve as a reinforcement of the possibility for women who had already considered home birth before receiving antenatal care (Bliss, 2010; Lavender & Chapple, 2005; Ashley & Weaver, 2012a; Bliss, 2010; Rogers et al., 2005; Andrews, 2004a; Ng & Sinclair, 2002). The process of decision making is referred to as a process of unlearning and relearning (DiFilippo, 2015; Chadwick & Foster, 2014; Cheyney, 2008; Catling et al., 2014).

The best timing for antenatal discussions may include information and discussion at booking (Mitchell-Merril, 2006; Dancy & Fullerton, 1995; Hollowell et al., 2015), thirty-four weeks gestation (Jervis, 2014), or throughout pregnancy (Mitchell-Merril, 2006; Dancy & Fullerton,

1995). Dagustun (2009) writes that the one-to-one discussions between midwife and woman may not be the most appropriate 'forum' for information provision.

A combination of written and spoken individualised information was felt to be the most useful way for midwives to convey their knowledge about birth place options (Rogers et al., 2005; Hollowell et al., 2015). A multi-dimensional approach combines leaflets, positive and informative discussion on an individual basis and during parent craft and home birth group meetings, and viewing natural birth videos (Lothian, 1995; Mitchell-Merril, 2006), and holding home birth meetings (Mills Shaw, 2009; Richley, 2011; O'Connell et al., 2012; Rogers et al., 2012; McLaughlin, 2006; Kemp & Sandall, 2010; Carter, 2012; Edwards, 2009) may be useful. An electronic app has been used to provide information and stimulate discussion (Walton et al., 2014) and the use of internet resources is recommended (Noble, 2015). In addition to midwives providing information to women, midwives can be facilitative of women having the opportunity to inform other women about home birth (Davis, 2011; Carter, 2012; Lothian, 1995; Jervis, 2014; Noble, 2015).

Discussion should include mutual disclosure by woman and midwife regarding the services provided by the midwife, the qualifications and clinical experience that she and any midwife colleague who may attend the birth have, contingency planning for transfer and the home based and hospital based management of obstetric and neonatal emergencies and a description of the client's responsibilities in terms of disclosing any relevant health or social issues that may impact on her suitability for home birth (Dancy & Fullerton, 1995; Davies Floyd & Davies, 1996). Sufficient time to discuss a combination of the Birthplace England findings (Birthplace in England Collaborative Group, 2011), the requirements of the NICE Intrapartum care guidelines (2014), and local guidance is recommended as content for information provision (Finigan & Chadderton, 2015; Walton et al., 2014; Noble, 2015; Jervis, 2014; Rogers et al., 2015). It is important for midwives to inform women that they do not need to have undue fear of birth, and that there are real reasons to give birth at home (Lothian, 1995; Lothian, 2002 Howe, 2013). In addition, midwives should engage in the emotional side of pregnancy and home birth decision making (Dancy & Fullerton, 1995; Johnson & Davis-Floyd, 2006).

Routine antenatal information provision about planned home birth is frequently reported to be unsatisfactory by women and midwives (Care Quality Commission, 2013; Bourke, 2013;

Edwards, 2005; Dodwell & Gibson, 2009b; Hagelskamp et al., 2003; Soltani et al., 2015; RCM, 2011), and is not suitable or supportive of the concept of women planning a home birth (Dancy & Fullerton, 1995; Mander & Melender, 2005; Lothian, 1995). Whilst it is accepted that some women do continue to plan for home births despite negative references to their plans being made by their caregivers, or insufficient information being provided (Andrews, 2004a; Rogers et al., 2005; Shaw & Kitzinger, 2005; Edwards, 2005), this situation results in many women dismissing the idea in its infancy, or altering their plans (Bourke, 2013; Lavender & Chapple, 2005). Being told that the option of home birth exists does not equate to a woman being able to make an informed decision about this option, and, within the context of the UK maternity services, home birth being mentioned by a midwife at the start of a pregnancy is not always sufficient to enable a woman to consider this option for herself (Coxon, 2012; Dagustun, 2009).

Where midwives were not perceived to have raised the idea of home birth, or to have provided information about home birth, women who have chosen hospital based births either appear to interpret this neglect to mention or discuss home birth with them as confirmation of their own pre-formed opinion that hospital birth is best (Madi, 2001; Longworth et al., 2001; Houghton et al., 2008; Soltani et al., 2015), consider that there was no choice to be made about birth place that included the option of a home birth (Lavender & Chapple, 2005; McCourt, Rance, Rayment & Sandall, 2011; Rogers et al., 2005; Pitchforth et al., 2009; Soltani et al., 2015), or that while they know that home birth is technically a possibility, they unfortunately did not believe it to be a real option (Lavender & Chapple, 2005; Madi, 2001). Dagustun (2009) refers to this information failure as being driven by power dynamics, and as a key area of concern in relation to women being able to exercise choice. McCourt, Rance, Rayment and Sandall, (2011) concluded that not many midwives 'proactively' informed women about the option of home birth – and where high home birth rates were achieved, this was often the result of several midwives working in a more dynamic manner than the norm.

If women are not given information on natural birthing, then their only option may be to choose a medicated, institutionalised birth, and routine birth classes prepare women for a medical birth (Jimenez et al., 2010; Jouhki, 2012). The influence of poor information provision, and support for choice in place of birth can restrict a woman's choice outside the

social norm, and diminish autonomy in place of birth (DiFilippo, 2015; Ferreira Lessa et al., 2014; Bernhard et al., 2014).

Many midwives assume that the birth experience of women in their care would take place in hospital, and block the flow of information so that no conversation that challenges this assumption takes place (Madi, 2001; Lavender & Chapple, 2005; McCourt, Rance, Rayment & Sandall, 2011; Houghton et al., 2008; Coxon, 2012; Ashley and Weaver, 2012a). This may also be because midwives have a lack of understanding about the support that women need to choose home birth (Rogers et al., 2005; Soltani et al., 2015), believe that women may not fully understand the information (Knightley, 2007; Houghton et al., 2008), or to protect women from making unwise choices (Floyd, 1995; Hosein, 1998; Hagelskamp et al., 2003; Rogers et al., 2005; Houghton et al., 2008; Law et al., 2009). Where midwives are not motivated to offer, provide information about home birth or support a choice of home birth, this often arises from a personal concern about the safety of home birth (Madden, 2005; Hosein, 1998; Houghton et al., 2008).

Uncertainty is felt by midwives around how to discuss planned home birth with women, and this is suggested by Bick to have occurred because of the way that findings of current research findings are published in the media (Bick, 2012; Houghton et al., 2008) or simply because midwives were unaware of them (Houghton et al., 2008; Coxon et al., 2013).

Flexibility in the timing of decision making:

Flexibility, in terms of decision making, in a home birth service is a facilitative feature (Catling et al., 2014; Fleming et al., 2007; Richley, 2011; Griffiths, 2015b; Collins & Kingdon, 2014). The most frequently discussed feature of flexible care is the provision of early labour assessments at home for women (Redshaw, 2011; O'Connell et al., 2012; Stephens, 2008) as this allows women and their partners to learn about home birth and gain confidence in their ability to give birth, and then to make the decision to birth at home.

Prioritisation of normal birth by individual midwives:

Promoting normal birth in all settings appears to be linked to facilitating women to plan home births (Davies Floyd & Davies, 1996; Lothian, 2002; Lothian, 1995; Dancy & Fullerton, 1995; Collins & Kingdon, 2014; Brown, 2006; Kemp & Sandall, 2010; Richley, 2011).

Where negative discussions about birth are held, such as through the indiscriminate discussion of perinatal morbidity and mortality statistics, there is potential for maternity care to create fear of birth, and to sustain this as a result of interactions (Ball, 2014). Where women are not fearful of birth, they may be more able to consider the option of home birth.

Theme 4: The context of midwifery practice:

The literature suggests that contextual factors that operate outside of the immediate midwife-woman and partner relationship will also influence planned home birth decision making.

The influence of other healthcare providers:

Positive relationships between the home birth midwives and other midwifery and obstetric services were felt by women to be a facilitative approach in the decision to give birth at home (Catling et al., 2014). Positive working relationships with local obstetricians facilitate midwives in their provision of a successful home birth service (Brintworth & Sandall, 2013; Carter, 2012; O'Connell et al., 2012; Sandall, 2013; Jervis, 2014; Collins & Kingdon, 2014; McCourt, Rance, Rayment & Sandall, 2011, Wiegers et al., 2000).

Midwives also report finding the promotion and support of home birth more difficult where medical colleagues provide sub-standard information (RCM, 2011; Sandall, 2001; Edwards, 2009; Floyd, 1995; Griffiths, 2010; Law et al., 2009; Lowden, 2012). Where midwives are institutionalised and do not have professional autonomy, planned home birth rates are generally low in these countries (O'Boyle, 2013; Kontoyannis & Katsetos, 2008; Mander & Melender, 2005).

Home birth amongst other available birth settings:

'Bias towards middle-class women having planned home birth is less pronounced when home birth is actively supported by the local health services' (Nove, Berrington & Mathews, 2008, p.26), resulting in the choice of home birth being normalised within the service (Richley, 2011; Brown, 2006; Kemp & Sandall, 2010; Brintworth & Sandall, 2013; Rogers, 2009). Prioritisation of home birth within Canadian maternity services has facilitated the

increase in local planned home birth rates (Murray-Davis et al., 2012; McMurtrie et al., 2009; Catling-Paull et al., 2011).

Support for the increase in MLUs continues from professional bodies such as the Royal College of GPs and the Royal College of Obstetricians and Gynaecologists (McNutt et al., 2014). Since 2010 the number of OUs has reduced from one hundred and eighty to one hundred and sixty, and the number of AMLUs has increased from fifty-one to ninety-seven, and FSMLUs have increased from fifty-six to sixty-two (Hollowell et al., 2015). This is also the case internationally (Newman & Hood, 2009; Janssen et al., 2009; MacDorman et al., 2013). While home births were found to be more common in Trusts which had obstetric units and at least one free standing midwifery unit, and in Trusts with all three types of unit, compared to Trusts with only obstetric units (Redshaw, 2011); the increased development of MLU services seems to be related to a reduction in planned home birth rates (Rogers et al, 2005). An area's low home birth rate may reflect that the promotion of MLU's is favoured by the individual midwives, or the maternity service as a whole, above home birth (Rogers et al., 2005; Beake & Bick, 2007). Women will not routinely regard home birth to be a viable option to them if their local areas home birth rate is below five percent (Dodwell & Gibson, 2009a).

Midwives working within one 'hub and spoke' model, rotating between care provision in the hub OU to spoke FSMLUs reported experiencing benefit of their relationships with colleagues, in comparison to a sense of isolation that midwives who worked only in a community setting reported (McCourt, Rance, Rayment & Sandall, 2011).

The prioritisation of planned home birth within individual maternity services:

The allocation of midwives to case-holding, and home birth teams could be suggestive of the priority that a maternity service places, or individual teams of midwives (McCourt, Rance, Rayment & Sandall, 2011) place on the provision of planned home birth. The more recent literature included in this review illustrates the use of this service structure being employed when services attempt to increase their home birth rates (McCourt, Rance, Rayment & Sandall, 2011; Jervis, 2014; Noble, 2015; Carter, 2012; Richley, 2011). However, home birth rates can be improved using mechanisms other than case holding teams, such as a home birth lead, to support traditional community midwifery services in increasing their home birth rates (Mills Shaw, 2009).

In one of their case study areas, choice of home birth and the associated consideration of service user experience, was reported to be a 'fluffy' dispensable factor in service provision, in contrast to the need to consider the non-negotiable factors of finance, risk and safety (McCourt, Rance, Rayment & Sandall, 2011, p.32).

Midwifery leadership:

The quality of midwifery leadership has been referred to as a significant enabling factor by the midwives who work within such services (Thomas, 2003; Brintworth & Sandall, 2013; Finigan & Chadderton, 2015; Hollowell et al., 2015) as where midwifery leaders had strong voices it was easier to ensure that local maternity users had more balanced information about their choices (Rogers et al., 2005).

Supportive management results in the recruitment of Community Midwives who are also enthusiastic about home birth, and who contribute to team philosophies that promote normality (Edwards, 2009; Kemp & Sandall, 2010; McLaughlin, 2006; Fleming et al., 2007; Richley, 2011; Brintworth & Sandall, 2013; Brodie, 2012; Carter, 2012).

The acceptability and uptake of midwife led care options, such as home birth, can be increased through high-level organisational commitment and by implementing specific measures, including training and support for midwives, to ensure that the information and guidance given to women is evidence based (Brintworth & Sandall, 2013; Sandall, 2013; Hollowell et al., 2015; Collins & Kingdon, 2014).

The impact of poor staffing levels:

Maternity services need to plan for capacity of thirty percent of births to take place outside of an OU, and to ensure that their workforces are prepared for the change (Warwick, 2012). However, a lack of infrastructure to support this increase has been noted within multiple publications (Beake & Bick, 2007; Dodwell & Gibson, 2009b; Rogers et al., 2015; Rogers et al., 2005; Edwards, 2008c; Hosein, 1998; Carter, 2012).

Perceived difficulty with staffing for home births have been mentioned by service users as a concern or a reason to not plan a home birth (McCutcheon & Brown, 2012; Shaw & Kitzinger, 2005; Mottram, 2008), and by midwives (RCM, 2011; Beake & Bick, 2007; Edwards, 2008a; Edwards, 2008b; Noble, 2015; McNutt et al., 2014). McCourt, Rance, Rayment and Sandall (2011) report occasions where women who had planned to birth at home were

advised to attend an institutional birth setting because a midwife was not available to attend them at home.

Theme 5: Intervention studies that aimed to increase the rates of planned home birth:

This theme has concentrated on clinical interventions that have been implemented with the sole intention of increasing the home birth rate. There are further service evaluations and intervention studies undertaken with the aim of increasing all non-OU birth (Collins & Kingdon, 2014; Rogers et al., 2005; Rogers et al., 2015; Walton et al., 2014), but because these therefore include midwife led unit birth they have not been included in this section of the review.

Intervention studies aimed solely at increasing planned home birth:

Only one on-going clinical intervention study was found, which is being conducted as part of the Manchester Collaborations for Leadership in Applied Health Research & Care, with the sole intention of increasing planned home birth as a birth place choice (Noble, 2015). A team midwifery model was implemented, with a midwifery support worker (MSW), rather than a midwife, attending home births as the second birth attendant. A course was created to provide suitable training for the MSWs for this new role. The team created opportunities for face to face contact with women and their families by attending children's centres and home birth groups, and holding informal meetings where women can meet the midwives and MSWs. Posters about the team were placed in GP surgeries, and the team are also active on social media, and within Trust publications. Women can also receive a discount on a birth pool if they book with the home birth team.

The intervention will run for three years, with the aim to reach a three percent home birth rate from the initial rate of naught point three one percent in 2013. Within ten months, the team had received 212 referrals, of which 173 were accepted to have a planned home birth. 139 women received care until labour, and sixty-one gave birth at home.

Thirty-three percent of women changed their mind at booking, although it is unclear whether this is the initial consultation at the start of pregnancy or when a women is booked with the home birth team later in pregnancy; and nine percent of women changed their mind as pregnancy progressed.

Strengths and limitations:

Strengths:

This is the first scoping review that I am aware of with a sole focus on the subject of planned home birth decision making.

This scoping review has employed a broad definition of the concept of decision making, and encompassed a large body of literature, and in doing so has included the voices of both maternity service professionals, maternity service users and other relevant groups.

Although this review is not a systematic review it was approached systematically using the steps suggested by Levac, Colquhoun and O'Brien (2010). Using a systematic approach has created an audit trail of the review process, allowing replication of the review.

The strength generated by the inclusion of non-research based sources, in addition to the inclusion of all relevant research studies, is considered to be that the experience of a wider range of individual midwives, women and partners who have not had the opportunity to participate in research in this area has also considered. This process is felt to have facilitated their epistemological knowledge to be heard, against a research context that is often funded by policy makers and guideline developers.

Limitations:

The review has not included literature that was not published in English or Welsh, and this may mean that some relevant information has not been included. This decision was made because of costs associated with translation services. However, it is felt to be unlikely that key sources of information have not been included as English is a dominant language for publication.

No critical appraisal has been performed on the included sources. Levac, Colquhoun and O'Brien (2010) state this is not required for a scoping review, and it was also felt that in limiting inclusion based on critical appraisal a strength that has been gained by the inclusion of non-research based sources would be lost. However, as discussed in the body of the text, it is acknowledged that quality appraisal could have been applied to the empirical sources, as this may have provided additional confidence in the review findings.

The majority of the decisions around the inclusion or exclusion of the sources were undertaken independently, and this is therefore considered to be a limitation of this review, as Levac, Colquhoun and O'Brien (2010), and more recent authors (Peters et al, 2017) employed in advancing scoping review methodology note this to be an important element of scoping review rigour.

While a scoping review is felt to have been a useful review approach to take for this initial exploration of the published literature, it is considered that a beneficial approach in the future would be to conduct a realist review in order to understand the individual context of any interventions that are viewed as successful in increasing an areas home birth rate (Peters, et al. 2017).

Discussion:

To recap, the aims of this review were to:

1. To broadly explore the published literature surrounding women's decisions to plan a home birth.

2. To highlight any gaps in the existing literature

3. Suggest directions for future research in to the process of women's home birth decision making.

In relation to the first aim, the review found that the published literature provided a useful insight into the process of home birth decision making. All sources were considered to have provided relevant information, but a particular strength was felt to have been gained from the inclusion of the non-empirical sources, as this enabled the independent voice of maternity service users and individual professionals to be heard alongside the broader research agenda.

In gaining an insight about the experience of planning a home birth, the literature suggests that there are several factors that appear to facilitate or coincide for women when they plan to birth at home. There was a strong theme within the literature that a woman's individual social context can serve to support her in planning a home birth – a supportive partner was evident in the vast majority of cases, and it was common for women to report supportive

friends and family. The women planning home births also appeared predominantly to have certain sociodemographic characteristics that may serve to support them in exercising their autonomy and accessing home birth services.

In relation to how women who plan home births view birth itself, the literature shows that this is viewed as a positive and manageable experience that can safely be achieved at home – possibly after a experiencing a previous positive home or hospital birth. However, many women also reported difficult experiences in a hospital setting that they did not wish to repeat. This aspect of decision making also relates to a woman's birth preferences where priority was placed upon relationships with experienced midwife caregivers, and an environment that promoted physiological birthing but with recourse to emergency care provision as needed, rather than immediate access to care from the maternity multi-disciplinary team.

Midwifery care was found to be a positive factor within the literature in relation to the way that midwives provided information and support to women who wish to birth at home, and assisted women to have the confidence in their clinical abilities that enabled them to feel safe to birth at home. Additionally, among what appeared to be a minority group within home birthing women, midwives acted as the catalyst for their initial consideration of home birth. Where women did not hold facilitative sociodemographic characteristics, or have a social network that independently provided support for the idea of home birth, the role of the midwife and the wider maternity service was suggested to be very beneficial in supporting this process throughout pregnancy. However, at points, some women who wished to birth at home reported less positive influences that led to them needing to access external support and to rely on the support of their social networks and personal resources in order to retain this option.

Conversely, the literature suggests that for women who did not plan to birth at home, their social networks do not often provide support or information about this option, and were mostly seen to encourage hospital birth. Where women were not planning home births much of their discussions about birth, and rational for the choices that they were making suggest that birth was viewed with more caution and concern than the women planning to birth at home. This appeared to have been formed from previous experiences that served to create subsequent expectations and preferences for a more medically supported

environment, and the fact that their midwife's clinical skills were not viewed as sufficient to provide appropriate care in an emergency situation. Amongst this group of women, their midwifery care had not been viewed as influential in terms of supporting home birth decision making as a sense in the literature was that no home birth decision making had been engaged in.

The professional perspective gained from this review acknowledged how the prioritisation of home birth within an individual maternity service, the availability of other birth settings and the strength of midwifery leadership in relation to support for home birth all influence planned home birth decision making.

In relation to the second aim - to highlight gaps in the published literature, while a large body of literature was included within the review, only one source reported an intervention that aimed to increase rates of planned home birth (Noble, 2015). While this study appears to be working to address several of the barriers to home birth decision making that are, according to this review, suggested to exist for women – such as a lack of knowledge about the option of home birth, and lack of support for home birth within their social networks, no research has been published that explores how this approach could be best defined and undertaken. Therefore, a finding of this review is that a significant gap in the literature exists in relation to evidence based approaches to increasing home birth rates.

Consideration will now be given to the third aim of this review - to note the direction for possible future research. I will then return to consider how this aligns with the gaps noted within the literature. As part of this process, I will first discuss the ways in which the findings of the initial exploratory study [Chapter 3] support or report disconfirming findings to those found in this scoping review [Chapter 4].

The initial exploratory study [Chapter 3] provides some support for the beneficial effect that a woman's social network, in particular a supportive partner, can provide for her decision to birth at home. However, the case note audit provided a contrary finding by noting that approximately one quarter of the women planning to birth at home during the audit period were not married or cohabiting.

In relation to any support provided by the initial exploratory study in relation to sociodemographic characteristics of the women planning to birth at home, it was interesting

to note that woman Faye did not appear to hold these characteristics as she described herself as single and living in social housing. Facilitative aspects of her decision making was the support of her mother for home birth, and that her first birth had been after a precipitate labour – which had resulted in her community midwifery team recommending home birth for her subsequent births.

The initial exploratory study provides support for the review finding that women planning to birth at home have often experienced previous positive home births, and view birth as a manageable and safe process. Additionally, midwifery care had been experienced positively, especially by woman Erica, who reported her midwife has highly supportive and facilitative of her decision to birth at home. Woman Faye also commented favourably about her midwives wider colleagues.

The initial exploratory study findings all provide some support for the scoping review findings where women had not decided to birth at home. Most of this group of women in the initial exploratory study were not familiar with home birth via their social networks, and also reported that the midwifery care they had received, whilst all perceived as meeting their needs during their antenatal period, had not influenced their views of birth, or the location in which they planned to birth.

This study also provides some support for the scoping review findings in relation to the maternity service provider perspective. Several of the Community Midwives commented that the extent to which home birth is prioritised within service provision affects the way that this option can be provided to women, and that supportive midwifery leadership in terms of management is required if midwives are to be supported and encouraged to make this option possible for women.

In combination, the initial exploratory study [Chapter 3] and scoping review [Chapter 4] are suggested to have generated possible avenues for future research within home birth decision making. To return to the broad questions asked of the literature, and to consider these in light of the findings of these two chapters, it appears that possible answers to both questions are developing. These can now perhaps be considered in terms of modifiable practice related factors in terms of how midwives, and the maternity services approach this aspect of practice, and the way in which the individual context in which a woman makes the decision about home birth is supported to be as optimal as possible.

Modifiable practice related limitations on the efficacy of home birth decision making were noted in chapters 3 & 4, in terms of the way that home birth is often discussed and offered with women. An limiting approach to the offer, such as only making brief mention of the option, was seen in the midwifery practice in the initial exploratory study [Chapter 3], and this style of practice was also noted within the review of the published literature – especially amongst the care of women who did not plan to birth at home [Chapter 4]. In both chapters the findings suggest that a large percentage of women were reaching the end of their pregnancy and deciding where to give birth without have being assisted by their midwives to consider the option of home birth – possibly because once a woman has declined the offer of home birth, their midwife is then placed in a passive position and unable to directly discuss home birth further. These findings suggest that the way the concept of 'offering' planned home birth is being currently used and understood within clinical practice varies widely, and may not always be effective in achieving its aim. More optimal midwifery practices that were noted within the literature review were the provision of a clear offer of home birth to women, effective information provision, demonstration of midwifery clinical expertise and experience, and flexibility in terms of the timing of decision making. It is possible that these, and other factors, may combine to provide a more effective approach to supporting home birth decision making.

Modifiable contextual factors surrounding individual women were also noted by the initial exploratory study and the scoping review. These were that women's social networks could be supported to become accepting and positive about home birth, and women could also be assisted to become more positive about their ability to give birth, and to become more knowledgeable and accepting of the option of home birth. It may also be possible for wider society to be supported to adapt its prevailing birth culture towards become more accepting of home birth. Supporting an optimal context for home birth decision making could also arguably be an aspect of midwifery care that could be integrated within routine practice. It is interesting to note that Noble (2015) writing about the ongoing intervention to increase home birth rates in Birmingham, describe how elements of this approach is being employed within the study area. It is felt that midwives taking a more active approach towards supporting women in this potentially difficult aspect of decision making could be beneficial.

Conclusion:

While the published literature and the initial exploratory study suggest that these factors may be relevant aspects of home birth decision making to consider, no research has been published that explores what the exact components of an effective, perhaps more active, offer of planned home birth would be. To return to discuss the gaps that exist within the current literature base, it is interesting to note that while the one study that aimed to increase home births rates (Noble, 2015) does appear to be addressing many of these factors in terms of the way that the home birth team of midwives and maternity service workers are promoting home birth and provide care to women who decide to birth at home, no discussion of the underpinning rational for these elements of the intervention has been provided. Therefore, in recognising the potential for midwives to facilitate informed planned home birth decision making more effectively, it was felt that a beneficial avenue for further research would be to seek greater understanding of how the offer of planned home birth could most effectively be made to women. The need for an approach that feels active rather than passive, in order to overcome the sociological barriers that are present specifically in relation to home birth as a birth place choice, is considered to be an important aspect of how an offer should be made. Therefore, the next chapter of the thesis describes a concept analysis (Walker & Avant, 2011), which was conducted with the aim of exploring and defining the use of the term 'offer' in relation to planned home birth, and creating an active offer for planned home birth.

Chapter Five: Concept analysis of an active offer of planned home birth

Introduction:

The previous chapters [3&4] generated the conclusion that a more active approach to offering planned home birth may be beneficial in assisting women to make informed decisions about this option. This approach may also be useful within maternity services where an aim is to increase planned home birth rate. This benefit is considered to be obtained because where a passive approach is taken by midwives, women without a prior knowledge about home birth are not likely to consider birthing at home birth, and will potentially not make an informed decision about this birth place option. More active approaches to the offer of home birth were noted within the initial exploratory study [Chapter 3] and the scoping review [Chapter 4] and it is suggested that a more effective way of offering this birth place option to women could be developed if this approach is adopted. However, at present no clear understanding exists of what the necessary components of a more active offer would be.

As a result of interactions with bi-lingual lecturing staff within my department, I was aware of the concept of 'active offer' in terms of the provision of health services in both official languages in Wales. The findings of the initial exploratory study [Chapter 3] and scoping review [Chapter 4] suggested that there may be potential for the active offer concept to be applied to the offer of planned home birth. Therefore, this chapter presents the exploration of this process, and the subsequent development of a concept analysis for an 'active offer' of planned home birth.

Methods:

In line with the approach taken within mixed methods research, this chapter uses a concept analysis approach, drawing upon multiple types of evidential sources, as a way of applying the findings of the previous two chapters. Additional literature in relation to current applications of the term 'active offer', to generate a suggested 'active offer of planned home birth' was also accessed. On searching a number of databases, to my knowledge there has

not been a concept analysis of active offer undertaken before, and it is the first time that it has been applied to maternity care.

This concept analysis has used an adapted version of the staged approach suggested by Walker and Avant (2011). Walker and Avant (2011) write that they have refined and simplified an earlier concept analysis process that was produced by Wilson (1963). Their process involves eight steps, although they state that the analysis process will not necessarily be linear. The steps are:

1. Select a concept

2. Determine the aims or purposes of the analysis

3. Identify all the uses of the concept that you can discover

4. Determine the defining attributes

5. Identify a model case

6. Identify borderline, related, contrary, invented and illegitimate cases

7. Identify antecedents and consequences

8. Define empirical referents

The adaption to the concept analysis process concerns the use of qualitative primary research data taken from the exploratory study [Chapter 3], in addition to published evidence in steps 3 and 4. This approach, combining primary qualitative data and literature review findings, has been employed in numerous concept analyses that adopt the hybrid approach to conducting a concept analysis (Schwartz-Barcott & Kim, 2000). Therefore, the process suggested by Walker and Avant (2011) remains unchanged with the addition of the inclusion of primary data from the initial exploratory study [Chapter 3] during stages 3 and 4.

The table below provides a summary of the concept analysis process during each stage:

Table 18. Table to illustrate the concept analysis process

Stage of concept analysis	Process undertaken and rational
Select a concept	Aware of 'active offer' concept within minority languages

	Concept chosen to explore, as it resonated as potentially applicable to home birth decision making.
Determine the aims or purposes of the analysis	Consideration of findings of Chapters 3 and 4 – disparity in the way that home birth 'offered' to women, and lack of clarity amongst maternity services about how to effectively offer home birth. Use of the term 'offer' is not clear. Aim to use concept analysis process to provide initial exploration of how an offer of home birth, provided according to 'active offer' approach, could be created.
Identify all the uses of the concept that you can discover	Literature reviewed as per discussion below [Table 19]. This initially included the subject areas of minority languages and home birth, but was then expanded to include the areas of advertising and marketing. Initially the minority language literature was explored to assess if it was potentially applicable to home birth provision. Secondly, the developing active offer theory was applied to home birth to establish potential aspects for consideration within the defining attributes.
Determine the defining attributes	All included sources of literature were analysed with the aim of extracting any reference to home birth provision that aligned with the dictionary definitions of 'active' and 'offer', any aspects noted to relate to the barriers or policy drivers around minority and official language service provision [Table 21], and any components of care provision that relate to the active offer theory (Cardinal & Suave 2010) [Table 22]. Four defining attributes were determined as the result of this process.
Identify a model case	Cases were created from the service perspective, and aimed to highlight the way a midwife (within a maternity service) can actively offer home birth to women who are either knowledgeable or not currently knowledge able about home birth.

	The way that each of the defining attributes are provided within the model case, and the way that the elements and mechanisms outlined by Cardinal and Suave (2010) were considered [Appendix 16].
Identify borderline, related, contrary, invented and illegitimate cases	Borderline and contrary cases were created to reflect, from the service user's perspective, the way a midwife (within a maternity service) can offer home birth in a passive, or negative manner. The cases were constructed with consideration to an omission to provide the defining attributes of the suggested active offer.
Identify antecedents and consequences	Antecedents and consequences identified throughout the process.
Define empirical referents	Empirical referents identified throughout the process.

Data sources:

Data used within this concept analysis were obtained from several sources. In the first instance, the Welsh Assembly Government and Canadian Government websites were searched for references and publications discussing 'active offer' in relation to the provision of services in official and minority languages. Additionally, open web searching on Google, Firefox and Chrome search engines, using the terms 'active offer', was also undertaken, and 'active offer' in relation to the terms 'minority language provision'. This search aimed to retrieve information on the way that 'active offer' is being constructed and employed within the provision of services in minority and official languages.

Secondly, all of the sources obtained during the literature search undertaken for the scoping review [Chapter 4] were included [n=195] [Appendix 15]. Each was re-read and areas highlighted if it was felt that they provided a useful insight into this process, in terms of discussing a behaviour within clinical care that could serve as a component of an active offer. Additional searches of CINAHL and Medline using the terms 'active offer' and 'active offer + home birth / home childbirth' were also undertaken to ensure that all relevant home birth sources were included in the concept analysis.

Thirdly, the observation and interview data [Chapter 3] was re-read with the new objective of considering possible components of an active offer of home birth.

Fourthly, an open web search (rather than a more systematic search) using the search engines listed above was conducted using the terms 'marketing' and 'advertising' in relation to active offer. These were included as it felt reasonable to consider that 'active offer' may be a concept or approach that had been used within service industries and selling, such as marketing and advertising.

Results:

Selection of a concept for analysis:

Where a word or phrase is potentially used ambiguously in clinical practice, Walker and Avant suggest that undertaking a concept analysis may be of particular benefit (Walker & Avant, 2011). In this sense, use of a concept analysis in the respect of the use of the word 'offer' in relation to home birth is felt to be relevant.

In addition to the way that the field of minority language provision have adopted 'offer' as a way of expressing the ability of speakers of minority languages to access a service using the language of their choice, the word 'offer' was originally selected for this concept analysis because 'offering home birth' is one way that midwives refer to the process of women being aware of the option of home birth. However, prior to commencing this analysis I felt that if 'active offer' was a suitable concept to be aligned with home birth, then 'offer' would need to be conceptualised broadly within this definition, as the findings of chapters 3 and 4 had suggested to me that factors in addition to the literal 'offer' of home birth were important additional considerations. The need for standardised language is important within clinical practice, especially where, as has possibly happened with the offer of home birth and the increase of the rhetoric of choice within maternity policy, the offer of home birth has been diluted in some cases to a 'tick box' scenario.

In accordance with the approach taken within minority language provision, the word 'active' has been paired with 'offer' to create the suggestion of an option for planned home birth that is dynamic and alive throughout pregnancy. As seen in the previous chapters, possible ways this would be demonstrated are where home birth is routinely raised with a woman by

her midwife, that home birth is discussed as often as is required throughout pregnancy and that clarification, formal or informal, of a woman's decision making process is undertaken to ensure that an informed decision has been made.

Determine the aims or purposes of the analysis:

The aim of this analysis is to examine the basic elements of the concept of an 'active offer' for home birth, and provide clarity and direction as to what an active offer of home birth could look like in clinical practice.

Identify all the uses of the concept that you can discover:

The following uses of the word 'active' and 'offer', and the term 'active offer' were found during the literature searches:

Table 19. Table to illustrate the way that all uses of the words 'offer' and 'active' were found

Word or term	Search method	Source
Active	Open web	Dictionary English
Offer	Open web	Dictionary English Legal
Active offer + home birth / home childbirth	CINAHL and Medline databases	No sources
Active offer + home birth	Open web	No sources
Active offer + minority	Open web Government websites	Key publications obtained: Government policy re. minority language provision

language provision		Theoretical discussion of active offer within minority language provision
Reference to 'active' or related derivatives	Existing scoping review sources	Dodwell and Gibson (2011a and 2011b) Rogers (2009) McCourt, Rance, Rayment & Sandall (2011) Nove, Berrington and Mathews (2008)

Uses of the word 'active':

The Collins English Dictionary (2009) states that the word 'active' can be used as an adjective or a noun. As an adjective its meaning is to participate or be engaged in a particular sphere or activity, especially physically energetic pursuits; and as a noun it suggests a dynamic, or engaging form of the verb.

Uses of the word 'offer':

The word 'offer' can be used as a verb, or a noun. As a verb, it is defined by the Collins English Dictionary (2009) as the presentation or proffering of something, someone or oneself for acceptance or rejection. It also means to provide, or make something accessible, and to show or express a willingness to do something.

As a noun, a proposal or bid is offered.

Offer also has specific legal and business definitions, which relate to contract law and the binding nature of an offer once it has been accepted. It also refers to the detailed knowledge about the component parts of an offer that the potential accepter must be familiar with prior to accepting.

Uses of the term 'active offer':

The active offer of home birth:

No references to an 'active offer' of home birth were found in an internet open web search using these key words, or in the database search.

Reference to 'active' processes within the offer or provision of home birth services:

There is a sense in several pieces of writing about home birth provision that appears to acknowledge the current passive offer of home birth that is being provided by the maternity services and suggests that it would be an improvement if the service were to provide a more active offer to women. A prominent publication which discusses the way that home birth is currently offered to women is Dodwell and Gibson's 'Location, Location, Location' report for the NCT (Dodwell and Gibson, 2009b). The authors report that the five percent uptake figure that is employed within the report to categorise women's access to a birth place option was chosen in the belief that 'if the rate is lower than this we believe it is unlikely that women are actively being offered the choice of a home birth'[pg. 10]. Additionally, the word 'proactive' has been use in a further report, and one example of this is seen where reference is made to the benefits of a proactive offer of home birth:

> '…where there is a proactive approach to offering a home birth service there is up-take from women. It may be that in some communities women and families have a greater or lesser inclination towards home birth, but those attitudes and beliefs are influenced by the extent of the service provided, by staffing levels and the information about different birth settings provided by midwives, GPs and hospital doctors' (Dodwell and Gibson, 2009a).

In addition, this report recommends that 'active advocacy' as part of the proactive approach is undertaken by service providers. While this quote refers directly to more women making the decision to give birth at home where a more proactive approach to offering home birth is taken, it is also important to consider how a more proactive approach would ensure that women routinely make informed decisions about all birth locations. This idea is also mentioned by Rogers (2009, p.509) who observed a 'proactive approach to offering home birth' that was used by her midwife mentors during her midwifery placements as a student midwife. These references to a proactive stance to offering home birth that should be undertaken by maternity professionals, supports the decision to continue my studies exploring how maternity services can be assisted to improve their offer of home birth to women. As stated in the scoping review [Chapter 4] McCourt, Rance, Rayment & Sandall (2011, p.43) concluded that not many midwives 'proactively' informed women about the option of home birth.

As was noted within the definition of 'offer' – midwives need to do more than proffer the option of home birth to women, we need to make it accessible to them. While Dodwell and Gibson (2009b) list 'midwives, GPs and hospital doctors', initially concentrating on the dyadic relationship between a midwife and pregnant woman appears to be the most effective stance to take as midwives provide the majority of maternity care to women in the UK. While there appears to be support for the idea of a more 'active' way of offering home birth to women, there is no formal definition of what are the constituting elements of a more active offer aside from the suggestion that discussion and information about home birth are required.

Additional use of the term 'proactive' is seen in on-line forum discussions where women who hope to plan, or have planned home births talk about *their* need to be 'proactive' in mentioning their plans to their midwives, or becoming knowledgeable about their clinical situation in terms of their own suitability for home birth. This behaviour is not only discussed in terms of obtaining supplementary information, but rather that the women have had to undertake this process because of a perceived deficit of information and support that was being provided by their maternity care providers. This proactive behaviour is that reported by Shaw and Kitzinger (2005) in their study which analysed the conversations of callers to a home birth help line, and in numerous other studies reported within the scoping review (Edwards, 2005; Halton, 2006). Clinical practice that requires women to be proactive could be argued to be the result of providing a passive offer of planned home birth.

The term 'actively supported' is used by Nove, Berrington and Matthews (2008) in relation to entire health services that provide a dynamic home birth service.

'Active offer' in relation to official and minority languages:

Numerous references to the active offer of services within the official and minority languages in Canada, Wales and Australia were found during open web searching and searches of the respective Canadian and Welsh government websites. A link to the Australian use of 'active offer' was provided during one of these searches. Their use of the term 'active offer' will be discussed below.

'Active offer' is referred to within the literature discussing the provision of official or minority languages within three countries worldwide – Canada, Wales and Australia. As the

name suggests, it refers to the way in which a service is offered to members of the public who may wish to access this service in either of the official languages of their country. The following table briefly illustrates the degree to which the active offer approach has been implemented:

Table 10. Table to illustrate the way in which the Active Offer approach has been implemented within public policy in three countries

Country	Official Languages Act in place?	Active offer within public policy? Which areas?
Canada	Yes – since 1969	Yes: All public sectors including healthcare
Wales	Yes – since 2012 Previously - Welsh Language Act, 1967 & 1993	Yes: Healthcare, Social care
Australia	No – although the Gov. of the Northwest Territories aims to provide an 'active offer' of services in Aboriginal languages	Unknown

As Table 20 shows, both Canada and Wales have enacted legislation such as the Official Language Acts within their jurisdictions that enshrine official language status of both English and French in the case of Canada (Official Languages Act, 1969), and English and Welsh in the case of Wales (Official Languages Act, 2012). Canada appears to be the country that has developed the active offer concept to the greatest extent of the three countries currently using this approach. The earliest reference to active offer retrieved from the Canadian Government website was written in 1993, while the term 'active offer' appears to have been first used within Welsh policy documents in 2012 (Welsh Government, 2012).

Similar requirements are made within Canada and Wales in terms of active offer provision. Service providers must accept their responsibility to provide an active offer, and clearly and spontaneously demonstrate that services can be provided in both official languages; and clients should be encouraged to the use the official language of their choice. To support this

there is a requirement for service providers to ensure that 'services of comparable quality' are available in either language (Lorte & Lalonde, 2012; Welsh Government, 2012).

Within the gaze of service users, both the Canadian and the Welsh active offer includes practical measures such as bilingual greetings, posters and signage to increase the visibility of the option of language choice within service environments (Welsh Government, 2012; Lorte & Lalonde, 2012). Behind the gaze, the ability of staff to provide an active offer is supported through the designation of posts as bilingual required or essential, and language training for staff who are not yet bilingual (Welsh Language Commission, 2013b).

In both countries, events to sustain and promote the use of the official minority languages within the local communities through cultural activities such as art are included within the terms of the active offer as they are used to demonstrate to society at large that it is appropriate to use both official languages. In Canada this has been facilitated by the Commissioner for Official Languages' requirement that 'positive measures' (Official Language Commissioner, 2013) are employed by Federal Institutions within their communities.

The applicability of using an active offer to support the offer of home birth:

Cardinal and Suave (2010), in their discussion of the offer of French Language Services, state that a passive offer provides a 'less conducive and less favourable climate for exercising one's rights [to FLS]. In fact, even if the service is available…service users are at risk of not noticing it' (p. 19). This sentiment appears to be applicable to the offer of planned home birth, based upon the findings of the previous two chapters [3&4].

It is my suggestion that demonstrable similarities exist between the offer and choice to use the official and minority languages of Canada and Wales, and the offer and choice of planned home birth in the UK, and also in other developed countries that include planned home birth within their maternity service provision. This means that the overall approach being taken to enact an active offer in the area of language choices may also be transferable to the context of home birth provision.

The similarities are listed in the table below.

Table 11. Similarities between the ability to access a minority language service and decide to plan a home birth

Issue:	Seen by:
Historical	The historical subordination of both minority language use and the choice of home birth
Current access to services	Equality amongst those service users in terms of those who are currently accessing and those who are not accessing the services potential service users, at times, need to request their required service, rather than a systematic approach being taken by the providers to offer and facilitate this option That visibility of the services is felt to be relevant to service provision within the literatures The need for clear leadership within the provision of choices The current social and cultural norms that support dominant language use and hospital as a birth location
Service improvement	The existence of statutory or policy requirements to ensure the provision of the specific services The suggestion of improved clinical outcomes if the relevant service is provided The fact that improvement of the services would assist the achievement of the aim that health service users are enabled to be in control of their own healthcare

These individual factors are discussed in greater detail below.

***The historical subordination of minority language use and home birth*:**

Both Wales and Canada have a historical past containing periods of British political dominance, where the Welsh and French languages were made subservient to the English language (Canadian Government, 2009; Penny, 2002). The historical situation of both these minority languages, although both now have official status in their respective countries is

still felt to be relevant to the way in which the offer of services needs to be approached. This is apparent in the references made to the need to ensure that Welsh is treated no less favourably than and that 'the citizen, whether by experience or expectations, psychologically or hypothetically knows that English is stronger than Welsh in all parts of Wales (Welsh Language Commissioner, 2014, p.89).

Home birth in the UK also experienced a decline in popularity based on political decision making, when between the 1950's to 1970's several investigations into the UK maternity services recommended initially that seventy percent of women (Ministry of Health, 1959), and later one hundred percent of women gave birth in hospital (Ministry of Health, 1970; Davis, 2013). The rates of home birth during this period are documented as reducing from approximately thirty percent in the 1960's, to one percent by the mid 1980's (ONS, 2013). The findings of the initial exploratory study were that the women participants often anticipated that their Community Midwives would not feel favourably towards home birth, and this could be an effect of this decline in home birth and the demonstrated health service preference for hospital birth, or that the perception of some service users that home birth care is a 'second class service' when compared to hospital care (Halton, 2006, p.4).

Equality is not being achieved amongst the population of potential service users:

It appears that minority language speakers are not able to access sufficient health services in their own languages. It is a stated aim of the Chair of the Inquiry Panel that produced the investigative report 'My health, my language' (Welsh Language Commissioner, 2014, p.7) that the report is able to support work which guarantees Welsh speakers in Wales are 'ensured equitable access to primary care services in the language that best serves their health, wellbeing and dignity'. In Canada, where access to health services is not generally associated with financial barriers such as income, there still appears to be that language and cultural barriers to the provision or of services in persist certain circumstances (Bowen, 2001). Several circumstances were observed, with those preferring to receive healthcare in a minority language being one such circumstance. In addition, groups such as immigrants and deaf people were also found to experience language barriers, and Cardinal, Lang and Suave (2006, p.35) suggest that one reasons for this may be that 'vulnerable groups do not always request FLS [French Language Services], even when they know they are entitled to receive such services'.

Within the home birth literature, and as was noted in the scoping review of planned home birth decision making, work by Coxon (2012) and McCourt, Rance, Rayment & Sandall (2011) noted that the women who currently achieve home births in the UK belong to a societal cross-section of mothers with a 'privileged identity' – namely British born, white, married, financially well off, and educated. This inequality of service access has been noted in other published literature, and has reportedly served as a reason for one Trust to stop funding specific home birth services (Thomas, 2003; Thomas, 2006). However, in certain areas of the UK women from a wider socio-demographic profile are seen to achieve home births which, as was stated in the literature review, suggests that where an effective offer of home birth is made, not only women within the 'privileged identity' can choose (Nove, Berrington & Mathews., 2008; Green, 2016). This is reported in the previously referenced NCT report that recommended 'proactive' home birth services and 'active advocacy' (Dodwell & Gibson, 2009b). Therefore, a potential effect of an 'active offer' could be to widen the availability of a service.

Potential service users need to request their required service, rather than a systematic approach being taken by the providers to offer and facilitate this option:

The literature discussing minority language service provision makes frequent reference to research findings that potential service users have to request a service in their preferred language (Welsh Language Commissioner, 2014; Lorte & Lalonde, 2012; Cardinal & Suave, 2010). The authors of 'My health, my language' (Welsh Language Commissioner, 2014, p.67) state that this, along with other deficiencies in the manner of service provision, create a service that is 'being driven by the needs of the providers rather than the service users'. Many individuals who would prefer to speak a language other than English actually receive their service in English. Where services are received in a minority language, the authors believe that this is more by luck than design (Welsh Language Commissioner, 2014).

Within the UK home birth literature it is evident that women who were able to plan a home birth often initiated this themselves by asking their midwives about the option, although it is not known if the midwives would have later offered this option to them. Aside from a minority of articles documenting the practice of midwives who appear to attempt to provide systematic approach to discussing home birth (Brintworth & Sandall, 2013; Kemp & Sandall, 2010; Green, 2016) the remainder of the articles could at times create the impression of a

service being provided 'by luck' for privileged women who are able to vocalise their desire for this clinically beneficial service, or where midwives provide this clinical care on their own initiative (McCourt, Rance, Rayment & Sandall, 2011).

Social and cultural norms support use of the dominant language and hospital as a birth location:

The research that informed the development of the active offer for minority language services, in healthcare and other sectors such as the judiciary, refer to the fact that speakers of the minority languages now believe it to be 'the norm' to receive services in English (Welsh Language Commissioner, 2014; Cardinal & Suave, 2010; Lorte & Lalonde, 2012). This is explained by Lorte and Lalonde (2012, p.10) as occurring 'after several decades without French language health services, people have the impression they are impossible to obtain'. It has also been noted that for many health professionals, the possibility and importance of providing care in languages other than the socially dominant language is also not apparent (Welsh Language Commissioner, 2014). Within healthcare specifically, both Canada and Wales make reference to the importance of the active offer principle being applied broadly so as to ensure that a community's health status, and the historical and current social reasons for the lack of minority-language health services are considered within all relevant policies (Welsh Language Commissioner, 2014; Lorte & Lalonde, 2012).

Research into home birth within the UK maternity services suggests that a similar situation exists. It has been the social norm to attend a hospital OU to give birth, rather than choose to give birth in your own home for at least the last forty years. This is reflected in the statistics mentioned in the earlier discussion of the historical subordination of home birth. This has resulted, amongst the generation of UK women giving birth within the last ten or so years of an assumption that they would give birth in hospital, that home birth is not a real option for them, and stereotyped opinions of women who choose to give birth at home (Madi, 2001; Houghton et al., 2008; Coxon, 2012; Coxon et al., 2013; Lavender & Chapple, 2005; Green, 2016).

The rise in the development and promotion of alongside MLUs as the most suitable birthing location for low risk women may also serve to continue the bias against home birth within society (Rogers et al., 2011) and within the maternity services themselves (Redshaw, 2011; Rogers et al., 2005; Bourke, 2013; McCourt, Rance, Rayment & Sandall, 2011).

Visibility is felt to be relevant to the provision of an active offer of minority language services:

The active offer literature, considering the provision of minority language services demonstrates that visibility has been felt to be a constituent part in the active offer of language services in Canada and Wales. Visibility has been identified by the Société Santé en Français (SSF) as one of the 'six bases' for standards in primary care health services, with the five other bases being public awareness and acceptance, accessibility, client continuity and guidance, cultural and linguistic quality and institutional identity (Lorte & Lalonde, 2012).

The word visibility has mostly been used in terms of 'visibility of services' within the minority language active offer literature, although the requirement for offers to be physical and tangible are also mentioned (Lorte & Lalonde, 2012, p.9). In Wales, the link between a service being visually demonstrated and its perceived availability was found to be high, with very high levels of agreement by service users that posters in Opticians displaying which services are available in Welsh, and websites containing details about which primary care practitioners are able to speak Welsh both made a Welsh language service appear more obtainable (Welsh Language Commissioner, 2014). This approach is also advocated within the Canadian justice services method of ensuring an active offer of French Language Services, although the increase in visibility via information on the internet is only seen as a 'short term' measure to deal with the problem of French speakers not requesting services in the medium of French (Cardinal, Lang & Suave, 2006).

Only one reference to the concept of 'visibility' in relation to home birth is found within the published literature. A PhD thesis discusses the way that home birth associations in Australia raise the public visibility of their groups and home birth policies in order to raise the profile of planned home birth (Dallenbach, 1999). However, no reference to the visibility of home birth in terms of individual women was made.

The previous chapter [Chapter 3] reports the findings of the initial exploratory study and discussed my consideration of how the visibility of planned home birth may be a factor in a woman's ability to consider and choose home birth. However, as the study discussed a range of positive and negative examples of home birth visibility, it therefore suggests that not all visibility would be a facilitative within an active offer. This is referred to by Brighenti (2007) in his discussion of the three 'thresholds of visibility' – low, correct and supra thresholds.

This has not been discussed in the literature about the active offer of services in minority languages. The scoping review [Chapter 4] provided findings that could be interpreted to suggest that for women who inhabit the 'correct' threshold of home birth visibility the offer and choice of home birth was more possible, and more likely to be thought of as an acceptable option for them. In brief, this included knowledge about the way in which home birth is provided (Catling-Paull et al., 2011), friends and family being supportive (Dobson, 2009; Gannon, 2005; Halton, 2006), and possibly experienced in the choice of planned home birth (Lothian, 2010) and being aware of a midwife's clinical skills and experience attending home births (Catling-Paull et al., 2011; Kemp & Sandall, 2010; Lindgren et al., 2005; Lothian, 2010; Murray-Davis et al., 2012; Ng & Sinclair, 2002; Lavender & Chapple, 2005). Therefore, an active offer of home birth could serve to increase the level of positive home birth visibility amongst women currently inhabiting the low threshold of visibility, and would serve to counter the impact of the supra-visibility that home birth experiences both within the media and potentially within social networks with low levels of home birth experience. This approach has been alluded to by Noble (2015) and Green (2016) in their respective discussions about the ongoing home birth intervention study in Birmingham.

The need for clear leadership and management:

Health service managers are noted as one of the influential parties in service provision in a minority language (Welsh Language Commissioner, 2014; Lorte & Lalonde, 2012). References are made within 'My health, my language' (Welsh Language Commissioner, 2014) to the Welsh Government policy development at macro level requiring a similar strong policy drive at a local level to ensure implementation. One of the evidence statements is that 'the balance between national and local in Wales has often been somewhat ambiguous' (p 120). It appears that on a more micro level, individual service providers have not been sufficiently encouraged to provide bilingual services (Welsh Language Commissioner, 2014; Lorte & Lalonde, 2012; Cardinal & Suave, 2010).

Within the literature included in the scoping review on home birth decision making [Chapter 4], it was noted that maternity service managers played an important role in ensuring proficient home birth services were provided (Brintworth & Sandall, 2013; Brodie, 2012; Carter, 2012), and were also referred to where midwives were encountering difficulties in providing a home birth service (McLaughlin, 2006; Thomas, 2006). In the initial exploratory

study [Chapter 3] a number of the community midwife participants alluded to their belief that they would be assisted to offer an improved home birth service if their own managers valued the work that they undertook in the community setting, and placed more emphasis on ensuring that community midwives provided an effective home birth service.

Improvement of the services would assist the achievement of the aim that health service users are enabled to be in control of their own healthcare:

The literature proposing use of an active offer for minority language services all make reference to the benefit of patients, within a healthcare context, being partners in their own care and developing their care with their health professional. It is suggested that as a patient becomes more involved in their care, 'the more and more central to the process of making decisions on his/her care, there is a need to help them identify their needs, including language needs' (Welsh Language Commissioner, 2014, p.134).

Home birth, sitting within the general maternity policy agenda on 'choice', and more specifically 'informed choice', requires that women are involved and informed about all their options for care, and are then facilitated to make choices based upon the information provided (NICE, 2014a). As in the research about minority language service provision, the women participants in the observation and interview study [Chapter 3] who were not choosing home birth often expressed a lack of knowledge about home birth, with several acknowledging that they were making their choice in place of birth without sufficient information about home birth. The scoping review [Chapter 4] also found that women in the literature who had not chosen home birth were often unknowledgeable about important aspects of home birth that may have prevented them from making informed choices about their care (Dahlen et al., 2010).

The existence of recent statutory or policy requirements to support the provision of the specific services:

Canada and Wales are bilingual countries, with French and English, and Welsh and English named as their respective official languages. Both countries have Official Language Commissioners employed to ensure that policy development and implementation continues in a positive direction.

Within the UK maternity policy, for the last twenty years home birth has been included in policy documents as a birth place option that should be offered to women (DoH, 1993). This has continued throughout the last two decades with national policies such as the National Service Frameworks (DoH, 2004; Welsh Government, 2005a) and Maternity Matters (DoH, 2007) stating that home birth, as a birth place option, should be offered to women. The awaited NICE Intrapartum care guidelines will clarify this further.

Wales set a national target in 2002 to increase the home birth rate to ten percent by the year 2007 (Welsh Government, 2002), and although this target was reached it remains a goal of the maternity service in Wales to increase its home birth rate (Ferguson, 2010).

The existence of the suggestion of improved clinical outcomes if the relevant service is provided:

Publications discussing the active offer of healthcare services conducted in the Welsh and French languages both include consideration of the ethical reasons for ensuring an active offer is made, and similar arguments to these are also made within the home birth literature.

Lortie & Lalonde (2012, p.6) state that 'the active offer of French-language health services to Francophone minority populations in Canada is an issue of quality, safety, legitimacy, and, consequently, an issue of ethics'. The authors suggest that the active offer of services in the most appropriate language for an individual is an issue of quality and safety as it relates to the effective communication between patients and health workers. Communication problems, such a reduced patient compliance, reduced access to preventative care, mistaken diagnosis, increased medical tests and consultations, negative health repercussions, critical incidents, lower patient and provider satisfaction and higher health care costs, are suggested to be reduced by the use of an active offer (Bowen & Roy 2009, in Lortie & Lalonde, 2010).

Within the home birth arena, a similar argument around the potential benefits of home birth is taking place in the literature, with research suggesting the achievement of equivalent safety outcomes for mothers and babies, and reduced morbidity levels for mothers, when they birth their subsequent babies at home (Birthplace in England Collaborative Group, 2011). In addition to potential safety benefits, research also suggests that women who give birth at home experience higher rates of emotional satisfaction with their birth experiences,

in comparison to mothers who give birth in hospital settings (Viisainen, 2001; Munday, 2003a; Andrews, 2004b).

The decision to apply the active offer approach within home birth provision:

After consideration of the above factors, it appears reasonable to further consider the application of the active offer approach within home birth provision. The chapter this far has explored the ways that commentators and policy makers have considered and developed this approach in relation to the provision of services in minority and official languages, and it is my suggestion there are significant similarities within these arenas that influence the way that the respective services are currently provided. Therefore, this could be interpreted to suggest that the overall approach being taken to enact an active offer in the area of language choices is transferable to the context of home birth provision.

It is on this premise that the remainder of the chapter now moves to discuss the application of active offer theory within home birth provision, and discussion around the creation of the initial concept analysis for an active offer of home birth.

Applying the theoretical understanding of active offer within minority language services to planned home birth services:

There is limited published theoretical discussion about the active offer process. However, Cardinal and Suave (2010) have suggested that there are four theoretical elements with related mechanisms that have been effective in the provision of French Language Services within Ontario's Justice Sector. These are 'prerequisite', 'subjective', 'objective' and 'integration' elements.

Each element is listed below in the following table [Table 22], with the associated mechanisms noted also. The only alteration to the mechanism components that are stated by Cardinal and Suave (2010) is within the integrative element. In the original publication the authors list several population groups that the active offer of French Language Services need to focus on, such as the elderly and women, and these have been condensed to summarise the findings of the scoping review [Chapter 4] in terms of women who do not have a

privileged sociodemographic background, and those who do not have a social network that is supportive and informed about planned home birth.

Table 12. The potential application of the Prerequisite, Subjective, Objective and Inclusive elements (Cardinal and Suave 2010) to the offer of planned home birth

Element	Mechanisms - adapted to be relevant to the active offer of planned home birth
Prerequisite - Elements that must be considered	Aims to ensure that the organisational culture is conducive to the provision of the active offer. This includes the attitudes, behaviours and shared values of service providers, and also the social and organisational interactions: Recruitment Training Designated positions Planning Employee awareness Tools and resources Governance Promotion Accountability
Subjective - The verbal and non-verbal aspects	Aim to put the service user at ease in relation to the offer of services, and to ensure that the service user is immediately aware that the service is available to them Verbal communication Non-verbal communication and welcome
Objective Material and visual elements to support the offer	Must be displayed to unequivocally reflect the availability of all services Signage Documentation

	Pins and stickers Correspondence Announcement and news releases	Websites Other
Integration –Consideration of the needs of target groups	Women without a social network that is informed or supportive about planned home birth Women without a privileged sociodemographic background Significant others – partners, family members, friends	

As the table demonstrates, the elements and mechanisms that Cardinal and Suave (2010) note to be underpinning the active offer of French Language services within the Justice Sector also appear to be broadly applicable to the active offer of planned home birth. This is considered in more depth below:

The prerequisite element:

The scoping review [Chapter 4] noted how the context surrounding a midwife's practice was influential on her ability to offer planned home birth effectively. Several midwifery sources make reference to the like-mindedness of colleagues and the importance that this has within service provision both within clinical care provision and also in terms of management (Kemp & Sandall, 2010; Brintworth & Sandall, 2013; Fleming et al., 2007; McCourt, Rance, Rayment & Sandall, 2011). Midwives should be assisted to develop positive views of home birth (Vedam et al., 2010; Wiegers et al., 2000; Floyd, 1995; Stephens, 2008) and to be proud of assisting women to achieve physiological births (Hagelskamp et al., 2003; Kemp & Sandall, 2010; Jennings, 2005; Goldstein, 2012; Davies-Floyd & Davies, 1996). This was also referred to by several of midwifery participants in the initial exploratory study [Chapter 3].

The 'promotion' mechanism, defined by Cardinal and Sauvé (2010, p.18) as the process of identifying 'ways of promoting activities and resources intended to bring attention to and promote the availability of FLS among the francophone population', is a service user focused mechanism and was noted within the initial exploratory study [Chapter 3] where the midwives were organising occasional public events in local supermarkets to publicise home birth within the community, and also within the scoping review literature [Chapter 4] where films (Kaufman, 2010), and community groups (Noble, 2015; Green, 2016) were being used with this aim.

The subjective element:

The initial exploratory study and the scoping review [Chapters 3 & 4] reflect the importance of the subjective element in terms of a midwife's verbal and non-verbal communication about planned home birth. Verbal communication is used to convey firstly the offer of planned home birth, but also to provide information about how home birth is conducted; and non-verbal communication, for example in terms of how relaxed or confident the

midwife is in discussing the option of home birth was also noted within several sources (Goldstein, 2015; Catling-Paull et al., 2011).

The objective element:

The objective element was also referred to in both chapters [Chapters 3 & 4] in terms of the written information about planned home birth that women received. The scoping review [Chapter 4] also included sources where a wider range of mechanisms, such as posters and social media, were being employed to advertise home birth groups (Noble, 2015; Green, 2016).

The integrative element:

In relation to the integrative element, the scoping review [Chapter 3] highlighted two main mechanisms for consideration; the first being the influence that social networks, in particular partners, have on a woman's decision making – suggesting that it would be beneficial to include significant others within the active offer of planned home birth; and secondly, that women who do not belong to a privileged sociodemographic background are underrepresented within the cohort of women who plan to birth at home, and so this this suggests that they could possibly be considered a 'target group'.

In applying these four elements with this concept analysis, the focus has been placed upon the service user's perspective of service provision, because extensive consideration of the wider service provider related factors that will support or inhibit the implementation of an active offer was felt to be beyond the scope of this piece of work. Therefore, the subjective, objective and integration elements of the Cardinal and Sauvé's (2010) approach have been the central focus in terms of the interaction between the midwife-woman dyad in relation to the offer of planned home birth, with consideration of the prerequisite element only given in terms of the promotion of the home birth service.

Defining the attributes of an active offer of home birth:

The defining attributes of the analysis are the essential parts of the concept, as identified by the refining process (Walker & Avant, 2011).

The process of determining the defining attributes involved assessment of the included literature to collate any reference to clinical practice approaches or behaviours that would support the key elements that were included within the dictionary definition of 'offer' noted at the start of this concept analysis process – these are highlighted below in bold text within the definitions:

The word 'offer' can be used as a verb, or a noun. As a verb, it is defined by the Collins English Dictionary (Collins, 2009) as 'the **presentation or proffering of something**, someone or oneself for **acceptance or rejection**. It also means to provide, or **make something accessible**, and to show or express a willingness to do something'

The Collins English Dictionary (Collins, 2009) states that the word 'active' can be used as an adjective or a noun. As an adjective its meaning is to participate or be engaged in a particular sphere or activity, especially physically energetic pursuits; and as a noun it suggests a '**dynamic, or engaging** form of the verb'.

Additionally, any references that related to methods of home birth care provision that could serve to overcome the barriers to home birth decision making, or to facilitate the provision of services according to policy directives were collated.

Lastly, reference to possible facilitative processes in line with the elements of developing active offer theory outlined by Cardinal and Suave (2010) [Table 23] were collated.

All of the possible components, or attributes, of an active offer of planned home birth were collated into documents and time spent considering the ways in which the approaches or behaviours outlined in the sources could be appropriately condensed. Walker and Avant (2010, p.68) state that the aim of this stage of the process is to 'try to show the cluster of attributes that are the most frequently associated with the concept and that allow the analyst the broadest insight into the concept'. The wide range of sources included within this analysis are viewed as achieving this aim, and the resultant four defining attributes were considered to accurately reflect the elements selected from these sources.

The four attributes for an active offer of planned home birth are Creating the Conditions, Information Provision, Positive Reinforcement and Challenging the Cultural Assumption of Hospital Birth.

The attributes are intended to be appropriate for use within any maternity services current model of care. While it is acknowledged that providing high levels of continuity of carer during antenatal, intrapartum and postnatal care appear to provide some of the most favourable conditions for promoting and providing home birth (Benjamin, Walsh & Taub, 2001; Sandall, Davies & Warwick, 2001) most maternity services in the UK are not currently operating in this way, nor may be able to adapt their services to encompass this model of care (Beake & Bick, 2007; McCourt, Rance, Rayment & Sandall, 2011). Additionally, the development of home birth teams may also be beneficial (Noble, 2015), but again, is not an approach that is being taken within all maternity services. The implementation of the active offer of home birth would require the engagement of midwives and their employing maternity service organisations – potentially in line with the mechanisms that Cardinal and Suave (2010) outline.

The following table summarises the four attributes as they would be undertaken within an active offer of home birth, and how these relate to the four elements and their associated mechanisms that were outlined by Cardinal and Suave (2010):

Table 13. Proposed active offer of PHB domains in relation to Cardinal & Suave's (2010) elements and mechanisms

Attribute	Domain	Element	Mechanism
Creating the Conditions	Midwife mentions and offers home birth to woman at first meeting, making direct reference to the woman's previous birth experiences	Subjective	Verbal communication
	Idea that home birth will continue to be discussed throughout pregnancy regardless of woman's initial thoughts about home birth, and that no decision about home birth is required at the start of pregnancy	Subjective Objective	Verbal communication Documentation Film Email Multimedia
	Ensure that birth partner is included in discussion or communicated with via specific written material	Subjective Objective Integration	Verbal communication Documentation Websites Film Email

			Significant other
Information provision	Information is provided, from the start of pregnancy, that supports the philosophy of normality in midwifery care	Subjective Objective	Verbal communication Non-verbal communication Documentation Websites Film Email
	Woman provided with multiple formats of evidence based information, and with ongoing discussion in style of SDM used to ensure ongoing consideration and to support her decision making	Subjective Objective	Verbal communication Non-verbal communication Documentation Home birth groups Film

			Email Multimedia
	Partner provided with evidence based information and support	Subjective Objective Integration	Verbal communication Documentation Home birth groups Websites Film Email Significant other
	Information includes reference to a midwife's professional experience of home birth, and those of her team	Subjective Objective	Verbal communication Non-verbal communication Documentation Websites

	Information provision ensures that women have a clear picture of home birth is undertaken	Prerequisite Subjective Objective	Community events Verbal communication Non-verbal communication Documentation Websites
	Partners are informed they are not responsible for the care of the woman, or hosting the midwives during a home birth	Subjective Objective Integration	Verbal communication Documentation Websites Significant other
Positive Reinforcement	Women receive personal, positive support and encouragement to consider home birth in verbal and non-verbal ways	Subjective	Verbal communication Non-verbal communication

	Midwife show their professional support for a woman's personal consideration or choice of home birth	Subjective Objective	Verbal communication Non-verbal communication Provision of information sources
	Birth discussions frame birth as a normal physiological process	Subjective Objective	Verbal communication Non-verbal communication Documentation Sources of information
	Previous birth experiences of woman's own (or of friends or family members) discussed in terms of their suitability of a choice of home birth	Subjective	Verbal communication
	Partners are enabled to view birth, and their own previous experiences of birth in a positive way	Subjective Integration	Verbal communication

			Significant others
Challenging the cultural assumption of hospital birth:	Help women and their partners to consider how their own previous conceptualisation of birth may affect the birth place choices that they feel able to consider and chose	Subjective Objective Integration	Verbal communication Documentation Websites Film Email Significant other
	Midwife demonstrate that the choice of home birth is not unusual in the local area	Prerequisite Subjective Objective	Community events Verbal communication Documentation Information sources
	Acknowledge media influence in portrayal of home birth choices	Subjective Objective	Verbal communication Information sources

	Information is provided at the start of pregnancy	Subjective Objective	Verbal communication Information sources
	Midwife to offer different professional viewpoint (if required)	Subjective Objective	Verbal communication Information sources

Creating the Conditions:

Creating the Conditions is concerned with how women are informed about home birth, the way in which the connected features of their past and ongoing maternity experiences relate to their ability to consider home birth as an option for themselves. In effect, this attribute suggests the idea of a seed being planted (Madi, 2001). Several of the midwives (Mw Anna, Carole and Grace) in the observation and interview study [Chapter 3] referred to this process.

With regard to how women are informed about home birth, the literature review highlighted the fact that many women enter the care of the maternity services without knowing about the availability of home birth, or considering it as an option for themselves. For these women, as has been found to be the case for service users preferring to receive services in a minority language, it is vital that their midwife mentions home birth to them in order to shift their awareness of the different locations that are available to them. To not do so would potentially reduce a woman's ability to feel confident in the option (Welsh Language Commissioner, 2014; Madi, 2001; Rogers et al., 2005; Watts et al., 2003; Andrews, 2004b; Ashley & Weaver, 2012b; Ashley & Weaver, 2012a; Dahlen et al., 2008). The act of mentioning and offering home birth could be viewed as the initial step in countering the assumption of the superiority of hospital birth that many maternity service users hold throughout their pregnancy experiences (Madi, 2001; Bedwell et al., 2011). Particularly in relation to home birth rather than minority language services because of the on-going nature of decision making that culminates in a birth place choice, it is important that this attribute allows the idea that the discussion around home birth is something that will be continued as the pregnancy progresses, rather than that the dialogue represents a completed conversation (Rogers, 2009; Madi, 2001; Bogdan-Lovis & Vries, 2013; Houghton et al., 2008). This may necessitate the midwife being able, or feeling able, to re-visit the idea of home birth after other health professionals have already suggested it to be an unsuitable option (Floyd, 1995; Coxon, 2012). Therefore, a component of the active offer would be to ensure women understand that no decision about home birth is required at the start of pregnancy.

Where women already know about the option of home birth and feel that this is something they would like to consider, it is still important for their midwife to raise the option of home

birth with them as this allows the creation of confidence in the maternity system to adequately support home births (Catling-Paull et al., 2011; Wiegers & Keirse, 1998; Edwards, 2008a) and to open up supportive and equitable discussions about home birth between the midwife – woman dyad as the pregnancy progresses (Rogers, 2009; Parratt & Fahy, 2004; Rogers et al., 2005; Brintworth & Sandall, 2013; Ng and Sinclair, 2002; Nieuwenhuijze & Low, 2013,;McCutcheon & Brown, 2012; Cheyney, 2011). This is also supported by the models of active offer currently in use within minority language services, where service providers work to demonstrate to service users that they can expect to receive a quality service in their chosen language, comparable to that they would receive via the English language (Welsh Language Commissioner, 2014).

In both examples, this process is supported across all current active offer approaches in both healthcare and other settings, which has noted the importance of the service provider taking responsibility to formalise and facilitate the services (Welsh Language Commissioner, 2014; Cardinal & Suave, 2010). This process also serves to increase, in a positive manner, the visibility of home birth both in terms of providing a visual demonstration, and personalised perspective to a woman of her personal options for birth location, and in terms of demonstrating to her, through discussion of relevant local and national guidance for home birth, a favourable representation of home birth (Dagustun, 2011; Rogers et al., 2005).

The second aspect of this attribute concerns the way in which the subject of birth itself is discussed within the dyad. The literature review suggested that where antenatal care provision encouraged the discussion and consideration of women's previous birth experiences (Munday, 2003; Nieuwenhuijze & Low, 2013; Regan & McElroy, 2013), and facilitated discussion in pregnancy about the current choices that women were able to make for their forthcoming births from the perspective of birth being a natural event rather than a medicalised event, then home birth was more likely to be viewed as a desirable option (Bailes & Jackson, 2000; Hagelskamp et al., 2003; Lindgren et al., 2006; Kemp & Sandall, 2010; Hildingsson et al., 2006; Regan & McElroy, 2013; Edwards, 2008c; Ashley & Weaver, 2012a; Jimenez et al., 2010; Dahlen et al., 2008; Jennings, 2005; Jouhki, 2012). Newburn (2003) has raised a discussion based around findings that women are increasingly worried about labour, asking if this is related to how midwives are talking about birth with women. Midwives need to enable women to reach 'realistic expectations' about birth (Andrews,

2004a). Of particular note is how the concept of safety and risk are discussed with women, as the literature suggests that there may be value in including a woman's view of physical, emotional and spiritual safety rather than purely focusing on the technical safety that appear to dominate in professional perspectives about home birth (Parratt & Fahy, 2004; Edwards, 2008c).

The third element of this attribute is the acknowledgement of the influence of a woman's significant others in her birth place decision making, and the inclusion of these individuals into discussions around home birth. The literature review and the observation and interview study highlighted the powerful influence that women's partners held in their decision making around home birth (Anthony et al., 2005; Madi, 2001; Houghton et al., 2008; Mottram, 2008; Bedwell et al., 2011), and this is also the case for family and friends, in particular the expectant women's mothers and sisters, whose own birth experiences and information provision are very influential on women (Regan & McElroy, 2013; Wiegers & Keirse, 1998; Dahlen et al., 2008; Chadwick & Foster, 2013; Coxon et al., 2013). The inclusion of significant others, discussed by Cardinal and Sauvé's framework for an active offer of French language justice services (2010) in terms of the 'integration of diversity element' reflects this need. In addition to including women's partners and family in this element, it is important for midwives to be mindful of the current exclusion of women who did not fit the 'privileged' mother definition and ensure that all women are included in this offer (Coxon et al., 2013).

Information provision:

The second attribute of the active offer proposed within this concept analysis is information provision. Four main elements make up this attribute – the philosophy underpinning the process of information provision, the style or format of the information that is provided, the content of the information and the inclusion of significant others within the information provision aspect of antenatal care. Within the existing models of active offer that are used within minority language provision the process of informing service users of the ability to access services in a language other than English is central to the offer process (Welsh Language Commissioner, 2014; Cardinal & Suave, 2010; Lorte & Lalonde, 2012). However, while the information process in both situations is initially used to inform services users about the availability of the service, the information provision within the home birth service

is multi-layered in that it also necessitates the facilitation of a more detailed discussion about wider aspects of the practical nature of clinical service provision than that concerning of the availability of language choice.

The aim of information provision, as in relation to many aspects of antenatal care is to facilitate informed decision making, and in order to achieve this the literature demonstrates that midwives need to be committed to the process of giving and sharing evidence based information, and to hold an autonomous view of women and midwives (Bliss, 2010; Dagustun, 2009; Madi, 2001; Parratt & Fahy, 2004; Floyd, 1995; Regan & McElroy, 2013; Dahlen et al., 2008; Lindgren et al., 2010; Janssen et al., 2009). Maternity professionals need to be aware of how their own biases may affect how they provide information to women, in order to successfully overcome any barriers to informed decision making that may occur around blocking the 'flow of information' to and from women (Houghton et al., 2008; Regan & McElroy, 2013; Shaw & Kitzinger, 2005; Dagustun, 2009). Emphasis should not be placed upon giving women information and expecting them to make a decision unaided, but instead to facilitate an approach similar to that noted in the shared decision making literature (Bliss, 2010; Hagelskamp et al., 2003; Nieuwenhuijze & Low, 2013; Regan & McElroy, 2013; Edwards, 2005; Dahlen et al., 2008).

The sources and formats of any information should also be considered. It appears from the literature review that information provision should take place, from the start of pregnancy, in multiple formats in order to be as effective as possible. While written resources have been noted to be useful sources of information to women (Andrews, 2004; Rogers et al., 2005; Ashley & Weaver, 2012a; Ashley & Weaver, 2012b; McMurtrie et al., 2009), it appears to be widely acknowledged that written information on its own is not a sufficiently powerful method of providing information to women. The literature frequently refers to the benefit of providing written information and supplementing it with discussions between midwives, women and their partners (Ashley & Weaver, 2012b; McMurtrie et al., 2009; Andrews, 2004; Rogers et al., 2005; Bedwell et al., 2011; Ashley & Weaver, 2012a; Watts et al., 2003 Vedam et al., 2010).

Women can also be provided with information at home birth support groups, or by using other ways to reach sectors of the population who may not respond to more traditional methods (Anthony et al., 2005; Halton, 2006; Mottram, 2008). It may be beneficial for

service providers to acknowledge the negative effects of home births location within both the lower and supra visibility thresholds that were discussed beforehand (Brighenti, 2007), and to work to address this issue within their practices (Houghton et al., 2008).

The literature review provided many suggestions of what women require to be included in the information that they receive about home birth. The information needs to be evidence based, accurate, unbiased, consistent, and clear (Houghton et al., 2008; Floyd, 1995; Newburn, 2003; Regan & McElroy, 2013; Ashley & Weaver, 2012a), and preferably formatted to facilitate a woman's ability to know what her personal choices are, based on her own situation (Dagustun, 2011; Chamberlain et al., 1999; Regan & McElroy, 2013; Rogers et al., 2005).

In terms of the specific information that women require, it is felt beneficial to provide sufficient information to enable consideration of the benefits and problems of both home and hospital, and MLU birth locations (Chamberlain et al., 1999; Hagelskamp et al., 2003; Edwards, 2008; Halton, 2006; Houghton et al., 2008; Silverton, 2012; Haken et al., 2012) and that this information should ensure consideration of the social and psychological outcomes of birth place, in addition to physical risks (Houghton et al., 2008; Nieuwenhuijze & Low, 2013). In addition to this, women wish to be provided with information about the actual service delivery for home birth (Haken et al., 2012; McCutcheon & Brown, 2012; Shaw & Kitzinger, 2005) including the pain relief that is available to them at home birth (Pavlova et al., 2009; McCutcheon & Brown, 2012; Jimenez et al., 2010), transfer rates and service arrangements (Dabrowski, 2012; Rogers et al., 2011; Catling-Paull et al., 2011), and that the attending midwives will be confident, experienced and professional (Bedwell et al., 2011; Watts et al., 2003; Mottram, 2008; Catling-Paull et al., 2011; Goldstein, 2012; Janssen et al., 2009).

Aside from information provision specific to home births, women also require that information that is provided about birth includes, in a positive light, the possibility of nonmedical methods for facilitating the birthing process and coping with pain (Jennings, 2005; Catling-Paull et al., 2011; Hagelskamp et al., 2003; Mitchell-Merril, 2006; Jimenez et al., 2010; McCutcheon & Brown, 2012; Ashley & Weaver, 2012a).

Information needs to be provided to women at the most appropriate time and the literature review suggests that home birth should be raised and offered to women by their midwife

during their initial contact (Edwards, 2005; Rogers, 2009; Rogers et al., 2005; Nieuwenhuijze & Low, 2013; Shaw & Kitzinger, 2005), or early in pregnancy (Bedwell et al., 2011; Houghton et al., 2008; Hendrix et al., 2009) but that that they should not be expected to make any decision regarding where they wish to give birth at this point of their pregnancy (Rogers et al., 2005; Rogers, 2009; Brintworth & Sandall, 2013; Bedwell et al., 2011; Furlong-Davies & McAleese, 2008). Instead, women should be able to engage in continued discussions about their choices as their pregnancies progress, potentially until early labour (Rogers et al., 2005; Brintworth & Sandall, 2013; Bedwell et al., 2011; Hagelskamp et al., 2003; Rogers, 2009). No research has been conducted, in the way that there has been for breastfeeding (Breastfeeding Insight, 2009) which enables healthcare professionals to be confident about the best times to discuss home birth, but it is possible that some correlation exists. This would suggest an optimum time as being between twelve and thirty-two weeks gestation to be when women are most receptive to birth place location options, as the report states that women are 'actively looking for birth related information' during this time period; and that from thirty-four weeks gestation until birth as the point when women are focusing on their forthcoming birth experience but may still be receptive to further birth place options (Breastfeeding Insight, 2009). Research has shown how most women who had considered home birth at some point during their pregnancies no longer do so by the end of their pregnancies (Lavender & Chapple, 2005).

Women's birth partners, and significant others such as family and friends should be considered and included when information is being provided to ensure that decision making is informed by current evidence and knowledge of how the home birth service is provided – to include the information that they will not be responsible for providing any care to the woman during labour or birth, or for hosting the midwives (Hendrix et al., 2009; Bedwell et al., 2011; Dahlen et al., 2008; Houghton et al., 2008; Madi, 2001; McCutcheon & Brown, 2012; Nieuwenhuijze & Low, 2013). Discussions with partners should be encouraged both between women and themselves, and between their midwives and themselves, in addition to providing only written information (Mottram, 2008; Houghton et al., 2008; Madi, 2001, Bedwell et al., 2011). Information regarding the process of labour at home, with the aim of reassuring partners should be provided to them (Blix, 2011; Mottram, 2008).

Positive Reinforcement:

The scoping review [Chapter 4] highlighted the need for women to receive Positive Reinforcement from their midwives about considering or deciding upon home birth. This attribute is important for all women, but possibly all the more so for women, and their partners, who do not have social networks that are knowledgeable or supportive of this option (Ashley & Weaver, 2012b; Shaw & Kitzinger, 2005; Catling-Paull et al., 2011; Ashley & Weaver, 2012a; Dagustun, 2009). Women may be offered choices in pregnancy, but where these are not actively supported by staff they will rarely be taken up (Mottram, 2008). Verbal and non-verbal elements of Positive Reinforcement are discussed in the literature and so will be considered below.

Verbal positive reinforcement is the most frequently referenced method of providing reassurance to women that appears in the literature review (Catling-Paull et al., 2011; Bliss, 2010). Midwives need to demonstrate their professional enthusiasm and support for women and their significant others to consider or choose home birth by presenting information and discussions around choices in a positive way – including reference to previous birth experiences (Houghton et al., 2008; Brintworth & Sandall, 2013; Shaw & Kitzinger, 2005; Ashley & Weaver, 2012a; Ashley & Weaver, 2012b; Edwards, 2005), both in terms of the personal considerations that may make home birth preferable (Dagustun, 2011), but also in terms of the scientific considerations that allow birth discussions to be framed as a physiological process (Howe, 2013). Midwives should create relationships with women that enable them to provide support and encouragement to women in this way (Bliss, 2010; Bailes & Jackson, 2000; McCutcheon & Brown, 2012; Dahlen et al., 2011). It should be remembered that women often commence antenatal care with the perception that their midwife may feel negatively towards a choice to give birth at home, and that this needs to be demonstrated by midwives to be incorrect (Ashley & Weaver, 2012a; Dagustun, 2009; Ng & Sinclair, 2002). Midwives should encourage women to engage in conversations about home birth, in order to dispel the belief that they prefer births to take place in hospital and to ensure that women know that a choice needs to be made (Houghton et al., 2008; Howe, 2013; Madi, 2001).

Non-verbal Positive Reinforcement takes the form of individual midwives actions, and the configurations of the maternity service providing care. Models of care should be created that ensure that home birth is seen as a viable and acceptable option for women to choose

(Nove, Berrington & Mathews, 2008; Brintworth & Sandall, 2013; Rogers, 2009) by continuing to demonstrate that home birth is a visible topic throughout pregnancy and into the intrapartum period. Midwives can demonstrate their positive support for home birth by lending birth pools to women (McMurtrie et al., 2009; McLaughlin, 2006), ensuring women are aware that home births are happening in their local area (Watts et al., 2003), attending home birth support groups in their local areas (Halton, 2006), developing tools such as websites to increase women's awareness of the availability and support for home birth in their area (Rogers et al., 2005; Mottram, 2008; Noble, 2015) and providing early labour assessments at home (Brintworth & Sandall, 2013). Written information should also be worded positively or not overly cautiously, while retaining accuracy (Ashley & Weaver, 2012a; Ashley & Weaver, 2012b; Newman & Hood, 2009).

Challenging the cultural assumption of hospital birth:

The literature demonstrates that many women who did not choose home birth were influenced by the fact that our birth culture assumes birth to take place in hospital (Madi, 2001; Rogers et al., 2005; Houghton et al., 2008; Green, 2016), and that women who did choose home birth were often aware of others who had birth at home previously (Andrews, 2004; Ng & Sinclair, 2002; Madi, 2001; Rogers, 2009). Women are also shown to also vary in the way in which they engage with making choices in their maternity care, from acceptors to active choosers (Pitchforth et al., 2009) and so for the group of women who prefer to 'accept' a suggested or implied choice, home birth needs to be presented as a socially acceptable option to those who would otherwise have 'accepted' a hospital birth (Shaw, 2007). The literature discussing the provision of an active offer of minority language provision suggests the importance of reversing the long standing cultural denigration of minority language use as a way of enabling service users to expect, and choose to receive services in their preferred languages (Welsh Language Commissioner, 2014; Lorte & Lalonde, 2012).

The literature suggests that where the cultural and social norms do not encourage home birth, merely having a model of care provision available is not sufficient to enable women to make this choice (Newburn, 2003; Pitchforth et al., 2009; Pitchforth et al., 2009; Newburn, 2003). Instead choice in child birth location should be a norm for every maternity service (Ashley & Weaver, 2012a) and women should understand that a decision is required to be

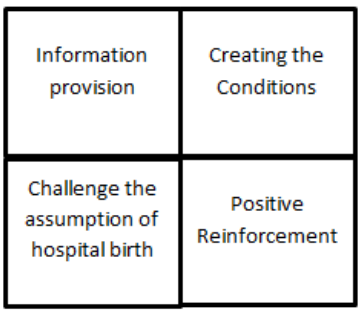
made (Newburn, 2003). Midwives should assist women to consider how their own conceptualisation of birth may have subconsciously influenced their decision making about place of birth (Dagustun, 2011; Regan & McElroy, 2013). Support from the maternity services to ensure adequate provision by experienced and supportive staff who take pride in their service demonstrates to women that home birth is a good choice for them to make (Edwards, 2005; Hagelskamp et al., 2003; Houghton et al., 2008; Shaw & Kitzinger, 2005). Of particular need is to ensure sufficient information, in a consistent manner, is provided to counter the negative view of home birth that is presented by the media (Hans & Kimberley, 2011; Edwards, 2008c). The literature review also suggests and demonstrates the positive effect that the media can provoke when used by the maternity services as a way of increasing knowledge about home birth and to counteract any negative coverage (Rogers et al., 2005; Hans & Kimberley, 2011; Bedwell et al., 2011).

Midwives should attempt to demonstrate that the choice of home birth, if need be in other areas, is not unusual, and to work to prevent a feeling of isolation that may occur if a woman does makes this choice, possibly by facilitating access to others who have made the choice to birth at home (Bliss, 2010; Halton, 2006; Shaw & Kitzinger, 2005; Furlong-Davies & McAleese, 2008).

The resultant concept analysis of an active offer of planned home birth [AOPHB]:

The following figure illustrates the resultant concept analysis for an active offer of planned home birth:

Figure 10. Concept analysis model of the active offer for planned home birth



The four defining attributes are suggested to work in combination to provide women with the required input so as to facilitate them to make an informed decision about planned home birth.

Development of cases:

The cases that follow reflect the wide range of the reality women's current experiences in being offered a home birth. They provide from the perspective of the midwifery service user, a demonstration of the way in which a midwife or maternity service can negatively, passively, and actively offer home birth to women who are either knowledgeable or not currently knowledgeable about the possibility of giving birth at home.

The concept analysis process only allows for the development of one model case. This requirement has been adhered to, but it is acknowledged that in doing so, no reflection of the different ways that women, in particular of differing parities, may make the decision to plan a home birth (Redshaw & Rowe 2010).

Appendix 16 contains tables that illustrate the way that each of the suggested defining attributes are provided within the model case, and how these are considered to relate to the elements and mechanisms that Cardinal and Suave (2010) outline.

Model case:

Sarah is a 29 year old woman who is pregnant with her first child. She has recently moved in to the area. She, and her partner Paul, meet their Community Midwife Asma when Sarah is around 8 weeks pregnant. Asma comes to their home to conduct their Initial Consultation. Asma talks with Sarah and establishes that she is suitable for midwifery led care. During their conversation, she asks Sarah if she has any thoughts on where she would like to her baby to be born. She explains that she, and the other midwives in her team all support home births and are very experienced in attending them, and that she would be very happy to offer this option to Sarah. She gives Sarah some written information about home birth, and the local numbers and outcomes of women of differing parities who have made this choice locally. Asma explains the NICE guidance on place of birth and explains the difference in outcome for primiparous and multiparous women giving birth at home.

Sarah has always assumed she would give birth in hospital and tells Asma this. Asma makes it clear that she understands that Sarah will probably need more information about home birth if she is to consider it for herself, as it is possible that she will not have known many people to make this choice, and that Sarah does not need to decide where she will have her baby until she is ready, which could be right up until she is in labour

At this meeting Asma also asks how Paul feels about birth, and home birth. Paul shares that he is actually quite nervous about birth as his sister had a difficult experience and required an emergency caesarean with her first baby last year. Sarah then says that this is also something that she thinks about sometimes.

During Sarah's pregnancy Asma is able to provide most of the care in her antenatal appointments, and together they discuss how the pregnancy is progressing and Sarah's feelings about the birth. They discuss a recent episode of Call the Midwife where a birth resulted in the need for neonatal resuscitation, and Asma talks about the equipment that midwives use at home and in hospital, and the training they receive. Asma suggests that Sarah reads some information about home birth, and tells her about a local Home Birth group run by women who have had home births that she can access if she wishes. Sarah does this and finds it interesting.

Sarah, and occasionally Paul, also attends antenatal classes run by a member of Asma's team and these classes reinforce the message that pregnancy is a natural process, and provides a place for informed discussion about all their choices in place of birth and the normal labour process. Materials used include home birth in the illustrations and examples. The facilitator shows that they are professionally supportive of women choosing home birth. She wears a lanyard that invites people to 'Ask me about home birth'.

As her pregnancy reaches its end, Asma and Sarah talk more about where she wishes to give birth. Sarah is considering giving birth at home or the local Alongside Midwifery Led Unit. Asma completes the local documentation to enable Sarah to later decide where she wishes to give birth. Asma talks with Sarah and Paul about the way that a home birth is conducted, including reassuring Paul that he would not be responsible for any of Sarah's care. It is agreed that when Sarah feels that she is in labour she will call Asma or the on-call midwife from her Community Team.

Sarah goes into labour at 39/40. She calls the on-call midwife, Carla, who visits her at home. A diagnosis of established labour is made, and Sarah decides she feels comfortable at home and that she would like to continue to labour and give birth there.

Borderline case:

Lisbeth is pregnant with her first child and she and her partner Gary meet her community midwife Alice for the first time. Alice says that recent guidelines suggest that low risk women like Lisbeth can chose where they wish to give birth, and so she could birth at home if she wants to, but that most women in the area plan MLU births. Lisbeth is surprised to hear she could birth at home, and feels more comfortable when Alice recommends that she plans to give birth in her local AMLU. It makes sense to her when Alice says she understands that for most women making this choice gives them the 'best of both worlds' as they can labour in comfortable rooms, but can also access epidurals easily without having to move far, and feel safe that doctors are there if they need them.

Lisbeth's pregnancy progresses normally. She meets with Alice or sometimes other members of the community midwifery team for her antenatal checks. Alice tells her everything is fine, but doesn't talk about how Lisbeth is feeling about her labour and birth. When Gary comes to an appointment Lisbeth welcomes him, but does not really include him in their conversation as it is mostly about Lisbeth's blood pressure and how the baby is moving.

Lisbeth, and sometimes Gary, attend antenatal classes where home birth is mentioned at points, and does include some information on how home births are provided. Lisbeth has never heard of a home birth happening near her, but now realises that some must happen as the midwife says that about 1% of local women give birth at home. Lisbeth thinks the midwife seems very positive about home birth – also, she wears a lanyard that says 'Ask me about home birth', and puts out some written information about home birth for people to take away with them at the end of the class. Lisbeth does this.

At home Lisbeth brings up the idea of home birth with Gary. He says that if she really wants to birth at home he would support her, but that he would not really be very comfortable with the idea. He thinks hospitals are safer as the midwives there have the doctors to support them, and reminds Lisbeth about their friend Amy who recently had a very difficult birth with her second baby – he says 'What if that had happened at home?'

Alice talks through Lisbeth's birth plan with her towards the end of her pregnancy and mentions the possibility of home birth again. Lisbeth knows that Gary is nervous about home birth and feels that it is safer for her to go to hospital for the baby's sake. Also, she isn't really sure what to expect from being in labour. Now Lisbeth doesn't tell Alice her reasons, but just says that she wants to go to hospital. Alice does not explore this further, and writes 'Planning hospital birth – possibly AMLU' in the birth plan.

Contrary case:

Dalal is pregnant with her third baby and meets her community midwife Mary for her Initial Conversation. Mary establishes that Dalal is suitable for Midwifery Led Care and quickly mentions that she can choose between giving birth at home, in an MLU or in the Obstetric Unit. Mary ticks a sticker on the notes to say that home birth has been offered to Dalal.

Dalal's pregnancy progresses well. She attends Antenatal Classes provided by the local District General Hospital, she has a look round the AMLU and OU, learns about labour, and the options for pain relief provided by the hospital.

Towards the end of her pregnancy, Mary completes Dalal's birth plan. She says to Dalal that she wants to give birth in hospital – probably in the AMLU, and Dalal agrees.

Related, illegitimate or invented cases:

No related, illegitimate or invented cases were created, as this was not felt to provide any additional support for this concept analysis process.

Antecedents and consequences:

Antecedents:

Walker and Avant (2010) define antecedents as 'events or incidents that must occur or be in place prior to the occurrence of the concept'. In relation to the concept of an 'active offer of planned home birth' it is suggested that the only required antecedent is contact between a pregnant woman and her midwife prior to the pregnant woman making an informed decision to birth in an institutional birth place, where both are willing to take an active approach.

Consequences:

Walker and Avant (2010, p.73) define the consequences of the concept as 'the events or incidents that occur as the result of the occurrence of the concept'. In relation to the concept of an active offer of planned home birth, consequences have been considered from the woman's perspective, and that of midwives. There are potentially two consequences for women, and these are that they will be offered the option of planned home birth in an effective manner, and will be supported to make an informed decision about whether they wish to birth at home. The consequence for midwives are that they will use a theoretically developed tool when offering women the option of home birth, and that they will make effective offers of planned home birth to women.

Empirical referents:

Empirical referents are 'classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself' (Walker and Avant, 2010, p.73). Suggested empirical referents for the concept of an 'active offer of planned home birth' may be that an increased percentage of women perceive that that they have made an informed decision about if they wish to birth at home. The rate of planned home births, and the rate of achieved planned home births, could also be measured.

Strengths and limitations:

Strengths:

The concept has been undertaken using a recognised approach, with the addition of primary data felt to add depth to the data included within the analysis.

Limitations:

A systematic review of the published literature around possible other applications of active offer principles was not undertaken. It is therefore possible that a more extensive search in other fields, such as marketing or advertising, may have yielded relevant literature that could have added further insight in to this concept analysis process.

Next steps towards the creation of an active offer for home birth:

This concept analysis, including the resultant defining attributes and cases, have been created from a synthesis of the findings of the scoping review of home birth decision making [Chapter 4], an observation and interview study with women and Community Midwife Dyads [Chapter 3], and the literature around the use of the implementation of an active offer of minority language provision.

As the next step towards the creation of a clinically appropriate active offer for home birth it was essential to explore if the resultant product, the concept analysis, had a suitable degree of 'fit' with previous service users experiences of being offered home birth, and with the experience of community midwives who offer home birth to women. The need to consider the opinions and experiences of Community Midwives derives from the importance of understanding their understanding of how and why home birth is currently offered, in order to best understand how to assist service improvements in line with a resultant active offer for home birth. The aim of an active offer for planned home birth would be that it aligns with the basic model and structure of a maternity service, without the need for drastic reconfiguration.

The next chapter [6] presents the creation and findings of active offer workshops with previous service users and community midwives.

Chapter Six: Active Offer Workshops

Introduction:

This chapter follows on from the concept analysis process which explored the potential defining attributes of an active offer of planned home birth [Chapter 5]. This process suggested that four defining attributes [Creating the Conditions, Information Provision, Challenging the Assumption of Hospital Birth, and Positive Reinforcement] are required in order to that maternity service users receive an active offer of planned home birth [Figure 10].

This chapter describes a study that was conducted to test the findings of the active offer for planned home birth concept analysis with three relevant stakeholder groups.

Methods:

Aims:

The study aims were to:

Test the findings of the active offer for planned home birth concept analysis with three relevant stakeholder groups

Refine the conceptualisation of active offer through exploring participants' experiences

Study design:

In line with a pragmatic approach, a workshop design was chosen as the data collection method within this study. Other data collection approaches were considered, such as individual interviews or a questionnaire, but in comparison to other methods a workshop approach was viewed as being the most appropriate method. Individual interviews were considered to be time-consuming in terms of time spent with each participant (Rees, 2011), which would also not allow a sharing of experience amongst participants. Data collected through questionnaires would have limited the richness of information that was required to refine the conceptualisation. A workshop approach provided an opportunity for members of stakeholder groups to meet and share their opinions and experiences on home birth decision making (Bate & Glenn, 2007).

On reflection, the study was closely aligned to the four principles of participatory research outlined by Bergold and Thomas (2012): use of a democratic approach within the research process, provision of a safe space for participants, community participation, and the principle of participation embedded within the research. The limitation in the application of the participatory principals was hindered by the researcher's inexperience with this approach and the perceived need to retain control of the timescale of the research process. However, despite these limitations, the provision of a democratic approach within the study, although it was not intended as a political or social vehicle in the way that is often associated with participatory research (Bergold & Thomas, 2012) was embedded within the sampling approach with the purposeful inclusion of women and partners from social groups that the literature suggests may be marginalised within home birth decision making. However, the literature also suggests that women who are not first-language English speakers are also marginalised from the option of home birth, and input from members of this community was not facilitated as the financial restrictions prohibited the use of translation. Provision of a 'safe space' within the 'transition zone' of moving towards a more active offer of home birth – even though this research process only lasted a few hours for each participant, was an experience that strongly resonated with me as the researcher. As is noted within the description of the workshops, consideration to the atmosphere and support within the room was prioritised. It is considered that inviting the participants to attend workshops within their own participant groups allowed this sense of a safe space to be created. The three stakeholder groups were identified as the required 'community' for this study in terms of their 'common experiential background' (p.3.3) – previous service users (PSUs) in view of their experiences in home birth decision making in relation to their own pregnancies, or partner's pregnancies; and community midwives in view of their role in offering and providing home births. All groups could be considered as being the persons most immediately effected by the possible outcomes of the study. Lastly, the principals require consideration of how embedded the activities of the participants was within the research, and it is this principal that moves the adherence to the method away from the participatory process as in this study all of the decision making and analysis was undertaken by the researcher. It is therefore not possible to state that this study was undertaken using a participatory approach (Bergold & Thomas, 2012).

I also drew on the notion of 'touchpoints' (Bate & Glenn, 2007) within the workshop process, in an attempt to highlight important points in home birth decision making. Bate and Glenn (2006) define touchpoints as the key moments and places where people come in to contact with the service, with their experience shaped as a result of this contact. Touchpoints are an integral part of Experience Based Co-Design within healthcare research (Bate & Glenn, 2007), and also within marketing (Baxendale, McDonald & Wilson, 2015).

Data collection:

The active offer concept was embedded within the data collection process in the ways outlined within tables 24 and 25. This involved creating opportunities for the participants to explore the way that the subjective, objective, integrative, and at times prerequisite, elements outlined by Cardinal and Suave (2010) were felt to be beneficial within an active offer of planned home birth; in addition to gaining an insight into how the proposed domains of the active offer of planned home birth concept analysis [Chapter 5] had been experienced or were viewed by the participants.

All of the workshops sessions were held in the same community venue. The workshop sessions lasted two and a half hours. Similar exercises were completed by all groups, but were not identical because of the different roles that each of the group of participants takes within the offer of home birth. Most of the exercises were completed seated around a table – two exercises were undertaken as a group, one exercise in pairs. One exercise acted as an icebreaker for the PSUs and required the group members to move around the room. The Community Midwives did not take part in this exercise as most were familiar with each other.

Information about the exercises was provided in several ways - a projector displayed information on the wall of the room, written material was provided to everyone and the information was read out as the workshop progressed.

All of the exercises, with the exception of the PSU's first exercise, were digitally recorded with the consent of all of the workshop participants.

My role was of group facilitator. I introduced each activity and followed an approximate schedule to ensure that we were able to cover the content of each exercise. I facilitated

group members to participate by noting when they wished to be included in a conversation, and at points refocused our conversation to ensure that our discussions remained on topic. Ground rules were discussed that ensured that all participants understood that they could share their views in a supportive environment.

The following tables illustrate the component activities for the community midwives, and PSU workshops:

Community Midwives' (CMs) workshop plan:

Table 14. Structure of CM workshops

Ex.	Aim	Activity	Link to the active offer concept and the proposed active offer concept analysis
1	To gain a picture of how the CMs tended to offer and discuss home birth during their routine antenatal care provision	Working individually, the CMs were provided with the option of voice recording their experiences, or using one of two types of A3 prompt sheets that they could write on to record their experiences [Appendix 18]. We discussed their experiences as a group afterwards	Allowed consideration of how the CMs currently included the subjective, objective and inclusive elements within their current practice Discussion around how clinical practice could develop in line with the active offer concept
2	To explore the CMs opinions about the overall care provision in each hypothetical scenario	As a group, the CMs were asked to consider midwifery care scenarios that were based upon the example cases for the concept analysis of an 'active offer of home birth'. To clarify the discussions we used the terms 'Ideal' way to offer of home birth, 'Could be improved', and 'Terrible' way to offer home birth that	Consider response to the example cases in terms of the four defining attributes of the proposed concept analysis Consider the extent to which the CMs felt that the subjective, objective and

		could serve to limit a service users ability to consider or chose to plan a home birth.	inclusive elements were provided within the scenarios
3	To explore the CMs opinions about the overall care provision in each hypothetical scenario	CMs worked in pairs, or groups of three. Each pair was provided with an answer booklet [Appendix 19] and a sheet of stickers with brief, anonymised quotes printed on them. The answer book contained pages labelled 'Ideal active offer of home birth', 'Could be improved', 'Terrible', and 'Not to do with the active offer of home birth'. They were asked to place the stickers on the page that they felt was the most appropriate, indicate why they felt this way and note any ideas that they had for improving the clinical practice into a more 'active offer'.	Enabled consideration of how isolated components provided effective aspects of an active offer. Included consideration of subjective, objective and inclusive elements of an active offer.

Previous service users' workshops:

Table 15. Structure of PSU workshops

Ex.	Aim	Activity	Link to the active offer concept and the proposed active offer concept analysis

1	To develop a picture of the home birth awareness of the social networks that surrounded the PSUs Ice-breaker for participants	Five pieces of flip-chart paper placed around the room. Each had a different heading -'Family', 'Friends and Colleagues', 'The media', 'Employment' and 'General society'. PSUs asked to comment on 'positive' or 'negative' comments to them about home birth in relation to each area of life, or if no interaction about home birth had taken place between them.	Activity permitted consideration of the way that the inclusive element requires consideration within an active offer of home birth, and how the subjective and objective elements were addressed within social networks Activity permitted consideration of how the defining attribute ' Challenge the assumption of hospital birth' was required within the active offer – for woman and significant others Allowed collection of any touchpoints within social networks
2	To gain a picture of how the PSUs had been offered home birth during their antenatal care provision	Working individually, the PSUs were provided with the option of voice recording their experiences, or using one of two types of A3 prompt sheets that they could write on to record their experiences [Appendix 20]. All but one chose to write about their experiences on the prompt sheets. We discussed their experiences as a group afterwards	Allowed consideration of how the subjective, objective and inclusive elements had been provided by CMs within their childbirth experiences Discussion around how the PSUs felt that care provision could develop in line with these elements to enhance their care experience Allowed collection of any touchpoints within antenatal care
3	To explore the PSU's opinions	As a group, the PSUs were asked to consider midwifery care scenarios	Consider response to the example cases in terms of the four defining

	about the overall care provision in each hypothetical scenario	that were based upon the example cases for the concept analysis of an 'active offer of home birth'. To clarify the discussions we used the terms 'Ideal' way to offer of home birth, 'Could be improved', and 'Terrible' way to offer home birth that could serve to limit a service users ability to consider or chose to plan a home birth.	attributes of the proposed concept analysis Consider the extent to which the PSUs felt that the subjective, objective and inclusive elements were provided within the scenarios Allowed collection of any touchpoints within antenatal care, where PSUs linked the scenario to their own experience
4	To explore the PSU's opinions about the overall care provision in each hypothetical scenario	PSUs worked in pairs, or groups of three. Each pair was provided with an answer booklet [Appendix 19] and a sheet of stickers with brief, anonymised quotes printed on them. The answer book contained pages labelled 'Ideal active offer of home birth', 'Could be improved', 'Terrible', and 'Not to do with the active offer of home birth'. They were asked to place the stickers on the page that they felt was the most appropriate, indicate why they felt this way and note any ideas that they had for improving the clinical practice into a more 'active offer'.	Enabled consideration of how isolated components provided effective aspects of an active offer. Included consideration of subjective, objective and inclusive elements of an active offer. Allowed collection of any touchpoints within antenatal care, where PSUs linked the scenario to their own experience

A debrief sheet was available for all of the PSUs to take home after participating in the workshop [Appendix 17].

Sample:

The sampling approach was purposive in line with qualitative research perspectives (Rees, 2011), with three stakeholder groups included:

- Community Midwives (Cm Mw): any Community Midwife employed by the local Health Board and who were working within the area serving the local DGH were eligible for inclusion
- Previous services users (PHB PSUs): the inclusion criteria were any previous maternity service user, aged over 18 years of age, who given birth or had a child where the birth planned to take place at home within the last 5 years and were fluent in either the English or Welsh languages.
- Previous services users (Non-PHB PSUs): the inclusion criteria were any previous maternity service user, aged over 18 years of age, who given birth or had a child where the birth was not planned to take place at home within the last 5 years and were fluent in either the English or Welsh languages.

Particular sampling approaches were used in terms of how certain socio-demographic groups became aware of the study, to try to ensure that the maximum variation amongst women and partner participants was achieved. This was important in light of research findings that suggest that in the UK women and partners from lower socio-economic groups are less likely to opt for a planned home birth (Nove, Berrington & Mathews, 2008). This required specific attention being paid to participation from women and their partners from all socio-economic groups who did not choose to give birth at home, and women and their partners who did choose to give birth at home.

Additionally, the aim was to recruit partners to participate as it is acknowledged that they are influential in women's decision making around birth place choices (Mottram, 2008), and considering this influence, have historically been under-represented within home birth decision making research.

Further attention was paid to the ethnic origin and socio-demographic makeup of these participants groups, as published literature has demonstrated a narrow demographic amongst women who currently choose to give birth at home (Nove, Berrington & Mathews., 2008), and a phenomena of reduced engagement in terms of shared decision making during

their antenatal care amongst women from lower socio-economic groups and ethnic minority groups (Dougherty et al., 2012). The latest data from the Office of National Statistics (2011) suggested that approximately seven percent of the local population were non-white and that for Wales and England the non-white population was seventeen percent of the total population. Therefore, to ensure a representative sample, attention was paid to the responses provided (if any) to the voluntary questionnaire included in the consent form for previous service users, with the aim of including a number of participants (up to twenty-five percent, equating to three participants) from lower socio-economic groups and ethnic minority groups in each of the workshops. Sampling was only undertaken in the local region for practical and logistical reasons, and because with these sampling considerations in place it was felt that an appropriate range (relative to UK demographics) of participants could be accessed. This approach is reflected on further in the strengths and limitations section of this chapter.

The aim was to recruit up to ten participants to each PSU workshop (Bate & Glenn, 2006), and to run two workshops of non-home birth choosers, and two workshops with those participants who did choose a home birth. The ambition was to recruit sufficient midwives to hold up to eight workshops with four midwife participants in attendance at each session. This figure was reached after discussion with the local Health Board maternity service management, and allowed adequate clinical Community Midwifery cover to be maintained during the workshop sessions.

Identification of, and approaching participants:

Community Midwives:

Community Midwives were identified through their employers at the local Health Board.

Community Midwives Study Information Packs (CMSIP) were sent to the eligible Community Midwives at their work address [Appendix 21]. The CMSIP were bilingual in Welsh and English, and contained a Community Midwife Study Information Sheet (CMSIS) and a Community Midwife Study Consent Form (CMSCF) a stamped addressed envelope addressed to my University address. Community Midwives were asked to return their CMSCF to me if they wished to participate. Several Midwives who were not currently employed as Community Midwives but had worked as Community Midwives within the local

Health Board until the past three months were also identified and invited to participate (three midwives – two DGH Staff Midwives, one University Lecturer). Reminder CMSIP were sent to all the potential Community Midwives that had not replied to the first invitation to participate. The Reminder CMSIS [Appendix 22] informed the Community Midwives that they would not be sent any further study details about the study.

Consenting Community Midwives provided their preferred contact method (either work mobile telephone number or work email) and we communicated in this way to arrange the workshop sessions at times that best suited their work patterns.

Previous service users:

Previous service users (PSUs) were approached in two ways.

Through childcare facilities (crèches) in the local area:

The first part of this process was to secure the consent of local crèches to hand out Previous Service User Study Invitation Packs (PSUSIP) [Appendix 23] to parents of the children who attended their establishments. As stated above, the intention was to include PSUs from all socio-demographic groups. As a result, Flying Start crèches were identified as serving the most socially deprived members of our local population and so the three crèches supported by this initiative were specifically contacted, without this specific rational being discussed with them. All three sites consented to participate. Secondly, crèches that served areas of the locality with a higher percentage of ethnic minorities were approached. The University and DGH crèches were identified as specifically serving these population groups; both were contacted and both agreed to participate.

In total twelve crèches were contacted, and eight local crèches consented to participate following a telephone conversation or a personal visit to the crèche. The required number of PSUSIPs were provided to the crèches for them to handout to parents (375 PSUSIPs in total, including 144 provided to the Flying Start crèches and 105 to the University and Hospital crèches). The crèches then handed out a PSUSIP to each parent as they collected their child. The PSUSIP were bilingual in Welsh and English, and contained a Previous Service User Study Information Sheet (PSUSIS) and two Previous Service User Study Consent Forms (PSUSCF) in case two parents in a household wished to participate in each language. A stamped

addressed envelope addressed to my University address was included. No reminders were sent to PSUs via the childcare facilities.

Through a local Facebook group for people with an interested in home birth: (https://www.facebook.com/groups/homebirthfriends/).

The group had approximately one hundred members at this time. It was deemed necessary to approach the group members of this specialist interest group because of the low numbers of home births in the area. We aimed to ensure that a similar number of PSUs who had planned home births, and those that had not planned home births were participating in the workshops. Consent to approach group members through the Facebook group site was requested from the group administrators prior to approaching members. A personal bilingual message [Appendix 24], which contained information about the study and bilingual PDF copies of the PSUSIF and PSUSCF was sent to each member of the Facebook group. Additionally, a bilingual, non-personal message advertising the study was posted on to the main feed of the Facebook group, with the Welsh and English PSUSIS and PSUSCF uploaded onto the Facebook groups 'file' section. One reminder message was sent to members who had not responded [Appendix 25].

Through both approaches to PSUs, the consenting participants were asked to provide me with their preferred method of communication. These included email addresses, mobile telephone numbers and, in the case of a few of the home birth group members, Facebook contact details. These were stored in password protected files, within the University IT system. The PSUs were asked to snowball the study to any friends that they felt may be interested in participating in the workshops, and on fourteen occasions further participants from both groups contacted me via Facebook for further information. They were all sent the PSUSIS and PSUSCF to read and complete if they wished to take part. Communication with the PSUs participants enabled us to create suitably timed workshop sessions.

Ethical approval:

Ethical approval for this study was granted by the Bangor University Healthcare and Medical Sciences Academic Ethics Committee on the 11th of December 2013 [Appendix 26].

R&D approval to approach the Health Board Community Midwives was granted on the 7th May 2014 [Appendix 27].

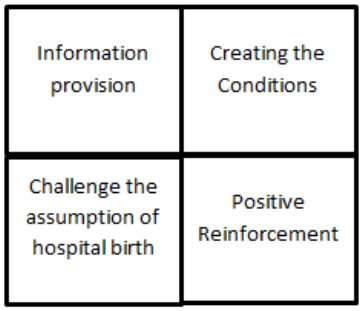
Data analysis:

All written data were anonymised, typed into individual WORD documents for each workshop, with an identifier noting if the group was populated by previous service users who had chosen a planned home birth (PHB PSU), previous service users who had not chosen a PHB (non-PHB PSU) or Community Midwives (Cm Mw). These were saved onto the password protected Bangor University computer network. Paper originals were retained and locked in filing cabinets during the period of data analysis and study reporting.

All digital recordings were transcribed. An initial (such as 'A') was allocated to each participant in each transcription so that the thread of conversation could be followed throughout each exercise whilst not revealing the identity of the participant.

Framework analysis was used to analyse the transcribed data (Richie et al., 2014). This was undertaken in an incremental way, with the starting point for the analysis being the model for the active offer of planned home birth that had emerged from the concept analysis [Chapter 5]. In this model all four defining attributes were afforded equal weight within each service user's decision making process, with the need to consider the support and inclusion of significant others contained within each of the four categories.

Figure 10. Concept analysis model of the active offer for planned home birth



The staged framework analysis process is presented below:

Table 16. Stages of framework analysis

Analysis stage	Analysis undertaken	Outcome of this stage of the analysis

1	.1	Data re-familiarisation process – all data read a number of times	
2		A table was created for each of the four defining attributes (based on the concept analysis model [Chapter 5])	Decision made to test out the data analysis only using two tables to collect data across all groups – 'Creating the Conditions' and 'Positive Reinforcement' Data were coded within the tables without any pre-formulated conceptions about what the individual domains of the two defining attributes may ultimately be
	.1	Data from one of the PHB PSU workshops inputted into the tables. Personal data could be applied to the 'Creating the Conditions' or 'Challenging the assumption of hospital birth' attributes, for some but not all of the PHB PSUs, although all of the group provided opinions on aspects of care relating to this process The Positive Reinforcement attribute was relevant for all of the PHB PSUs, as was information provision. However, this last attribute felt like a contributing element (a possible domain) to the Positive Reinforcement process, rather than an independent attribute. Codes were created as required	

	.2	Data from one of the non-PHB PSU groups was inputted into the tables. No data related to these service users' personal experiences that applied to the 'Positive Reinforcement' attribute. The 'Creating the Conditions' was very relevant to this group, as were the attributes to 'Challenge the assumption of hospital birth' and 'Information provision'. However, these last two attributes were felt to contribute to the 'Creating the Conditions' process (as possible domains), rather than acting as independent attributes. Codes were created as required.	
3	.1	The personal experiences and touchpoints that each PHB and non-PHB PSU participant discussed were inputted into the 'Creating the Conditions' and 'Positive Reinforcement' tables. Codes were created as required.	Data from each of the PSU groups, and the Cm Mw groups fitted naturally into the two tables. The two stage process became the refined working 'model' for the active offer of planned home birth
	.2	Data that included the PSUs discussion about the hypothetical scenarios that were explored within the workshops was then inputted to the two tables. Further codes created as required	
	.3	All Cm Mw data inputted to the two tables. Further codes created as required.	

	.4	Touchpoints across all three participant groups were highlighted within the tables, and also recorded in a separate table.	
4	.1	All of the data in both defining attribute tables were condensed	The number of codes for 'Creating the Conditions' was condensed from 34 codes into 5 domains, and the number of codes for 'Positive Reinforcement' was condensed from 26 into 4 domains
	.2	The codes in the tables were grouped together to create several domains within each defining attribute. This was undertaken by grouping codes that dealt with related or similar experiences or aspects of care provision, until all codes were included within a well-defined domain.	
	.3	The potential code groups that were then cross checked with the raw data to ensure that each opinion and experience was represented within the proposed domains.	
	.4	Attention was paid to where participant touchpoints occur within each of the defining attribute domains	
5	.1	The raw data from across all participant groups for each domain (within both of the defining attributes) was then assimilated to create the constituting elements of each of the domains. Each domain has between 4 and 7 constituting elements that are deemed to be the precise requirements of each domain of the active offer.	The constituting elements of each of these domains were then formulated within each of the two defining attributes The final two stage process 'model' for the active offer was created

	.2	For both defining attributes, preventative and beneficial outcomes were suggested for each domain as a result of the inputted raw data	
6	.1	The personal experiences and touchpoints that each PHB and non-PHB PSU participant discussed were re-read with consideration given to when and how they experienced the domains within the two defining attributes	Assessment of the extent to which the PSUs had experienced the defining attributes, and the ways in which this had been achieved

Initial results:

The chapter now moves to discuss the study findings. These are structured to provide information about participant recruitment, before moving to provide discussion in relation to the study aims:

Test the findings of the active offer for planned home birth concept analysis with three relevant stakeholder groups.

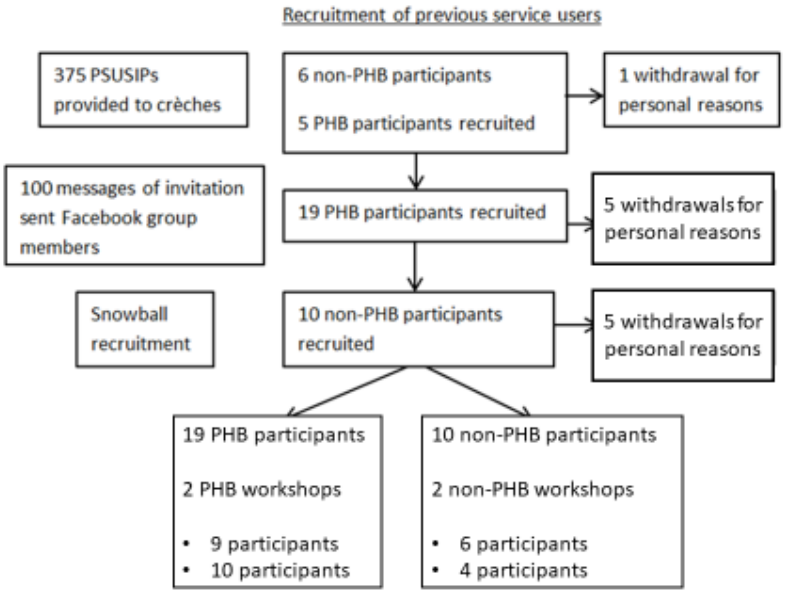
Refine the conceptualisation of active offer through exploring participants' experiences.

Participants:

This study involved the recruitment of three different participant groups – community midwives, previous service users who did plan to birth at home (PHB PSUs) and previous service users who did not plan to birth at home (non-PHB PSUs).

The following flow chart illustrates the recruitment of the PHB PSUs and non-PHB PSUs participants:

Figure 11. The PSU recruitment process



The flow chart illustrates that following the recruitment process nineteen PHB PSU participants were recruited to the study, and took part in two workshops; and that ten non-PHB PSU participants were recruited and took part in a further two workshops.

PSU participant characteristics:

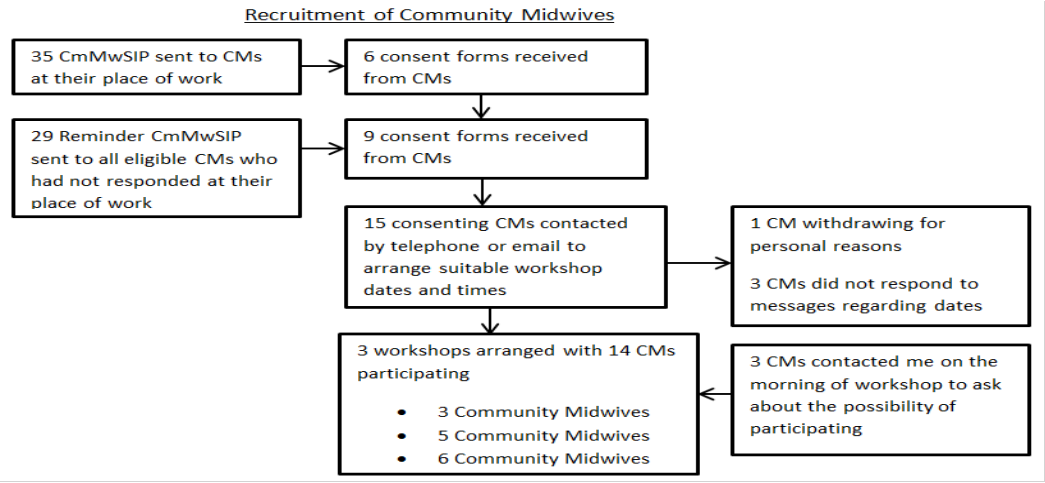
The participant's sociodemographic characteristics [Appendix 28 & 29] demonstrate that all of the participants identified with being 'Welsh/English/Scottish/Northern Irish/Welsh' with the exception of three participants who identified as 'other white background' and were from Spain and Germany.

The majority of the participants were employed, with most being employed in professional or skilled manual occupations. Three of the women were full-time mothers. Two of the participants were male partners who were employed in skilled manual occupations.

Using the approximate measurement of social grade by postcode, a range of grades was recorded. Three participants lived in a postcode area of ABC1, thirteen out of the twenty-nine of participants lived in postcode areas with grades of C1C2D, and one lived in an area with the grade C2DE.

The following flow chart illustrates the recruitment of Community Midwives to the study:

Figure 12. The Community Midwife recruitment process



The flow chart illustrates that following the recruitment process, fourteen Community Midwives consented to take part in the study, and attended three different workshops.

Community midwife participant characteristics:

None of the Community Midwives stated that they had attended more than five home births in the previous year, six of the Community Midwives stated that they had attended fewer than five home births in the previous year, and ten did not state this information on their consent forms.

Framework analysis findings:

The chapter now moves to discuss the study findings in relation to the aims of the study.

Test the initial findings of the active offer for planned home birth concept analysis [chapter 5] with three relevant stakeholder groups:

This study, through the activities outlined above [Table 26], tested the findings of the concept analysis for the active offer of planned home birth that had been created following the concept analysis process (Walker & Avant, 2010) [Chapter 5].

The initial conceptualisation included the four defining attributes – Creating the Conditions, Challenging the assumption of hospital birth, Positive Reinforcement, and Information provision [Figure 10], and suggested that these would be applicable to all maternity service users during their home birth decision making. However, as was outlined in table 26, during the second stage of the framework analysis process, it became apparent that this

conceptualisation did not 'fit' with the data reporting the experiences of the previous service users. Instead, only two defining attributes – Creating the Conditions, and Positive Reinforcement, aligned with their experience.

Below, the way that the four defining attributes from the previous conceptualisation of the active offer of planned home birth were considered to operate are discussed in relation to the PSU experiences:

Creating the Conditions:

The previous conceptualisation of the Creating the Conditions defining attribute is similar to the way that it is conceptualised in this study. However, whereas the previous conceptualisation of Creating the Conditions was that all service users would require input according to this defining attribute, the experiences of some of the PHB PSU participants in this study suggests that this is not the case.

The reported PSU experiences suggested that there was a need for some members of both groups to be assisted to consider or decide upon the option of planned home birth:

> 'This time round I feel that there's not been, they've not made any sort of effort, I mean it might because I'm still early on and there's still loads of time, but as yet, nobody has probed me as to what happened last time, or, I mean I have mentioned that it was a very rapid labour, and I thought that at that point they could have said 'Well, have you considered a home birth?' but she said 'Oh, that's unusual' and just sort of carried on. But to me, that was a natural progression of the conversation to become about home birth. But it never became' (Non-PHB PSU M)

> 'I think I was divided in where to labour right up to when I went passed the day – 10 day overdue mark. I really just wanted to give birth and labour in a pool and not be interfered with. If I could have guaranteed a pool at the hospital and not be pressured into pessaries and 'the drip' so much and other proddings/pokings I think I would have gone to hospital. But having read so much on home birth and lots of Ina May Gaskin I knew I wanted to be somewhere comfortable and not so doctor-led. So home birth came to be the most obvious choice' (PHB PSU H)

However, not all of the PHB PSUs discussed experiences that could be classified as generating the possibility for them to consider and decide to birth at home – often as a

result of previous home birth experiences or because of a high level of home birth visibility amongst their social networks. Quotations illustrating these experiences are included below in relation to Positive Reinforcement.

Information provision:

The previous conceptualisation of the active offer of planned home birth included information provision as a defining attribute. However, while study findings demonstrated the importance of information provision for members of both the PSUs groups, the type of information that was required appeared to differ between that which served as part of the process of the PSUs being able to consider or decide on birthing at home, or as providing detail for the PHB PSUs in planning their home birth. Therefore, the former has been conceptualised as being part of the process of Creating the Conditions for these PSUs:

> 'There's so much conflicting stuff, a complete [unclear] really. Had I been told 'This is how it would work, and these are the contingencies, if you hear this then that is possibly true, but only in these circumstances, if you hear this that's also an outcome' You know, just, almost a Q&A – there's nothing is there?' (Non-PHB PSU C)

> 'Our midwife (who saw us through the 2nd pregnancy and who I now regard as a friend) is very positive about home birth and encouraging us to consider it. I trust her and value her opinion so we are thinking it through. We've not had a proper long chat about it yet, but my main concerns are around: what if I need an emergency CS, we live fifteen to twenty minutes away from the hospital; what about all the mess! Who will clean it up? Will all the carpets and furniture get ruined?' (Non-PHB PSU M)

> 'Although I really wanted a home birth I felt I needed to find out all about it 'officially' – what the process and procedures were, what the risks were - then I could make an informed intellectual decision as well as from my heart' (PHB PSU J)

And the later has been conceptualised as being part of the Positive Reinforcement process within the active offer:

> 'Once I'd made the decision…I began to prepare mentally and physically by practising mindfulness, and I also began excitedly prepare my home, asking my Community Midwife about everything that I could do for myself, husband, midwife and baby to make it a safe and comfortable and calm place to have our baby. She suggested a

birthing pool, small nutritious snacks, music, comforting objects and scents.' (PHB PSU Y)

'…the week they allow me to do it and so I just, the midwife came home, we were just checking where to put the pool and then, my yoga teacher lent me a pool and plastics to put on the floor, and we were thinking of what could I do, and my yoga teacher came home and we were discussing some positions and breathing – tools to use while I was having a home birth' (PHB PSU M)

Therefore, in contrast to the previous conceptualisation of information provision operating as a defining attribute within the active offer process, the way that the PSUs discussed their need for information, or the type of information that they had required, resulted in my decision to consider the process of information provision as a domain within both of the resultant defining attributes.

Challenging the assumption of institutional birth:

In the previous conceptualisation of the active offer of planned home birth, challenging the assumption of institutional birth was viewed as a defining attribute that all women would require. However, many of the PHB PSUs provided examples of their decision making experiences that showed that they did not hold an assumption of institutional birth, and that this had been an important aspect of support for their decision to birth at home:

'I was a bit unusual because I had decided when I was a teenager that I wanted to have home births, because I'd been born at home and that was something I was always quite proud about. And then, when my sister in law had her first two children at home before I had my eldest, it just kind of reinforced it, it was normal, and what I wanted to do. So I knew before I got pregnant' (PHB PSU A)

'I think that was the same for me though, Mum and Dad had had a home birth with me and so it was always discussed and it was always quite normal. I think that sort of influenced me, although I didn't know at the time that it was, but I think it did' (PHB PSU F)

In contrast, many of the non-PHB PSUs provided examples that suggested that they had held an assumption of institutional birth throughout their pregnancies:

> ‘I started with my first child, convinced even before I conceived that it was hospital birth for me, I hadn’t contemplated anything else. And for my first pregnancy things that happened to me just seemed to confirm that that was the best choice – points I’ve noted here are that when my Community Midwife spoke to me and introduced the idea to me in early pregnancy, she sort of used the terminology ‘Have you thought about home birth? It’s not as bad as you think’’ (Non-PHB PSU C)

The data also illustrated how some of the PHB PSUs experienced the process of challenging their previously held assumptions of institutional birth as part of their home birth decision making journey:

> ‘I was really petrified about labour, as soon as I found out I was pregnant I thought ‘Oh my god, what have I done?’ I didn’t want to know, I didn’t want to research, but like I had loads of negative stories from my friends like you feel like you’re going to die, and then somebody leant me the other book, not Spiritual Midwifery…Guide to Childbirth, and I just thought ‘yeah, what a load of drivel’ and carried on being completely petrified and then people started talking to be about ‘you know there’s an option, why don’t you have a home birth?’ (PHB PSU Y)

In both of these examples, and across the data, the impact or process of challenging an assumption of institutional birth occurred alongside other preventative or facilitatory inputs – such as being confident about the process of childbirth or having sufficient information about home birth, rather than operating in isolation. Therefore, in this sense, my previous conceptualisation of challenging the assumption of institutional birth as being a defining attribute was altered, as I then started to consider viewing this aspect of decision making as operating as a domain, within the overarching defining attribute of ‘Creating the Conditions’.

Positive Reinforcement:

While the original conceptualisation of the active offer process included Positive Reinforcement as a defining attribute that would need to be experienced by all women, it became apparent that this defining attribute had only been experienced by the members of the PHB PSU group. Members of this group discussed their experiences of their remaining weeks of their pregnancy once they had made the decision to birth at home – appearing to

make reference to the need for encouragement and support, for further information gathering that supported and deepened their understanding of home birth, and for continued learning about birth. None of the non-PHB PSU group talked about experiences that aligned with this process:

> 'I talked to a friend who had had all her children at home about the technicalities mostly. She said I could borrow her birthing pool and was wonderfully supportive' (PHB PSU H)
>
> 'I looked up home birth stories on the internet and this gave me confidence but also helped me prepare for the chance that I would need to transfer' (PHB PSU V)
>
> 'Actually they were really good at helping me consider 'Well, if these things happen you might have to go in' and I had come to terms with that, did really want a home birth but I knew if things out of our control happened, and I was OK with that so if I had to have go in then I would have been alright but because I was so relaxed I was so lucky and I had that midwifery support, that I'm so grateful for them giving me that opportunity and making me feel respected and empowered, and it was wonderful' (PHB PSU C)

Therefore, the conceptualisation of the active offer for planned home birth was adapted to include the Positive Reinforcement defining attribute as a stage that only service users who planned to birth at home would require.

Therefore, in light of this analysis, a secondary study focus for this study emerged during the analysis process:

The following section outlines how the data obtained from this study suggests that an active offer of planned home birth could be conceptualised. The suggested defining attributes and how they relate to each other within the concept is discussed, before moving to discuss the constituent domains and the way in which they were experienced by the PSUs of both groups.

Redefining the concept analysis - the two defining attributes for an active offer of planned home birth:

As stated briefly above, stage two of the framework analysis process suggested that only two defining attributes were required to satisfactorily define the concept of an active offer for planned home birth. These are 'Creating the Conditions' and 'Positive Reinforcement', and a broad explanation of both are outlined below:

Creating the Conditions:

One of the Community Midwives talked about a hypothetical scenario in terms of how she saw her role in the offer of planned home birth, and provided support for the idea that some women on entering pregnancy will need to have the correct elements put in place for them, therefore the conditions created, to be able to consider a planned home birth:

> "Having a baby is like going to do a new degree that you know nothing about. Some women do know, and some women don't, and it's a strange environment and unless we nudge them along the way and give them information and discussion and what have you, we end up with this [institutional birth]" (Cm Mw P)

The possibility of Creating the Conditions to generate support within the process of decision making is also referred to in the following quote by a non-PHB PSU participant. The PSU used a hypothetical scenario to relate to her own, and other group members' experiences:

> "That midwife is clearly very encouraging and even though she dismissed the notion of having the baby at home right at the beginning, the midwife hasn't dismissed discussing it with her. Where as that is what we've said before, when someone has said 'Oh, I don't want to have a home birth' they are not being encouraged afterwards, whereas that woman, with a different midwife who hadn't encouraged her, she'd probably have ended up with a hospital birth" (Non-PHB PSU M)

Positive Reinforcement:

One of the PHB PSUs provided a broad illustration of how the Positive Reinforcement stage functions to support women who have decided to birth at home. The following quote was her response to a hypothetical scenario that was uniformly considered to be an excellent example of a way to offer planned home birth by all of the study participants:

> "I think in all of this there is 'discuss, provides information, support, there's reassurance, she helps her find information, directs her to more stuff', and then even at the end she 'hopes Isabelle will be there, but she knows that otherwise'… she is equipped right from the get go as an individual with information isn't she. She's come with that option to start with, and the midwife has picked that up and given her substantially more. Not just 'Yes, you can do', she's fed into her knowledge base even more than she had to start with" (PHB PSU F).

Similar positive elements about this scenario were also noted by a non-PHB PSU:

> "There's reassurance, there's team, there's support, you're leading it, it's your decisions but we are here to back you up on whatever decisions you make. You can't ask for more than that, can you?" (Non-PHB PSU L).

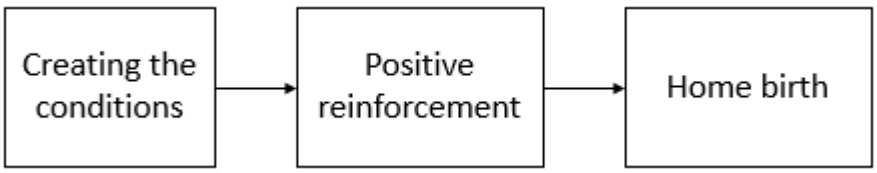
The structure of the concept of an active offer of planned home birth:

In comparison to the initial concept analysis findings [Chapter 5] which suggested that all four of the defining attributes were applicable to the active offer of planned home birth for every woman [Figure10], the analysis process revealed that the concept can be viewed as a two-stage process. An additional development is that both stages will not always be required for every woman. This is explained further below, with reference to PSU stories to support this conceptualisation:

Both stages of the active offer required:

A woman enters pregnancy without having already decided that she would like to birth at home. She then receives input according to 'Creating the Conditions' up to the point that she decides she would like to birth at home. At this point, for the remainder for her pregnancy she receives input according to 'Positive Reinforcement'.

Figure 13. Illustration of PSU experience of both of the concept analysis stages



PSU PHB Y commenced her pregnancy terrified of birth and thinking that she would ask for an elective caesarean section. During her pregnancy she received input that meant she

started to think about birthing at home, and eventually made this decision late in her pregnancy. She then received input to support this decision for the remaining weeks of her pregnancy, and gave birth at home.

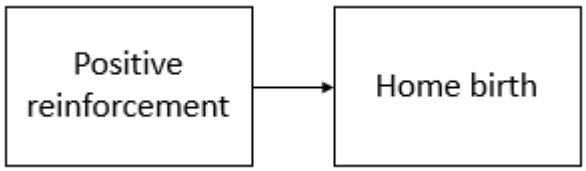
PSU PHB J commenced her pregnancy interested in home birth but needing to learn more about it before making this decision. As her pregnancy progressed she decided she wished to birth at home - initially only telling her midwife, partner and her mother. She was supported in her decision and gave birth at home.

One stage of the active offer process is required:

There were two broad sets of experiences that appeared within the data where only one stage of the active offer process was required.

In the first example, a woman entered pregnancy already knowing that she wished to birth at home. Therefore, she did not require input according to 'Creating the Conditions', but did require input according to Positive Reinforcement.

Figure 14. Illustration of PSU experience of one defining attribute [Positive Reinforcement]

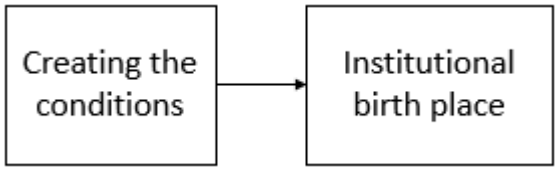


In her first pregnancy PHB PSU R knew she wanted to give birth at home from the start of her pregnancy, and was supported in this decision throughout her pregnancy and gave birth at home.

In her second pregnancy, PHB PSU F knew she wanted to give birth at home from the start of her pregnancy. She was supported in this decision throughout her pregnancy and gave birth at home.

In the second example, a woman enters pregnancy not already knowing that she wished to birth at home. Therefore, she requires input according to Creating the Conditions, but does require input according to Positive Reinforcement because she does not make the decision to birth at home.

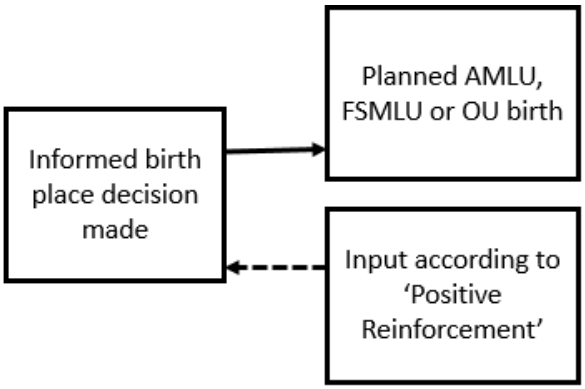
Figure 15. Illustration of PSU experience of one defining attribute [Creating the Conditions]



In her second pregnancy non-PHB PHB T receives input that enables her to make an informed decision about if she wishes to birth at home, and decides when she goes into labour that she wishes to give birth in her local obstetric unit.

Another important aspect of the re-conceptualised active offer for planned home birth, was the inclusion of where a woman made an informed decision to change her decision from birthing at home, to birthing in alternative location.

Figure 13. Illustration of PHB PSU experience of making an informed decision to alter their birth place decision



PHB PSU S decided to birth at home during her pregnancy, and then received support for this decision until the 3rd trimester of her pregnancy when observation of fetal growth suggested that she then required obstetric input. She then made an informed decision to birth in an obstetric unit.

PHB PSU K decided to birth at home, and received input that support this decision until the latent phase of her labour. During this time fetal observations were unreassuring and she made an informed decision to birth in an obstetric unit.

The chapter now moves to discuss the domains that the study data suggested would make up the two defining attributes.

The domains:

Seen within the two-stage process, the domains are essential elements that are required to be evident in a woman's pregnancy experience if she is going to be considered to be in receipt of either the Creating the Conditions stage, or Positive Reinforcement stage of the Active Offer of Planned Home Birth. Justification for the suggested domains within the two defining attributes is provided in the following discussion.

The suggested domains are listed in the table below:

Table 17. The AOPHB two defining attributes and their individual constituent domains

Suggested defining attributes	Creating the Conditions	Positive Reinforcement
Suggested domains within each defining attribute	Initiate the unambiguous, on-going offer of a planned home birth	
	Provide detailed and balanced information and discussion about home birth	Provide detailed and balanced information and discussion about home birth
	Challenge the assumption of institutional birth and what it represents	
	Talk about their feelings and help women learn about physiological birth	Talk about their feelings and help women learn about physiological birth
		Provide reassurance and support for a woman's decision making
	Inclusion of significant others	Inclusion of significant others

The five 'Creating the Conditions' domains:

The two stage process [Figure 13] suggests that each of the five domains of Creating the Conditions need to be present for a service user who requires input according to this attribute, to be able to consider the option of birth at home, and to ultimately decide to give birth at home. The rational is that where these are present it is possible for service users to

make an informed choice about planned home birth. It is not suggested that on receipt of all of these domains that all women will decide to give birth at home - many will continue to have preferences for birth elsewhere and will therefore not require input according to Positive Reinforcement. This is reflected within the final conceptualisation of the two stage AOPHB process [Figure 17], and in Appendix 32 where greater detail about how the AOPHB would appear in clinical practice is provided.

The five domains contained within the Creating the Conditions attribute are:

'Initiate the unambiguous, on-going offer of a planned home birth';

'Provide detailed and balanced information and discussion about home birth';

'Challenge the assumption of institutional birth and what it represents';

'Talk about their feelings and help women learn about physiological birth'

'Inclusion of significant others'.

In Cm Mw P's quote [pg. 206] illustrating the importance the 'Creating the Conditions' stage in the home birth decision making process, the domains of initiating the offer of planned home birth, providing information and discussion, and challenging the assumption of institutional birth are particularly addressed. The content and relevance of each of the five domains is presented below.

Initiate the unambiguous, on-going offer of a planned home birth:

The potential impact on decision making around planned home birth where an unambiguous, on-going offer of a planned home birth domain is not provided was illustrated by many of the non-PHB PSUs reported experiences.

The following quote was made by a PSU who had previously been interested in a planned home birth because of the support and encouragement of her first community midwife, but the uncertainty of the birth process had prevented her from making this choice. She had not experienced encouragement to consider home birth in her second pregnancy, and her labour had been very short, and she felt that she had only just made it to hospital in time to give birth. She was pregnant with her third child at the time of the workshop, and describes that planned home birth would be a choice that she was interested in and had actually

started to make plans for giving birth in her mother's house so as not to disturb her children. However, she needed her community midwife to raise home birth with her soon in order to be able to consider this option in her current pregnancy:

> "I'm 16 weeks at the moment, I've seen her [community midwife] a few times now but it always seems it's just happened that it's not come up yet and I don't want to say 'Well, what about this?... some of us are a bit unconfident when we meet our midwives, definitely for me, if I have to bring it up with my midwife and I don't feel confident that they are happy with home births and happy to discuss it with me then it would make me feel 'well actually, they aren't the right person, or this isn't the right situation'" (Non-PHB PSU M)

The next quotes illustrate the importance of a personalised offer of PHB being made to women in early pregnancy, and how the offer of PHB was not explored further with the PSU when she declined:

> "…mention it in the first or second meeting so then it's in there. 'This is an option for me; I could have my baby at home'" (Non-PHB PSU M)

> "When discussing my birth plan, I made the decision to labour in hospital. My midwife did offer a home birth at this meeting, but when I said I wasn't sure, she did not mention it again" (Non-PHB PSU E)

However, one of the non-PHB PSUs provided an illustration of how her community midwife created the conditions in terms of providing a flexible approach to decision making that facilitated her ability to wait until early labour to decide where to give birth:

> "…I always felt there was a strong chance that she'd come quick, so basically what I said to [community midwife] is 'I think I'm probably going to go to hospital…but if it seems like the baby is just going to come there and then, can I change my mind at the last minute?' And she was so amenable to that, I felt really lucky she was quite happy, it didn't feel like I had to set in stone what I was going to do until the end, and actually she had that written down in my notes, and she'd informed the other midwives that it was going to be a hospital birth but if I changed my mind at the last minute then they would have come, and I think that is a brilliant tact for a midwife to take" (Non-PHB PSU T)

It is important to note, in relation to Non-PHB PSU T's experience and ability to raise this possibility with her Cm Mw - she was highly educated and articulate, and had a large pool of experience of successful PHBs within her family and friends. Without this she may not have felt able to ask for this option to be made available to her.

Additionally, one of PHB PSUs (Y) also provides an example of the approach suggested within this domain of the AOPHB being effective in supporting her decision making. This PSU had been offered planned home birth at the start of her pregnancy but had been adamant that she wished to go to hospital for her birth. However, her community midwife had kept the option open for her to make this choice during her pregnancy:

> "I told the Community Midwife at 37 weeks that I'd decided I wanted a home birth" (PHB PSU Y)

The community midwife participants' discussions also supported this domain. This community midwife supported the idea that birth place decision making does not need to be concluded in early pregnancy:

> "I don't really think there's any need to write down 'planning hospital birth', until the later end of the pregnancy, because what difference does it make?" (Cm Mw R)

One quote, discussing a hypothetical scenario, illustrated the importance of exploring a woman's decision making when she makes the decision to birth away from her home:

> "Explore why she wants to go to the hospital. Just say 'Why would you like to go to the hospital', you only had Gas and Air last time, just find out if there is a reason, obviously she doesn't, but you don't know that at the time, you need to find out" (Cm Mw M)

The idea of being able to assess women at home in early labour was also felt to be a positive approach to supporting decision making around planned home birth:

> "I've come across quite a few people, would like to decide in labour. And I think that is a good idea. They can't always see themselves having a home birth, but then if you see them in labour and you're telling them, 'Everything is going normal, you're half way there'. I think if we were able to assess more at home, I think it would improve

> it. And I think it would improve the numbers of people staying at home, or going to the free standing midwife led unit" (Cm Mw L)

Therefore, as these quotes have illustrated, this domain is required to ensure that all women are clear in the knowledge that it is possible for them to choose to give birth at home at any point in their pregnancy, and that they are personally encouraged to consider this choice for themselves. This is to prevent a woman deciding on an institutional birth place before she is able to make an informed decision about planned home birth, either at the start of her pregnancy, or early in pregnancy before her midwife is able to provide the AOPHB. Additionally, this domain also serves to prevent a tick-box offer of home birth being made by a midwife, and women being unsure that the option of home birth exists for them, and so opting for an institutional birth place.

Provide detailed and balanced information and discussion about home birth:

The potential impact on decision making where detailed and balanced information and discussion about home birth is not provided was illustrated by the participants in their reported experiences.

The following quote illustrates how the offer of home birth, and potential information provision about home birth was provide too late for this non-PHB PSU as she had already started to visualise herself giving birth in hospital:

> "…Don't wait until like me they've visualised it in hospital, have dreams about having my baby in hospital and then birth plan, sort of, you're 33, 34 weeks pregnant 'Oh, you know you could have your baby at home' 'I don't want it at home' 'Ok then', that's when you make the decision isn't it, but you need the information before that" (Non-PHB PSU E)

The next quote illustrates how the depth of information that is required is needed to elevate any existing knowledge about PHB that a woman has to actually feeling that she is sufficiently informed about PHB and the way in which PHB is provided:

> "I just think that it's important that a woman is able to make an informed decision. At the moment, there is no way that I can decide because I'm not informed enough

about any of it. I mean, I know hospital birth because I've done it but I haven't got enough information about home birth to decide whether that is what I would do or not" (Non-PHB PSU M)

Information provision throughout pregnancy enabled one of the PHB PSUs to decide to give birth at home:

"'Have you thought about home birth?' - well maybe initially the home birth thoughts are really quite negative, 'what about the mess' was all I could think about but until you actually know the ins and outs and talk about your feelings towards it, then I think you're not going to have converted her [woman in the scenario] either" (PHB PSU Y)

PHB PSU S empathised with women undergoing this decision making process, although she herself had not required care provision in line with the Creating the Conditions domains:

"Do you think home birth needs a bit more explanation because it is quite unusual? Everybody kind of knows what it's all about to have a baby in hospital, you see it everywhere, so maybe it needs to be more emphasized to explain what happens…" (PHB PSU S)

Without anticipating a need for additional explanation about PHB than institutional birth, it is suggested that the experience of the following non-PHB PSU will occur:

"Midwife asked rather casually if I'd consider home birth. I took the leaflet but knew I'd not really change my mind" (Non-PHB PSU C)

What was apparent about the way that the PSUs who later went on to plan a home birth discussed information provision and discussion was that their social networks where clearly influential sources of information for them during their pregnancies:

"For me it was fundamental, I mean it was this idea from the midwife but then meeting you who had had babies at home that was just…I remember going to (participants) house to watch the video by Ina May, the film, I found that so empowering, so beautiful, I thought 'That's what I want for me'" (PHB PSU M).

> "…then people [friends] started talking to me about 'You know there's an option, why don't you have a home birth' and then I got in touch with you guys [Home birth group] and then all of a sudden all of these positives" (PHB PSU Y).

In terms of uniform information provision, several PHB PSUs felt that there was a lack of information provision taking place within their local individual community midwife – woman dyads, as well as within routine antenatal classes. The following conversational quote illustrates two PSUs reactions to a hypothetical experience, and the way that they relate this situation to how they viewed service provision:

> "She's been going to the antenatal classes and the discussion of PHB has been very much pushed aside even more". [….] "I think this scenario is probably true for most people in most places, in most appointments, where 'this is the system'" (PHB PSUs K and C)

The community midwives acknowledged that the way in which home birth is discussed within routine care is not appropriate in terms of the amount of information about PHB that is provided, and in terms of balance.

> "It shouldn't be a pick first, then information should it, it should be information about everything and then make a decision… it's probably true though, to a degree. I do think we give more information, or we talk more about that particular service [hospital based maternity service]" (Cm Mw P).

> "There is an information leaflet in the home birth policy but not everybody gets it. They get it if they are interested in home birth basically" (Cm Mw A).

The way in which decision making was facilitated by community midwives was also suggested to be biased towards birth in a district general hospital in an additional way. The midwives acknowledged that if a low risk woman decided to plan a birth in an obstetric unit, despite evidence to suggest that this increased her chance of requiring an emergency caesarean section and other potential risks, no reference to this was made:

> "Very rarely, well never, have I ever sat down with someone who is choosing a hospital birth have I gone, 'Well, if you choose to be in hospital then there are more rates of intervention, MRSA and there's other risks as well…' So, it's our balance of

> the information that we are providing, we don't really go over the risks of hospital birth as well" (Cm Mw H)

Therefore, as the quotations have illustrated, this domain is required to ensure that women are routinely provided with information from the start of their pregnancy and throughout their pregnancy, and in response to any request for information that they make. The rational for this domain is to ensure that women are not merely provided with nil or a shallow level of information by their care provider, or that they have to rely on potentially inaccurate information that is provided by a member of their social network. It also prevents information provision occurring too late in pregnancy for a woman to be able to become used to the idea of PHB, or before a woman has visualised herself giving birth in an institutional setting. The requirement for balance will prevent home birth being portrayed within NHS information, as more dangerous for the woman or her baby than another birth setting (where this is clinically incorrect). Uniform message provision across a whole service prevents individual care providers being seen as positive about home birth, while the remainder of the maternity service or the NHS being seen as uncertain or unclear about home birth.

Challenge the assumption of institutional birth and what it represents:

The potential result of a woman having an assumption of institutional birth that is not addressed during pregnancy is illustrated below in the following quotations:

> "Yeah, because I was very much 'No' and I'd never ever, not until giving birth to [1st child] ever considered home birth and I think that was a cultural thing for me" (Non-PHB PSU C).

> "I think the assumption is that the first one should be in the hospital, but the second one, if it's been alright, if you want to have it at home you can" (Non-PHB PSU L).

Reasons for these assumptions, and a further illustration of how powerful a woman's own assumptions for institutional birth are was provided by the following quote given by a PHB PSU participant in relation to her first pregnancy. In this quote the PSU discussed concerns around the safety of non-institutional birth:

> "I remember overhearing someone talk about home birth and remember thinking 'why?' and 'it's surely safer and better to give birth in hospital'. I don't remember being asked to consider a home birth so I went with the system" (PHB PSU C – 1st baby institutional birth place).

Another assumption was that early postnatal care is better provided within an institution than at home:

> "I was so exhausted but I wanted to breastfeed and a healthcare assistant sat with me, checked me through the night and made sure about her latching on, and she was fantastic. And because of that experience I will definitely go back to hospital again….how long do midwives stay with you after you've had your baby at home?" (Non-PHB PSU E).

> "I thought that, after I had had (1st baby) I felt actually they were brilliant. Immediately afterwards they were great, the same midwife sat with me for hours and taught me how to do it because I'd never done it, and they made me feel like I didn't want to go home and I was there for 5 days" (Non-PHB PSU D).

Several of the community midwives demonstrated their awareness that women often hold pre-conceived assumptions that they will give birth in an institutional location, and that they saw their role as assisting women to consider their viewpoints:

> "Making them question their own assumptions as well isn't it. They may have, like you say, preconceived ideas, or she may have thought 'Well, I've got no choice this time' so it's exploring that, or allowing her to explore isn't it" (Cm Mw M)

The following community midwife illustrated how the home environment is useful for dispelling myths or preconceived ideas about home birth, and for demonstrating the benefits of a home setting for a woman's labour:

> "Visit all of them at home, because you could say 'Oh, it would be lovely, ideal there, nice a little spot there'. So, point out the advantages of the home setting, and how it all works" (Cm Mw S).

However, in light of the current service provision for home birth and the way in which the information provision about birth place choices was presented to women, one community midwife stated her opinion that:

> "That assumption that hospital is safe, we're supporting it" (Cm Mw K)

Two PHB PSUs highlighted the need for planned home birth to be more visible to women, in order for the myths that surround home birth, and the assumptions that institutional birth is either safer or better, are broken:

> "I think that's the thing. It needs to be spoken about so once people know it's normal, it's not weird, it's an option on the table then isn't it, not something crazy, listening to whale music and stuff, it's not like that" (PHB PSU V).

> "If the whole media, and the midwives and the doctors make this more as the normal option and if you have a problem then go to hospital then I think many more people would consider it" (PHB PSU T).

Therefore, this domain is required to ensure that women are routinely aware that they have a decision to make about birth place choices that includes consideration of planned home birth. The rationale behind this approach is to ensure that women do not opt to give birth away from home because of an assumption that better care is provided in institutional settings - during either the intrapartum or postnatal periods; or because of an overriding assumption, their own or their midwife's, that they would give birth elsewhere.

Talk about their feelings and help women learn about physiological birth:

The need for this domain to be included within the Creating the Conditions stage was illustrated by the study participants. PHB PSU Vi empathised with the situation that women without support experience, as in the hypothetical scenario that she was reacting to, as she was encouraged to have a home birth with her first child but declined because she was unsure of how she would cope with labour:

> "She's never considered home birth because she's already c****ing herself about having a baby" (PHB PSU O).

This sentiment was also echoed by a further non-PHB PSU:

"You can only go for it [planned home birth] if you are confident" (Non-PHB PSU).

The need for discussion around birth experiences and the way in which they influence future place of birth decision making was illustrated by the following quote by non-PHB PSU S. It demonstrates the enormous influence that close family members' experiences with labour and birth have on women, and suggests the potential benefit that the opportunity to discuss these fears may have had for this PSU, where ever she decided to give birth:

> "…my mum had two very extended labours and one of them had ended up in a scary scary emergency C-section, and Mum and I, you know, we've always been just so similar it just made me think, the history is there so I didn't really consider it [PHB], but there wasn't somebody to really properly talk to about it…" (Non-PHB PSU S).

The need to talk with a midwife is also highlighted by a different non-PHB PSU in relation to one of the hypothetical scenarios that we discussed within the workshops:

> "Yes, she [the midwife] needed to expel those fears, and she needed to instil her with confidence and get her through the process" (Non-PHB PSU R).

When confidence in a woman's own ability to give birth is fostered, the option of PHB is suggested to then become a potential for her to consider. Non-PHB PSU M felt able to consider PHB for this reason:

> "But as far as I can see it, I've had one complicated, one went absolutely fine – I could have done it on my own probably, and so I'm sure that the third time round it will be just as easy, if my labours have gone from 3 days to 45 minutes, I dread to think how fast the next one's going to be!" (Non-PHB PSU M).

PHB PSU Y describes her initial fear of birth, but then states how her thought process transformed during her pregnancy to enable her to plan a birth at home with her first baby:

> "[Early pregnancy] I was petrified by the thought of childbirth, to the point of asking myself 'what have you done?' I even hoped for a C-section." "[Late pregnancy] I literally went from the 'I don't want to know cos I'll just take the drugs and it will be horrendous so ignorance is bliss' attitude to researching the physicalities of labour, coping strategies and focusing on the positive aspects and welcoming our baby into our home and a calm, warm environment" (PHB PSU Y).

While PHB PSU Y describes how she personally researched much of the birth related information that ultimately assisted her to plan a home birth, the benefit of professional conversations about birth experiences and thoughts on an upcoming birth is suggested to be very important for all women. This includes where women have given birth before, and several of the non-PHB PSUs suggested that they would have preferred any or more discussions during their subsequent pregnancies:

> "I definitely feel that because I have had two babies 'She knows what she's doing'. Yes, I know what I'm doing with a new-born baby, and I know that I can go to the loo with one hand!...But actually …my actual labour in total probably lasted 3 hours of my entire very long life, so in those 3 hours I can't possibly be expected to know how I would feel giving birth at home without anybody discussing it with me" (Non-PHB PSU M).

> "…they [midwives] might have done but I think it might have been early on and I just don't remember it. Often they were just doing the checks, you know, making sure the important stuff was done and then the peripheral conversations…I think they assume you know what you're doing…" (Non-PHB PSU S).

Where PSUs have gained knowledge about physiological birth processes and how the labour environment may influence birth experiences and outcomes, it is suggested to influence their decision making towards considering PHB. PHB PSU Hi discusses her thought process in this area:

> "I think I was divided in where to labour right up to when I went passed the overdue mark. If I could have guaranteed a pool at the hospital and not be pressured into pessaries and 'the drip' so much and other proddings/pokings I think I would have gone to hospital. But having read so much …I knew I wanted to be somewhere comfortable and not so doctor-led. So home birth came to be the most obvious choice" (PHB PSU H).

Again, it was interesting to see that the process of learning about physiological birth that this PHB participant had undergone was mostly self-initiated, and supported by several close friends who were also experienced and knowledgeable about birth outside of hospital.

The positive influence of caregivers providing this element of care throughout pregnancy was discussed hypothetically and experientially by many of the PHB PSUs:

> "I think that is really important…talk through what your perceived concerns were, or perceived trauma whether it was real or not. It's good that that's the starting point, then your options, your emotions and feelings as to why you might want to choose something different" (PHB PSU J).

> "She was talking with her all the way through. Talking about her feelings, not just information, at different times as well" "Yeah, at different times talking about…not just a one off conversation" (PHB PSU F & M).

The community midwives also held positive opinions towards this aspect of care being provided to women:

> "I think all women, well most women, like to talk. And I think, probably more times, women having the second one will want to talk more because they've got some experience to reflect upon" (Cm Mw N).

However, they were also mindful that at points this was not always facilitated in current practice as well as it could be:

> "I think this [hypothetical scenario] does happen, that she didn't have the opportunity to discuss about her feelings and her fears… and sometimes clinic settings don't allow that anyway" (Cm Mw T).

Therefore, the rationale for this domain is to ensure that women are encouraged to talk about previous birth experiences with their midwives, and that these experiences can include not just their own personal experiences but also those of their family and friends, as well as any reported within the media that have influenced them. The aim of this domain is to prevent women harbouring potentially inaccurate concerns about labour or birth, and the outcome that she may decide she feels safer giving birth in an institution with obstetric facilities if these fears or concerns are not addressed.

Inclusion of significant others:

The importance of this domain within the 'Creating the Conditions' stage for maternity service users was discussed by several of the non-PHB PSUs. Their discussions illustrated the need to be inclusive in terms of the 'significant' relationships that women have in terms of their birth place decision making:

> "I think that's one of the things I've noticed from our conversations that for a lot of us, even though it's our bodies and we're giving birth" "It's just as important for them isn't it…it's their baby…it's as much their decision as it is ours" (Non-PHB PSU T & M).

> ""It seems as though it's a woman's choice, but partners can be blockers. So even if it's the woman's choice, then men can, or even birth partners, it could be more your mother, your birthing partner, whoever is going to help you. For example, if your mum was particularly pro something or other, and your sister, that might greatly influence how you would go, just because you trust them" (Non-PHB PSU C).

From the way that several of the non-PHB PSUs discussed their place of birth decision making it appears that their partners had influenced their decision making for an institutional birth place, and also illustrated the potential impact that uncertainty about labour and birth, and previous birth experiences can have on significant others:

> "He also wouldn't really entertain the idea [PHB] because of that, I think he didn't know what labour was going to be like" (Non-PHB PSU E).

> "I think I had always felt quite open to having either a hospital or a home birth though my partner had experienced a tricky birth with his daughter, so between that and the miscarriages we both 100% wanted a hospital birth for baby No.1" (Non-PHB PSU T).

The two non-PHB PSUs who were pregnant at the time of the workshop were both in attendance so as to be able to gain information for themselves about PHB, and also to provide this to their partners:

> "I hope to inform my husband more about home birth so that we can make an informed decision" (Non-PHB PSU D – late pregnancy).

Of the three PHB PSUs who had experienced the elements of this domain and had gone on to plan home births, two made reference to the way in which their social networks had particularly supported them in the process of including their partners in their decision making:

> "My partner is not here, but for him as well it was key that you [local PHB group members] were there because his answer was 'No, you go to hospital' and then he was talking to you and that was the difference for him, and then he was really into it, I think as much as me at the end" (PHB PSU M).

The potential role for midwives was discussed by several non-PHB PSUs. As an example, the following quote is a response to a hypothetical scenario that resonated personally with the PSU:

> "Maybe if Gary [partner] was present there and he said 'Oh no, I'm really nervous about home birth' and the midwife could have said 'Oh, can you tell me about your concerns?, and 'Maybe we could talk through them and I could tell you a little bit about what it can be like' and 'If there's anything you're anxious about then we could discuss it'" (Non-PHB PSU E).

The community midwives also discussed the inclusion of significant others during the workshop sessions. This was mostly in a hypothetical sense, in relation to the scenario exercises, and included consideration of resolving partners' fears about labour and birth and how they would cope at home, uncertainty about planned home birth, and of the large influence that partners have on women's decision making:

> "…with the partner being not on board, he wanted maybe a bit of a discussion and if you could alleviate any sort of fears that he might have then maybe he could have changed his mind, or thought about it at least" (Cm Mw T).

> "I think they have a fear that they won't cope with it" (Cm Mw R).

> "…invite Samir because it's him that you need to include, because he's the one that's not keen" (Cm Mw G).

Therefore, the rationale for this domain is to ensure that caregiver interactions with significant others are undertaken with the understanding that they can have very strong

influences on women, and can be 'blockers' to their consideration or preference for PHB. This domain aims to prevent significant others not feeling positive about a woman's consideration of birth at home, and women needing to inform their partner about home birth without the support of their caregiver. This is because a lack of partner support for home birth could result in a woman not being able to experience the required conditions to consider PHB for herself.

Within this process, where one of the domains of 'Creating the Conditions' is not experienced it is unlikely that a woman will consider and decide to give birth at home.

Conclusion for Creating the Conditions:

'Creating the Conditions' appears to be an appropriately named defining attribute in the concept of an active offer for planned home birth. The title suggests the intention that women are supported in inhabiting the required social and clinical environment in order that they are enabled to consider the option of planned home birth, and make an informed decision on whether they would like to birth at home. Within the defining attribute, five domains were revealed that are each required, and work symbiotically to create the required conditions for women.

The extent to which the PSUs from both groups reported receiving input that aligns with the five domains that are conceptualised to make up the Creating the Conditions defining attribute is illustrated below [Table 28]. It is suggested that many of the non-PHB PSUs did not receive input that aligns with all five of the Creating the Conditions domains, but that all of the PHB PSUs who required input according to this defining attribute did receive this input – making a finding of this study being that variation existed across the PSU participants in terms of their access to input that related to all of the domains within this defining attribute.

This study did not aim to provide a robust assessment of the PSUs receipt of this conceptualisation of the AOPHB, therefore it has not been possible to provide an illustration of each of the PSU reported as not all provided sufficient data for this assessment to be made. This is therefore considered to be an avenue for future research. However, according to this initial assessment, it appears that receipt of input according to the five domains

within the Creating the Conditions defining attribute, may be facilitative of a maternity service user deciding to give birth at home.

Table 18. Table to illustrate reported PSU experiences in relation to the receipt of input that supports the Creating the Conditions defining attribute

PSU group	PSU	Offer	Info	Learn	Challenge	Sig others
Non-PHB	D					
	T					
	E					
PHB	M					
	Y					
	H					

When a woman does experience each of these domains, it is possible that she would then decide to birth at home. According to the two-stage process she would then need to start experiencing the domains included within the Positive Reinforcement defining attribute [Figure 14]. Alternatively, she may make an informed decision that she wishes to birth away from her home, and will then require support to make an informed decision about other available birth place options [Figure 16].

The chapter now moves to discuss the domains within the Positive Reinforcement defining attribute:

The four Positive Reinforcement domains:

The process suggests that each of the four domains of 'Positive Reinforcement' need to be present for a service user to be able to continue to plan to give birth at home.

The four domains contained within the 'Positive Reinforcement' defining attribute are:

'Provide detailed and balanced information and discussion about home birth',

'Talk about their feelings and help women learn about physiological birth',

'Provide reassurance and support for a woman's decision making'

‘Inclusion of significant others’

In the two PSU quotes [p. 206-207] that were used to illustrate what is broadly intended to be understood about the process of Positive Reinforcement, the domains of providing information and discussion, and providing reassurance and support for decision making are particularly referred to. The relevance of each of the four domains will be presented below.

Provide balanced information and discussion about planned home birth:

All of the PHB PSUs experienced the required elements of this domain, but it is apparent that they were not all provided within their maternity service care provision. PHB PSU M, who had the idea of PHB raised with her by her community midwife but then received the majority of the ‘Creating the Conditions’ domains from her social network, then went on to receive the information provision and discussion in terms of Positive Reinforcement through her social network – primarily the members of the local PHB group:

> “My midwife was supportive in a way that ‘Yeah, it’s fine’ and every time I went for my appointment she was asking me again ‘Are you still thinking of home birth’ ‘Yes’, but I wanted to discuss it a bit more and she’d say that we’d have to wait for week 36 or 37 …I wanted to be more encouraged and to be able to discuss with her… so if I didn’t have the support of the home birth group, it didn’t come from a midwife even though I had the same midwife from the very beginning” (PHB PSU M)

Outside of their relationships with their community midwives, the PHB PSUs reported that the routinely provided antenatal classes did not provide a great deal of PHB related information, and also suggested that the information providers did not appear to be familiar with PHB. Additionally, reference was made to the focus of the information provision being around potential obstetric interventions that the women may experience:

> “The antenatal classes didn’t help, as home birth was barely mentioned and lots of the time seemed to be spent discussing intervention tools like forceps and Ventouse” (PSU PHB A).

> "I think that's why the antenatal classes thing, I thought 'You don't know anything about this do you?' because she probably didn't. Lots of people [midwives] who were talking hadn't ever been to a home birth, or seen one" (PHB PSU S).

The community midwife participants also reported being aware that the information and discussion that they are required to provide to women planning a home birth appears to be negative towards PHB, again referring to the fact that institutional birth is portrayed as a risk free choice:

> "Yes, because they have to sign don't they, they have to sign that, and I argued against that, because I thought 'Nobody signs in hospital'. Nobody talks to you in hospital about mec [meconium] stained liquor or shoulder dystocia, or any of those things but they said 'No, no, no, it's a high risk', and I said 'Why?' You know, I think women who choose a home birth, the vast majority of the time take greater responsibility to learn" (Cm Mw P).

> "I sort of say to them 'Well, you know, we have this checklist, and it's not us trying to put you off, but if you want to stay at home you need, you have to have thought about these things' because we have to say we're an hour away from the hospital, so we have to act a little bit quicker don't we" (Cm Mw L).

Therefore, the rationale behind the domain is to provide balanced information and discussion about planned home birth to women throughout their pregnancy, in the understanding that women may not necessarily have a sufficient level of knowledge about home birth despite the fact that they are intending to birth at home. This domain aims to prevent women needing to independently access sources of information, or rely on potentially inaccurate sources of information about home birth, with the result that a woman feels unprepared for birth at home and chooses to give birth elsewhere.

Talk about their feelings and help women learn about physiological birth:

Most of the PHB PSUs discussed the components of this domain when they discussed their PHB decision making. The importance of this domain is illustrated within the following quote:

> "The factor that influenced me most was confidence of my midwife and trust in my own body / ability to give birth without pain relief. She helped me believe that I could do it. Without that preparation and confidence not sure I would have been successful" (PHB PSU U – 1st birth, in Spain with independent midwife).

Frequent references to independent sourcing of information on physiological birth were also mentioned, as was the way that their social networks had facilitated their learning:

> "I was given 'Spiritual Midwifery' by Ina-May Gaskin by my sister in law. Reading that made me aware that birth can be empowering and remarkable, something to celebrate not just tolerate. I felt great in trimester two which helped me trust my body" (PHB PSU A).

Additionally, care providers' omissions in not including this information within routine care were also noted – in addition to how the PHB PSUs felt that this style of information could be helpful to all women, not just those planning PHBs:

> "There was not mention [in antenatal classes] of breathing, walking or visualisation" (PHB PSU A)

> "It doesn't have to be 'you have to have a home birth' but you can use those tools to support you to stay longer at home, or help you through your labour. They should be encouraged to discuss the topic, even if the person is not keen because there is so many things around that…if it was fed to you more about the whole natural birth thing, rather than you having to go and find out about it I think maybe a lot more people would have more positive experiences in hospital" (PHB PSU Y).

Therefore, the rationale for this domain is to ensure that all women have the opportunity created for them to discuss their previous birth experiences, and how they feel about their forthcoming birth. This domain aims to prevent women who had planned a home birth altering their decision making because of unaddressed doubts or concerns that result in them feeling safer to birth away from home.

Provide reassurance and support for a woman's decision making:

The importance of this domain is evident in the following quotes from PHB PSUs:

> "I was so lucky and I had that midwifery support, that I'm so grateful for them giving me that opportunity and making me feel respected and empowered - it was wonderful" (PHB PSU U).

> "She was so positive and she was so, very supportive and from that day onwards that gave me faith and confidence in myself" (PHB PSU B).

However, this input was not uniformly experienced by the PHB PSUs:

> "I felt like that, I mean mine was the second birth so I think that maybe they just assumed that everything is fine, but I would quite like to, I mean I never had a chance to talk about anything – it was literally blood pressure, and then out you go 'quick!', you know. There was never 'How are you feeling? 'Have you got any worries?' sort of thing, so if they actually had time to talk about that sort of stuff then it would be great" (PHB PSU C).

> "I said 'I want this one at home' with the 3rd one and she [midwife] was saying 'Well, we'll see' sort of thing as if I kind of had to, if I behaved myself I could and it was a completely different attitude towards it – she was quiet about the idea" (PHB PSU O).

A reduction or removal of support was also experienced by the PHB PSUs who had required obstetric input after having made the decision to birth at home.

> "All midwifery support vanished. Suddenly you are on your own." (PHB PSU F).

Several of the PHB PSUs had a similar experience to that reported here. While the expectation of 'reassurance' around birth at home may not necessarily be possible if a clinical risk is identified, those PHB PSUs who had not immediately accepted advice to birth in an obstetric unit voiced a sense of being on their own attempting to understand the information and weigh up the risks and benefits pertaining to their own situations, without feeling any midwifery support that sustained their sense of personal autonomy during this decision making process.

Support and reassurance from social networks was also important for many of the PHB PSUS, and for several of them it appears that the majority of the components of this domain were felt to have been mostly provided in this way.

In addition to verbal support, support for a decision to birth at home was also seen by the PSUs as being demonstrated through the lending of birth pools or other resources:

> "My yoga teacher lent me a pool and plastics to put on the floor" (PHB PSU M).

> "Midwife was very happy and supportive about my decision. Helped by lending birth pool and told me about Facebook group" (PHB PSU J).

Support for this domain was provided by several of the community midwives, and is illustrated in the following quote:

> "…how women feel emotionally is important. I often say that to women 'Yes, I check your blood pressure and do your wee at every appointment, and listen to baby, but how you feel emotionally is important'" (Cm Mw H).

Therefore, the rationale for this domain is to support women in their decision making for a planned home birth in the knowledge that they may be experiencing concerns or doubts about their decision from their partner, family or friends. This domain aims to prevent a negative response to a woman's decision to birth at home impacting on her confidence to make this decision, and her need to alter her plans as she does not feel supported in her decision making.

Include significant others:

Several of the PHB PSUs provided an illustration of how useful their caregivers' inclusion of their significant others had been for them:

> "She [community midwife] would always ask my Mum or my partner, whoever was with me how they were feeling about it as well, because it all comes into it" (PHB PSU J).

> "She gave [partner] confidence as well, and we thought that home would be the best environment" (PHB PSU B).

However, this level of inclusion had not been experienced by all of the PSUs, and was specifically referred to by one of the PHB PSU partners who attended the workshops. His own birth, reported to him by his mother, made him have serious doubts about the safety

of his partner's preference for planned home birth and he would have welcomed the opportunity to talk about this with a midwife:

> "I had my doubts with twelve weeks and so, I wanted to discuss it in advance to be sure what I wanted to do and why. Not in the week thirty-five, so yeah, I missed a first conversation about options" (PHB PSU E).

His concerns impacted on his partner who also mentioned this during the separate workshop that she had attended:

> "He was really worried and had these nightmares over me having a lot of troubles giving birth so I think the support of the midwife there, explaining a bit more and being able to talk about it not from the week 36 but before it would have probably helped him with that, and myself as well" (PHB PSU M).

Concerns about planned home birth were also felt by several partners who were now expecting a baby with a new partner:

> "He [partner] had had baby before and his previous partner's experience in hospital was just horrific and he said it was just the worse thing, watching her go through it and he had just loads of strong opinions about why that was awful" (PHB PSU F)

> "Discussions with my partner, who had 3 children in hospital before, made me aware that I need to have facts and good reasons for having this baby at home" (PHB PSU T).

As a group, the PHB PSUs stated that increased input from their caregivers towards their partners would have been beneficial:

> "We knew from the beginning because of my sister having her home birth but I think he thought 'Oh God' so he knew but it wasn't until right the day before that …we had the home birth plan when they came to the house and he happened to come in and she said 'Sit down, what do you think about a home birth?'" (PHB PSU R).

> "Husband slightly less certain about home birth, but completely supportive of my choice – would have been really helpful to have more information about what home birth would /could entail to support him / prepare him" (PHB PSU – mid pregnancy).

The community midwives acknowledged that planning a home birth potentially brings different concerns and information needs for significant others than when an institutional birth is planned:

> "I think they have a fear that they won't cope with it [woman in labour at home]" (CM Mw R).

Therefore, the inclusion of significant others within the Positive Reinforcement attribute is similar to that discussed within the Creating the Conditions attribute, with the addition of the need to reiterate to them that a woman's choice to birth at home is a good choice, and to assist them with their home birth preparations. This domain aims to prevent significant others not feeling positive about a woman's preference to birth at home, or worrying about this decision so that a woman feels that they are required to prepare their significant others for home birth. A lack of support by a significant other may result in a woman changing her decision and birthing elsewhere.

Conclusion regarding 'Positive Reinforcement':

In the same way as 'Creating the Conditions', it appears that 'Positive Reinforcement' appears to be an appropriate name for this defining attribute. Its location as the second stage in the concept of an active offer for planned home birth [Figure 13], and its applicability to women when they have decided to birth at home [Figure 14], highlights the intention that women are supported in inhabiting the required social and clinical environment in order that they are enabled to continue to plan to birth at home.

The extent to which the PSUs from both groups reported receiving input that aligns with the four domains that are conceptualised to make up the Positive Reinforcement defining attribute is illustrated below [Table 29]. It is suggested that none of the non-PHB PSUs received input that aligns with any of five of the Positive Reinforcement domains, but that all but one of the PHB PSUs did receive this input. This study did not aim to provide a robust assessment of the PSUs receipt of this conceptualisation of the AOPHB, therefore it has not been possible to provide an illustration of each of the PHB PSUs as not all provided sufficient data for this assessment to be made. This is therefore considered to be an avenue for future research. However, according to this initial assessment, it appears that receipt of input

according to the four domains within the Positive Reinforcement defining attribute, may be facilitative of a maternity service user who has decided to give birth at home in continuing to feel confident and supported in this decision. The PHB PSU O who was not considered to have received input according to all four of the domains, did not continue planning birth at home as they did not feel supported to do so.

Table 19. Table to illustrate reported PSU experiences of input according to Positive Reinforcement

PSU group	PSU	Balanced information and discussion	Talk and learn about physiological birth	Support and reassurance	Inclusion of significant others
PHB	O*				
	J				
	R				
	C				
	B				
	M				
	Y				

O* refers to this PHB PSUs' last birth experience where she birthed in an OU.

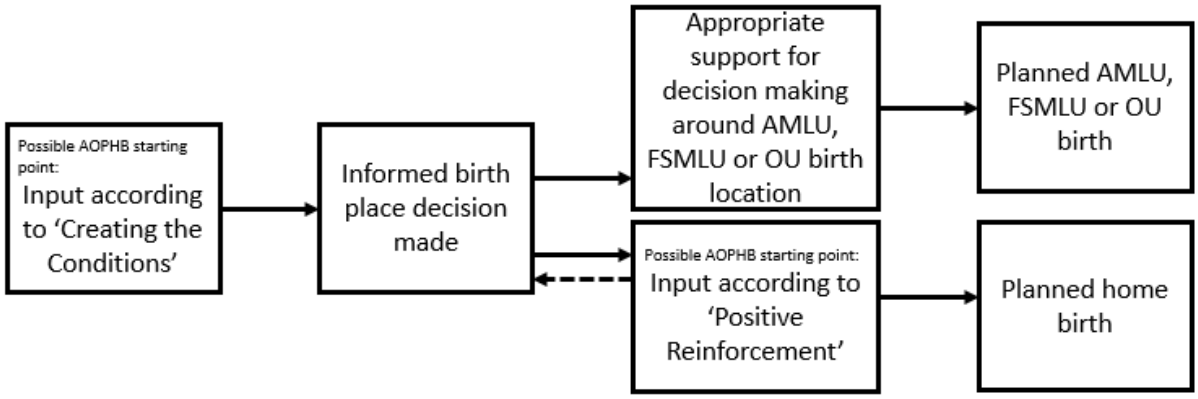
Within the defining attribute, the four domains are each required, and work symbiotically to provide the required conditions of support and reassurance for women who are planning to birth at home. While the expectation is for the AOPH process to be linear, failure to experience one of the domains could result in a woman requiring care according to 'Creating the Conditions'. Additionally, a woman may alter her plan to birth at home and these two possibilities are reflected in the final conceptualisation of the two stage AOPHB process [Figures 17 & 18].

Conclusion: The revised conceptual model for an active offer of planned home birth:

The findings of this study support the conceptualisation of the active offer for planned home birth as a two stage process, comprising of two defining attributes – Creating the Conditions and Positive Reinforcement. In moving on from discussing the two stage process that underpins the AOPHB, in order to more accurately reflect the PSU participant experiences, figure 17 below illustrates the final conceptualisation of the two-stage AOPHB process.

Provision of the AOPHB:

Figure 14. The final conceptualisation of the two-stage AOPHB process



There are two possible starting points for the AOPHB process, as discussed in figures 13 and 14.

The intended process is illustrated by the solid arrow running from left to right. The data from this study suggests that most women would require to commence the AOPHB from the 'Creating the Conditions' stage. They would then require input according to Creating the Conditions, and then make an informed decision as to whether they wish to birth at home, or in an institutional setting. If a woman decided to birth at home, she would then require input according to the Positive Reinforcement stage. If the woman decided she would prefer to birth in an institutional setting she would then require support for this decision, appropriate to her chosen birth place – however, detailing the components of this support is outside the scope of this study.

If a woman knows that she wishes to birth at home from the start of her pregnancy, then she would require input according to the Positive Reinforcement stage.

The arrow moving from right to left from the Positive Reinforcement stage to the point of 'informed birth place decision made' reflects the experience of the PHB PSUs who altered their decision whilst receiving input according to the Positive Reinforcement stage, and

instead made an informed decision to birth elsewhere. Within the study data this was mostly seen in relation to the development of an obstetric risk factor during pregnancy or early labour. Therefore, the final conceptualisation reflects the important requirement for women to make an informed decision to birth away from their home at either point in the two-stage AOPHB process.

Omissions in the experience of the AOPHB:

It felt important to demonstrate the experience of the PSU participants in this study where input according to the AOPHB process was not received. This is illustrated in figure 18 below:

Figure 15. Illustration of a PSU experience where the AOPHB process is not experienced

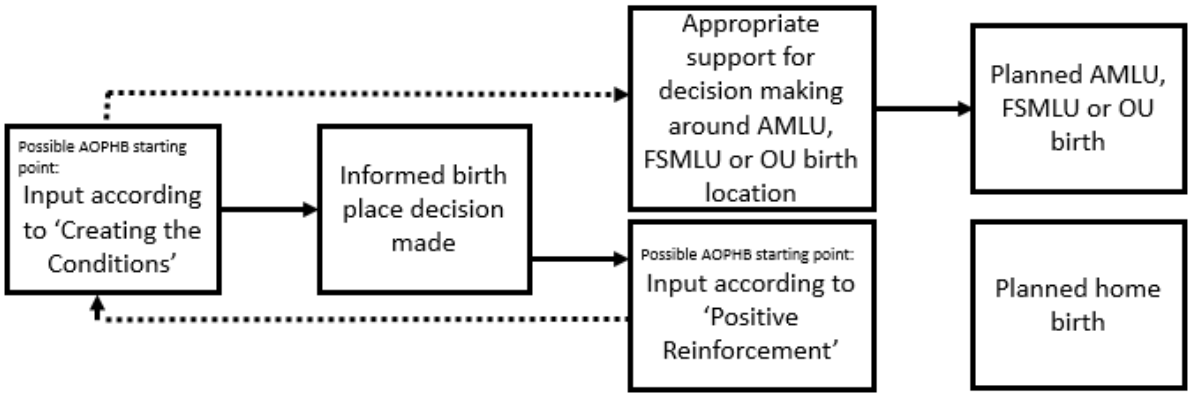


Figure 18 suggests that two possible configurations occur when the AOPHB process is not experienced.

The dotted arrow moving from left to right from the Creating the Conditions stage to the 'appropriate support for decision making around AMLU, FSMLU and OU birth location' suggests that an informed birth place decision that includes planned home birth has not been made, prior to the woman deciding on an institutional birth location. It is suggested that many of the non-PHB PSU participants in this study experienced this approach to birth place decision making.

The dotted arrow moving from right to left from the Positive Reinforcement defining attribute to the Creating the Conditions defining attribute demonstrates the experience where a woman is not receiving the required input according to the Positive Reinforcement defining attribute and changes her mind on birthing at home. This may be a lack of support

for her decision making amongst her social network, or by her maternity care professionals. She therefore returns to requiring input according to Creating the Conditions until she is able to make an informed birth place decision. One of the PHB PSUs was felt to have experienced this process (PHB PSU O).

The broader context surrounding the provision of the AOPHB:

An additional finding of this study was to illustrate that the provision of the active offer of planned home birth should be considered within a broader social context. During the process of data analysis, it became apparent that three main sources of input were referred to within the PSU experiences. These were their community midwife or antenatal class midwife, members of their social networks, or themselves. Although the initial 'ice-breaker' activity in the PSU workshops had been to facilitate some broad, anonymised, consideration of how the process of challenging the assumption of hospital birth had been experienced by the PSU participants [Table 25, Exercise 1], this analysis was not an intended aim for this study. Therefore, unfortunately, it is not possible to provide a categorical assessment for each PSU participant as sufficient experiential data was not provided by each PSU participant. This has been recognised as a possible avenue for further research.

What follows below is an illustration of the context of the provision of the AOPHB components in relation to the source of this input. This is initially discussed in relation to the domains within Creating the Conditions, and then the domains of the Positive Reinforcement defining attribute.

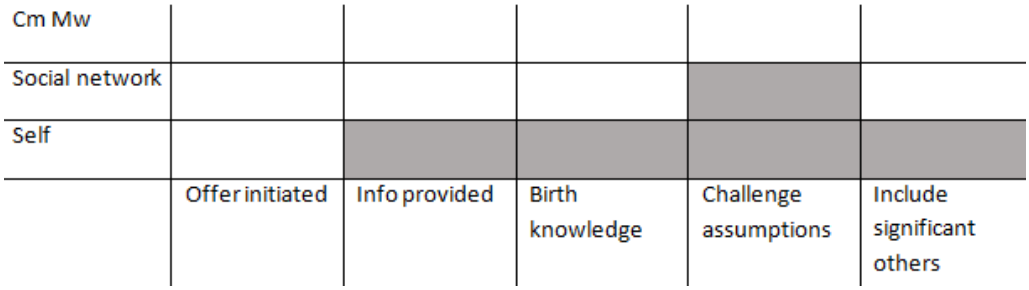
Creating the Conditions:

The following summaries provide illustrations of the PSU decision making experiences in relation to the Creating the Conditions defining attribute. They illustrate who provided the input for the PSUs across the five component domains. A range of PSU experiences have been selected to illustrate the varied ways in which the content of the domains were accessed:

Non-PHB PSU D:

Touchpoints that assisted this PSU's consideration of PHB were having experienced a positive physiological birth in her previous pregnancy, and having had the idea of planned home birth promoted by her previous community midwife, who was a friend of her mother. Touchpoints that hindered her consideration were that she was yet to have an offer of home birth initiated by her current community midwife, did not know sufficient information about planned home birth to be able to make this choice, and that her partner was not supportive of her consideration of planned home birth. Other than through her previous community midwife, planned home birth was not known about within her social network. She was attempting to access the information that she needed by attending the workshop, in order to inform and challenge her partner's assumptions.

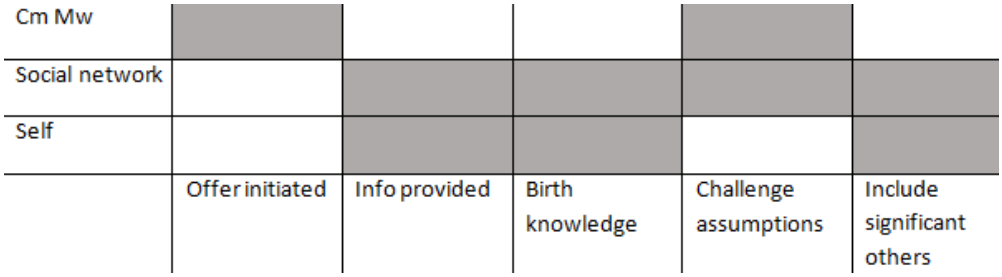
Figure 16. Receipt of Creating the Conditions input - Non-PHB PSU D



PHB PSU M

This PSU's touchpoints facilitated her consideration of planned home birth. She experienced all of the 'Creating the Conditions' domains, having had an offer of planned home birth initiated by her community midwife at the start of her pregnancy which served to challenge her strong cultural assumption of institutional birth. Additionally, she then received information and support in relation to physiological birth and planned home birth from her social network, which also supported her partner to be able to accept and understand her consideration of planned home birth.

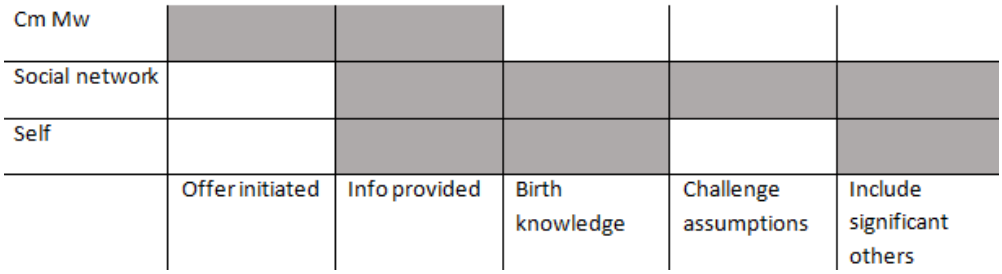
Figure 7. Receipt of Creating the Conditions input - PHB PSU M



PHB PSU Y

The touchpoints for this PSU also facilitated her consideration of planned home birth. She received all of the 'Creating the Conditions' domains, having received an on-going offer of planned home birth from her community midwife at the start of her pregnancy - which she declined. She then received information and support in relation to physiological birth and planned home birth from her social network and this started the process of her consideration and learning about this option – a process which continued until the end of her pregnancy. The social network also supported her partner to be able to accept and understand her consideration of planned home birth.

Figure 8. Receipt of Creating the Conditions input - PHB PSU Y

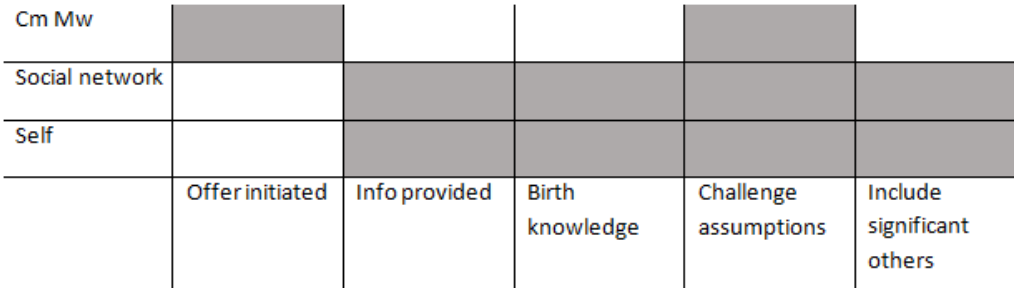


PHB PSU H

This PSU's touchpoints all facilitated her consideration of planned home birth. She received all of the 'Creating the Conditions' domains, having received an on-going offer of planned home birth from her community midwife at the start of her pregnancy and support from her community midwife for her consideration of this option despite the access to her property being unusual. She did not hold an assumption of institutional birth as her social network was familiar with this choice. She initiated her own learning, and also received information

and support in relation to physiological birth and planned home birth from her social network. Her partner was supportive of her consideration and decision to birth at home.

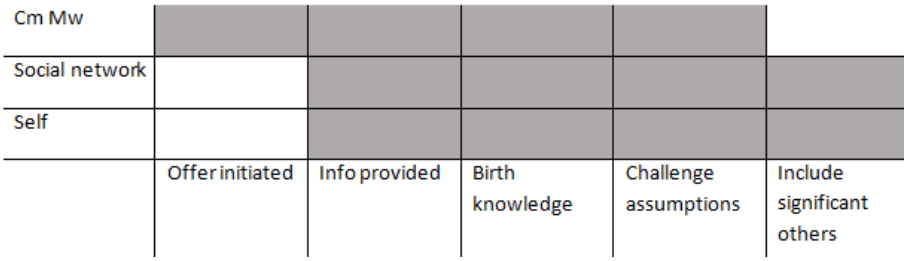
Figure 9. Receipt of Creating the Conditions input - PHB PSU H



Non-PHB PSU T

This PSU experienced many touchpoints that facilitated her consideration of planned home birth. She requested and experienced the on-going offer of planned home birth until early labour and experienced positive messages about physiological birth and planned home birth from her friends and close family. This served to provide the components of the Creating the Conditions stage. However, she had also experienced touchpoints that restricted her consideration - her partner had favoured institutional birth in their first pregnancy, and it was unclear what he felt about planned home birth in relation to her second pregnancy and had not been informed that pain relief other than Entonox was possible. Discussion in the workshop suggested that was a powerful influence in her decision to birth in an OU. Additionally, her discussions suggested an overbearing nature amongst her social networks, as she stated she needed to adapt her birth images to become more natural, rather than hospital, focused.

Figure 23. Receipt of Creating the Conditions input – Non-PHB PSU T



Non-PHB E

This PSU had not experienced any of the 'Creating the Conditions' domains during her pregnancy. Her decision making touchpoints reflected a lack of certainty around physiological birth, an assumption of hospital birth, no real offer of planned home birth during her pregnancy, no knowledge about planned home birth, and a belief that her partner would have been unsupportive about planned home birth had she wished to consider this option. Planned home birth was not known about within her social network.

Figure 10. Receipt of Creating the Conditions input – Non-PHB PSU E

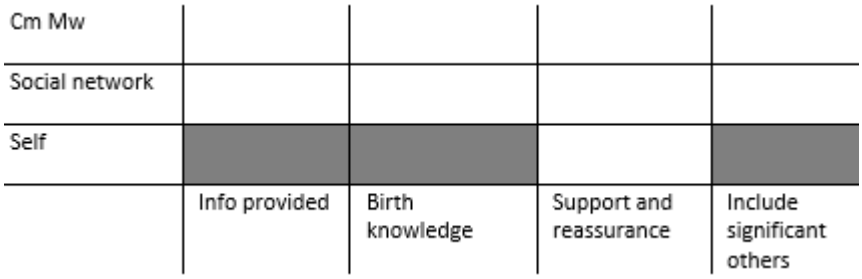
Cm Mw					
Social network					
Self					
	Offer initiated	Info provided	Birth knowledge	Challenge assumptions	Include significant others

Positive Reinforcement:

PHB PSU O

Facilitative touchpoints for this PSU, a nurse, were that she had received encouragement and support from her midwife to consider PHB with her first pregnancy, although she did ultimately not decided to birth at home, and that she had successfully birthed at home with her second child. She had commenced her third pregnancy knowing that she wished to birth at home, and her partner supported this decision. However, her current midwife was felt to be 'quiet' and unsupportive of this choice, and her obstetric consultant who she saw to discuss the decision as she would require a group and save being taken before labour, recommended her to birth in the OU. The PSU knew that this process been facilitated effectively following her previous home birth, and that she could discuss this with the consultant. However, her recollection was that she began to feel that 'They knew best' and agreed to birth in the OU. Despite her partner being supportive she was alone in her preference. He was not reported to have been vocal in support of her decision during the meeting with the consultant – instead remarking to her that she had not 'fought' very hard.

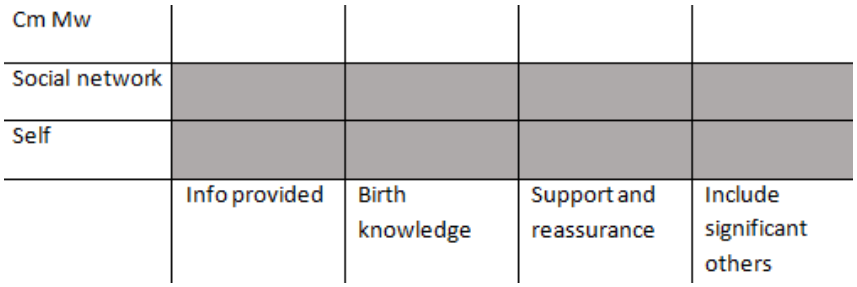
Figure 11. Receipt of Positive Reinforcement input - PHB PSU O



PHB PSU R

Facilitative touchpoints for this PSU were that her sister had had a PHB the year before her own pregnancy, and this served to be her most influential source of information and support for her decision. A touchpoint that was not supportive of her decision making was that her community midwife first spoke to her partner about his feelings about PHB the day before she gave birth. Therefore, while this PSU experienced each of the 'Positive Reinforcement' domains, she reported that this mostly came from her own self-learning and her supportive and informed social network.

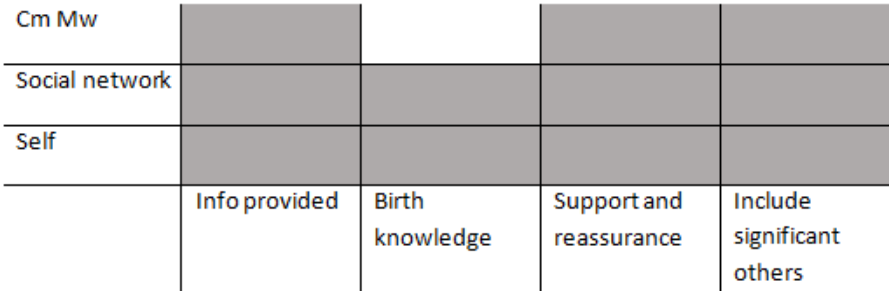
Figure 12. Receipt of Positive Reinforcement input - PHB PSU R



PHB PSU J

This PSU had experienced facilitative touchpoints across each of the four domains. She felt that her community midwife had included her significant others throughout her pregnancy, and had provided information and support for her decision to birth at home. She had learnt about physiological birth outside of her relationship with her community midwife. Her social network was knowledgeable about PHB, and several of her close family members had given birth at home.

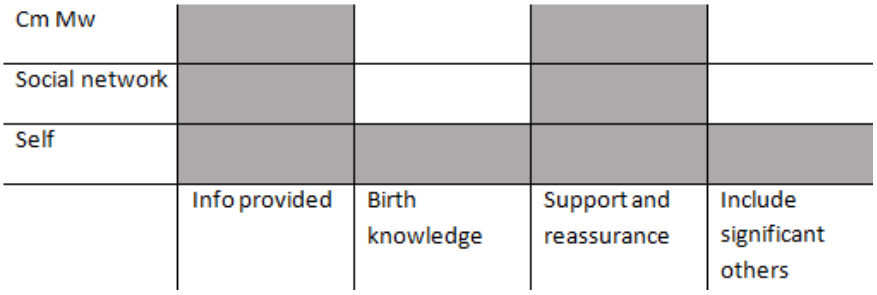
Figure 13. Receipt of Positive Reinforcement input - PHB PSU J



PHB PSU C

A facilitative touchpoint for this PSU had arisen in her first labour, where she had become aware of the benefit of mobility during labour and had wanted to stand at her own windowsill at home rather than labour in hospital. In her most recent pregnancy facilitative touchpoints were that she felt very well informed and supported by her community midwife and her social network for her decision to birth at home.

Figure 14. Receipt of Positive Reinforcement input - PHB PSU C



PHB PSU B

A facilitative touchpoint for this PSU was that she had experienced a previous physiological birth and felt confident in this domain as a result of this positive experience. Further supportive touchpoints were that she received information, support and reassurance, and inclusion of her partner from her community midwife, and support from a virtual home birth group. She had also undertaken to learn about home birth herself.

Figure 15. Receipt of Positive Reinforcement input - PHB PSU B

Cm Mw				
Social network				
Self				
	Info provided	Birth knowledge	Support and reassurance	Include significant others

PHB PSU M

This PSU decided to birth at home when she reached the mid stage of her pregnancy. From this point her touchpoints reflected that she felt that she received all of the 'Positive Reinforcement' domains predominantly from her social network and her own learning, until the later stages of her pregnancy when information and discussion about PHB was then provided by her community midwife.

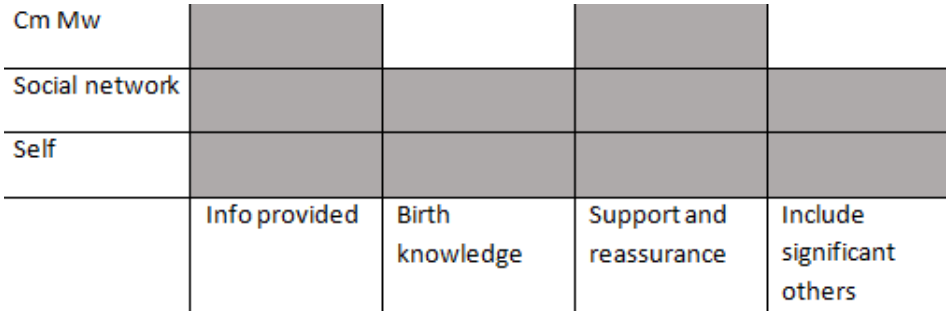
Figure 16. Receipt of Positive Reinforcement input - PHB PSU M

Cm Mw				
Social network				
Self				
	Info provided	Birth knowledge	Support and reassurance	Include significant others

PHB PSU Y

This PSU decided to birth at home when she reached the late stages of her pregnancy. Facilitative touchpoints from this point encompassed all of the 'Positive Reinforcement' domains. Information provision and discussion, and support and reassurance were provided by her community midwife and social network, in addition to her own learning; and the other two domains were heavily supported by her social network. She paid particular attention to personally learning about physiological birth.

Figure 17. Receipt of Positive Reinforcement input - PHB PSU Y



The PSU's sources of the input relating to the defining attribute domains:

Creating the Conditions:

The reported PSU experiences suggest that three sources of input in relation to Creating the Conditions domains were experienced. The PSUs across both groups accessed input for the five domains from their community midwives, their social networks and through their own personal activity.

The study findings suggest that none of the PSUs experienced input from their community midwife that provided access to all five of the domains, and that in several examples the PSU did not access any input that relates to any of the Creating the Conditions domains from their community midwife.

Across both participant PSU groups, the PSUs frequently referred to themselves as having provided input in relation to some of the Creating the Conditions domains.

Findings suggest that across the PHB PSU participants, their social networks served as powerful source of input in relation to the Creating the Conditions domains, in a way that was not demonstrated within the non-PHB PSU groups.

Positive Reinforcement:

The reported PHB PSU experience, in a similar way to that reported in relation to Creating the Conditions, was that a combination of self, social networks and their midwives had provided input for the four domains within Positive Reinforcement.

There was variation in the way that the PHB PSUs reported that their community midwife had provided input across all four of the domains, and in one example the community midwifery input was reported to have been minimal in terms of these areas.

The PHB PSU participants frequently reported how they provided themselves with the input in relation to several of the Positive Reinforcement domains.

In a similar way to that reported in relation to Creating the Conditions, findings suggest that across the PHB PSU participants that their social networks served as powerful source of input in relation to the Positive Reinforcement domains.

Discussion and Implications:

The two-stage AOPHB process [Figure 17] has been developed using an appropriate data collection method that has enabled a range of three relevant participant groups – community midwives, previous service users who planned to birth at home, and previous service users who did not plan to birth at home, to discuss their experiences and provide their feedback on the 'fit' of the findings of the concept analysis process [Chapter 5].

Support for the conceptualisation of the AOPBH as a two-stage approach:

Analysis of the generated participant data suggested that the original concept analysis findings – where four defining attributes were felt to be applicable to the active offer of planned home birth for all women [Chapter 5], should be revised to produce the new two-stage process. Returning again to the published literature, the resultant use of two defining attributes within the AOPHB process appears to align with the ideas that are evident in several studies. The scoping review [Chapter 4] provides detail about how women may experience the decision making process in terms of what is required for them to be able to consider planned home birth for the first time – often referred to as 'un-learning and re-learning' about birth (Andrews, 2004b; Cheyney, 2008; Dahlen et al., 2008; Lindgren et al., 2006; Regan & McElroy, 2013; Ferreira Lessa et al., 2014); and also refers to the importance of midwives gaining 'hearts and minds' in relation to women being willing to consider home birth (Noble, 2015). Additional evidence about decision making around FSMLUs also provides information on this process that could possibly be applied to home birth decision making (Grigg et al., 2015). These findings broadly relate to the Creating the Conditions

domains of information provision, learning about physiological birth and challenging the assumption of institutional birth. Several articles also explore the 'Positive Reinforcement' process in terms of what may be needed by women who have decided to birth at home (McCutcheon & Brown, 2012; Lindgren et al., 2006; Dancy & Fullerton, 1995). In particular these articles cumulatively address aspects of the 'Positive Reinforcement' domains of providing information about home birth, talking about feelings, provide reassurance and support for a woman's decision making, and the inclusion of significant others. However, this is the first time that these ideas have been drawn together, and the decision making process around planned home birth conceptualised in this way.

It is possible to reflect upon the participant home birth decision making experiences that were explored within the initial exploratory study [Chapter 3] and to consider that these also map on to the suggested two-stage conceptualisation outlined in this chapter. Several of the women could be considered to be requiring input according to the Creating the Conditions stage, with several (Wm A, C, D & G) not receiving all of the required content across the five domains to enable them to make an informed decision about the option of planned home birth [Figure 18]. However, woman B could be considered to have received this content, and to have then made an informed decision to birth away from her home. In relation to the two women who were planning home births (Wm E &F), woman E's description of her first pregnancy appears to align with the use of both stages of the AOPHB (Figure 13). In contrast, woman F's description of how she informed her community midwife during her current pregnancy that she wished to birth at home appears to illustrate the way that a woman may require input according to the Positive Reinforcement stage as she has already decided to birth at home (Figure 14).

Sources of input that support the provision of the AOPHB:

In addition to providing the experiential information that has enabled the two stages of the AOPHB process to be outlined, the PSU experiences highlighted the need for further consideration of how women received the required input in relation to each of the two defining attributes. Analysis of the PSU data suggested that there are three ways that the content of the two defining attributes were obtained – through their community midwife, through their social network, and by accessing the required content themselves.

Within the participant experiences that were sufficiently complete so as to be able to the experiences across the PSU participant groups, in terms of the PSUs experiences of receiving the Creating the Conditions attribute, the community midwives had provided a varied degree of input across the five domains. It appears that their role in providing the components within the 'Initiating and unambiguous and ongoing offer of PHB' domain may be vital. While it is acknowledged that some PSUs raised the option of PHB with their midwives themselves, the analysis of this domain suggests that where a woman does not raise this herself it is essential that the midwife does because this domain is not replicable via any other source of support. Many of the PSUs themselves, especially amongst those who had gone on to plan a home birth, had provided the content of many of the domains. However, it appears that unless a pre-existing understanding of the 'challenge the assumption of institutional birth' is held, this is a domain that the PSU themselves did not often provide this themselves during their pregnancy – and so this therefore needed to be provided by their social network or their community midwife. The input of social networks had provided many of the domains for the PSUs, especially those who had gone on to plan a home birth.

In terms of the provision of the Positive Reinforcement attribute, again the community midwife input varied. Where no obstetric input is required during pregnancy, there do not appear to be any domains whereby the content was not replicable by the individual PSU or social network if this was needed. All of the PSUs had provided content across most of the domains for themselves, and this was also the case in terms of support received through their social networks. However, in the example illustrated by PHB PSU O, the lack of community midwife support when combined with a lack of support from her obstetric consultant appears to have resulted in this PSU altering her plan away from birthing at home without making an informed decision. Midwifery support, where obstetric input is required during the antenatal period was reported to be an area for development within midwifery practice by several of the PHB PSUs. This is therefore noted as an avenue for future research in terms of providing a more detailed understanding of how this process would align with the AOPHB.

One of the community midwife participants (Cm Mw P) noted that in her experience, the women who plan to birth at home undertake a great deal of learning and research

themselves. Analysis of the PHB PSU data supports this idea with the summaries showing that their independent learning takes places across both of the AOPHB defining attributes. Additionally, there appears to be a reliance on members of the PSUs social networks in providing AOPHB input as this was not formally provided by maternity care professionals. Therefore, at present, it appears that in terms of the support for home birth decision making experienced by this group of PSUs, there may be a necessity for maternity service users to obtain much of the AOPHB independently of their midwifery care. To return to the published literature discussed within the scoping review [Chapter 4], this is supported by the review findings. While it was acknowledged, and provided the initial impetus for this study, that where midwives are taking a more active approach to discussing and facilitating the home birth decision making process with women, that they possibly provide the input to for both of the AOPHB defining attributes (Rogers 2009; Noble, 2015; Green 2016), this was not routine practice across the UK, or internationally.

Strengths and limitations:

Strengths

This was the first research study that I am aware of to ask previous maternity service users and community midwives what they feel should be included within an active offer of planned home birth.

This study has been undertaken with a relevant range of stakeholders and was successful in recruiting sufficient number of participants across each of the intended participants groups. While the number of community midwife participants was less than initially intended, sufficient data on community midwifery experiences was obtained. The recruitment process was successful in recruiting two male partners, and also a number of women participants who do not have the privileged socio-demographic background that is typically seen amongst women who plan home births [Chapter 4]. The inclusion of the three different participants groups, including the minority participant groups that were indicated by the scoping review [Chapter 4] and the theoretical understanding of the required elements for an inclusive active offer that Cardinal and Sauvé (2010) suggest [Chapter 5], provided the necessarily broad perspective about this subject area.

Using a workshop approach as the data collection method proved to be an effective way of collecting quality data. The range of varied data collection activities along with an informal and relaxed atmosphere is felt to have facilitated this process.

The same researcher facilitated all of the workshop groups, enabling consistency in approach across the groups, and immersion in the data prior to analysis.

The resultant 'product' of the research study, the two-stage Active Offer of Planned Home Birth [AOPHB] process, is felt to provide an accurate evidence-based depiction of what underpinning considerations an active offer should include.

Additional testing of the suggested concept analysis with relevant stakeholder groups has refined the resultant concept analysis of an active offer for planned home birth (Figure 17). Moving from the inclusion of four defining attributes, to the suggested two-stage process aligns with Walker and Avant (2010) when they state that simplicity within a concept analysis provides a strength to the resultant conceptualisation.

It is felt that this two-stage process is easily translatable into clinical practice, within differing models of care. For example, all community midwives could provide care according to both stages of the process, and midwives working as part of home birth teams could be viewed as providing care according to the Positive Reinforcement stage, when women are referred to them.

Whilst the suggested two-stage approach takes a potentially prescriptive approach, the woman-centred care focus is retained by highlighting to midwives that they should become knowledgeable about the particular domains within each of the active offer stage that a woman most needs to be supported with.

The suggested two-stage AOPHB process aligns with the underpinning elements, concentrating on the subjective, objective and integrative elements that were outlined by Cardinal and Suave (2010). This ensures that the theoretical understanding of the active offer process is being implemented appropriately.

Limitations:

This study was conducted in one locality, drawing participant community midwives and previous service users from three counties of Wales. Future research with a wider participant group would be beneficial.

Although a bi-lingual Research Officer attended the initial workshop, English was the only language that was used during any of the workshops. As this study took place in an area where many of the inhabitants speak Welsh as their first language, this may have inhibited the ability of some of the participants to input to the extent that they wished to. However, it is felt that this will, at most, only have minimally impacted on the data collection process as all of the participants spoke English fluently.

Lack of translators to facilitate the inclusion of PSUs who do not speak Welsh or English is felt to have limited the involvement of members of the relevant communities. Future research in this area would potentially benefit from the availability of a wider range of translatable languages to facilitate participation from a wider range of PSUs.

The communal, non-anonymous nature of the workshop environment may have prevented some of the participants from being fully transparent about their experiences or thoughts. However, there were opportunities provided for participants to write about their experiences (e.g. exercises 1 and 2 for the CM and PSU participants respectively), and this would not have been shared with the group without this content being volunteered by the participant.

While the study intended to facilitate the participation of relevant stakeholder groups towards the creation of a clinically appropriate active offer of planned home birth, the level of participation afforded to participants was minimal. This was felt necessary because of a lack of time and available resources in developing this research study. However, increasing the participatory element of this research is considered to be beneficial, and would be implemented into any follow-up that is undertaken.

It has not been possible to accurately assess all of the PSU experience in relation to access to the suggested domains that make up the two proposed defining attributes – further study aimed at assessing this could be beneficial.

The three participant groups took part in separate workshops, and there may be benefit to members of each group discussing their experiences with members of another participant group. This would be considered within any follow-up work that is undertaken.

Full consideration has not been given to how the pre-requisite element of the active offer (Cardinal & Suave, 2010) would be undertaken in the AOPHB. It was explained within the concept analysis chapter [Chapter 5] that this was felt to be outside of the scope of this research study. However, some consideration will be given to the pre-requisite element in relation to the design of an AOPHB clinical intervention in the following chapter [Chapter 7, Appendix 32].

Conclusion

The active offer for planned home birth has evolved from the initial conceptualisation [Figure 10] that had recognised the importance of the four defining attributes being included within an offer of planned home birth, to become a two staged process [Figure 17].

The adapted concept analysis two-stage process suggests a woman would either be considered to be requiring input according to the 'Creating the Conditions' stage or according to the 'Positive Reinforcement' stage. The two stages are mutually exclusive. A woman who commences pregnancy in the Creating the Conditions stage of decision making is theorised to be able to proceed to Positive Reinforcement stage at any point during pregnancy. It is also possible for a woman to return to the Creating the Conditions stage from the Positive Reinforcement stage at any point during pregnancy, and this would be theorised as occurring if any of the required domains within the Positive Reinforcement defining attribute were not sufficiently addressed [Figure 18].

Evidence to support the conceptualisation of these two defining attributes, with the inclusion of 'Challenging the assumption of institutional birth' and 'Inclusion of significant others' as domains within 'Creating the Conditions', rather than as individual defining attributes, was generated by the PSUs, and to a certain extent the Community Midwives. There was a clear sense within the PHB-PSU's discussions that their needs within the offer of planned home birth altered once the decision to birth at home had been made, and this therefore suggested that the process of 'Positive Reinforcement' for their decision making

commences at this point in time. Once the decision to birth at home was made, the importance of the on-going offer of home birth, and the challenge to the assumption of institutional birth were no longer required, and instead support and reassurance for a woman's decision making became important.

A key finding of this study was that many of the non-PHB PSUs had not been provided within the input suggested by this conceptualisation of an AOPHB that would facilitate them to make an informed decision about the option of planned home birth.

A second key finding was that where PSUs had experienced the required AOPHB input, this was not always provided by their community midwife. This is suggested to be significant as, while it may be assumed that a midwife is an influential or facilitatory factor in a woman's decision to birth at home, for many of the women in this study who decided to birth at home this was not the case. Instead, in many instances, it was actually a combination of the woman's personal activity, and the support provided by their social networks that provided the majority of the input that this concept of an active offer of planned home birth suggests is required.

Therefore, the findings of this chapter therefore suggest that the midwife's role within home birth decision making could be developed in line with the proposed conceptualisation of the AOPHB, in order to facilitate more women in making informed decisions about planned home birth.

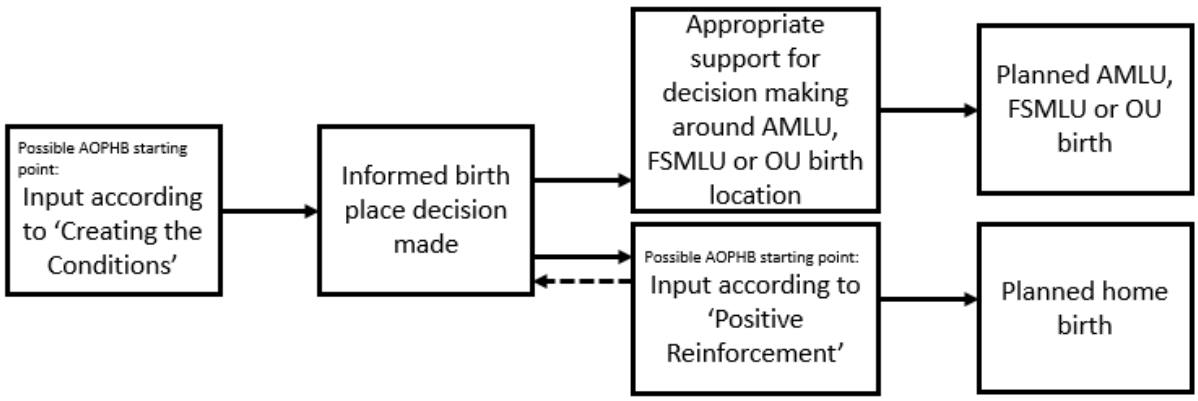
The next chapter moves to conclude this thesis by providing a summary of the main research findings from across the studies, and the resultant implications for practice, policy and research. The outline of a draft pilot study that would support the implementation of the AOPHB two-stage process within practice is also included. The chapter also discusses the suitability of using a pragmatic approach within this mixed methods study, before moving to outline the strengths and limitations of this episode of study; and lastly a section where the process of undertaking this period of research within the PhD programme is reflected upon.

Chapter Seven: Discussion, Implications and Conclusion

Introduction:

This thesis has reported a multi-stage, mixed methods study, using a pragmatic stance [Chapter 2]. The sequential studies have built upon my initial research aims to broadly explore the area of planned home birth decision making, in local and then UK and international contexts [Chapters 3 & 4], before moving to ascertain if active offer theory could align with how planned home birth is offered to women to create an active offer of planned home birth [AOPHB] [Chapter 5]. My initial conceptualisation of the AOPHB was then tested with three relevant stakeholder groups and refinements made to the initial conceptualisation [Chapter 6]. This process has enabled the final conceptualisation of the AOPHB to be created:

Figure 17. The final conceptualisation of the two-stage AOPHB process



This chapter now moves to summarise the thesis by providing a summary of the four key cross thesis findings. These are that a woman's ability to make an informed decision about planned home birth appears to relate to her access to home birth social capital via her social networks or as a result of her own sociodemographic characteristics, the degree of visibility of planned home birth within her antenatal experience, the impact of her belief in her own ability to give birth, and the extent to which she receives passive or active approaches to planned home birth decision making via her midwifery or wider maternity care provision.

A discussion of the suggested implication and recommendations, and original contributions arising from this thesis, including an initial draft of a AOPHB pilot intervention is provided, followed by an account of how the reflexive process was employed throughout the PhD progress is included, prior to conclusion of the thesis.

Summary of cross study findings:

Across the components of this thesis four overarching findings emerge that relate to a woman's ability to make an informed decision about planned home birth. These are social capital related to social networks and planned home birth; the visibility of planned home birth within a woman's antenatal experience; the impact of a woman's belief in her ability to give birth; and the impact of passive or active approaches to planned home birth decision making. These meta themes are not mutually exclusive, however, in the first instance they will be presented separately before drawing them together to demonstrate how it is suggested that they inter-relate, and the way that the AOPHB when provided by midwives, and other maternity care professional, may be facilitative in creating a greater level of equity across maternity service users' experiences of planned home birth decision making.

The relationship between home birth social capital, social networks, sociodemographic characteristics and home birth decision making:

The studies in this thesis suggest that a woman's social network and her own socio-demographic characteristics will impact on her ability to make an informed decision about planned home birth, in relation to her individual ability to access 'home birth social capital'. The term 'home birth social capital' is used to suggest that this a form or combination of 'capital' that particularly relates to planned home birth. This idea has developed gradually as the sequential phases of the research that make up this thesis were designed and undertaken. While it is not possible to be categorical about what home birth social capital may look like, it is possible that the current conceptualisation of the AOPHB [Figure 17], in terms of the input that aligns with the two suggested defining attributes [Table 27], may be a useful way of understanding what is required to enable women to make an informed decision about planned home birth. The way that this conceptualisation has developed has been the focus of this thesis.

Social networks:

Social networks constitute the structural dimension of social relationships (Due et al, 1999), with the relationship between an individual's social networks and their health being increasingly explored within research (Griffiths et al, 2015). Within the context of birth place decision making, including decision making around planned home birth, it appears from this research that family members, friends and colleagues can all be part of a woman's social network, and this is supported within the published literature in relation to other subject areas (Faria, Barrett & Goodman, 1985; Griffiths et al, 2015).

Within the published literature, social networks are suggested to be the glue that binds people together (Kossinets & Watts, 2009), with their influence alluded to by Dietz and Henry (2008, p.13189) who state that network members 'continually reshape beliefs, norms and values, and ultimately actions'. In relation to wider place of birth decision making, it is suggested within the published literature [Chapter 4], that a woman's social network does indeed have influence on how she shapes her birth place 'norms and values, and ultimately actions' (Dietz & Henry, 2008; Coxon, 2012). To discuss this further in relation to home birth decision making, in the initial exploratory study [Chapter 3] it was noted that access to knowledge and support for planned home birth within a woman's social network – either at work, within her family, or friendship groups, had been a facilitative aspect of planning a home birth for several of the participants. The scoping review [Chapter 4] noted that the women within the published literature who had planned to birth at home were commonly referring to supportive partners, and knowledgeable friends and family members when discussing their home birth decision making, and that the majority of women birthing at home held certain privileged sociodemographic characteristics – however, it was also noted that where more active approaches to the provision of home birth services were taken by midwives, this divide was less apparent. The workshop study [Chapter 6] noted that amongst the PHB PSU participants, it appeared that members of their social networks, frequently family members, or friends, but also members of planned home birth groups, had provided them with the components of the current conceptualisation of the AOPHB (Figures 19-31). In contrast, where women did not plan to birth at home, while several participants of the initial exploratory study [Chapter 3] did refer to members of their social networks who had birthed at home, they did not report that they had received input from them that had supported them to personally consider planned home birth in any detail. The

scoping review [Chapter 4] reported that where women were not planning home births there was often an understanding amongst their social networks that they would birth in a hospital; and in the workshop study [Chapter 6], while many of the non-PHB PSUs did receive input from their social networks about planned home birth, this was not the case for all, and the extent to which social networks were discussed as providing the required AOPHB input was less.

While many women will receive input from social networks that were established prior to their pregnancy commencing, it is also possible that influential social networks can be created during pregnancy, for example through membership of a local home birth group [Chapters 4 & 6]. This idea has been explored within other aspects of maternity and early parenting experience in relation to group antenatal care (Benediktsson et al, 2013) and use of an on-line pregnancy and parenting support group (Drentea & Moren-Cross, 2005). As in the case of Drentea & Moren-Cross (2005), research is also exploring the way in which on-line or virtual social networks may be influential or supportive in relation to maternity care, or across others areas (Huber et al, 2011; Sadovykha, Sundarama & Piramuthub, 2015).

In terms of the impact of social networks, while it is accepted that networks may have some influence on members, it is relevant to planned home birth decision making to explore if networks are considered to have an impact on a member's decision making. Research exploring the impact on women's decisions to undergo a termination of pregnancy (Faria, Barrett & Goodman, 1985) found that social networks were impactful in this area so it is therefore possible that social networks may be influential on a woman's decision making around planned home birth. However, as the discussion will explore below, while the impact of social networks is predominantly suggested to be facilitative where a social network contains the required social capital (Lin, 1999), or potentially neutral or unfacilitative where this social capital is not available, it is important to understand that such access may not always result in a positive experience. This was illustrated by the experience of Non-PHB PSU V, who reported that she felt she should apologise to members of her social network for giving birth in hospital and using analgesia.

This discussion will now move to connect this overview of social networks, with access to social capital.

Social capital:

Theories of social capital developed from the classical theory of capital that was outlined by Marx, and have arisen within the development of neo-capital theories that include social capital, along with human capital and cultural capital (Lin, 1999). While much of the literature discussing social capital concerns public health on a community level (Putnam, 1995), consideration of the impact on individual behaviours is also being explored in relation to building social capital through the provision of peer support within breastfeeding (Thompson, Balaam & Hymers, 2015). Therefore there is potential for a woman's decision to birth at home to be influenced by her access to home birth social capital.

Discussion about social capital within health research has developed over the last two decades (Thomson, Balaam & Hymers, 2015), and within much of the literature has been categorised into two domain-specific dimensions: structural and cognitive/social cohesion (Drentea & Moren-Cross, 2005; St. John, 2017). However, Kirkwood (2016) provides a differing conceptualisation – viewing structural, cognitive and relational social capital as domains within an inclusive definition of social capital, suggesting that each dimension joins together to 'form social capital'. Defined broadly, structural social capital is related to the resources that are available to an individual or community that are embedded within their social networks (Bourdieu, 1986; Lin, 2001), and cognitive social capital that creates social cohesion is defined as the presence of trust, reciprocity and sanction available to group members (Coleman, 1988; Putnam, 2000). Kirkwood (2016) supports the definition of structural social capital; but suggests that relational social capital concerns issues such as trust, norms and sanctions, among others, which are usually related to Putnam's (2000) definition of cognitive social capital, and that cognitive social capital relates to resources that have shared meanings amongst groups of parties. The discussion that follows adopts the more commonly used conceptualisation of social capital, but does refer to Kirkwood (2016) in relation to structural social capital. In considering how home birth social capital aligns within these approaches, it is relevant to note that it is cognitive social capital, as proposed by Putnam (2000), that has been most frequently explored within healthcare research over the last two decades (Kirkwood, 2016). However, as relevant research studies have also used structural social capital as their definition (Drentea & Moren-Cross, 2005),

there is merit in considering both conceptualisations of social capital, and so both will be discussed below, with references to home birth social capital made.

The concepts of bonding and bridging in relation to home birth social capital can be explored in relation to both conceptualisations of social capital. Stretzer and Woolcock (2004) differentiate between bonding social capital as a process of connecting close actors and bridging social capital as connecting distant actors. In the case of home birth, bonding social capital could be considered as bonds between members of a social network who also have an interest or connection because of planned home birth, and bridging social capital could be viewed as a relationship that develops between those who are not already connected via bonding social capital within a social network, but who then form connection initially solely as a result of their interest in planned home birth.

Cognitive social capital:

As was stated above, it is cognitive social capital that is discussed most frequently within health research (Kirkwood, 2016). This includes research exploring the role of social capital in facilitating health facility delivery in Tanzania (Semali et al, 2015) and building social capital through peer breastfeeding support (Thompson, Balaam & Hymers, 2015). Using Putnam's (1995) conceptualisation of cohesive social capital, Thompson, Balaam and Hymers (2015) discuss their understanding of how network connections bond similar people, and bridge diverse people through norms of reciprocity, and how trust is formed and maintained amongst groups. In Thompson, Balaam and Hymers' study (2015), as well as others, this process is viewed as having the potential to reduce health inequalities on a community level.

Therefore, a potentially important aspect of cognitive social capital is trust. Trust is known to play an important part within relationships and within midwifery care (Lewis, Jones & Hunter, 2017), and could therefore be suggested to be an important element underpinning a social network's ability to provide home birth social capital. Within this thesis, there were several reports of trust in terms of how the participants trusted their midwives [Chapters 3 & 6], and some references to trust reported by the participants in terms of the input that members of their social networks provided for them in terms of receiving information and support being received from family members or good friends – they could perhaps be suggested to have developed a trusting relationship aside from discussing their home birth

decision making. However, it could be anticipated that trust could be a particularly important aspect to consider if maternity service users are to be supported in developing new social networks during pregnancy, with the aim of supporting them to make informed decisions about planned home birth. This is discussed within the developing research area exploring social capital and virtual social networking (Kirkwood, 2016; Huber et al, 2011; Drentea & Moren-Cross, 2005).

Structural social capital:

As stated above, one of the findings of this thesis is that the PHB PSUs had received much of the input that provided them with the component domains of the AOPHB process from within their social networks. Therefore, it feels appropriate to consider that it may be that structural social capital, with its focus on the influence of social networks, would facilitate a woman's access to home birth social capital from within her social network. This consideration is supported by Lin (1999, p.28) who stated that 'social capital is captured from embedded resources within social networks', and in 2001, summarised her conceptualisation of structural social capital on an individual level stating that it 'proves that it is who you know, and what you know that makes a difference in life and society' (Lin, 2001). Applying Lin's (1999) suggestion that membership of a particular social network may render a person more likely to be offered choices that may not have been available if this membership were not obtained, I would argue that in this thesis this has been illustrated across the individual studies [Chapter 3, 4, & 6]. This of course suggests that where a woman does not have such access, then choices are less likely to be offered to them.

Within structural social capital, Kirkwood (2016, p.23) explains that the ties between the members of a social network can be assessed in relation to their strength, viewed as 'a reflection of the amount of time, emotional intensity and reciprocal intimacy that characterises the tie'. As may be expected, strong ties are found where network members know each other well, and over a long period of time, while weak ties are found to be more distant, with a lack of closeness. Reflecting on the reported experiences within this thesis, as noted above, the participants make frequent reference to the influence of close family members and friends, but also to the influence of members of home birth groups that they have joined during pregnancy [Chapters 3, 4 & 6]. Therefore, within this study, it could be suggested that the participants were influenced by members of their social networks with

whom they may have had strong or weak ties, but that most of the discussion related to strong familial or friendship ties that would relate to the bonding form of social capital. Additionally, in relation to the possible way that home birth social capital may be transmitted within bonds of varying strength, within stronger ties, members of a network tend to know other members of the members networks because of the high degree of similarity between the members of strong social networks, and this results minimal new information being transmitted because members tend to share the same information across the network. This pattern could possibly be viewed across friendship groups or families where the choice to birth at home is made frequently [Chapter 6]. Conversely, weaker social ties were associated with weaker connections, but with greater informational benefits as members may join a network for a singular, novel, reason – related to the bridging form of social capital. Kirkwood (2016) makes reference to use of the internet for the creation of connective platforms, and this could perhaps be linked to the use of virtual home birth support groups, but it is also possible to consider relationships that are built in face to face home birth groups as being an illustration of this [Chapter 6].

Therefore, in relation to structural social capital, when social networks have the required embedded resources, in that they are informed and experienced with planned home birth, and able to activate this knowledge when necessary, the social capital that enables women to make an informed decision about planned home birth is provided. This process can operate to supplement any offer of home birth that a midwife provides.

Where a woman's social network does not have the required embedded resources, her access to the required social capital through their social network is therefore not possible, and she is then reliant on her midwife to provide an effective offer of planned home birth. Additionally, a further barrier to decision making could be generated within the network - Bourdieu's (1997) explanatory phrase 'people like us' could be suggested to align with the idea of 'people like them' have home births, potentially serving to exclude a woman from the ability to consider planned home birth if she does not belong to such a societal network.

Sociodemographic characteristics and social capital:

In the same way that a woman's social networks appear to be able to provide the necessary social capital to facilitate planned home birth decision making, women can also inherently have this by virtue of their own socio-demographic characteristics. Levels of social capital

are widely understood to be affected by an individual's socio-demographic background – such as their marital status, their age, their ethnicity, employment status, their level of education and their income (Bourdieu, 1986; Scriven & Garmen, 2007), and these factors are similar to those highlighted within the scoping review [Chapter 4] that women who birth at home are more likely to hold. While there is a link between a woman's socio-demographic characteristics and those of her social network, the initial exploratory [Chapter 3] and workshop studies [Chapter 6] have provided a few examples of where women with privileged characteristics were able to provide for themselves, or supplement themselves, the domains of the AOPHB with only minimal input from a social network. This may be explained by Zadoroznyj's (1999, p285.) view that 'cultural resources such as education, language, social milieu and material resources play a significant part in shaping the character of medical encounters, including obstetric encounters', resulting in women with more privileged backgrounds being able to assert their wishes more effectively. This idea is aligned to Bourdieu (1986) who writes that access to such resources, as a result of privileged characteristics, will permit social actors to acquire particular dispositions, such as a preference for planned home birth, in a way that would not be possible for those without access to such resources by virtue of their social situation. This is significant, as it should be remembered that because the UK's achieved planned home birth rate is only around 3 percent, therefore, despite having privileged characteristics, a woman's social group will not automatically hold the required social capital to suggest home birth to them.

In some examples from the workshop study [Chapter 6], women explained how they were able to draw upon their personal resources, such as the ability to advocate for themselves and access information and support themselves, to enable them access the option of home birth despite being slightly outside of the 'low risk' parameters in terms of age and also where possible obstetric complications such as gestational diabetes arose during their pregnancy. In the later example some of PHB PSUs spoke about how midwifery support for their decision making was withdrawn, and they had needed to advocate for themselves with obstetricians and midwives. However, in these examples, for the majority of women, this process occurred within the sphere of support via their social network, suggesting that bonding, or more infrequently bridging, home birth social capital was also present for these maternity service users.

Where women do not personally have privileged socio-demographic characteristics, they may lack the required social capital such as the ability to advocate for themselves or independently access supporting literature, or the perception that this is a beneficial process to engage in (Zadoroznyj, 1999). As a result they appear to be less likely to be able to access an effective offer of planned home birth where a midwife, or maternity service, does not work to ensure that this happens routinely for all women [Chapter 4]. It is acknowledged that the two-stage AOPHB cannot alter a woman's sociodemographic background in the same way that an intervention could be employed to assist in the creation of a supportive social network with the resultant access to home birth social capital. However by employing the components of the Creating the Conditions domains and so routinely making women aware that they have the option to birth at home, challenging the assumption of institutional birth, providing sources of information in relation to home birth, and talking about physiological birth, the reliance on the availability of personal social capital would be reduced, and an awareness that making a decision about place of birth that includes home birth is important for them, would be developed.

Conclusion regarding social capital and social networks:

To conclude this consideration of how social networks may relate to a woman's access to home birth social capital, the two conceptualisations of social capital – cognitive and structural, may have relevance to different aspects of planned home birth decision making. In terms of considering how home birth social capital has been suggested to have been provided for many of the PHB PSUs within the workshop study [Chapter 6], structural social capital may explain how the maternity service users used the resources that were embedded within their social networks to supplement their needs that were not always provided by their midwives. Additionally, cognitive social capital may provide some insight into the way that maternity service users develop new social networks that provide them with these resources – in terms of how the develop sufficient trust within these weak ties that enables them to use the resources themselves. This is also relevant in terms of the way that the maternity services could look to develop the way that women without social networks that have the embedded resources within them, could effectively facilitate the development of such social networks for women. Within the published literature, the one intervention study being conducted to increase rates of planned home birth is reported to

be using group sessions as a way of gaining 'hearts and minds' towards the idea of home birth (Noble, 2015; Green 2016). It is therefore possible that this process is also serving to develop access to the required social capital within a newly developed social network for women who do not have access to these resources within their pre-existing social networks. Acknowledging the impact of home birth social capital and looking to replicate this for women who do not independently access these resources, could be an effective approach for maternity services aiming to increase the rates of women making informed decisions about planned home birth. This is possibly an important consideration, as the findings of this thesis suggest that without interventions to widen the access, home birth social capital may predominantly remain only within reach of the members of social networks where such social capital is currently held (Bourdieu, 1987). Further research to explore this process may be useful.

The relationship between visibility and home birth decision making:

Visibility has been suggested to be an underpinning support mechanism within an active offer of minority language services (Lortie & Lalonde, 2012), and this thesis provides support for this assertion within an active offer for planned home birth. The initial exploratory study and workshop study [Chapters 3 & 6] suggest that when women were exposed to a correct level of planned home birth visibility, in terms of the thresholds of visibility that Brighenti (2007) discusses, they were then able to make an informed decision about planned home birth. Correct levels of home birth visibility can be generated by women themselves, or within their social networks; or through interactions with a midwife.

On the contrary, both low levels of planned home birth visibility and supra levels of visibility may negatively influence a woman's ability to make an informed decision. The findings of this thesis suggests that women are possibly more likely to experience low or supra levels of home birth visibility than for OU, AMLU or FSMLU birth locations because of our cultural acceptance of institutional birth. Findings of the initial exploratory study [Chapter 3] and the workshop study [Chapter 6] suggest that for many women, midwives are currently routinely only generating a low level of home birth visibility within their care provision. Additionally, it appears that many of the participants in both of these studies had experienced a supra level

of visibility within their social networks or within the media, and that this was not addressed by midwives within their antenatal care.

The AOPHB process enables both of these visibility issues to be addressed by increasing, or adapting a service user's home birth visibility levels into the correct threshold (Brighenti 2007), in order for them to then make an informed decision. Within the Creating the Conditions attribute, the domains of challenging the assumption of institutional birth, and the provision of balanced information work to address the levels of home birth visibility that women experience during the decision making process. Support in the maintenance of an appropriate level of visibility continues within the Positive Reinforcement domain in terms of midwives providing support and reassurance for a woman's decision to birth at home, and also continuing to provide balanced information about home birth.

Additionally, the findings of this thesis suggest that there may, in addition to considering the level or type of home birth visibility that a woman is experiencing, be benefit on considering the level of planned home birth visibility within an individual midwife's practice. Where visibility is low a midwife may not be mindful of ensuring that the offer of planned home birth or discussion about home birth is maintained during a woman' pregnancy. The AOPHB intervention would address this through the use of individual midwife focused components, such as AOPHB documentation in the maternity handheld notes.

A woman's belief in her ability to give birth:

The importance of a woman believing that she is able to give birth safely appears to be crucial to planned home birth decision making. A theme within the initial exploratory study [Chapter 3] was around the importance of normal, physiological birth being seen as a possibility before a woman could consider the option of home birth. The scoping review [Chapter 4] suggests that women who plan home births have positive expectations for their birth experience in terms of birth being a safe and natural process as well as potentially a positive experience, and also found support for this premise amongst midwives. Findings also showed that home birthing women's expectations are generally more positive than those held by women who do not plan home births. Non home birthers often held concerns for their own outcome or that of their baby. It was common amongst the PSUs planning home births to have reinforced their confidence in their ability to birth by accessing

affirming literature, or practicing activities such as yoga that supports this process [Chapter 6].

Findings from the scoping review [Chapter 4] also suggest that the previous birth experiences of women themselves, and also those of close family members are influential in building birth expectations. This was illustrated in the workshop study [Chapter 6] amongst non-PHB PSUs who were concerned about their mother's birth experiences being similar to their own, and PHB PSUs who took comfort in the birth experiences of their sisters and mothers. When concerns were held, they had not always been shared with a midwife – but this may have been because this sharing of experiences was not encouraged between the dyad, and so they were therefore not always addressed [Chapter 6].

Within the AOPHB both of the defining attributes contain the domain 'talk and learn about physiological birth' with the expectation that a midwife would encourage a woman, and her partner, to talk about their thoughts and experiences around birth.

The impact of passive or active approaches to planned home birth decision making:

An overarching finding of this thesis is that women and midwives either take what could be termed a 'passive' or 'active' approach to the offer of planned home birth. The initial exploratory study [Chapter 3] suggested that the ability of a woman to consider and choose to birth at home depends on which approach is taken by either of these parties. Figure 8 shows my perception of how the care pathway that a woman received was influenced by her initial response to the offer of home birth. In the subsequent chapters [4, and 6] further information around these findings has emerged. This generates the conclusion that the interplay between woman and midwife is not simple, but in general terms would appear as follows:

Women taking a passive approach:

I define women as approaching planned home birth in a passive way when they assume that birth will take place within an institutional setting (mostly an OU or AMLU), anticipate that a midwife will suggest or recommend the most appropriate place of birth to them, do not discuss place of birth with any member of their social network, and decline planned home birth when offered by a midwife without actually learning about planned home birth. The

scoping review [Chapter 4] provides evidence that women not planning to birth at home frequently take this passive approach to home birth decision making, and this was further supported by primary research within my initial exploratory study [Chapter 3] and within my workshop study with many of the non-PHB PSUs [Chapter 6].

Women taking an active approach:

I categorise women as taking an active approach to planned home birth if they raise the fact that they would like to give birth at home with their midwife, or engage with a midwife's offer of home birth to the extent that they become able to make an informed choice about this option. The scoping review [Chapter 4] provides evidence that women who know that they wish to birth at home frequently raise this with their midwife at the commencement of their midwifery care, looked for further support to facilitate their preference for home birth when this was not forthcoming from their midwife and engaged with their midwife to learn about the option of home birth when this was suggested to them. This was supported by primary research within the initial exploratory study [Chapter 3] and within the workshop study where most of the PHB PSUs had known that they wished to birth at home prior to commencing midwifery care [Chapter 6].

Midwives taking a passive approach:

I categorise midwives as taking a passive approach to the offer of planned home birth if they wait for a woman to raise this option with them, offer planned home birth in the most limited sense only at the start of pregnancy, fail to include significant others in the decision making process or fail to ensure that women have sufficient support if they do decide to birth at home – including where discussion with wider clinical staff is required. Greater detail about this idea can be found within the concept analysis discussion in the borderline and contrary cases [Chapter 5]. The initial exploratory study [Chapter 3] provided some support for this in relation to the observed and reported care. Additionally, the Non-PHB and PHB PSUs in the workshop study [Chapter 6] reported multiple examples where care provision had taken this approach. There were frequent examples where midwives omitted to mention home birth to women, only discussed home birth at the start of pregnancy with women who did not then acknowledge an interest in this option, a reluctance to discuss home birth after the initial boking appointment until much later in pregnancy with those

who were interested in home birth, and a neglect to include significant others in the decision making process.

Midwives taking an active approach:

I categorise midwives as taking an active approach if they provide care in line with the AOPHB stages and component domains. The scoping review [Chapter 4] provides multiple examples of the shift in how the midwifery profession, or maternity services as a whole, are approaching birth place decision making to be a less passive process with the recent acceptance that women's preferences and expectations are not fixed and that midwives need to act more creatively in how they offer home birth. This has been seen within individual midwives' practices over the last decades, and now more recently within whole maternity services approaches to the offer of home birth. The initial exploratory study [Chapter 3] provides examples of how midwives are using some of the active approaches to the offer of home birth in terms of the initiation of the offer of planned home birth, the inclusion of significant others in the decision making process, and the provision of support and reassurance to women. This was also reported to me by some of the non-PHB and PHB PSUs in the workshop study [Chapter 6]. However, I would categorise a midwife as providing an 'active offer of planned home birth' if they clarify what care women require (Creating the Conditions, or Positive Reinforcement), and that they comprehensively tailor the input that a woman, and her significant others, require across these stages.

An integrated whole:

Of central importance to this thesis is that a midwife's influence in terms of whether she takes a passive approach, or an active approach that provides the AOPHB components that a woman requires, is instrumental to this process. This is important because whatever position a woman starts in as she begins to receive maternity care from a midwife – regardless of her belief about the safety of birth, her access to the required social capital through her social network or possession of privileged characteristics, and the level of home birth visibility that she is exposed to, she should be provided the opportunity to make an informed decision about place of birth that includes planned home birth (NICE, 2014).

Positioning a midwife in this seemingly pivotal position does not intend to create an 'expert – non expert' position in the midwife-woman relationship (Dagustun 2009). Instead, this

argument recognises that midwives have the professional responsibility to ensure that women are facilitated and supported to make informed choices about birth location and that facilitating this requires midwives to support women, and their significant others, in a tailored approach to address their knowledge about birth and planned home birth (NICE 2014; NMC 2015). This thesis has demonstrated that not all women currently have this level of support for their decision making, and has highlighted specific aspects of care where support should be provided.

Where midwives apply the AOPHB, women who may take a passive approach could be 'activated' to engage in home birth decision making. The implementation of the 'Creating the Conditions' stage of the AOPHB is suggested to encourage women to become actively engaged in the decision making process to point of being able to make an informed choice about planned home birth for themselves. The implementation of the 'Positive Reinforcement' stage of the AOPHB continues to encourage women to be actively engaged in their decision making and helped to resist external pressures, such as from her partner, at a time when she may otherwise have taken a passive approach and changed her planned birth place location.

The AOPHB provides practice with a new way of considering planned home birth decision making from the perspective of the influences that act upon women prior and during pregnancy, and uses this to create an evidence based clinical intervention that provides midwives with a constructive environment and a two stage process in which to tailor their care to effectively facilitate and support women to make informed decisions about planned home birth.

The thesis is also suggested to have acknowledged the relevance of social capital within home birth decision making, and to have provided some initial thoughts on how the differing conceptualisations of social capital could provide useful frameworks for maternity services to use to support women to make informed decisions about planned home birth. This leads the discussion to consider the implications for practice, policy and research that are suggested to occur as a result of this research.

Implications:

Three broad implications result from the development of the two-stage AOPHB process and are outlined below. These include the need for policy, practice and research arenas to consider the inequality in way in which women are able to make informed decisions about planned home birth based on their access to the required social capital; consideration of the implementation of the two-stage AOPHB process within the current NICE guidance; and practice and research based implications that arise from consideration of how to implement the AOPHB within clinical practice.

Inequality within women's abilities for informed decision making for planned home birth based on their access to social capital:

The research undertaken for this thesis suggests that the women who are currently accessing home birth services in the UK may be assisted to do so because of their access to the necessary social capital – either through their social networks, as a result of their own privileged characteristics or a combination of both factors. The maternity policies in England (DoH, 2016), Wales (WAG, 2011) and Scotland (SG, 2011) prioritise the future reduction in inequality in access to care, but do not specifically relate this issue to access to planned home birth. Research has previously demonstrated that the choice of home birth is more common amongst certain socio-demographic groups, but it is a new approach to link this knowledge to the concept of social capital. Thinking about this process in terms of social capital being the catalyst for informed decision making creates an implication for practice because it creates the opportunity for the generation of the required knowledge and support as a result of a woman's interactions with the maternity services. This is a shift in perspective from considering that women make decisions that simply mirror those in their social group, to considering that women make decisions because – possibly by virtue of being a member of the group - they have access to the necessary knowledge and support that enables them to make this choice if they wish.

At present, the way in which home birth is routinely offered by the maternity services does not serve to replicate this process to facilitate all women to make an informed decision about this option. A disparity is seen within the socio-demographic profiles of women who plan to birth at home and women who do not, but will also exist amongst women who do hold privileged characteristics but do not have access to the required social capital amongst their social networks. Social capital will exist within the networks of women who give birth

at home, but because the rate of home birth within the UK currently stands at around three percent, this means that this social capital is not widely available.

The two-stage AOPHB process provides a way for midwives to understand the components of the social capital that some women have access to, and to work to replicate it for women without this pre-existing source. Within both of the defining attributes, the constituent domains serve to provide the required informational and support needs to enable women to gain access to the conditions to consider planned home birth, and to receive support for their decision making if they wish to birth at home. Consideration of the difficulty that some women experience with 'choice' is noted within the published literature (Pitchforth et al., 2009), and it is felt especially important to consider this in relation to women who do not have the support of their social network, or the benefit of having privileged characteristics, during the decision making process. However, it is felt important in terms of supporting a woman's individual autonomy to ensure an effective offer of home birth is made, and that she is then supported to make an informed decision that is appropriate for her. Planned home birth is one of the four birth place options discussed by NICE (2014), and it has already been mentioned, it is an aim of this thesis that more women will be able to make a meaningful choice about these options. Part of making an informed decision is the ability to decline to birth at home, and it is an important aspect of the two-stage AOPHB process is that it includes the mechanism for women to make an informed decision to birth in a midwife led unit or obstetric unit.

This thesis suggests that employing home birth groups and social media groups within the AOPHB intervention may engage the 'bridging' form of social capital for women without these resources immediately available within their 'bonding' social networks (Stretzer and Woolcock, 2004). Draft AOPHB checklists have been created as part of the draft AOPHB intervention [Appendix 30 & 31] , and propose the inclusion of women who have birthed at home in antenatal classes, and attendance at home birth groups within routine antenatal care provision. This is explored further within the draft AOPHB intervention [Appendix 32].

Further research to explore the ways in which social capital relating to planned home birth is transmitted would be beneficial. This could possibly include the use of Social Network Analysis (Scott, 1988). The developing role of peer supporting within other areas of healthcare, including breastfeeding support in the way that NICE recommend for postnatal

care (NICE, 2006; p. 1.3.15; Thompson, Balaam & Hymers, 2015), could also prove helpful in understanding how peer support could perhaps be implemented within planned home birth decision making.

Use of the two-stage AOPHB process alongside the current NICE guidance:

In the UK, the current NICE guidance on antenatal care (NICE, 2008) and intrapartum care (NICE, 2014) for healthy pregnant women provides guidance to midwives on when and how to discuss birth place choices. However, while we now have a more robust evidence base on which to base our clinical recommendations around birth location (Birthplace in England Collaborative Group, 2011), the evidence around the timing and content of these interactions in order to make them effective for women, is limited. This is being acknowledged within research, for example within Hensall, Taylor and Kenyon's (2016) systematic review that recommends that we consider whether the initial consultation with women is actually the most effective time to discuss place of birth with women, and whether further input should be included in routine antenatal care; and also within services that are attempting to increase planned home birth rates (Noble, 2015). Where NICE guidance (2008 & 2014) is being adhered to in a literal sense, the visibility of planned home birth within a service is likely to be low for women not planning home births, mirroring the experiences of the women in the initial exploratory study [Chapter 3]. Considering the concept of visibility in relation to this finding allows a different understanding of birth place discussions to be initiated.

In terms of the content of birth place discussions, two main difficulties are identified. NICE (2008) do not acknowledge that the consideration or choice of planned home birth requires any specialist support or information, therefore placing the facilitation of the option of home birth as equal alongside OU and MLU birth locations. The findings of this research support the component domains within the AOPHB defining attributes [Chapter 6], which suggests that deciding to birth at home, especially where this is not your social norm, requires greater support and input than planning an AMLU birth, or even a FSMLU birth. The recent evidence synthesis by Coxon, Chisholm, Malouf, Rowe and Hollowell (2017, p.13) exploring the influences on women's experiences of birth place choice, preference and decision-making notes that planning an OU birth for low risk women was 'straightforward', but planning a home birth was 'complex and contested'.

It is also important to consider the approach to the providing the AOPHB where women are not low risk in their pregnancy. Specific guidance for intrapartum care for high risk women will not be published by NICE until 2019, but the ethos of the current guidance for low risk women is that all women should be supported in their birth place decision making (NICE 2014). The workshop study [Chapter 6] demonstrated that women experiencing pregnancies that came to require more complex care provision felt that the provision of the components of the Positive Reinforcement defining attribute would still have been beneficial to them. Consideration of whether the Creating the Conditions stage of the AOPHB should be provided for high risk women is possibly more complicated, although the provision of a balanced evidence based discussion would enable the clinically appropriate location to be recommended, with an explanation provided. This does also appear to be an approach to facilitating birth place decision making that the high risk participants in the workshop study [Chapter 6] would have appreciated. Women would have welcomed information provision tailored to their individual clinical situation and risk factors, discussion about the process of birth with regard to their own risk factors, and having the resultant ability to make the autonomous decision on if they wished to birth at home. One of the community midwives in the initial exploratory study [Chapter 3] stated that she discussed the option of home birth with all women, and tailored the discussion to their individual clinical situation. Using this comment as a prompt for discussion during the workshop study [chapter 6], it was referred to as good practice by most of the community midwife participants, whilst at the same time not being discussed as a routine part of their practice.

A further difficulty that the current NICE guidance provides is the requirement that all women are routinely provided with detailed information about caesarean section (NICE, 2011) and induction of labour (NICE 2008). PSUs in my workshop study [Chapter 6] voiced their interest in why they had been informed about induction of labour so early in their pregnancies, and the midwives voiced concerns about ensuring that the current NICE guidance requirements were adequately addressed during antenatal care, and that a further emphasis on the 'normal physiology' of labour and birth might detract from women's clarity on this issue.

However, while the NICE guidance does not currently require the components of the two-stage AOPHB process to be provided for women, it is suggested that the AOPHB process

does comfortably align with, and supplement, the basic requirements made within the NICE guidance. In particular, the requirement to 'support [women] in their choice' (NICE, 2014) when a place of birth has been decided upon could be considered to relate directly to the Positive Reinforcement attribute of the AOPHB.

While it is important that the AOPHB components are provided according to individual need, research exploring the most appropriate time point to discuss the domains within each of the defining attribute, in the way that has been conducted in relation to discussions about breastfeeding in the antenatal period (Breastfeeding Insight, 2009) would be useful. Research exploring the most effective approaches to providing the different component domains, or elements within the domains, would also be beneficial.

Consideration of wider service related factors:

The two-stage AOPHB process has generated a service user facing active offer of planned home birth – primarily centring on the way that the active offer would appear within the woman-midwife dyad, but also including reference to antenatal groups. However, it is acknowledged that a broader approach to implementation of the AOPHB would be required in terms of consideration of wider maternity service related factors. The importance of this broader consideration of the implementation process is discussed in relation to the active offer of FLS within a recent paper (Farmanova et al., 2017). The authors (2017, p.7) include a conformity scale for use in assessing an organisation's conformity with active offer of FLS designation criteria. It is therefore possible that following further research, criteria could be established in terms of conformity to the active offer of planned home birth. Additionally, the concept of 'organisational health literacy' in relation to the implementation of an active offer is explored, stating that 'like active offer, organizational health literacy emphasizes the shift of responsibility from an individual to the health care system to support patients in navigating information and services, steering them toward timely and appropriate care' (Farmanova, Bonneville, & Bouchard, 2017 p.6). This may also be an interesting approach to explore within further research, as this understanding aligns with the intention of the AOPHB. In defining a health literate organisation, (Brach et al., 2012) have outlined ten necessary attributes. In summary these include requirements for organisational leadership, strategic decision making, workforce preparedness, the accessibility of information in relation to oral communication and published media, and the design of services. Several of

these requirements relate to the prerequisite dimension that Cardinal and Suave (2010) state should be considered within an active offer, in addition to the application of the subjective, objective and inclusive dimensions that have already been discussed [Chapter 5]. The prerequisite dimension consists of several mechanisms that relate to the 'elements that must be considered when considering to deliver a FLS' (Cardinal & Suave, 2010), and the authors state that 'the literature attributes a great deal of importance' to these elements. The mechanisms that Cardinal and Suave (2010) list as existing within this domain in terms of FLS are listed below [Table 30], alongside a column that has adapted these mechanisms in terms of their possible application to the AOPHB:

Table 30. The prerequisite dimension in relation to the AOPHB

Mechanism	Possible application re AOPHB
Recruitment	Recruit midwives who are competent in offering and attending PHB
Awareness	Increase maternity service employees' awareness of the rights and particular needs of the childbearing population by means of activities, presentations and resources, and dedramatize PHB within the organizational culture, the work environment and senior management leadership.
Training	Develop training for midwives to improve and increase their capacity to offer a high quality PHB service.
Planning	Integrate PHB from the outset of planning for maternity services.
Governance	Consult the different maternity service partners and include them in preparedness for the active offer of PHB, including the roles and responsibilities of each.
Tools and resources	Develop tools and resources and make them available to employees to improve their capacity to offer a high-quality PHB service
Promotion	Identify ways of promoting activities and resources intended to bring attention to and promote the availability of PHB among the population.

As was discussed within the concept analysis chapter [Chapter 5], it was felt that consideration of the active offer of planned home birth within the wider service related factors that are outlined here, was outside the scope of this research project. However, aspects of many of these elements, such as recruitment, planning and promotion, are mentioned within the published literature and were discussed within the scoping review [Chapter 4] in themes three and four.

In addition to these elements, this thesis has highlighted the importance of considering the role of 'training' and 'tools and resources' for midwives in how to provide an effective offer of home birth to women. Arguably, there has been an historical lack of understanding amongst the broader UK midwifery profession about how to facilitate the home birth decision making process for women and their significant others that is not fully acknowledged within the literature. The initial exploratory study [Chapter 3] provides examples of how midwives are uncertain about what is required of them in order that

women without prior knowledge of home birth are able to make an informed decision. This was also discussed by the community midwife participants in the workshop study [Chapter 6] who, after discussion, acknowledged a lack of awareness of women's needs during this process.

This has two implications. Firstly, while an individual midwife could decide to implement the two-stage AOPHB process within her practice, it is likely that if her practice involves working within an employing organisation such as a local health board, this would be more effective when consideration is given to the wider factors that underpin practice within the wider employing organisation. Secondly, further research to explore in more detail the salient elements that would comprise the prerequisite domain in terms of the AOPHB would be required. A draft pilot AOPHB intervention has been created [Appendix 32] that starts to include consideration of the prerequisite dimension and associated organisational health literacy components within the active offer process.

An additional third implication for research would be to work to further develop the AOPHB pilot intervention, and to test this approach within clinical practice. If the AOPHB is successful in the aim of increasing the percentage of women who make informed decisions about planned home birth, and in increasing the percentage of women who decide to birth at home, it would be important to understand the elements of the two-stage process that facilitated this. This would then allow further development of the AOPHB intervention in order to best apply the two-stage AOPHB process into clinical practice. The suggested pilot AOPHB intervention is briefly presented below.

The draft pilot AOPHB intervention:

The following section briefly outlines a draft version of a pilot AOPHB intervention that has been designed in light of the four main thesis findings, and aims to address each of the previously outlined implications. The intention in developing this intervention is that providing an active offer of planned home birth would position midwives to increase the demonstration of midwifery support for planned home birth, replicate the supportive social capital that most of the women who currently plan to birth at home receive and empower more women to engage in home birth decision making. In doing so the goals of the AOPHB are:

To enable more women (a high percentage of women) to have made an informed decision about whether to birth at home

Ideally, an increase in the number of women who do decide to give birth at home where appropriate

The proposed AOPHB is a complex intervention (Medical Research Council, 2006). Rogers et al (2005) concluded that multiple-component interventions are more successful than single component interventions when attempting to influence birth place choices. The thesis thus far has focused upon how the interactions that take place between women and midwives may influence planned home birth decision making [underpinned by the subjective and objective dimensions that Cardinal and Suave have outlined (2010)]. However, while this process does have a substantial role within the AOPHB intervention, the multiple components take a wider scope - being both 'midwife and employing organisation' focused – [which will also be underpinned by the prerequisite dimension (Cardinal & Suave, 2010)], or 'service user' focused. This approach is similar to the approach taken within the Baby Friendly Initiative (UNICEF UK, 2017) and is suggested to be more effective in increasing the inclusion of 'patients' in decision making than employing an intervention that focuses on either healthcare professionals or patients alone (Legare et al., 2014). Within the midwife and employing organisation focused interventions there is an additional component focused on student midwives if the organisation provides clinical placements. Within the service user focused interventions there are components focused on women, and also those on their significant others.

The intervention has been designing in line with the TIDieR checklist (Hoffmann et al., 2014) in order to ensure that adequate consideration has been paid to the initial design of the AOPHB intervention, and that sufficient detail has been given to describing the AOPHB to allow understanding of how the intervention is intended to be implemented. The TIDieR checklist was originally designed to enable researchers 'to describe interventions in sufficient detail to allow their replication' (Hoffmann et al., 2014, p.2). However, in this application of the checklist it has been used to describe the pilot AOPHB intervention prior to its initial testing. The checklist consists of twelve points, but because the AOPHB is at an early stage of development, only the first to ninth stages of the checklist have been used

here. This has meant that points ten, eleven and twelve have not been commented on as these report the way in which the intervention was implemented.

Table 31. The AOPHB in relation to the components of the TIDieR checklist

TIDieR checklist: Number and topic	Discussion of the AOPHB intervention
No. 1 Brief name	Aims of the intervention (Pg. 277)
No. 2 Why – rational, theory or goal of the elements to the intervention	Summary of main messages from thesis (Pg. 256) Aims of the intervention (Pg. 277)
No. 3 What (materials)	Discussion of intervention components (Pgs. 279-181 & Appendix 32)
No. 4 What (Procedures) – including any enabling or support activities	
No. 5 Who provided the intervention	
No. 6 How (modes of delivery)	
No. 7 Where (types of locations)	
No. 8 When and how much	
No. 9 Tailoring – if intervention is to be personalised, titrated or adapted then describe what, why, when and how	Discussion of student midwife focused component (Pg. 280)

A full version of the pilot intervention can be found in Appendix 32. Below is a summary of intervention components 'facing' the midwife and employing organisation.

AOPHB intervention components 'facing' the midwife and employing organisation:

AOPHB components that are focused on the employing organisation:

a. Audit of current organisational practice in the offer of PHB against the AOPHB standards
b. Employing organisation's intranet uploaded with AOPHB podcast for professionals
c. Link to the AOPHB website on the employing organisation's intranet
d. Identification and use of an Opinion Leader within the Health Board to lead and promote the AOPHB
e. Annual audit
f. Audit data uploaded to the intranet demonstrating on-going benefits and outcomes of the AOPHB

AOPHB components that are focused on individual midwives:

g. Initial AOPHB training programme
h. Annual AOPHB update
i. AOPHB documentation in handheld notes
j. Interaction with previous service users who have received the AOPHB

Student midwife focused interventions:

Where student midwives attend a practice placement where the AOPHB has been implemented by the employing organisation, they would be able to receive a student midwife focused AOPHB intervention. Three educational components would be implemented within the pre-registration education programme:

k. A programme of classroom sessions
l. Documentation of x5 episodes of care provided according to the AOPHB
m. Attendance at least one PHB during training

A summary of intervention components service user 'facing' components:

AOPHB components focused on women:

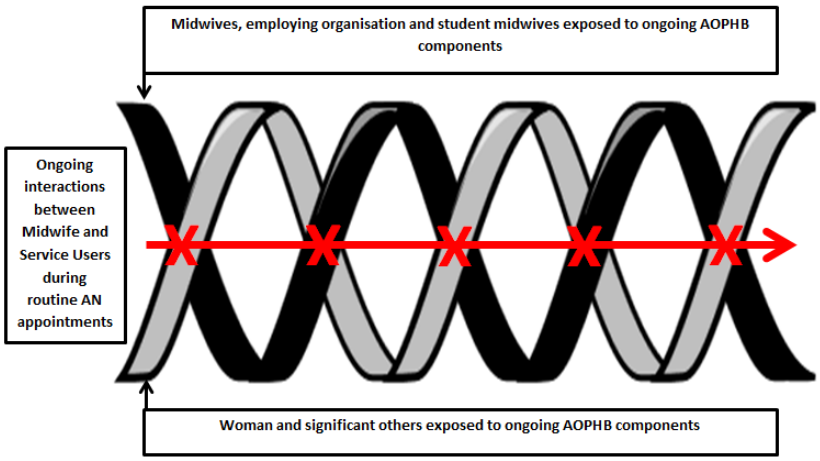
a. Care for women according to the required 'Creating the Conditions' and 'Positive Reinforcement' AOPHB stages
b. Service user focused AOPHB podcast uploaded to the employing organisation's website and social media pages
c. Woman focused AOPHB resources and invitations to AN classes (active birth classes, home birth groups, and parentcraft classes) publicised on organisation website and social media pages)
d. Women interacting with service users who have received the AOPHB
e. Midwives lend resources for planned home births to women who wish to birth at home

Significant other focused AOPHB components:

f. Care for significant others according to the required AOPHB stage
g. Significant other focused AOPHB resources and invitations to AN classes publicised on organisation website and social media
h. Significant others interacting with service users who have received the AOPHB

The following illustration uses a double helix idea to provide a suggestion as to how these two areas of focus align to provide the overall AOPHB intervention. It suggests that while there are concrete moments when a midwife will interact with a woman during a routine antenatal appointment in a manner that supports the AOPHB intervention [Appendix 32], the impact of the AOPHB intervention for both midwife and woman will be greater than these isolated moments of contact.

Figure 18. The impact of the AOPHB throughout pregnancy



Original contributions:

Several original contributions have arisen from this thesis, which are described below:

Addition to the developing knowledge base around planned home birth decision making:

This thesis has added to the developing knowledge base of the way in which maternity service users would like to be offered the option of planned home birth. The voice of the maternity service user has been privileged within the discussion of how to most effectively offer planned home birth. In doing so this knowledge incorporated into an active offer of planned home birth that aims to support midwives in this area of their practice.

Creation of the two-stage AOPHB process – a flexible framework that can be used in clinical practice:

This thesis has provided a further contribution through the creation of the two-stage AOPHB process [Figure 17]. To my knowledge this is the first time that a concept analysis has been undertaken with the aim to develop knowledge of the components that constitute an active offer of planned home birth.

Additionally, I believe that a contribution of this thesis is that the two-stage AOPHB process is the first tool that has been developed to guide and support clinical care provision with the aim of increasing the ability of women to make an informed decision about whether they wish to birth at home.

Application of the active offer theory within planned home birth decision making:

A contribution of this thesis is the application of the concept of the 'active offer' within the offer of planned home birth. To my knowledge this is the first occasion that the concept of the active offer has been applied outside of the offer of services in minority languages. The idea of 'actively offering' a home birth has recently been noted within Coxon, Chisholm, Malouf, Rowe and Hallowell's (2017, p.11) evidence synthesis, but no reference to the concept of the active offer is made.

The application of the theoretical active offer dimensions that have been proposed as supporting the active offer of FLS (Cardinal & Suave, 2010) within the active offer of planned home birth also provides an original contribution to the maternity services understanding of how to effectively offer planned home birth to women.

Consideration of planned home birth social capital:

This thesis found that the participants who planned to birth at home were supported by their social networks in this decision, and that a significant proportion of the content of the AOPHB was provided to them by their social networks, rather than by the maternity services. Findings also suggested that where women do not have access to the required planned home birth social capital through their social networks, where this is not routinely provided by the maternity services this may then limit their ability to make an informed decision about the option of planned home birth. In approaching this within clinical practice, the thesis has provided some initial thoughts on how the differing conceptualisations of social capital could provide useful frameworks for maternity services to use to support women to make informed decisions about planned home birth.

Consideration of visibility in relation to planned home birth decision making:

This thesis has also suggested that there is a potential link between the visibility of home birth and home birth decision making. Visibility has been referred to in relation to home birth within one published source, but this was not made in relation to the level of visibility that home birth has for an individual woman but instead in terms of the visibility of home birth groups on a political level (Dallenbach, 1999).

Additionally, the thesis also suggests for the first time that the level of home birth visibility that a midwife experiences within her clinical practice may also affect home birth decision making in terms of her propensity to make it visible to the women that she cares for.

Strengths and limitations of this thesis:

The strengths and limitations of each of the studies have been presented throughout, here the perceived strengths and limitations of the thesis as a whole are outlined:

Strengths:

The original contributions made in this thesis are described above.

Within this thesis epistemological privilege was given to the knowledge that the maternity service users provided about what is required of the maternity service, in particular within midwifery care provision, in order to create an effective offer of planned home birth. This ensured that the confines of policy or practice, that may influence the community midwife perspective, did not blur the 'ideal' approach that was voiced by the service user.

This thesis provides research findings that are focused solely on the offer of planned home birth. While research has recently been increasingly focused on this one birth place location (Noble, 2015), it is more common to focus on the choice of home birth alongside the choice of a midwife led unit birth. While it is realistic to anticipate that some of the findings in relation to birth in an MLU, especially a free standing MLU, will overlap to home birth setting, the fact that home birth requires a woman to decline an institutional birth place in favour of her home does generate additional considerations.

This thesis has been designed to ensure trustworthiness. Credibility has been ensured through the use of established qualitative research methods, a sampling method that while targeting the participants groups that were felt to be important for this research allowed anyone who met the inclusion criteria to become a study participant, data triangulation across studies and participant groups, and the use of methods that enabled participants to speak freely about their experiences. In addition, I have received frequent supervision sessions that required me to explain and justify my research findings, and was subject to peer and service user review during the process of undertaking the initial exploratory study [Chapter 3], and also through conference presentations of my findings throughout my PhD process. A systematic approach has been used within each study with sufficient details reported so as to allow for replication within a different location, and multiple methods have been used in order to build a holistic picture of planned home birth decision making.

The confirmability of the research findings are assisted by the use of triangulation, and this, along with the reflective process that I undertook during the research process serves to reduce the opportunity for personal bias to influence the findings.

Limitations:

Consideration of the pre-requisite dimension within the AOPHB was minimal.

All of the studies undertaken as part of this thesis were conducted prior to the NICE Intrapartum Care guidance (2014) being implemented in practice. The result may be that the findings are not as relevant to current routine practice as data that was collected about experiences of the offer of home birth post-implementation.

It has now been three years since the workshop data were collected. The intention was to test the applicability of the resultant two-stage AOPHB process with the PSU and community midwife participants as part of the next stage of the participatory research process, but this will now be undertaken as post-doctoral work. Use of Experience Based Co-Design (Bate & Glenn, 2006) may be appropriate within this phase of the research process.

Reflexivity:

Finlay (2002) states that it is no longer required for the researcher to abolish their presence within their qualitative studies, but that it is now accepted practice to acknowledge their own social context to the reader. Attia and Edge (2017, p.35) appear to hold a similar perspective on the prospective process when they write that rather than seeing an individual's personal situation as a potential for data contamination, instead this should be viewed as a way to assist researchers to understand and acknowledge the 'knowledge, feelings and values' that they bring to a research question, and how this has influenced the research process that they were engaging in.

Therefore, Finlay's (2002) reflective question of herself as a researcher 'Should I be objective, is it OK to be subjective?' is one that I have also reflected upon during the process of my PhD research. Like many researchers who undertake to explore the experience of planned home birth, from either a personal or professional perspective, I am a midwife (Andrews, 2004b; Noble, 2015), and also a mother who chose to have home births with

both of my children (Dagustun, 2009). My personal position as a mother who felt a tremendous benefit to being able to choose to birth at home is something that I have reflected upon during this research process. Unlike the vast majority of my PHB PSU participants, I had no supportive social network to draw upon for the home birth social capital that I have described within my work as I knew no-one who had given birth at home before, and had no friends or family who had recently had children. However, I did have personal social capital in the form of a partner who supported my plans, and the benefit of education that facilitated my confidence in raising my idea with my community midwife. I think that my personal journey to deciding to birth at home arose from nowhere other than an instinctive feeling that home was the best place for me to give birth which was probably generated by my own birth in a free standing midwife led unit. I was very fortunate that my midwife was a supportive of planned home birth and so reacted positively to my request to birth at home, as despite my privileged characteristics I am not sure that I would have queried a dismissive response.

In my professional role, I attended numerous home births as a student midwife and one as a qualified midwife, and this has given me a degree of insight into the professional perspective – although I have never worked as a community midwife.

On reflection, as I suggest above, it is more through the lens of a maternity service user than as a midwife that I have taken my personal view of this research process as I feel that this has been a more profound influence in my journey towards my personal construction of birth. However, while I acknowledge that it is my passion for the subject matter that has sustained me throughout this PhD process I have attempted to ensure that I have not awarded myself an epistemologically privileged position. Instead, as I have stated earlier in this thesis [Chapter 2], an important decision was made to award this to the maternity service users that have been the participants in these studies. The findings of this thesis have emerged from the voices of my participants, aside from my own personal experience. In considering how my experiences would relate to the components of the two-stage AOPHB process, in terms of my first pregnancy I feel that aside from the offer of home birth being made available to me I had a belief (rather than understanding) of the other Creating the Conditions domains, and this continued throughout the Positive Reinforcement stage until the end of pregnancy when I realised that I knew nothing about birth and went to the

local university library to access some literature. In relation to my second pregnancy, I can again reflect that I actively sourced the content of the 'talk and learn about physiological birth' domain as part of the Positive Reinforcement attribute, as my need to transfer to the OU for slow progress in my first labour made me consider this in more detail in my subsequent pregnancy.

Additionally, while the aim of the reflective process is to move beyond merely providing transparency about my personal context, it is necessary to state that as a result of conducting my research within the local area in which I live and practice as a midwife, I knew on a professional basis several of the community midwife participants who participated in the initial exploratory study [Chapter 3], and most of the community midwife participants who took part in the workshop study [Chapter 6]. Additionally, from my involvement in setting up and taking part in the running of a local home birth support group, I also knew a number of the participants of the workshop study [Chapter 6].

In terms of how I feel that my relationship with the participants has influenced the research process, I discuss in chapter 3 how I feel that having a pre-existing professional relationship with several of the community midwife in this study actually provided me with an important opportunity to reflect upon the difficulty that enthusiastic and experienced community midwives appear to have in offering home birth to women. The notes that I made following the interview with one of the community midwives reflects my awareness that the research process was providing me with a perspective that I had never obtained within my professional role. This was also the case in terms of the maternity service user participants that I knew. While I had discussed planned home birth with several of them through the home birth support group I had never 'sat back' and attempted to understand their decision making journey until commencing this research. While I was certainly aware of some of the areas of need – such as around information provision, and had attempted to address this within the support group, I had not gained the overarching perspective that allowed the two-stage AOPHB process to be realised until stepping out of the situation and attempting to gain a more objective perspective through the research process.

Conclusion:

This PhD thesis has provided a focused programme of enquiry that has centred upon generating knowledge and understanding of the planned home birth decision making process, and has translated this knowledge into the creation of the tool that can be used by community midwives within clinical practice to facilitate this process for women.

This thesis has described the research process that has been undertaken during the development of the two-stage AOPHB process. Chapter 1 provided an overview of the situation of birth place choices within current UK maternity policies, and also provided an overview of the way that the concepts of choice and decision making are included within these policies. Chapter 2 outlined the methodological considerations and decisions that were made to conduct mixed methods research, using a pragmatic stance. The initial exploratory study [Chapter 3] explored the way in which planned home birth was being discussed and offered to low risk women in one local health board; and chapter 4 described how a scoping review that included a wide range of published literature to further understand the barriers and facilitators to home birth decision making was undertaken. Chapter 5 describes how a concept analysis that accessed the published literature around the active offer of services within minority languages and applied the findings to my developing understanding of home birth decision making generated the components of an active offer of planned home birth. The suggested AOPHB approach was then tested within a workshop setting with previous service users who had planned to birth at home, previous service users who had not planned to birth at home, and community midwives who offer and attend planned home births [Chapter 6]. The findings of this study suggested that a two-stage process, consisting of two defining attributes rather than the four that were initially highlighted during the concept analysis process [Chapter 5], provides an appropriate framework to support midwives in making an active offer of planned home birth to women, and to support women in being able to consider and decide to birth at home.

Further work to explore the potential use of the proposed AOPHB two-stage process is anticipated in the future.

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Wilson, J. (1963). *Thinking with Concepts*. Cambridge University Press: Cambridge

Appendix 1 – Initial exploratory study [IES] observation proforma

Observation checklist for 36 week birth planning meeting

Date _____

Mw No. _____ Verbal consent recorded on tape _____

Wm No. _____ Verbal consent recorded on tape _____

Location	Woman's Home	GP clinic	Other clinic	Other	
People	Woman	Com. Midwife	Partner	Children	Other
Prominent Objects					

Detailed sketch of room where observation being conducted

Include: all people present

major furniture

all animals

doors and windows, lights, floor coverings etc.

state approximate room dimensions

Prominent noises	Family members	Health professionals	Other	Other

Time observation commenced	

Refreshments offered to CmMw:	Yes	No
	Accepted	Declined

General (non midwifery) chat:	*Start:*	*Finish:*	*Start*	*Finish*
Midwife topics raised:				
Woman topics raised:				
Partner topics raised:				
Others present topics raised:				

Routine A/N checks	*Start:*	*Finish:*	*Start*	*Finish:*
Topics raised by midwife:				
Topics raised by woman:				
Topics raised by partner:				
Topics by others present:				

Woman already written anything for her birth plan?	Yes	No
If yes -	In the birth plan section of notes	On a separate piece of paper
Is this discussed fully or in a quick manner?	Yes	No

Does the midwife appear supportive of ideas?	Yes	No
Time spent	*Start:*	*Finish:*

<u>Birth planning discussion</u>	*Start:*	*Finish:*	*Start:*	*Finish:*
Using pre – written plan in notes?	Yes	No		
Referral to woman's notes (if made prior).	Yes	No	N/A	
Who is writing?	Cm Mw	Woman	No-one	Other
	Offered woman to write – Yes/ No			Offered woman Yes /No
Goal of 'doing it together' apparent?	Yes	No	Comments:	

<u>Use of props.</u>	Yes	No			
If yes, please describe.	Photos:	Acting:	Leaflets:	Stories:	Others:
People involved:	Wm. Y/N Partner Y/N Others Y/N	Wm Y/N Partner Y/N Others Y/N	Wm Y/N Partner Y/N Others Y/N	Wm Y/N Partner Y/N Other Y/N	Wm Y/N PartnerY/N Other Y/N
Women :	Asking questions: (x each time)		Answering questions: (x each time)		
	Topics				
Cm Mw:	Asking questions: (x each time)		Answering questions: (x each time)		
	Topics				

Place of birth discussed:	*Start:*	*Finish:*			
Women :	Asking questions: (x each time)		Answering questions: (x each time)	*Start*	*Finish*
	Topics				
Cm Mw:	Asking questions: (x each time)		Answering questions: (x each time)		
	Topics				
Evidence discussed:					
Idea of ongoing discussion a possibility?	Yes		No		
References to positive outcome:	Themes:		References to negative outcome:	Themes**:**	

Pain in labour					
Who mentions first?	Woman	Midwife	Partner	Other	
Cm Mw prevailing themes	Positive and reassuring	Negative	Woman able to cope	Fear	Other
Cm Mw personal feelings apparent?	Yes		No		

Woman prevailing themes	Positive	Negative	Able to cope	Fear	Other
Options at home mentioned separately?	Yes – what?		No		
Options at hospital mentioned separately?	Yes – what?		No		
Evidence discussed	Yes – brief description		No		
Literature given	Yes – brief description		No		

Interventions during labour	Stats.	Rational	Themes	*Time spent discussing*
I.O.L.			Cm Mw	
			Wm	
Augmentation			Cm Mw	
			Wm	
Episiotomy			Cm Mw	
			Wm	
Instrumental birth			Cm Mw	
			Wm	
Caesarean births			Cm Mw	
			Wm	
Neonatal resus.			Cm Mw	
			Wm	
SCUBU			Cm Mw	

			Wm	

Normality focus	Brief description
Needs of other children discussed	
Support partners discussed	
Positive language used re ability to give birth	
Overt philosophy of normality	

Women's Autonomy				
Clear statement for woman's autonomy	Yes	No	Suggestion made	
Evidence discussed openly	Yes - describe		No - describe	
Support given to wishes and ideas	Yes - examples		No- examples	
Info provided or offered to find out as needed	Yes - describe		No- describe	

Who to contact when in ? labour:	Cm Mw – gives phone number	Labour Ward in DGH	Other

Does this differ in day / night?	Yes	No	Describe:
Choice given to woman?	Yes	No	Describe:
Appear that woman would prefer to contact Cm Mw?	Yes	No	Describe:
Woman happy with plan?	Yes	No	Describe:

Time observation completed	

Inform Cm Mw and Wm, and others that this is the end of the observation and that tape is turned off.

Thank everyone involved.

Appendix 2 – IES ethical approval

North Wales Research Ethics Committee - West
Bangor
Clinical Academic Office
Ysbyty Gwynedd Hospital
Betsi Cadwaladr University Health Board
Bangor
Gwynedd
LL57 2PW
Tel/Fax: 01248 384 877

Ms J.C. Field
Midwife/Researcher
School of Healthcare Sciences
Bangor University
Fron Heulog
Bangor, Gwynedd
LL57 2EF

22 April 2011

Dear Ms Field

Study title: **Home birth: an investigation into maternity practice across North Wales.**
REC reference: **11/WA/0021**

Thank you for your letter of 21 March 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

Appendix 3 – IES R&D approval

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Panel Arolygu Mewnol Y&D – Y Gorllewin
R&D Internal Review Panel – West Division

Ysbyty Gwynedd
Clinical Academic Office
North Wales Clinical School
Bangor, Gwynedd
LL57 2PW

Telephone/Facsimile: 01248 - 384.877
Email: Rossela.Roberts@nww-tr.wales.nhs.uk

PRIVATE & CONFIDENTIAL
Ms J.C. Field
Midwife/Researcher
School of Healthcare Sciences
Bangor University
Gwynedd
LL57 2EF

18 April 2011

Dear Ms Field,

Re: Project Review:

Field 11/WA/0021 Home birth: an investigation into maternity practice across North Wales

The above research project was reviewed at the meeting of the Internal Review Panel held on 5 May 2011. Thank you for responding to the Committee's request for further information.

The Chairman considered the response on behalf of the Committee and is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application.

I have pleasure in confirming that the Internal Review Panel is pleased to grant approval to proceed at Betsi Cadwaladr University Health Board (West sites).

The study should not commence until the Ethics Committee reviewing the research has confirmed final ethical approval - favourable opinion.

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (August 2009).
An electronic link to this document is provided on the Trust's R&D WebPages.
Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If you would like further information on any other points covered by this letter please do not hesitate to contact me. On behalf of the Committee, may I take this opportunity to wish you every success with your research.

Chairman/Cadeirydd – Dr Richard Tranter

Appendix 2.3 – Proforma for audit
V. 2. 9/3//11

Audit No. A_____

Pregnancy details

Gravida	
Parity	
EDD	/ / .

Previous pregnancies (if appropriate)

Date of last birth				
Place of last birth	CLU- DGM	MLU- DGM	Free standing - MLU	Home
Type of last birth	Normal	SVD	Ventouse	Forceps

Maternal characteristics

Age at time of child's birth				
Marital status	Married	Single	Cohabiting	Other
Employment situation	Unemployed	Employed		
BMI at booking				
Alcohol intake during pregnancy	0	….	……	
Smoking status	Never	Gave up in pregnancy	…….	……
Languages spoken	English	Welsh	Other European	Other
Medical history	Nil of note			
DA1 completed	Yes	No		

Address details

Postcode		
	Urban	Rural

Antenatal care

Associated District General Hospital

DGM	Y. Gwynedd	Y Glan Clywd	Wrexham Maelor
Miles to DGM from home			

Appendix 2.3 – Proforma for audit
V. 2. 9/3//11

postcode			

First contact

Gestation at first contact with mat. services			
Professional undertaking first contact	GP	Com. Midwife	Other
Location of first contact	GP surgery	Home	Other

Further antenatal care

No. different midwives in handheld notes	1	2	3	4	5	More
Evidence of com.s between Cm Mw and Obs - medical condition /factors re place of birth	N/A	Heam	Infective	Endocrine	Skeletal	Gastrointestinal
	Cardio	Prev. compli	Current preg.	Fetal indication	Gynae history	Age 35 +
			BMI 30-34 At booking			Age 40 +
No. GP visits	1	2	3	4	5	More
No. Obs. visits	1	2	3	4	5	More
Location of care and frequency at location	GP surg.	Home	ANDU	Con.'s clinic	Birth centre	Other
Doc. that place of birth discussed	No	Initial Contact with Cm Mw	Other : state gestation ……..	Other: state gestation ……..	Other: state gestation ……..	Other: state gestation ……..
Birth plan form completed in full	Yes	In part	Blank	Other birth plan in notes		
Location of birth	GP surger	Home	Birth Centre	Other		

Appendix 4 – IES audit proforma

plan visit- 36/40	y									
Types of reference s to home birth in birth plan	None	Ticked section	Written explanation of service	Leaflet provided	Statistics discussed/ documented	Other				

Care in labour										
ELA at home	Yes	Declined	Not offered							
Fetal heart monitoring	None	Sonicaid	CTG	Pinard	FSE					
Gestation at birth	37+	38+	39+	40+	41+					
Analgesia	None	Entonox	Water	Opiate injection	Epidural	Spinal	GA			
Interventions undertaken	Prostin IOL	ARM IOL	Symto. IOL	ARM. aug.	Synto aug.	Epis.	FBS			
Active 3rd stage	Yes	No								
NLP part III started	Yes	No								
NLP part III completed	Yes	no								

Birth outcomes								
Place of birth	Home –with Cm Mw	Home - BBA	CLU- DGM	Free standing MLU	MLU - DGM	Other		
Reason for change of birth location choice	Transferred to CLC in A.N period	Maternal choice in A.N. period.	No Com. Midwife available	Transferred to CLC in labour for reason other than analgesia	Wished further pain relief.	Other		
Reason if stated……								
Professional who delivered	Com. Mw	Hosp. Mw	St. Mw	Med. St	Dr.			
Type of birth	Normal	Other SVD	Ventouse	Forceps	El. C/S	Em. C/S		

Appendix 2.3 – Proforma for audit
V. 2. 9/3//11

Complications						
Time of birth	00:01-06:00	06:01-12:00	12:01-18:00	18:01- 00:00		

V. 1
20/1/11

Appendix 1.1

Letter to introduce study to CmMW

PRIFYSGOL BANGOR UNIVERSITY

Dear

I am writing to invite you to take part in a study that I am conducting at Bangor University. The title of the study is:

Home births: an investigation into maternity practice across North Wales.

Please find enclosed an information sheet which explains details of the study. There is also a consent form and stamped addressed envelope for the return of the consent form if you do wish to take part.

Thank you for your time

Jude Field

V. 2
20/1/11

Appendix 1.2

Study Information Sheet - (CmMw)

PRIFYSGOL BANGOR UNIVERSITY

Invitation to participate
You are being invited to participate in a research study to explore how the home birth service is implemented in North Wales. The title of the project is underlined below:

Home births: an investigation into maternity practice across North Wales

Please read this information sheet before deciding whether to take part in the study. It explains why the research is being done, and what it will involve. Please contact me if there is anything you would like to discuss.

What is the purpose of the study?
The study aims to provide a picture of how maternity service providers working in the Betsi Cadwaladr University Health Board (BCUHB) feel about promoting and providing home birth.

Why have I been chosen?
All Community Midwives working within BCUHB have been contacted with this information and invited to take part in this study. This is because research has shown that Community Midwives are the health professionals who have the greatest influence on maternity service users with regard to birth place choices.

Do I have to take part?
No. It is entirely voluntary. If you decide to take part please retain this information sheet, sign the enclosed consent form, and send it to me in the stamped addressed envelope provided. At the birth planning meeting, and in your individual interview I will confirm that you give consent for the proceedings to be audio-taped. You are able to withdraw your consent at any time.

What do I have to do if I agree to take part?
Initially I would ask you to hand out information leaflets to all women on your case load at or beyond 24 weeks gestation, aged 18 or over, and who are currently receiving Midwifery Led Care. In addition to these inclusion criteria, I would also ask you to consider a woman's suitability for the study in terms of her personal/ social history – this is in order that there is no possibility of an involuntary breech of confidentiality. Examples of this would be where by a woman prefers not to share information regarding previous pregnancies/ miscarriages/ terminations with those who may attend her 36 week birth planning appointment.

You would not need to explain the study to the women or ask for their involvement. The letter would invite them to take part in the study, and to consent to my observation of their 36 week appointment and a following interview. The letter would also ask their consent for my access to their relevant medical and midwifery case notes so as to complete an audit for a separate phase of my study. Whilst the entire study consists of three phases – the information in this sheet relates only to the first phase of the study.

If a woman on your caseload consents to take part in this study, she will send me her consent form and I will send confirmation of this to you. I would then attend to observe the 36 week appointment, and would ask the permission of both yourself and the woman, and any others present to audio-tape the appointment.

I would also ask that I could interview you individually after the appointment at a date, time and location of your choosing. The aim of the interview would be to gain information about your attitudes towards home birth and will use a series of prompts to lead us through a discussion. The individual interview will last approximately 15 minutes, and anything you say will be kept strictly confidential.

I aim to observe and interview 15 midwives and women throughout BCUHB.

Language choices
A researcher fluent in Welsh would also attend the 36 week appointment to complete an observation checklist if you normally speak Welsh with a woman who chooses to take part in this study. Should you choose to take part in this study, any woman on your case load who consents will be asked if she normally speaks Welsh with you.

The interview following the 36 week appointment would be conducted in English and only attended by me.

What are the benefits or disadvantages of taking part?
The benefits are that you will be able to voice your opinion on your experiences and views of home birth. I do not anticipate any disadvantages.

Will my taking part in the study be kept confidential?
Yes. If you consent to take part in this study, all of the information that is collected during the course of the research will be kept strictly confidential. Your employer will not be informed that you are participating in this study. However, due to the nature of this project, the issue of disclosure of information must be specifically addressed in relation to unsafe clinical practice (NMC 2008) and child protection (Children Act 1989).

Questionnaires, tapes and transcripts will be securely stored at Bangor University and only accessed by members of the research team. Anonymised transcripts will be kept for ten years after publication, but the original recordings will be destroyed following transcription.

What will happen to the results of this research?
I plan to disseminate the findings of this research by means of:

V. 2
28/02/11

Appendix 1.4 Consent form and study recruitment pack (CmMw)

PRIFYSGOL BANGOR UNIVERSITY

CONSENT FORM

Home births: an investigation into maternity practice across North Wales

Please initial box to indicate agreement

		Yes	No
1	I agree that I have read and understood the information sheet dated 20/1/11 for the above study and have had the opportunity to ask questions.		
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal and employment rights being affected.		
3	I consent to the audio taping of my appointment with my client, and the individual interview with the researcher.		
4	I consent to anonymised quotations from either / both of the appointment and individual interview being used in any publications arising from this project.		
5	I understand that I may withdraw my consent regarding the use of my anonymised quotations at any time before publication - via email, letter or telephone, without giving any reason, and without my legal and employment rights being affected.		
6	I agree to take part in the above study		

Name (Community Midwife) Date Signature

Preferred contact details

Name (Researcher) Date Signature

V. 2
20/1/11

Feedback reports to all participating community midwives and women, managers and obstetricians
Feedback reports to BCUHB
Possible publication in peer reviewed journals and on the World Wide Web
Conference presentations

Who is organising or funding this research?
This research is being funded by a small grant from the North Wales Clinical School. It is being organised by me under supervision from members of the School for Healthcare Sciences, University of Bangor.
I am a recently qualified, part time Band 5 midwife at Ysbyty Gwynedd, Bangor, and also work part time as a research support officer at Bangor University.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher on the contact details provided, who will do their best to answer your questions.

If you remain unhappy, or if you have any complaints about the way the researcher carriers out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Dr. Malcolm Godwin
Acting Head of School, School of Healthcare Sciences
College of Health and Behavioural Sciences
Bangor University
Gwynedd LL57 2EF
Tel: 01248 383117

What happens if I don't want to carry on with this study?
You can decide to withdraw from the study at any time and without giving a reason. You can withdraw by telephone, email or writing to any of the contact details listed at the bottom of this information sheet. If you do decide to withdraw all of your data will be destroyed.

What happens next?

- Please contact the researcher using the contact details provided if you would like any more information or require clarification of any issues.

Name Jude Field
Contact address Fron Heulog, School of Health care Sciences, Bangor University, LL57 2EF
Contact telephone number Work: 01248 382802
Contact email address j.c.field@bangor.ac.uk

- Please fill in and return the consent form if you wish to take part in the study. I will contact you upon receipt of the consent form, and provide you with copies of the invitation packs to hand out to the women on your case load.

V. 2
28/02/11

Please provide me with an indication of the number of women on your caseload who are Midwifery Led Care. This will ensure I send you enough number of packs to hand out. No. of women _____

Demographic details as per protocol:

What year did you qualify as a midwife? _____

Home birth experience this year, as first or second midwife >5 ___ <5 ___

Appendix 6 – IES community midwife reminder letter

V. 1.
20/1/11

Appendix 1.1 - reminder

Letter to re-introduce study to CmMW

Dear

Two weeks ago I sent you an information pack relating to my study:

Home births: an investigation into maternity practice across North Wales.

As I have not received a reply from you, I wanted to ensure that you had received the study information pack. I apologise if you have done, and have decided not to take part. I will not be sending any further reminders to you.

Please find enclosed an information sheet which explains details of the study, and a consent form and stamped addressed envelope for the return of the consent form if you do wish to take part.

Thank you for your time, .

Jude Field

V. 1
20/01/11

Appendix 1.5

PRIFYSGOL BANGOR UNIVERSITY 1884

Invitation to participate

Your Community Midwife has decided to take part in a study that I am conducting at Bangor University, and has been asked by me (the researcher) to hand out these study information packs to every woman on her caseload who is experiencing a low risk pregnancy.

The title of the study is:

Home birth: an investigation into maternity practice across North Wales.

I would value your opinion as a woman currently experiencing maternity care within the Betsi Cadwaladr University Health Board, and invite you to take part in this study, whether or not you are considering a home birth. This would be an opportunity for you to express your views on the service that is being provided to you.

Your Community Midwife's participation in this study is not reliant upon your participation in this study and s/he is not part of the study team. The care that you receive from him/her during your pregnancy and after you have had your baby will not be affected by your decisions related to participating in this study.

Please find enclosed an information sheet which explains details of the study, and a consent form and stamped addressed envelope for the return of the consent form if you do wish to take part.

Thank you for your time,

Jude Field

V. 2
28/02/11

Appendix 1.6

Study information sheet – (Woman)

PRIFYSGOL BANGOR UNIVERSITY 1884

Invitation to participate
You are being invited to participate in a research study to explore how the home birth service is implemented in North Wales. The title of the project is underlined below:

Home births: an investigation into maternity practice across North Wales

Please read this information sheet before making your decision to take part in this study. It explains why the research is being done, and what it will involve. Please contact me if there is anything you would like to discuss. My contact details are on the bottom of this information sheet.

What is the purpose of the study?
The study aims to provide a picture of how maternity service providers working in the Betsi Cadwaladr University Health Board feel about promoting and providing home birth.

Why have I been chosen?
This study aims to explore the way in which maternity care is provided to women experiencing a low risk pregnancy.

Do I have to take part?
No. It is entirely voluntary. If you decide to take part please retain this information sheet, sign the enclosed consent form, and send it to me in the stamped addressed envelope. I would then inform your Community Midwife about your intention to take part in this study.

What would I need to do if I agree to take part?
If you agree to take part I would ask your consent to observe your 36 week appointment with your Community Midwife. I would not be involved in the care that you receive, but would be present to observe your care and would complete an observation form during your appointment. I would also ask both you and your Community Midwife to consent to my audio-taping your discussions so that I can transcribe them accurately at a later date.

If you think that you will have anyone else present at your 36 week appointment – for example your husband/ partner/ friend/ other birth partner – please let them read the information sheet titled 'Study information sheet – (Husband's/ Partner's/ Friend's/ Other health professional's)' before your appointment. At the appointment I would

ask them to sign a consent form saying that they are happy for me to audiotape their contributions to the discussion.

I would also ask your consent to take part in an individual semi-structured interview with me following your appointment with your Community Midwife. If it is not convenient for you at this time then we can arrange a time and date to suit you. The aim of this interview would be to gain more information about the care that has been provided to you, and will use a series of prompts to lead us through a discussion. The interview would last approximately 15 minutes. I would ask for your consent to audio-tape this interview also, so that I can transcribe it accurately at a later date.

Thirdly, I would ask your consent for me to have access to your relevant medical and maternity notes to enable me to complete an anonymous audit of maternity care for a separate phase of my study.

I would also ask your consent, and that of any other person present at your appointment, for me to use anonymised quotations from either/ both your appointment with your midwife or your interview with me in any of the publications that arise from this project. Due to the process of anonymisation, no individuals would be identifiable from these quotations.

Language choices
A researcher fluent in Welsh is available to attend the 36 week appointment with me to complete an observation checklist, if you normally speak Welsh with your Community Midwife and wish to do so at this appointment. If you do wish to take part in the study, please indicate your language choice on your consent form.

The interview following the 36 week appointment would be conducted in English and only attended by me.

What are the benefits or disadvantages of taking part?
The benefits are that you will be able to voice your opinions on home birth, and your experiences of considering it as an option. I do not anticipate any disadvantages.

Will my involvement in the study be kept confidential?
Yes. Questionnaires, tapes and transcripts will be securely stored at Bangor University and only accessed by members of the research team.

Any documentation regarding your medical or maternity care will remain in the Hospital under which you have received care, and any information about you which leaves the hospital will have all names and addresses removed so that no-one can be recognised.

All documents about your involvement in this study will be kept in locked filing cabinets in Bangor University, or on password protected computers, and will not be disclosed in any reports. Anonymised transcripts will be kept for ten years after publication, but the original recordings will be destroyed following transcription.

V. 2
28/02/11

However, due to the nature of this project, the issue of disclosure of information must be specifically addressed in relation to unsafe clinical practice (NMC 2008) and child protection (Children Act 1989).

What happens if I don't want to carry on with this study?
You can decide to withdraw from the study at any time and without giving a reason. You can withdraw by telephone, email or writing to any of the contact details listed at the bottom of this information sheet. If you do decide to withdraw all of your data will be destroyed.

Who is organising or funding this research?
This research is being funded by a small grant from the North Wales Clinical School. It is being organised by me under supervision from members of the School for Healthcare Sciences, University of Bangor.
I am a recently qualified, part time Band 5 midwife at Ysbyty Gwynedd, Bangor, and also work part time as a research support officer at Bangor University.

What will happen to the results of this research?
I plan to disseminate the findings of this research by means of:
Feedback reports to all participating community midwives and women, managers and obstetricians
Feedback reports to BCUHB
Possible publication in peer reviewed journals and on the World Wide Web
Conference presentations

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher on the contact details provided, who will do their best to answer your questions.

If you remain unhappy, or if you have any complaints about the way the researcher carriers out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Dr. Malcolm Godwin
Acting Head of School, School of Healthcare Sciences
College of Health and Behavioural Sciences
Bangor University
Gwynedd LL57 2EF
Tel: 01248 383117

Please fill in and return the consent form in the stamped addressed envelope provided if you wish to take part in the study. I will contact your Community Midwife upon receipt of the consent form so that she can inform me of the arrangements you make for your 36 week appointment.

Thank you for taking the time to read this information sheet and for considering taking part in this study

V.2
28/02/11

Appendix 1.7 Consent form and study recruitment pack (woman)

PRIFYSGOL BANGOR UNIVERSITY

ID No _____ (to be completed by researcher)
(Links to CmMw _____)

CONSENT FORM

Home births: an investigation into maternity practice across North Wales.

Please initial box to indicate agreement

		Yes	*No*
1	I agree that I have read and understood the information sheet dated 28/02/11 for the above study and have had the opportunity to ask questions.		
2	I understand that my participation is voluntary and that I am free to withdraw -at any time via email, letter or telephone, without giving any reason, and without my medical care or legal rights being affected.		
3	I understand that relevant sections of my medical notes and data collected during the study may be looked at by the researchers involved in this study, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.		
4	I consent to the audio taping of my appointment with my Community Midwife, and the individual interview with the researcher.		
5	I consent to anonymised quotations from either / both of the appointment and individual interview being used in any publications arising from this project.		
6	I understand that I may withdraw my consent regarding the use of my anonymised quotations at any time before publication - via email, letter or telephone, without giving any reason, and without my legal rights being affected.		
7	I agree to take part in the above named study.		
8	I understand that a copy of this consent form will be sent to my Community Midwife to inform her of my participation.		

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Name (Participant) _____ Date _____ Signature _____

Name (Researcher) _____ Date _____ Signature _____

Demographic Details
Is this your first pregnancy? YES_____ NO_____
If no, have you had a home birth before? YES_____ NO_____

Language Choices
Are you fluent in English? YES_____ NO_____
Do you normally speak Welsh with your Community Midwife? YES_____ NO_____
If yes, please indicate if you consent to the presence of a support officer fluent in Welsh during your 36 week appointment. YES_____ NO_____

FOR RESEARCHER TO COMPLETE:

DATE OF 36/40 APPPOINTMENT _____
LOCATION _____
TIME _____

WELSH LANGUAGE RESEARCH OFFICER (AS APPLICABLE)
Notified of coming appointment _____

Informed of appointment date _____

Appendix 1.8

Study information sheet – (Husband's/ Partner's/ Friend's/ Other health professional's)

PRIFYSGOL BANGOR UNIVERSITY

Information sheet regarding your wife's/ partner's/ client's/ friend's invitation to participate

Your wife/ partner/ client/ friend has been invited to participate in a research study to explore how the home birth service is implemented in North Wales. This information sheet has been included in her information pack to provide you with information of how the study may relate to you.

The title of the project is underlined below:

Home births: an investigation into maternity practice across North Wales

Please read this information sheet before making your decision to take part in this study. It explains why the research is being done, and what your part in it would involve. Please contact me if there is anything you would like to discuss. My contact details are on the bottom of this information sheet.

What is the purpose of the study?
The study aims to provide a picture of how maternity service providers working in the Betsi Cadwaladr University Health Board feel about promoting and providing home birth.

Why has my wife/ partner/ client/ friend been chosen?
This study aims to explore the way in which maternity care is provided to women experiencing a low risk pregnancy.

What would I need to do if I agree to take part?
The information sheet provided in this study pack for your wife/ partner/ client/ friend explains how the study relates to her. It asks if she would agree to take part in the study, and consent to my observing her 36 week appointment with her Community Midwife. It also asks her consent to my audio-taping of her discussions with her Community Midwife so that I can transcribe them accurately at a later date.

This information sheet is intended to provide you with the opportunity to consider if you, as a person attending this appointment, would give consent for any anonymised

quotations of your input in to the meeting to be used in any publications. Due to the process of anonymisation, no individuals would be identifiable from these quotations.

Your wife/ partner/ client/ friend is also being asked to consent to attending an individual interview with me. No one else will be present during our discussion, and so this information sheet does not relate to that part of the research.

Language choices
A Welsh language researcher is available to attend the 36 week appointment to complete an observation checklist if your wife/ partner/ client/ friend normally speaks Welsh with her Community Midwife, and she wishes to do so at this appointment.

I am unable to provide Welsh Language services if your wife/ partner/ client/ friend does not speak Welsh with her Community Midwife, or does not consent to the presence of a Welsh language researcher.

What are the benefits or disadvantages of taking part?
The benefits are that you will be able to voice your opinion on your experiences and views of home birth. I do not anticipate any disadvantages.

Will my involvement in the study be kept confidential?
Yes. Questionnaires, tapes and transcripts will be securely stored at Bangor University and only accessed by members of the research team.

All documents about your involvement in this study will be kept in locked filing cabinets in Bangor University, or on password protected computers, and will not be disclosed in any reports. Anonymised transcripts will be kept for ten years after publication, but the original recordings will be destroyed following transcription.

However, due to the nature of this project, the issue of disclosure of information must be specifically addressed in relation to unsafe clinical practice (NMC 2008) and child protection (Children Act 1989).

What happens if I don't want to carry on with this study?
You can decide to withdraw from the study at any time and without giving a reason. You can withdraw by telephone, email or writing to any of the contact details listed at the bottom of this information sheet. If you do decide to withdraw all of your data will be destroyed, and any anonymised quotations will be withdrawn from the data – providing that you withdraw prior to its publication.

Who is organising or funding this research?
This research is being funded by a small grant from the North Wales Clinical School. It is being organised by me under supervision from members of the School for Healthcare Sciences, University of Bangor.
I am a recently qualified, part time Band 5 midwife at Ysbyty Gwynedd, Bangor, and also work part time as a research support officer at Bangor University.

What will happen to the results of this research?
I plan to disseminate the findings of this research by means of:

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Feedback reports to all participating community midwives and women, managers and obstetricians
Feedback reports to BCUHB
Possible publication in peer reviewed journals and on the World Wide Web
Conference presentations

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researcher on the contact details provided, who will do their best to answer your questions.

If you remain unhappy, or if you have any complaints about the way the researcher carriers out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Dr. Malcolm Godwin
Acting Head of School, School of Healthcare Sciences
College of Health and Behavioural Sciences
Bangor University
Gwynedd LL57 2EF
Tel: 01248 383117

If you are present at the 36 week appointment, I will provide you with a consent form to complete at this time. You do not need to complete a consent form now.

Thank you for taking the time to read this information sheet and for considering taking part in this study.

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Appendix 1.10: Consent form for others present at birth appointment

PRIFYSGOL BANGOR UNIVERSITY

Links ID No _____
(Links to CmMw _____)

CONSENT FORM

Home births: an investigation into maternity practice across North Wales.

Please initial box to indicate agreement

		Yes	*No*
1	I agree that I have read and understood the information sheet dated 20/01/11 for the above study and have had the opportunity to ask questions.		
2	I understand that my (wife's/ partner's/ friend's/ client's) participation is voluntary and that she is free to withdraw at any time - via email, letter or telephone, without giving any reason, and without her medical care or legal rights being affected.		
3	*I consent to anonymised quotations from the appointment being used in any publications arising from this project.*		
4	I consent to the audio taping of this appointment with my (wife's/ partner's/ friend's/ client's) Community Midwife.		
5	I understand that I may withdraw my consent regarding the use of my anonymised quotations at any time before publication - via email, letter or telephone, without giving any reason, and without my legal rights being affected.		

Name (Participant) _____ Date _____ Signature _____

Name (Researcher) _____ Date _____ Signature _____

Appendix 8 – IES woman semi-structured interview schedule

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Appendix 1.12

Semi-structured interview schedule (woman)

- **Demographic detail**

Age ranges
Married/ Cohabiting/ Single
Other children – ages
Anything else?

- **Birth planning meeting**

Describe how you felt about the birth planning meeting?
Was it similar to other meetings with your midwife?
Where do you normally meet your midwife?
Have you met that midwife before?
How many community midwives have you met this pregnancy?

- **Beliefs prior to pregnancy re home birth and childbirth**

Since before first pregnancy
Following prior pregnancy/ies if applicable

- **Describe how you feel home birth has been discussed during this pregnancy**

Remember when it has been discussed – feeling of once, all the way through, first time now…..
Aware of any research on subject
Info sheets given
WAG publicity
Awareness of how home birth would be undertaken – staff, equipment, analgesia, continuity of care, how to contact Mw, etc
Did you have enough information to make your decision?
Do you feel significant others had enough info to support your feelings?

- **Do you feel that you have had to make a choice for place of birth at the birth planning meeting, or do you feel that the decision is still to be made?**

Assessed at home in labour possibility
Will only phone hospital if hadn't said yes to home birth
Want to stay at home as long as can, would you phone CmMw or hospital for advice?

- **Get any feelings about what your midwives felt about home birth?**

- **How feel about home birth/ childbirth in general now?**

Location, pain relief, support, philosophy, empowerment and ability to cope well
Understand what is going to happen
Would you like more information – what type ?
See it as part of family life, social, something to keep separate…
Has this been influenced by time with a midwife

Appendix 9 – IES community midwife semi-structured interview schedule

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Appendix 1.14

Semi-structured interview schedule (CmMw)

- **Demographic detail**

1. What year did you qualify as a midwife? .....

2. How many years have you practised as a community midwife? .....

- **Observed birth planning meeting**

Was the interview that I observed the 'norm' for practice, if not what were the differences. Why did they occur?

How often had you met ..... before? And her partner etc....?

Talking about the birth planning visit, what do you feel the purpose of the visit is?

1. DID YOU ATTEND ANY HOME BIRTHS THIS YEAR?
If yes- how many, can you tell me about them?
If no - when did you last attend a home birth, and can you tell me about it?

2. WOULD YOU LIKE TO ATTEND MORE HOME BIRTHS?
If yes – what would help?
If no – why not?

3. DO YOU OFFER HOME BIRTH TO LOW RISK WOMEN?
If yes – why?
If no – why not?
Does your practice change according to the women? In what way?

3. DO YOU FEEL THAT THE WELSH ASSEMBLY GOVERNMENT POLICIES HAVE INCREASED YOUR HOME BIRTH RATE?
Yes - Why/ How
No – Why not

4. ARE YOU AWARE OF ANY BELIEFS ABOUT HOME BIRTH THAT YOU HELD BEFORE BECOMING A MIDWIFE?

5. DO YOU FEEL THAT YOUR VIEWS ON HOME BIRTH HAVE CHANGED AT ANY POINT DURING YOUR CAREER?
Yes- can you explain how?
No – how do you feel about this

6. HOW WERE YOU PREPARED DURING YOUR MIDWIFERY TRAINING FOR ATTENDING HOME BIRTHS?
Mentors
Experiences
Course theory

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7. IN YOUR WORKING LIFE AS A COMMUNITY MIDWIFE WHAT DO YOU FEEL ABOUT HOW THE ONGOING TRAINING AND UPDATES PREPARE YOU FOR ATTENDING HOME BIRTHS?
Are there any?
Are they sufficient?
Are they mandatory?

8. CAN YOU DESCRIBE THE ASPECTS OF YOUR PRACTICE THAT YOU FEEL INFLUENCE THE NUMBER OF WOMEN CHOOSING TO GIVE BIRTH AT HOME IN YOUR AREA?
Positive- what enables you to do this
Negative aspects – do you want to change this? / why do you not want to change this?/ why do think this happens?

If not raised by midwife- is practice rural/ urban, and distance to CLU.

9. HOW SUPPORTED DO YOU FEEL WHEN ATTENDING HOME BIRTHS?
Team- does your whole team share a philosophy?
Supervisor of Midwives
Hospital staff
Medical staff
Managers
Other support needed/received

10. CAN YOU TELL ME ABOUT HOW YOU FEEL THAT YOUR PERSONAL RESPONSIBILITIES RELATE TO YOUR ABILITY TO PROVIDE HOME BIRTH?
Family
On-call issues
Personal hobbies etc
Other

11. DO YOU FEEL THAT YOUR EXPERIENCES OF CHILD BIRTH, PERSONAL AND PROFESSIONAL, INFLUENCE YOUR PRACTICE?

12. HOW WOULD YOU DESCRIBE YOUR PHILOSOPHY TOWARDS PREGNANCY AND CHILDBIRTH?
How do you see midwifery knowledge fitting in to this?
How do you view obstetric knowledge?

13. WOULD YOU HAVE A HOME BIRTH?
If yes – what factors influence your decision?
If no – what factors influence your decision?

14. ANYTHING ELSE YOU WISH TO DISCUSS.....

Thank you very much for your time.

73 and 73-1 observation

Filename: 73 and 731 observation

Length of recording: 00.48.08

Date: 9/1/12

Key:

CmMw = Community Midwife

Wm = Woman

Pt = Partner

Res= Researcher

Transcription notes:

Took place at woman's home

Student Midwife present

00.00.00 CmMw: Ok, I'm just going to have a quick recap...so, you're not far off now are you?

00.00.10 Wm: No, 36 weeks on Friday just gone.

00.00.17 CmMw: And the spine hasn't been a problem has it? (pre-existing back problem)

00.00.21 Wm: not really no, my hips are sometimes a bit sore, but nothing too bad.

00.00.27 CmMW: Lots of people get a bit sore, if you think about the joints in your pelvis, they're like strong elastic at the front an two at the back, and there's a lot of movement in the pelvis with all that extra weight, it's not surprising to be uncomfortable, it's not unusual it's just finding strategies to make it easier. Warm baths, the ball, off this (indicates the sofa) (laughs).

00.00.57 CmMw: Thanks very much (cup of tea from partner). Are you Ok here? (Partner to sit on sofa at her side). I won't be a minute (reading through notes)... last week 33 weeks, so we do actually need to do a check today as well not just a birth plan. Shall we do that now? Is that OK with you?

00.01.26 Res: That's fine

00.01.29 CmMw: if I do what I normally do...

00.01.30 Res: Yeah, that's the idea

00.01.33 CmMw: I'll ignore that (indicates recorder) (laughs) Ok... do you want to get the stuff out [St Mw] while I just. Are you getting excited now?

00.01.48 Wm: I've got everything ready now, everything's set up and waiting, I just need the baby now (laughs).

00.01.56 CmMw: and what are your thoughts about where to have your baby.

00.01.59 Wm: Hospital

00.01.59 CmMw: Yeah, definite? Have you read the information about the choices? Because you've been low risk all the way through the choice would be to have your baby at home or to have your baby in hospital. (taking blood pressure)

00.02.10 Wm: Yeah, hospital.

00.02.13 CmMw: Is that because you feel safer?

00.02.16 Wm: Yeah (laughs). Yeah.

00.02.19 CmMw: You do know there's lots of evidence that says that having your baby at home is as safe as hospital, there's some latest evidence that says that first time mums having babies at home there is a higher incidence of being transferred in, but if your decision is made and you're very clear about it, did you look at both options.

Appendix 11 – Scoping review search strategy

Applying the search strategy:

Literature searches of the CINNAHL and Ovid Medline databases were undertaken using the key word 'home childbirth'.

Additional searches of relevant professional journals were also undertaken, along with the reference lists from retrieved publications.

Applying the inclusion and exclusion criteria:

Decisions about inclusion and exclusion criteria were made in consultation with my supervisory team and with the aim of being able to fully address the above questions, therefore in order to be included in the review, publications had to:

* Be authored by relevant personnel – either research studies, or written by academic or clinical practitioners or maternity service users

* Refer to the experience of home birth or beliefs about home birth

* Be published during or since 1993

* Be published in either the English or Welsh languages

* Be conducted within, or be written about health services with comparative resources to those of the UK's National Health Service

The cut-off date was chosen as 1993 was a prominent date in the development of UK maternity policy in terms of support for women's choices in birth place, and the re-emergence of discussion of home birth as a suitable location for women to choose (Health, 1993). Language choice was determined by the fact that this PhD is being conducted in Wales, a bilingual country where English and Welsh are both official languages and access to welsh translation services for free, and the lack of funds for the translation of articles that were not published in Welsh or English. The decision to include research and comment from comparative countries was made from a lack of knowledge about the extent of research findings generated from with the UK, and a desire to obtain professional opinion and research findings from as wide a relevant knowledge base as possible.

Appendix 12 – Scoping review completed data extraction form

Title	Birthplace qualitative organisational case studies: How maternity care systems may affect the provision of care in different birth settings
Reference	McCourt C.,Rance S.,Rayment J.,Sandall J. (2011) Birthplace qualitative organisational case studies: How maternity care systems may affect the provision of care in different birth settings. Birthplace in England research programme. Final report part 6. NIHR Service Delivery and Organisation programme (No. 124)
Country	UK
Participants and location	The research took place in four 'best' or 'better performing' NHS Trusts as identified by the Health Care Commission Review of Maternity Services in England in 2007 in different health regions in urban and rural locations, with differing socio-demographic populations in the following configurations of care: 1) obstetric unit 2) obstetric/alongside midwife unit 3) Split site obstetric units and freestanding midwife unit 4) obstetric/ alongside unit and freestanding midwife units. Service providers, managers and other key stakeholders including user-group representatives (n=86), service users and their birth partners (n=72). Other data included document analysis (approximately 200 documents) and observation of key 'nodes' in the service (n=50 transcripts)
Study design and process	Organisation case studies Data collection focused on Trust policies and practice, and the experiences of women and birth partners in their journey through the system of care from March through to December 2010. Interviews Documentary analysis

Study findings	<u>Choice of birth place locations:</u> Choice was influenced by geographical, organisational, service culture and provider factors. Some women were not aware that choice of birthplace was possible, and lacked sources of evidence-based information on which to base choices. Women's views of safe care were influenced by what was locally on offer, their previous experience and that of other women that they knew. The prospect of intrapartum transfer was a major consideration when women made a decision around place of birth, and women often cited concerns about transfer distance as reasons for planning labour in hospital. Women who did exercise more agency had greater access to information, skills and confidence in asking for the choices they wanted, and had the support of family friends and health professionals in doing so. There was considerable variation in service provision between and within sites due to geography, and the variation in the organisation of community midwifery services. In all sites, there were examples of service and information provision designed to reduce in equalities in access and choice for women with complex social needs, those from poorer socio-economic localities and women who needed English language support <u>Delivery of care:</u> Deployment of community midwifery staffing across distributed settings was a key challenge for managers in all sites. For example, coverage for women living in more rural areas, staffing free-standing units, and reducing variation in models and coverage of community midwifery services.

	Less attention [than given to FSMLU midwives] to the needs of midwives working in AMUs or community midwives providing home births, some of whom attended very few births each year. Community midwives appeared to be less integrated in such processes, and some reported a sense of isolation and exposure when attending births at home. In all sites this was mitigated in models of care where midwives worked across the continuum of care, and both in the community and hospital settings. For example within team/case load models or where midwives rotated between community and the different units in order to maintain a range of skills as in the 'hub and spoke' model where an obstetric unit serving a number of freestanding midwife units. The management of complications, escalation and transfer emerged as a key issue. These include the management of physical, geographical, professional and inter-personal boundaries, not only when transfers of women or staff were needed, but also in terms of information, knowledge and resources. Effective and safe transfer was contingent on good communication systems, clear guidelines that were used appropriately to support decision-making, trusting and respectful relationships between staff groups, management of conflict over resources, and the confidence and competence of professionals. <u>Women's experiences of escalation and transfer:</u> Although some women's experience of transfer and escalation was characterised by feelings of worry, disempowerment or disappointment, most women were prepared for the unpredictability of events in childbirth. Clear and careful explanation of events by professionals was a common theme that ran through women's positive narratives about escalation. Trust

	in professionals was an important aspect of feeling safe, physically and psychologically. Some women described difficulty in being listened to when they raised concerns about complications they had noticed themselves, while concerns about medicalisation or previous negative birth experiences led women to avoid intervention in some cases, or request it in others. A few professionals viewed service users as both 'risky' and 'demanding' and consequently were less open to listening to their views, which were often not seen as relevant to safety <u>Decision making:</u> Research into how women and their families make decisions about where to give birth has tended to focus on home birth. This research suggests that the following factors are consistently important to women: finding a balance between safety of the baby and the satisfactory birth experience of the mother, and the influence of friends, family and doctors, social class and cultural values. Other authors have identified that a strong moral agenda operates when women choose birth in a non-traditional setting and that women have to deal with accusations of irresponsibility, or conflicting advice and 'cultural ambiguity' from a maternity service that in theory at least, supports home birth. This body of work has largely focused on 'home birth mothers' as a minority and exceptional group, and apart from a few exceptions, more generally, there is an indication that the model of care on offer is an important factor. Longworth found that women who had chosen a home birth valued continuity of care, a homely environment and the ability to make their own decisions about what happens during labour and delivery.

	<u>Service provision:</u> It is also unclear to what extent the expansion of MLU and birth at home can help meet the needs of individuals and communities that have been traditionally under- served, or have lost consultant services. There is a need to investigate what kind of features work in practice to ensure equity of access. <u>Philosophy of care provision etc:</u> The health geographies literature has problematised the role of the 'home' as a desirable site for healthcare, suggesting that it may not enable 'patients' to retain control in the face of clinical practice in the home. There is also a question as to how far we should assume that home is an inevitable place of safety, empowerment, autonomy or bodily control for women Recognised ideological differences have implications for the safety of care, and impact on the experiences of staff and labouring women needs further exploration. Suggests that issues of power and culture may be relevant to risk and safety and that inter-personal or professional issues may influence professional behaviour and decision-making
What helps women?	<u>Choice of birth place locations:</u> Women being aware that choice of birthplace was possible, and having sources of evidence-based information on which to base choices. Positive previous experience and that of other women that they knew. Women who did exercise more agency had greater access to information, skills and confidence in asking for the choices they wanted, and had the support of family friends and health professionals in doing so. Sufficient service provision

	Plans to assist access to services for those who are not usually able to access services <u>Delivery of care:</u> Support for midwives Integration of midwives so they did not feel isolated when working at home – working across community and hosp. care location effective here. Helped to maintain all skills. Effective and safe transfer was contingent on good communication systems, clear guidelines that were used appropriately to support decision-making, trusting and respectful relationships between staff groups, management of conflict over resources, and the confidence and competence of professionals. <u>Women's experiences of escalation and transfer:</u> Most women were prepared for the unpredictability of events in childbirth. Clear and careful explanation of events by professionals was a common theme that ran through women's positive narratives about escalation. Trust in professionals was an important aspect of feeling safe, physically and psychologically. Attitude towards women when expressing preferences and choices – respectful approach
What does not help women?	<u>Choice of birth place locations:</u> Some women were not aware that choice of birthplace was possible, and lacked sources of evidence-based information on which to base choices. Women's views of safe care were influenced by negative experiences and no women to discuss / learn from The prospect of intrapartum transfer was a major consideration when women made a decision around place of birth, and women often cited concerns about transfer distance as reasons for planning labour in hospital.

	Lack of agency re accessing info Lack of integration to facilitate women from excluded groups accessing services <u>Delivery of care:</u> Staffing issues in community Less attention [than given to FSMLU midwives] to the needs of midwives working in AMUs or community midwives providing home births, some of whom attended very few births each year. Community midwives appeared to be less integrated in such processes, and some reported a sense of isolation and exposure when attending births at home. <u>Women's experiences of escalation and transfer:</u> Some women's experience of transfer and escalation was characterised by feelings of worry, disempowerment or disappointment Some women described difficulty in being listened to when they raised concerns about complications they had noticed themselves, while concerns about medicalisation or previous negative birth experiences led women to avoid intervention in some cases, or request it in others. A few professionals viewed service users as both 'risky' and 'demanding' and consequently were less open to listening to their views, which were often not seen as relevant to safety <u>Decision making: (Discussion – overview of published literature)</u> Previous authors have identified that a strong moral agenda operates when women choose birth in a non-traditional setting and that women have to

	deal with accusations of irresponsibility, or conflicting advice and 'cultural ambiguity' from a maternity service that in theory at least, supports home birth. This body of work has largely focused on 'home birth mothers' as a minority and exceptional group, and apart from a few exceptions, more generally, there is an indication that the model of care on offer is an important factor. Longworth found that women who had chosen a home birth valued continuity of care, a homely environment and the ability to make their own decisions about what happens during labour and delivery. <u>Service provision: (Discussion – overview of published literature)</u> It is also unclear to what extent the expansion of MLU and birth at home can help meet the needs of individuals and communities that have been traditionally under- served, or have lost consultant services. There is a need to investigate what kind of features work in practice to ensure equity of access.
Aimed at increasing home birth rates?	No

Appendix 13 – Scoping review example of coding

What helps/ helped women to choose planned home birth?

Relationship with midwife (wanting to develop/ have developed)

The women said that they 'trusted their midwife' (Ng and Sinclair 2002)

The women who chose home birth were more likely to have been visited regularly by the same midwife, and a reason for choosing home birth was that 'the midwife discussed' with them. Even if they did not have the same midwife for the birth it was important to the women to know that the team 'knew about them, and were all nice, confident and professional' (Watts et al 2003)

All visits made at home so helped midwife to get to know the family (McLaughlin 2006)

Parratt and Fahy (2004) show that women who felt safe at home had formed a relationship with an autonomous midwife over a period of time and had become familiar with, and was able to respect, the woman's particular situation and thus provided 'true woman centred care'.

Newburn (2003) writes that it was envisaged by policy makers that increasing the numbers of women experiencing continuity of care and the opportunities to make informed choices would increase the number of home births, by changing the pattern of provision.

Munday (2003) states that 'the trust engendered and the confidence inspired by having continuity of care and carer were all seen as important parts of the role and the relationship with the midwife'

Janssen et al (2009) found that an overriding theme noted by the 500 women who experienced a home birth in Canada was "the confidence that clients had in the ability of their midwives to take care of them". They felt that the midwives knew about evidence based care and had a high professional competence. This was coupled with a strong sense of receptivity to the "input, wishes and choices of both the women and their partners". Women seemed to know the criteria for competence that they understood, and were "waiting for them to be demonstrated".

Davis (2008) describes how being a member of the One to One team in Sheffield, which provided antenatal, intrapartum and postnatal care to women in her caseload, enabled her to "build a unique relationship of trust which stood us in great stead for labour", and that she "always felt very involved and responsible for the care I gave my women".

The reputation of their midwife often helped women to "finally decide" on a home birth (Dahlen et al 2008), based on the reputation of knowledge of the midwife.

Women planning home birth wanted to be looked after by "known carers" (Coxon et al 2013)

The midwives were "very influential to the women's choice as they shared information and allayed fears" (Catling-Paull et al 2011)

"An interaction of provider and user behaviour may be driving place of birth decisions" (Brintworth et al 2013)

Appendix 14 – Scoping review codes under the resultant study themes

Resultant themes (1-4)	What helps	What does not help
The influence of a woman's individual social context	Health	Negative comments/views from others (lay people and health professionals)
	Marital status	Negative views from partners
	Race	Negative views from close family
	Social class/ household income	Age
	Education	Parity
	Parity	Medicalised birth culture (in UK) – giving impression that hospital birth is safer
	Age	Wider social impact
	Friends / colleagues influence	Local area
	Supportive partner	Media influence
	Culture	
How a woman views birth	Previous poor (hospital) birth experience/ fear of hospitals	Preferring what they had done before
	Birth technology	Assumption that home birth is a lifestyle choice/ not the norm
	Identity as a woman	Risk during birth for the fetus
	Safety and risks	Assumption of hospital birth
	Birth expectations	Pain relief availability

	Wanting relaxed and familiar environment	Transfer needs
	Childcare/ not wanting to leave other children	Medicalised birth culture (in UK) – giving impression that hospital birth is safer
	Previous sexual abuse	Safety and risk of home birth
	Still birth	Birth expectations
	Idea that risks are not confined to home birth	
	Previous experience of home birth	
The context of the maternity service care provision	Relationship with their midwife / anticipation of this	Information levels
	Early labour assessment at home	Low home birth rates
	Midwifery service provision	Negative comments/views from others (lay people and health professionals)
	Midwifery leadership	Midwifery staffing levels
	Home birth groups/ women + partners talking to other women etc	Stand-alone MLU have advantages over home
		Knock on effects of midwifery inexperience
		Conflict between professional groups/ within professional groups
The influence of the midwifery care	Midwife raised idea of home birth	Women not able to access their rights to a home birth
	Confidence in midwives to provide effective clinical care	Information levels

that a woman receives	Joined up working with maternity professionals	Lack of knowledge about childbirth choices
	Normal birth is important	Assumption of 1st birth needing to be in hospital
	The way midwives talk about home birth	Negative comments/views from others (lay people and health professionals)
	Aware of choice of home birth	Midwives role/ midwifery service provision
	Information gathering	Perception of the midwife's role
	Timing of decision making	Timing
	Felt had genuine choice	Difficult to change their mind on birth places

Appendix 15 – Scoping review included articles

No	Author and title	Methods	Participants	Country	Theme(s)
1	Andrews, A. (2004a). Home birth experience 1: decision and expectation. *British Journal of Midwifery*, 12(8), 518-523	Interview	8 women who planned home birth	UK	1, 2, 3
2	Andrews, A. (2004b). Home birth experience 2: births/postnatal reflections. *British Journal of Midwifery*, 12(9), 552-557.	Interview	8 women who planned home birth	UK	1
3	Angha, A. & Scaer, R. (2008). Water birth at home: two perspectives. *Journal of Perinatal Education*, 17, 4-8.	Personal anecdote	Birth activist and her daughter, a new mother, discuss her home water birth	USA	1, 2, 3
4	Anthony, S., Buitendijk, S., Offerhaus, van Dommelen, P. & Bruin, K. (2005) Maternal factors and the probability of a planned home birth. *BJOG: An International Journal of Obstetrics & Gynaecology*, 112(6), 748-753.	Cross-section study	160,329 women starting care under a midwife	Neth.	1
5	Arcia, A. (2015). US Nullipara's reasons for expected provider type and childbirth setting. *The Journal of Perinatal Education*, 24, 61-72.	220 nulliparous women – most choosing hospital birth	Questionnaire	USA	1, 2, 3
6	Ashley, S. & Weaver, J. (2012a). Factors influencing multiparous women to choose a home birth -an exploratory study. *British Journal of Midwifery,* 20(10), 710-715.	Interview	8 multiparous who have previously had a hospital birth	UK	1, 2, 3
7	Ashley, S. & Weaver, J. (2012b). Factors influencing multiparous women who choose a home birth --a literature review. *British Journal of Midwifery*, 20, 646-652.	Systematic review	Articles		1, 2, 3

8	Bailes, A. & Jackson, M. (2000). Professional issues. Shared responsibility in home birth practice: collaborating with clients. *Journal of midwifery & women's health*, 45 (6), 537-543.	Professional discussion	Practising Midwives	USA	1, 2, 3
9	Ball, C. (2014). *Homebirth in WA: why women make this choice*. (Masters dissertation), Edith Cowan University: Perth	135 AN women intending PHB (50 nullips, 85 parous)	Questionnaire	Aus	1,2, 3
10	Beake, S. & Bick, D. (2007). Maternity services policy: does the rhetoric match the reality? *British Journal of Midwifery*, 15(2), 89-93.	Questionnaire	9 NHS Trusts in England	UK	3, 4
11	Bedwell, C., Houghton, G., Richens, Y. & Lavender, T. (2011). 'She can choose, as long as I'm happy with it': A qualitative study of expectant fathers' views of birth place. *Sexual and Reproductive Healthcare*, 2(2), 71-75.	Interviews	19 expectant fathers – all planning hospital births	UK	1,2, 3
12	Benjamin, Y., Walsh, D. & Taub, N. (2001). A comparison of partnership caseload midwifery care with conventional team midwifery care: labour and birth outcomes. *Midwifery*, 17(3), 234-240.	Prospective, non-randomised clinical trial	303 in experimental group; 308 in control group	UK	3
13	Bernhard, C., Zielinski, R., Acherson, K. & English, J. (2014). Home birth after hospital birth: women's choices and reflections. *Journal of midwifery and women's health*, 59(2), 160-166.	20 women who had PHB after hospital birth	Focus groups	USA	1,2, 3, 4
14	Bick, D. (2012). Place of birth in England: Still a contentious issue? *Midwifery*, 28(1), 1-2.	Professional discussion	Midwife academic	UK	3
15	Bliss, A. (2010) My Albany. *The Practising Midwife*, 13, 19.	Personal anecdote	Midwife discussing her	UK	3

			daughter's care experience		
16	Blix, E. (2011). Avoiding disturbance: Midwifery practice in home birth settings in Norway. *Midwifery*, 27(5), 687-692.	Interview	12 midwives	Norway	3
17	Bogdan-Lovis, E. & Vries, R. D. (2013). Ethics and the architecture of choice for home and hospital birth. *The Journal of Clinical Ethics*, 24(3), 192-197.	Professional discussion	Academics in the field of ethics	USA	2, 3, 4
18	Boucher, D, Bennet, C., Macfarlin, B. & Freeze, R. (2009). Staying home to give birth: why women in the United States choose home birth. *Journal of midwifery & women's health*, 54(2), 119-126.	Online survey	160 women who had each planned home birth at least once, most within last 5 years	USA	1,2, 3, 4
19	Bourke, G. (2013). *Support overdue: Women's experiences of maternity services*. The National Federation of Women's Institutes. Retrieved from https://www.thewi.org.uk/campaigns/current-campaigns-and-initiatives/more-midwives?a=49857	Questionnaire	>5,5000 women members of the WI - ¾ of the women had given birth in 2012	UK	1, 4
20	Brintworth, K. & Sandall, J. (2013). What makes a successful home birth service: An examination of the influential elements by review of one service. *Midwifery*, 29(6), 713-721.	Interviews Analysis of maternity service data	Midwives, managers and 3 obstetricians Data analysis	UK	1, 3, 4
21	Brodie, P. (2012). Homebirth in Newham. *Midwifery Matters*, Spring (132), 20.	Professional discussion	Home birth team midwife	UK	3, 4
22	Brown, L. (2006). Service improvement award. *Midwifery Matters*, Spring, 6.	Professional anecdote	Midwife	UK	1, 3, 4
23	Budin, W. (2009). Witnessing a natural, safe and healthy birth. *Journal of Perinatal Education,* 18(3), 1-3.	Professional anecdote	Childbirth educator discussing a PHB	USA	1

			she had witnessed		
24	Budin, W. (2013). Where to give birth. *Journal of Perinatal Education,* 22(3), 127-129.	Professional discussion	Childbirth educator	USA	1, 2
25	Care Quality Commission (2013). *National findings from the 2013 survey of women's experiences of maternity care.* Retrieved from http://www.nhssurveys.org/Filestore/MAT13/MAT13_maternity_report_for_publication.pdf.	Survey	23,000 women	UK	3
26	Carter, E. (2012). Homebirth in Newham. *Midwifery Matters*, Spring (132), 18-19.	Practising Midwife	Professional anecdote care at PHB	UK	1, 3, 4
27	Catling-Paull, C., Dahlen, H. & Homer, C. (2011). Multiparous women's confidence to have a publicly-funded homebirth. *Women and Birth*, 24(3), 122-128.	Interview	10 multiparous women	Aus	1, 2, 3, 4
28	Catling, C., Dahlen, H. & Homer, C. (2014). The influences on women who choose publically-funded home birth in Australia. *Midwifery*, 30(7), 892-898.	Interview	17 PN women (7 primips, 10 multips)	Aus.	1, 2, 3, 4
29	Chadwick, J. & Foster, D. (2013). Technologies of gender and childbirth choices: Home birth, elective caesarean and white femininities in South Africa. *Feminism and Psychology*, 23(3), 317-338.	Interview	21 women (12 planning home birth)	South Africa	1, 2
30	Chadwick, R. & Foster, D. (2014). Negotiating risky bodies: childbirth and constructions of risk. *Health, Risk and Society*, 16(1), 68-83.	Interview	24 women	South Africa	1, 2, 4

31	Chamberlain, G., Wraight, A. & Crowley, P. (1999). Birth at home: a report of the national survey of home births in the UK by the National Birthday Trust. *Practising Midwife*, 2, 35-39.	Prospective survey	6000 women planning home births 4,700 women planning hospital births	UK	1, 2, 3
32	Cheyney, M. (2011). *Born at home, the biological, cultural and political dimensions of maternity care in the United States* (1st ed.). Belmont: Wadsworth Learning.	Interviews	Women planning PHB	USA	1, 2, 3
33	Christiaens, W., Verhaeghe, M. & Bracke, P. (2008). Childbirth expectations and experiences in Belgian and Dutch models of maternity care. *Journal of Reproductive and Infant Psychology*, 26(8), 309-322.	Questionnaire	611 women	Neth. & Belg.	2
34	Barbour Johnson, C. & Davies-Floyd, R. (2006) Home to hospital transport: fractured articulations or magical mandorlas? In Mainstreaming midwives: the politics of change. Edited by Barbour Johnson, C. & Davies-Floyd, R. (2006) pp. 469-507 Routledge: London	Interviews	Women who planned home births that required transfer to hospital	USA	1,2,3,4
35	Collins, M. & Kingdon, C. (2014). One to one midwives: first-year outcomes of a midwifery-led care model. *British Journal of Midwifery*, 22(1), 15-21.	Service evaluation - quantitative	Evaluation of One-to-One midwifery service	UK	1, 3, 4
36	Coxon, K. (2012). Birth Place Decisions. A prospective, qualitative study of how women and their partners make sense of risk and safety when choosing where to give birth. (Doctor of Health Studies Research PhD) Kings College London: London	Longitudinal, narrative interviews	41 women, 15 partners	UK	1, 4

37	Coxon, K., Sandall, J. & Fulop, N. (2013). To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions. *Health, Risk and Society*, 16(1), 51-67.	Longitudinal, narrative interviews	41 women, 15 partners	UK	1, 2, 3
38	Coxon, K., Sandall, J. & Fulop, N. (2015). How do pregnancy and birth experiences influence planned place of birth in future pregnancies? Findings from a longitudinal, narrative study. *Birth: Issues in perinatal care*, 42(2), 141-148.	Longitudinal, narrative interviews	41 women, 15 partners	UK	1, 2, 3,
39	Coxon, K. (2014b). Risk in pregnancy and birth: are we talking to ourselves? Health, Risk and Society, 16, 481-493.	Professional discussion	Academic midwife	UK	1, 2, 3
40	Craig, R. (2010). Birth from the other side. Midwifery Matters, Spring, 10-12.	Service user / Practising Midwife	Personal anecdote of her home birth	UK	1, 3, 4
41	Dabrowski, R. (2012). Travelling into the unknown. *Midwives*, 15(1), 36-38.		(Dabrowski, 2012)	UK	3, 4
42	Dagustun, J. (2009). *Working paper. Why do so few women give birth at home? Interpreting place in childbirth discourse.* Research summary. School of Geography Working Paper Series. Retrieved from: http://www.geog.leeds.ac.uk/research/csap/outputs/workingpapers/.	Interviews	13 women planning birth in all birth place options (discussing 26 births in total)	UK	1, 2, 3
43	Dagustun, J. (2011). Normalising home birth. *AIMS Journal*, 23(1), 4-5.	Professional discussion	Academic	UK	1, 3, 4
44	Dahlen, H., Barclay, L., & Homer, C. (2008). Preparing for the first birth: mothers' experiences at home and in hospital in Australia. Journal of Perinatal Education, 17(4), 21-32.	Interviews	19 women (7 planning home births)	Aus	1, 2, 3

45	Dahlen, H., Barclay, L., & Homer, C. (2010). 'Reacting to the unknown': experiencing the first birth at home or in hospital in Australia. Midwifery, 26(4), 415-423.	Interviews	19 women (7 planning home births)	Aus	1, 2, 3
46	Dancy, R. & Fullerton, J. (1995). Preparing couples for home birth. *Journal of Nurse-Midwifery*, 40(6), 523-528.	Professional discussion	CNMs and childbirth educators	USA	3
47	Davies-Floyd, R. & Davis, E. (1996) Intuition as Authoritative Knowledge in Midwifery and Homebirth	Interviews	22 Midwife members of MAMA	USA and Canada	3
48	Davis, W. (2011). Working on the 'One to One' team. Personal experiences and perspectives. *Midwifery Matters*, Winter(131), 8.	Professional anecdote	Practising PHB team Midwife	UK	1, 3, 4
49	Difilippo, S. (2015). Resistance and relearning: women's experiences choosing midwifery and home birth in Ontario, Canada. *The Canadian journal for the study of adult education*, 27(3), 43-63.	Interview	21 PN women who had PHB	Canada	1, 2, 3
50	Dobson, C. (2009). My home birth. *Midwifery Matters*, Autumn (122), 19.	Personal anecdote	Service user	UK	1, 3
51	Dodwell, M., & Gibson, R. (2009a). *Location, location, location: making choice of place of birth a reality*. Retrieved from https://www.nct.org.uk/sites/default/files/related_documents/PlaceofBirthFINALFORWEBv2-1.pdf	Data analysis	Maternity service data	UK	4
52	Dodwell, M., & Gibson, R. (2009b). *An investigation into choice of place of birth*. Retrieved from https://www.nct.org.uk/sites/default/files/related_documents/Choice%20of%20Place%20of%20birth%202009%20Dodwell%20and%20Gibson.pdf	Data analysis	Maternity service data	UK	4

53	Edwards, N. (2005). *Birthing autonomy. Women's experiences of planning home births*. Oxon: Routledge.	Interviews and observation	Women planning a home birth	UK	1, 3, 4
54	Edwards, A. (2008). Place of birth: can 'Maternity Matters' really deliver choice? *British Journal of Midwifery*, 16(12), 771-775	Professional discussion	Midwifery lecturer	UK	3, 4
55	Edwards, N. (2008a). Negotiating a normal birth. *AIMS Journal*, 20, 5-8.	Professional discussion	Academic Midwife researcher	UK	1, 2, 3, 4
56	Edwards, N. (2008b). Safety in birth: the contextual conundrums faced by women in a "risk society', driven by neoliberal policies. *MIDIRS Midwifery Digest*, 18(4), 463-470.	Professional discussion	Academic Midwife	UK	1, 3
57	Edwards, J. (2009). Reclaiming a home birth - midwives supporting women. Midwifery Matters, Autumn, 13-14.	Professional anecdote	Practising PHB team Midwife	UK	1, 2, 3, 4
58	Ferreira Lessa, H., Rubio Tyrell, M. A., Herdy Alves, V. & Pereira Rodrigues, D. (2014) Information for the option of planned home birth: women's rights to choose. *Text Context Nursing*, 23(3), 665-672.	Interviews	17 women who had given birth at home (13 primiparous)	Brazil	1, 2, 3
59	Finigan, V. & Chadderton, D. (2015). Facilitating home birth. *The Practising Midwife*, 18(6), 27-30	Midwives	Professional discussion	UK	3, 4
60	Fleming, A., Birch, J., Booth, C., Cooper, J., Darwin, J., Grady, A. & Downe, S. (2007). Narratives from the Blackburn West caseholding team: success stories. *British Journal of Midwifery*, 15(6), 337-341.	Case study of midwifery team	Midwife team leader	UK	3, 4
61	Floyd, L. (1995). Community midwives' views and experience of home birth. *Midwifery*, 11(1), 3-10.	Quest Interview	44 Community Midwives	UK	3, 4

62	Fraser, J. (2013). A risky business. *Midwives*, 16(6), 50-52.	Professional discussion	Student Midwife	UK	1, 2
63	Furlong-Davies, S., & McAleese, S. (2008). Sara's story. *Midwifery Matters*, Summer (117), 5-6.	Personal anecdote of the care episode	Service User and Practising Midwife	UK	1, 3, 4
64	Gannon, M. (2005) Birth of a midwife. *RCM Midwives*, Supplement 8: 6-7	Personal anecdote of her PHB	Practising Midwife	UK	1, 2
65	Geneviev, L. (2014). Passions of my life: birth and food! *Midwifery Matters*, Summer, 17-18.	Midwife	Personal anecdote	UK	3
66	Gibbons, N. (2015). Nora's story. *The Journal of Perinatal Education,* 24(1), 6-7.	Personal anecdote	16 year old sister – present at several PHBs of siblings	USA	1, 2, 3
67	Gifford, K. (2003). Deep cover (or being a community midwife in Nottingham). *Midwifery Matters,* Winter, 2-3.	Professional anecdote	Community Midwife	UK	1, 3
68	Godfrey, M. (2010). *Influencing factors on first time mothers in their decision making process in planned home births.* (PhD dissertation) Colorado State University: Boulder	Interviews and diary entries	9 women who planned home birth	USA	1, 2
69	Goldstein, R. (2012). Jonah's birth. *Journal of Perinatal Education*, 21(3), 138-144.	Personal anecdote	Service user discusses her home birth	USA	1, 2, 3
70	Goldstein, J. (2015). Amid fear and controversy, a doctor chooses a home birth. *Health Affairs*, 34(6), 1057-1060	Personal anecdote	Service user discusses her home birth	USA	1, 2, 3, 4
71	Grace, N. (2014). A baby came out of my vagina!!! At home!!!! Or how we do birth at Nottingham Home Birth Group. *Midwifery Matters,* Spring, 5-6.	Professional anecdote	Midwife Home Birth group leader, (and group members)	UK	1, 2, 3

72	Green, T. (2015). Empowering home birth - a student's perspective. Midwifery Matters, Spring, 13-17.	Professional anecdote	Student midwife	UK	1, 2, 3
73	Griffiths, J. (2010). Home births: midwives versus doctors? Midwives, 13, 14.	Professional discussion	RCM General Secretary	UK	4
74	Griffiths, J. (2015a). Remote control. Midwives, 57-59.	Professional discussion	Midwives professional discussions about remote practice	UK	3, 4
75	Griffiths, J. (2015b). What's changed? Midwives, Spring, 62-65.	Professional discussion	Summary of new NICE guidance	UK	3
76	Hagelskamp, C., Scammell, A., Gray, J. & Stephens, L. (2003). Staying home for birth: do midwives and GPs give women a real choice? *RCM Midwives*, 6(7), 300-303.	Questionnaire	22 midwives 60 GPs	UK	3
77	Halton, J. (2006). The Wigan home birth group, Midwifery Matters, *Midwifery Matters*, Spring (108), 3-4.	Personal anecdote	Home birth group leader	UK	1, 2
78	Hildingsson, I., Waldenström, U. & Rådestad, I. (2003). Swedish women's interest in home birth and in-hospital birth center care. *Birth: Issues in Perinatal Care*, 30(1), 11-22.	Questionnaire	3283 women	Sweden	1, 2
79	Hildingsson, I., Lindgren, H., Haglund, B., & Rådestad, I. (2006). Characteristics of women giving birth at home in Sweden: a national register study. *American Journal of Obstetrics and Gynecology,* 195(5), 1366-1372.	Quest.	352 women planning home births. 1760 women giving birth in hospital	Sweden	1
80	Hildingsson, I., Rådestad, I. & Lindgren, H. (2010). Birth Preferences that Deviate from the Norm in Sweden: Planned Home Birth	Quest.	671 women planning home birth and 126 planning El C/S	Sweden	1, 2, 3

	versus Planned Caesarean Section. *Birth: Issues in Perinatal Care*, 37(4), 288-295.				
81	Hoang, H., Le, Q., Kilpatrik, S., Jona, M. & Fernando, N. (2013). The commonalities and differences in health professionals' views on home birth in Tasmania, Australia: A qualitative study. *Women and Birth*, 26(1), 55-59.	Interview	20 maternity health providers	Aus.	3
82	Hollowell, J., Chisholm, A., Yangmei, L. & Malouf, R. (2015). *Evidence review to support the National Maternity Review 2015. Report 4: A systematic review and narrative synthesis of the quantitative and qualitative literature on women's birth place preferences and experiences of choosing their intended place of birth in the UK.* National Perinatal Epidemiology Unit: Oxford.	Systematic review and narrative synthesis	Quantitative and qualitative studies exploring birth place decision making		2, 3, 4
83	Hosein, M. (1998). Research. Home birth: is it a real option? *British Journal of Midwifery*, 6, 370-373.	Interviews	Community midwives	UK	3, 4
84	Houghton, G., Bedwell, C., Forsey, M., Baker, L., & Lavender, T. (2008). Factors influencing choice in birth place -- an exploration of the views of women, their partners and professionals. *Evidence Based Midwifery*, 6(2), 59-64.	Interviews and observations	50 women and partners. Longitudinal from AN period to PN	UK	1,2,
85	Howe, E. (2013). When a mother wants to deliver with a midwife at home. *The Journal of Clinical Ethics*, 24(3), 172-181.	Professional discussion	Professor of Ethics	USA	1, 2, 3
86	Hundley, V., Rennie, A., Fitzmaurice, A., Graham, W., van Teijlingen, E. & Penny, G. (2001) A national study of women's views of their maternity care in Scotland. *Midwifery* 16(4): 303-313	Questionnaire	1152 PN women	UK	3

87	Jackson, M., Dahlen, H. & Schmied, V. (2012). Birthing outside the system: Perceptions of risk amongst Australian women who have freebirths and high risk homebirths. *Midwifery*, 28(5), 561-567.	Interview	20 women: 9 who were either low risk and free-birthed at home; 11 had a 'high risk' PHB with Midwife	Aus.	1, 2
88	Janssen, P., Henderson, A. & Vedam, S. (2009). The experience of planned home birth: views of the first 500 women. *Birth: Issues in Perinatal Care*, 36(4), 297-304.	Questionnaire	559 women who had planned home birth in previous 2 years	Canada	1 ,2, 3, 4
89	Jennings, C. (2005). Midwife as mother, midwife as client. *Midwifery Matters*, Autumn (106), 18-21.	Personal anecdote	Midwife experience of her own PHB	UK	1, 3
90	Jervis, B. (2014). Home birth? Yes Please! Facilitating home birth within the NHS. *Midwifery Matters*, Spring, 8-11.	Professional anecdote	Previous home birth team midwife	UK	1, 3, 4
91	Jimenez, V., Klein, M., Hivon, M., & Mason, C. (2010). A mirage of change: Family-centred maternity care in practice. *Birth: Issues in Perinatal Care,* 37(2), 160-167.	Longitudinal interviews	36 women, before and after birth	Canada	1, 2, 3
92	Jouhki, M. (2012). Choosing homebirth – The women's perspective. *Women and Birth*, 25(4), e56-61.	Interviews	10 women who had had a PHB	Finland	1, 2, 3
93	Jowitt, M. (2014). Birth - a pas de deux. *Midwifery Matters*, Summer, 7-9.	Personal anecdote	Midwife discussing her PHB experience	UK	1
94	Kemp, J. & Sandall, J. (2010). Normal birth, magical birth: the role of the 36-week birth talk in caseload midwifery practice. Midwifery, 26(2), 211-221.	Interviews and observations	5 Caseholding Midwives, 5 couples	UK	1, 3, 4
95	Kightley, R. (2007). Delivering choice: where to birth? British Journal of Midwifery, 15(8), 475-478.	Professional discussion	Midwifery lecturer	UK	3

96	Kontoyannis, M. & Katsetos, C. (2008). What influences women in Athens to choose home birth? *British Journal of Midwifery*,16(1), 44-48.	Interview	12 women who had planned home births	Greece	1, 2, 3, 4
97	Kornelsen, J. (2005). Essences and imperatives: an investigation of technology in childbirth. *Social science and medicine*, 61(7), 1495-1504.	Interviews	50 women (25 PHB and 25 hospital birth)	Canada	1, 2, 3
98	Lavender, T., & Chapple, J. (2005). How women choose where to give birth. *Practising Midwife*, 8(7), 10-15.	Questionnaire	2902 AN women	UK	1, 2, 3
99	Law, S., Brown, M., Mccalmont, C., Lees, S., Mills, N., Mcgregor, F. & Thunhurst, C. (2009). Ensuring the choice agenda is met in the maternity services. *MIDIRS Midwifery Digest*, 19, 311-317.	Professional discussion	Academic and practising Midwives	UK	1, 3, 4
100	Lindgren, H., Hildingsson, I., & Radestad, I. (2005). A Swedish interview study: Parents' assessments of risks in home birth. *Midwifery*, 22(1), 15-22.	Interviews	5 couples who had planned home births	Swe.	2, 3
101	Lindgren, H. & Erlandsson, K. (2010). Women's Experiences of Empowerment in a Planned Home Birth: A Swedish Population-based Study. *Birth: Issues in Perinatal Care*, 37(4), 309-317.	Questionnaire	735 women who had given birth at home	Sweden	1, 3
102	Lindgren, H. & Erlandsson, K. (2011). She leads, he follows - Father's experiences of a planned home birth. A Swedish interview study. *Sexual and Reproductive Healthcare,* 2(2), 65-70.	Interviews	8 Swedish fathers, who's babies had been born at home	Sweden	1
103	Lindgren, H., Rådestad, I., Christensson, K., Wally-Bystrom, K., & Hildingsson, I. (2010). Perceptions of risk and risk management among 735 women who opted for a home birth. *Midwifery*, 26(2), 163-172.	Questionnaire	735 women who had given birth at home	Sweden	1, 2, 3

104	Longworth, L., Ratcliffe, J. & Boulton, M. (2001). Investigating women's preferences for intrapartum care: home versus hospital births. *Health and Social Care in the Community*, 9(2), 404-413.	Focus groups	10 home and 10 hospital birth choosers	UK	2, 3
105	Lothian, J. (1995). Questions from our readers. Home birth: how can the information be included in class? *Journal of Perinatal Education*, 4, v-vi.	Professional discussion	Childbirth educator	USA	3
106	Lothian, J. (2002). Questions from our readers: Home birth: safely protecting and supporting normal birth. *Journal of Perinatal Education*, 11, xiii-xvi.	Professional discussion	Childbirth educator	USA	1, 3
107	Lothian, J. (2010). How do women who plan home birth prepare for childbirth? Journal of Perinatal Education, 19(3), 62-67.	Interview	13 women planning home birth	USA	1, 2, 3
108	Lothian, J. (2013). Being safe: Making the decision to have a planned home birth in the United States. The Journal of Clinical Ethics, 24(3), 266-275.	Interview	13 women planning home birth	USA	1, 2, 3
109	Lowden, G. (2012). Who makes which decision? *AIMS Journal*, 24, 7-10.	Professional discussion	Academic	UK	1, 3, 4
110	Lundgren, I. (2010). Women's experiences of giving birth and making decisions whether to give birth at home when professional care at home is not an option in public health care. *Sexual and Reproductive Healthcare*, 1(2) 61-66.	Interviews	7 women who had planned home births	Sweden	1, 2
111	MacDorman, M., Declercq, E. & Menaker, F. (2011) Trends and characteristics of home births in the United States by race and ethnicity, 1990-2006. *Birth*. 38(1):17-23	2ndary data analysis of birth register data	Birth register 1990 - 2006	USA	1
112	MacDorman, M., Declercq, E., & Matthews, T. (2013). Recent Trends in Out-of-Hospital Births in the United States. *Journal of*	2ndary data analysis of	Birth register 2004-2010	USA	1

	midwifery & women's health, 58(5), 494-501.	birth register data			
113	Madden, E. (2005). A birth vision. Midwives, 8, 68-71.	Professional anecdote	Practising midwife	UK	1, 2, 3
114	Madi, B. (2001). *Women's decision making and factors affecting their choice of place of delivery: systematic review and qualitative study*. (PhD dissertation), University of Surrey: Guilford	Interview	33 low risk women, 20 – hospital, 13 - home	UK	1, 2, 3
115	Madi, B. & Crow, R. (2003). A qualitative study of information about availability options for childbirth venue and pregnant women's preference for a place of delivery. *Midwifery,* 19(4), 328-336.	Interview	33 low risk women, 20 – hospital, 13 - home	UK	1, 2, 3
116	Magri, K. (2012). Help, I'm a guy! Homebirth from a man's point of view. *Midwifery Today*, Winter(104), 46-47.	Personal anecdote	PN PHB father	USA	1
117	Mander, R. (2015). The 'madness' of home birth. The Practising Midwife, June, 42.	Academic midwife	Personal discussion	UK	2, 3
118	Mander, R. & Melender, H. (2005). Birth settings and pain control trends among women in Finland. *British Journal of Midwifery*, 13(8), 504-509.	Narrative literature review	Academic Midwives	Finland	3, 4
119	Mastroianni, C. (2012). Ella's birth: The Student's Tale. Midwifery Matters, Spring, 21.	Professional anecdote	Student midwife	UK	1
120	McCourt C.,Rance S.,Rayment J.,Sandall J. (2011) Birthplace qualitative organisational case studies: How maternity care systems may affect the provision of care in different birth settings. Birthplace in England research programme. Final report part 6. NIHR Service Delivery and Organisation programme	Organisation case studies	Service users Midwives Obstetricians Management	UK	1, 2, 3, 4

121	McCutcheon, R., & Brown, D. (2012). A qualitative exploration of women's experiences and reflections upon giving birth at home. Evidence Based Midwifery, 10(1), 23-28.	Interview	9 women	UK	1, 2, 3, 4
122	McLaughlin, T. (2006). Caseholding in south London. *Midwifery Matters* (110), 3-4.	Professional discussion	Community midwife	UK	3, 4
123	McMurtrie, J., Catling-Paull, C., Teate, A., Caplice, S., Chapman, M., & Homer, C. (2009). The St. George Homebirth Program: an evaluation of the first 100 booked women. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, 49(6), 631-636.	Questionnaire	100 women	Aus	1
124	McNutt, A., Thornton, T., Sizer, O., Curley, A. & Clarke, P. (2014). Opinions of UK perinatal health care professionals on home birth. *Midwifery*, 30(7), 839-846.	Questionnaire – Likert scales and free text responses	432 professionals – 224 midwives, 148 GPs, 32 Obs, 28 Paeds / Neonatologists	UK	3, 4
125	Merg, A. & Carmoney, P. (2012). Phenomenological experiences: homebirth after hospital birth. *International Journal of Childbirth Education*, 27(4), 70-75.	Interview	11 women	USA	1, 2, 3
126	Mills Shaw, M. (2009). A day in the life of a home birth lead. *RCM Midwives*, April/May, 58.	Professional anecdote	Home birth lead midwife	UK	3, 4
127	Milner-Smith, L. (2010). A Student's quest for the holy grail. *Practising Midwife*, 13, 46.	Professional discussion	Student Midwife	UK	3
128	Mitchell-Merril, N. (2006). The Alabama Birth Study: a statistical analysis of home birth midwives and childbirth education -- 1980 to 2000. *International Journal of Childbirth Education*, 21(3), 30-32.	Questionnaire	(Home birth) Childbirth educators in Alabama	USA	3

129	Morison, S. (1996). *A phemonological study of the home birth experience - the couple's perspective.* (PhD dissertation), Edith Cowan University: Perth	Interview	10 parent couples who had PHB	Aus	1, 2, 3
130	Morison, S., Hauck, Y., Percival, P. & McMurray, A. (1998). Constructing a home birth environment through assuming control. *Midwifery*, 14(4), 233-241.	Interview	10 parent couples who had PHB	Aus	1, 2, 3
131	Morison, S., Percival, P., Hauck, Y. & McMurray, A. (1999). Birthing at home: the resolution of expectations. *Midwifery*, 15(1), 32-39.	Interview	10 parent couples who had PHB	Aus	1, 2, 3
132	Mottram, L. (2008). First-time expectant fathers and their influence on decision making regarding choice for place of birth. *MIDIRS Midwifery Digest,* 18(4), 582-589.	Interviews	5 expectant fathers	UK	1, 4
133	Munday, R. (2003a). Women's experiences of the postnatal period following planned homebirth: a phenomenological study. *MIDIRS Midwifery Digest*, 13, 371-375.	Interview	10 women who had had a PHB	Canada	1, 3
134	Munday, R. (2003b). A phenomenological study of women's experiences of the postnatal period following planned homebirth. Part two. MIDIRS Midwifery Digest, 13(4), 519-523.	Interview	10 women who had had a PHB	Canada	1, 3
135	Murray-Davis, B., McNiven, P., McDonald, H., Malott, A., Elarar, L. & Hutton, E. (2012). Why home birth? A qualitative study exploring women's decision making about place of birth in two Canadian provinces. Midwifery, 28(5), 576-581.	Interview	34 women who planning a HB or who had had a PHB	Canada	1, 2, 3, 4
136	Murray-Davis, B., Mcdonald, H. & Hutton, E. (2014). Deciding on home or hospital birth: Results of the Ontario choice of birthplace survey. *Midwifery*, 30(7), 869-976.	Questionnaire	214 AN women (78 PHB, 123 hospital, 13 undecided), who chose	Canada	1, 2, 3, 4

			midwife led care in Canada		
137	Neuhaus, W., Piroth, C., Kiencke, P., Gohring, U. & Mallman, P. (2002). A psychosocial analysis of women planning birth outside hospital. *Journal of Obstetrics and Gynaecology*, 22(2), 143-149.	Interview	Women	Netherlands	2, 3
138	Newburn, M. (2003). Culture, control and the birth environment. *Practising Midwife*, 6(8), 20-25.	Question.	1944 women	UK	3
139	Newburn, M. (2012). Evidence should enable informed decision making, not limit choice. Practising Midwife, 15, 5.	Professional discussion	NCT Head of Research	UK	3
140	Newman, L. & Hood, J. (2009). Consumer involvement in the South Australian state policy for planned home birth. *Birth: Issues in Perinatal Care,* 36(1), 78-82.	Professional discussion	Lay PHB policy development group members	Australia	2, 3, 4
141	Ng, M., & Sinclair, M. (2002). Women's experience of planned home birth: a phenomenological study. *RCM Midwives Journal*, 5(2), 56-59.	Interview	9 PN women who had had PHB	UK	1,2, 3
142	Noble, S. (2015). Promoting homebirth: Intermediate homebirth report. *British Journal of Midwifery,* 23(4), 276-280.	Service evaluation - quantitative	Birth data	UK	1, 3, 4, 5
143	Nove, A., Berrington, A. & Matthews, Z. (2008). Home births in the UK, 1955 to 2006. *Population Trends*, 133, 20-27.	Secondary analysis data	All home births recorded between 1955 and 2006	UK	1, 4
144	O'Boyle, C. (2013). Just waiting to be hauled over the coals': Home birth midwifery in Ireland. *Midwifer*y, 29(8), 988-995.	Observation, interview and documentary analysis	Women, and midwives	S. Ireland	3, 4
145	O'Connell, S., Richley, N. & Williams, B. (2012). Northhampton homebirth team. *Practising Midwife*, 15(10), 19-22.	Professional discussion	Home birth team members	UK	3, 4

146	Ogden, J., Shaw, A. & Zander, L. (1997a). Women's memories of homebirth. Part 1. Women's memories of homebirth 3-5 years on. *British Journal of Midwifery*, 5(4), 208-211.	Interviews	25 women who had had a PHB	UK	1, 2, 3
147	Ogden, J., Shaw, A. & Zander, L. (1997b). Women's memories of homebirth. Part 2. Deciding on a homebirth: help and hindrances. *British Journal of Midwifery*, 5(4), 212-215.	Interviews	25 women who had had a PHB	UK	1, 2, 3
148	Parratt, J. & Fahy, K. (2004). Creating a 'safe' place for birth: an empirically grounded study. New Zealand College of Midwives, 30, 11-14.	Interviews	Women planning where to give birth	New Zealand	1
149	Pavlova, M., Hendrix, M., Nouwens, E., Nijhuis, J., & Merode, G. V. (2009). The choice of obstetric care by low-risk pregnant women in the Netherlands: implications for policy and management. *Health Policy*, 93(1), 27-34.	Discrete choice experiment	Low risk pregnant women	Neth	2
150	Perkins, L. (2009). Home birth: an eye-opener. Practising Midwife, 12, 29-30.	Professional discussion	Student Midwife	UK	3
151	Pitchforth, E., Watson, V., Tucker, van Teijingen, E., Ryan, M., Farmer, J., Ireland, J., Thomson, E.,Kiger, A. & Byers, H. (2008) Models of intrapartum care and women's trade-offs in remote and rural Scotland: a mixed-methods study. *BJOG*. Apr;115(5): 560-9	DCE quest.	Focus groups 877 women	UK	2, 3
152	Pitchforth, E., Teijingen, E. V., Watson, V., Kiger, A., Ireland, J., Farmer, J., Ryan, M. (2009). "Choice" and place of delivery: a qualitative study of women in remote and rural Scotland. *Quality and Safety in Health Care*, 18(1), 42-48.	Focus groups	PN Women	UK	3

153	Redshaw, M., Rowe, R., Hockley, C. & Brocklehurst, P. (2007). Recorded delivery: a national survey of women's experiences of maternity care. Oxford: National Perinatal Epidemiology Unit.	Cross sectional, postal survey	4,800 mothers who had given birth in 1 week 2006	UK	1, 2
154	Redshaw, M. & Heikkila, K. (2010). Delivered with care: a national survey of women's experience of maternity care 2010. Oxford: NPEU.	Questionnaire	5333 women	UK	1, 2
155	Redshaw, M. (2011). Mapping maternity care facilities in England. *Evidence Based Midwifery*, 9(2), 46-52.	Case study data analysis	Maternity services	UK	4
156	Reed, B. (2008). Sheelagh's story. *Practising Midwife*, 11(6), 28-31.	Professional anecdote	Midwife	UK	2, 3
157	Regan, M. & McElroy, K. (2013). Women's perceptions of childbirth risk and place of birth. *The Journal of Clinical Ethics*, 24(3), 239-252.	Test designed to assess each woman's understanding about birth, a focus group and then individual interview	Longitudinal: 49 AN then PN women	USA	1, 2, 3
158	Richley, A. (2011). A joyful experience: the story of the Northhampton home birth team. *Perspective - NCT's journal on preparing parents for birth and early parenthood,* September, 11.	Professional discussion	Practising Midwife	UK	1, 3, 4
159	Rogers, J., Barber, T., Marsh, S., Henty, D., Mccandlish, R., Alexander, J., Baker, K., Cornish, S., Cunningham, S., Guyer, C., Ockenden, D., Sweeny, P., Thannhauser, G. & Viccars, A. (2005). *Final report - Birth Places Choices Project.* Retrieved from: http://www.uhs.nhs.uk/Media/SUHTInternet/Services/ObsMidwiferyGynae/BirthPlaceChoice/BirthChoiceProjectFinalReport.pdf	Mixed methods	Women	UK	1, 3, 4

160	Rogers, I. (2009). Freedom of choice in childbirth: women need time to make a decision. *British Journal of Midwifery*, 17(8), 509.	Professional discussion	Student Midwife	UK	1, 2, 3, 4
161	Rogers, C., Harman, J., & Selo-Ojeme, D. (2011). Perceptions of birth in a stand-alone centre compared to other options. *British Journal of Midwifery*, 19(4), 237-244.	Survey	121 women – some AN and some PN	UK	2
162	Rogers, C., Yearley, C. & Littlehales, C. (2012). Turning the tide of childbirth. *British Journal of Midwifery*, 20(1), 28-33.	Professional discussion	Academic midwives, and HoM service	UK	3, 4
163	Rogers, C., Villar, R. & Harman Practice, J. (2015). Turning the tide of childbirth: Are we still adrift? *British Journal of Midwifery*, 23(1), 42-49.	Service evaluation post strategy implementation	Birth place choice data	UK	1, 3, 4
164	Royal College of Midwives (2011). *Survey of Midwives current thinking about home birth. Final report.* RCM Trust: London	Survey	553 RCM members	UK	3, 4
165	Saunders, D., Boulton, M., Chapple, J., Ratcliffe, J. & Levitan, J. (2000). *Evaluation of the Edgeware Birth Centre.* London: Barnet Health Authority.	Evaluation	Birth centre and associated care provision	UK	2
166	Sandall, J., Mccandlish, R. & Bick, D. (2012). Place of birth. *Midwifery*, 28(5), 547.	Professional discussion	Academic midwives and sociologist	UK	3
167	Sandall, J. (2013). Birthplace in England Research - implications of New Evidence. *Journal of Perinatal Education*, 22, 77-82.	Professional discussion	Academic Midwife and Social Scientist	UK	1, 4
168	Shaw, R. & Kitzinger, C. (2005). Calls to a home birth helpline: empowerment in childbirth. *Social science and medicine,* 61(11), 2374-2383.	Content analysis of telephone conversations	Women and family members calling helpline	UK	1, 2, 3, 4
169	Shaw, R. (2007). It's your body, your baby, your birth. Planning and achieving a home	Professional discussion	Sociology academic	UK	1, 3

	birth. *Feminism and Psychology*, 17(4), 565-570.				
170	Silverton, L. (2012). Making the right choices. Midwives (1), 3.	Professional discussion	RCM General Secretary	UK	2
171	Silveira, M., Copeland, L. & Feudtner, C. (2006) Likelihood of Home Death Associated With Local Rates of Home Birth: Influence of Local Area Healthcare Preferences on Site of Death. American Journal of Public Health, 96(7): 1243-1248	Analysis of death register 1989 - 1998	35110 deceased adults	USA	1, 3
172	Sinnhuber-Giles, L. (2008). Charlotte's birth. *Journal of Perinatal Education,* 17(3), 4-6.	Personal anecdote	PN woman discusses her PHB	USA	1, 2, 3
173	Sjöblom, I., Nordström, B. & Edberg, A. (2006). A qualitative study of women's experiences of home birth in Sweden. *Midwifery*, 22(4), 348-355.	Interview	12 women	Sweden	1, 2, 3
174	Sjöblom, I., Idvall, E., Rådestad, I. & Lindgren, H. (2012). A provoking choice—Swedish women's experiences of reactions to their plans to give birth at home. *Woman and Birth*, 25, e11-8.	Survey	735 PN women who had had a PHB	Sweden	1, 3
175	Sluijs, A., Cleiren, M., Scherjon, S. & Wijma, K. (2015). Does fear of childbirth or family history affect whether pregnant Dutch women prefer a home or hospital birth? *Midwifery*, 31(12), 1143-1148.	Questionnaires at 30 weeks gestation and 6/52 PN	104 low risk women	Neth.	1, 2
176	Soltani, H., Fair, F. & Duxbury, A. (2015). Exploring health professionals' and women's awareness of models of maternity care evidence. *British Journal of Midwifery*, 23(1), 22-31.	Quantitative research - questionnaire	117 women (AN and PN)	UK	1, 2, 3
177	Stephens, L. (2008). Nina's story: as good as it gets? *British Journal of Midwifery*, 16(1), 49-50.	Professional anecdote	Practicing Midwife	UK	1, 3, 4

178	Taylor, K. (2010). My lovely c-section. *Journal of Perinatal* Education, 19, 4-6.	Personal anecdote	PN woman discusses her PHB and transfer for C/S	USA	1, 2
179	Thomas, T. (2003). Open dialogue. Home birth proves more of a challenge than a choice. *British Journal of Midwifery*, 11(7), 454.	Professional discussion	Community Midwife	UK	2, 3, 4
180	Thomas, T. (2006). Open dialogue. Are midwives required to echo the rhetoric of equality and choice? *British Journal of Midwifery*, 14(3), 166-167.	Professional anecdote	Community Midwife	UK	1, 3, 4
181	Van Haaren-Ten Haken, T., Pavlova, M., Hendrix, M., Nieuwenhuijze, M., De Vries, R. & Nijhuis, J. (2014). Elicting preferences for key attributes of intrapartum care in the Netherlands. *Birth: Issues in perinatal care*, 41(2), 185-194.	Questionnaire	AN low risk nullips - 191 intending PHB, 152 intending MLU, 188 intending OU birth, 31 not sure	Neth.	1, 2, 3
182	Vedam, S., Stoll, K., White, S., Aaker, J., & Schummers, L. (2009). Nurse-midwives' experiences with planned home birth: impact on attitudes and practice. *Birth: Issues in Perinatal Care*, 36(4), 274-282.	Survey	1893 Midwives	USA	3
183	Vedam, S., Aaker, J., & Stoll, K. (2010). Assessing certified nurse-midwives' attitudes towards planned home birth'. *Journal of midwifery & women's health,* 55(2), 133-142.	Survey	1893 Midwives	USA	3
184	Vedam, S., Schummers, L., Stoll, K., Klein, M., Fairbrother, N., Dharamsi, S., Liston, R., Chong, G., Khee & Kaczorowski, J. (2012). The Canadian Birth Place Study: Describing maternity practice and providers' exposure to home birth. *Midwifery*, 28(5), 600-608.	Survey	825 care providers – 451 midwives, 235 Obs, 139 GPs	Can.	3

185	Viisainen, K. (2001). Negotiating control and meaning: home birth as a self-constructed choice in Finland. *Social science and medicine*, 52(7), 1109-1121.	Interview	21 women	Finland	1, 2, 3
186	Vries, C. D. (2010). Birth in an ordinary instant. *Journal of Perinatal Education*, 19(3), 4-7.	Personal anecdote	Grandmother's discussion of his daughter's PHB	Neth.	1, 3
187	Walsh, A., Walsh, P., Walsh, J. & Walsh, G. (2011). Welcoming Nora. *Journal of Perinatal Education,* 20(3), 126-129.	Personal anecdote	Parents discuss the PHB of their daughter	USA	1, 2, 3
188	Walton, G., Gaskell, E., Forrester, M. & Grosvenor, M. (2014). My place or yours? *Midwives*, (6), 48-49.	Intervention - Questionnaire (attached to App)	236 AN women	UK	1, 3
189	Walton, I. (2015). Midwives' ideas for the future. *Midwifery Matters*, Summer, 17-18.	Intervention - Questionnaire (attached to App)	236 AN women	UK	3
190	Warwick, C. (2012). Outcomes by planned place of birth: Implications of the Birthplace Study. *British Journal of Midwifery*, 20(1), 20-21.	Professional discussion	General Secretary of the Royal College of Midwives	UK	1, 3, 4
191	Watts, K., Fraser, D., & Munir, F. (2003). The impact of the establishment of a midwife managed unit on women in a rural setting in England. *Midwifery*, 19(2), 106-112.	Survey Interviews	8 women interviewed	UK	2, 3
192	Welch, M. (2001). Papato - homebirth from the father's perspective. *Midwifery Today*, Summer, 29-30.	Personal anecdote	Father discusses the PHB of his daughter	USA	1
193	Wiegers, T., Zee, J. V. D., Kerssens, J. & Keirse, M. (1998a). Home birth or short-stay hospital birth in a low risk population in the Netherlands. *Social science and medicine*, 46(11), 1505-1511.	Questionnaire	1,720 women planning PHB (1,076), MLU (631), undecided (13)	Neth.	1

194	Wiegers, T., & Keirse, M. (1998b). Maternity care in the Netherlands: the changing home birth rate. *Birth: Issues in Perinatal Care*, 25(3), 190-197.	Secondary analysis data	All home births recorded between 1965 and 1992	Neth.	1
195	Wiegers, T., Kerssens, J., & Keirse, M. (2000). Variation in home-birth rates between midwifery practices in the Netherlands. *Midwifery*, 16(2), 96-104.	Birth data	4420 births in 42 midwifery practices	Neth.	3, 4

Appendix 16 – Concept analysis study table to illustrate the way that defining attributes are provided within the model case, and the way that the elements and mechanisms outlined by Cardinal and Suave (2010) were considered

Defining attribute	Care component	Element / mechanism
Creating the Conditions	*Asma asks during Initial Consultation if Sarah if she has any thoughts on where she would like to her baby to be born. * Asma asks how Paul feels about birth, and home birth, and Paul shares his feelings. Sarah then also shares her feelings. * Asma makes it clear that she understands that Sarah will probably need more information about home birth if she is to consider it for herself, as she may not be familiar with this option *Asma completes the local documentation to enable Sarah to later decide where she wishes to give birth. * Sarah goes into labour and calls the on-call midwife, Carla, who visits her at home. A diagnosis of established labour is made, and Sarah decides she feels comfortable at home and that she would like to continue to labour and give birth there.	Subjective – verbal and non-verbal communication Integration – partner involvement Subjective – verbal and non-verbal communication + Integrative – lack of social network Objective – documentation Objective – ability to provide ELA at home
Information Provision	*Asma gives Sarah some written information about home birth, and the local numbers and outcomes of women of differing parities who have made this choice locally. *Asma suggests that Sarah reads some information about home birth, and tells her about a Home Birth	Objective - written information Subjective – verbal

	group run by local women who have had home births that she can access if she wishes. *Asma explains the NICE guidance on place of birth and explains the difference in outcome for primiparous and multiparous women giving birth at home. *Asma explains that she, and the other midwives in her team all support home births and are very experienced in attending them. Asma talks about the equipment that midwives use at home and in hospital, and the training they receive. *Asma talks with Sarah and Paul about the way that a home birth is conducted, including reassuring Paul that he would not be responsible for any of Sarah's care. * Materials used in the Antenatal Classes include home birth in the illustrations and examples.	Objective – home birth group Subjective - verbal Subjective – verbal Objective – information sources
Positive Reinforcement	*Asma tells Sarah she is very happy to offer her the choice of planned home birth * Sarah, and occasionally Paul, also attends Antenatal Classes run by a member of Asma's team and these classes reinforce the message that pregnancy is a natural process, and provides a place for informed discussion about all their choices in place of birth and the normal labour process. * The Antenatal Class facilitator wears a lanyard that invites people to 'Ask me about home birth'.	Subjective – verbal and non-verbal communication Objective – antenatal class

		Objective - lanyard
Challenging the Culture of Hospital Birth	* Asma gives Sarah and Paul some written information about home birth, and the local numbers and outcomes of women of differing parities who have made this choice locally. * Materials used in the Antenatal Classes include home birth in the illustrations and examples. *Sarah and Asma discuss how her pregnancy is progressing and Sarah's feelings about the birth. *Sarah and Asma discuss a recent episode of Call the Midwife where a birth resulted in the need for neonatal resuscitation, and Asma talks about the equipment that midwives use at home and in hospital, and the training they receive. * Asma suggests tells Sarah about a local Home Birth group run by local women who have had home births that she can access if she wishes.	Objective – documentation Integrative – partner and lack of social network Objective – information sources Subjective – verbal Objective – home birth group Integrative – lack of social network

Appendix 17 – Active offer work shop study previous service user debrief sheet

Women and partners debrief form 5.8.13 V.1

PRIFYSGOL BANGOR UNIVERSITY

School of Healthcare Sciences
Fron Heulog
Bangor University
LL57 2EF

Study title: The collaborative design of an active offer intervention for planned home birth by women, their partners and Community Midwives.

Thank you for attending today's workshop. I hope that you found it an interesting and enjoyable session.

If you have any further questions about this study please contact the researcher, Jude Field at the address stated above.

If you would like any further information or support about any of the topics that we discussed today, or any issue that you feel was raised as a result of attending today's workshop please consider contacting your GP or Health Visitor.

Many women and partners find it useful to access emotional support after childbirth, and the services detailed below are also available, if you feel that they are appropriate for your needs:

the birth trauma association
helping people traumatised by childbirth

The Birth Trauma Association

"It is clear that some women experience events during childbirth (as well as in pregnancy or immediately after birth) that would traumatise any normal person.

For other women, it is not always the sensational or dramatic events that trigger childbirth trauma but other factors such as loss of control, loss of dignity, the hostile or difficult attitudes of the people around them, feelings of not being heard or the absence of informed consent to medical procedures." (Birth Trauma Association 2013)

Women and their partners are encouraged to explore the site for information and support around traumatic birth experiences, and several specialist counsellors are also listed.

http://www.birthtraumaassociation.org.uk/

The Birth Trauma Association, PO Box 671, Ipswich, Suffolk IP1 9AT

The Association of Post Natal Illness (Post Natal Depression)

The Association provides a telephone helpline, information leaflets for sufferers and healthcare professionals as well as a network of volunteers (telephone and postal), who have themselves experienced postnatal illness.

"Women often find that talking, or writing to someone, who has had the illness and recovered, allows them to discuss the most distressing symptoms of the illness. The phone and e-mail volunteers also give women hope that they will eventually recover. For those who are not on the phone or e-mail we can offer the services of volunteers who will communicate by post. This service is also available to women who would prefer to be supported by post." (APNI 2013)

Website: http://apni.org/

Telephone: 020 7386 0868. Office hours 10:00 – 14:00 Monday - Friday

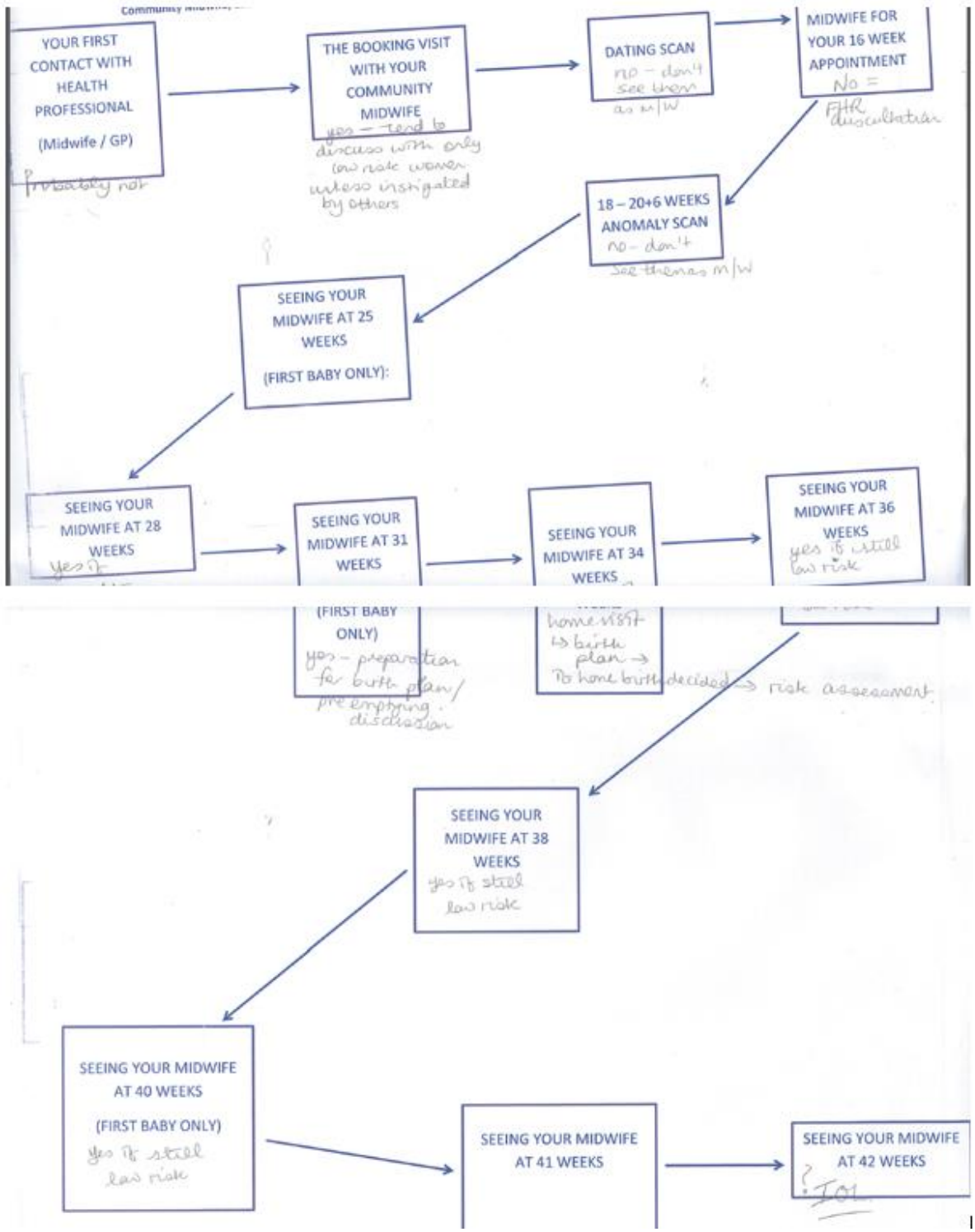
A Supervisor of Midwives

"Supervisors of midwives (SoMs) help midwives provide safe care for you, your baby and your family. They make sure that the care you receive from your midwife is right for you and will meet your needs. They also make sure that it is given in the right place and by the right person.

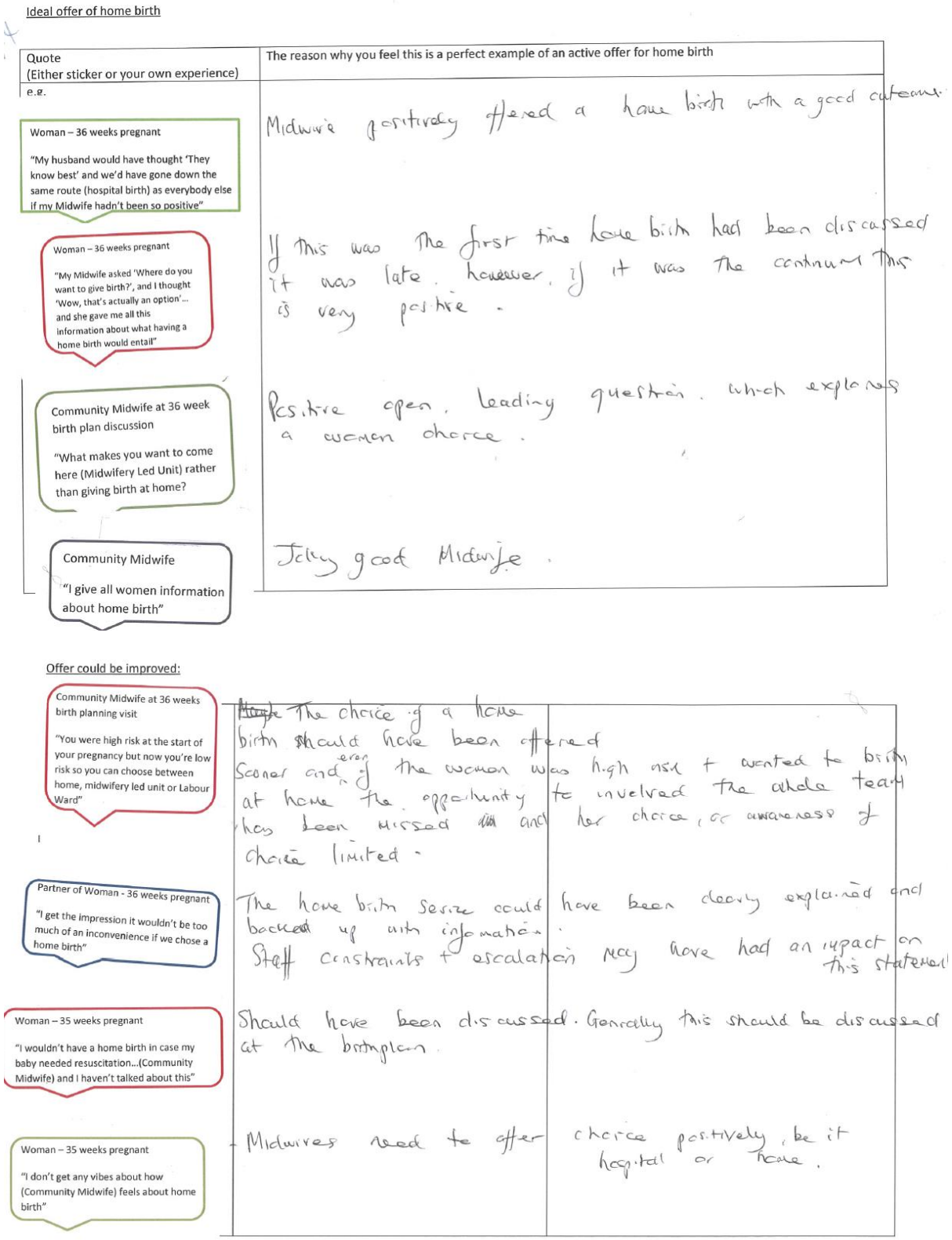
Supervisors of Midwives can listen to any concerns you may have about the level of care you have received from your midwife (for example, you may have concerns about your birthing experience) and then discuss these concerns with the midwife if appropriate." (LSAMO 2013)

Contact a Supervisor of Midwives via your local maternity unit, or http://www.lsamoforumuk.scot.nhs.uk/information-for-the-public.aspx

Appendix 18 – Active offer workshop study community midwife routine way of offering planned home birth



Appendix 19 - Active offer workshop study Community Midwife and PSU workshop exercise – assessment of an offer of home birth



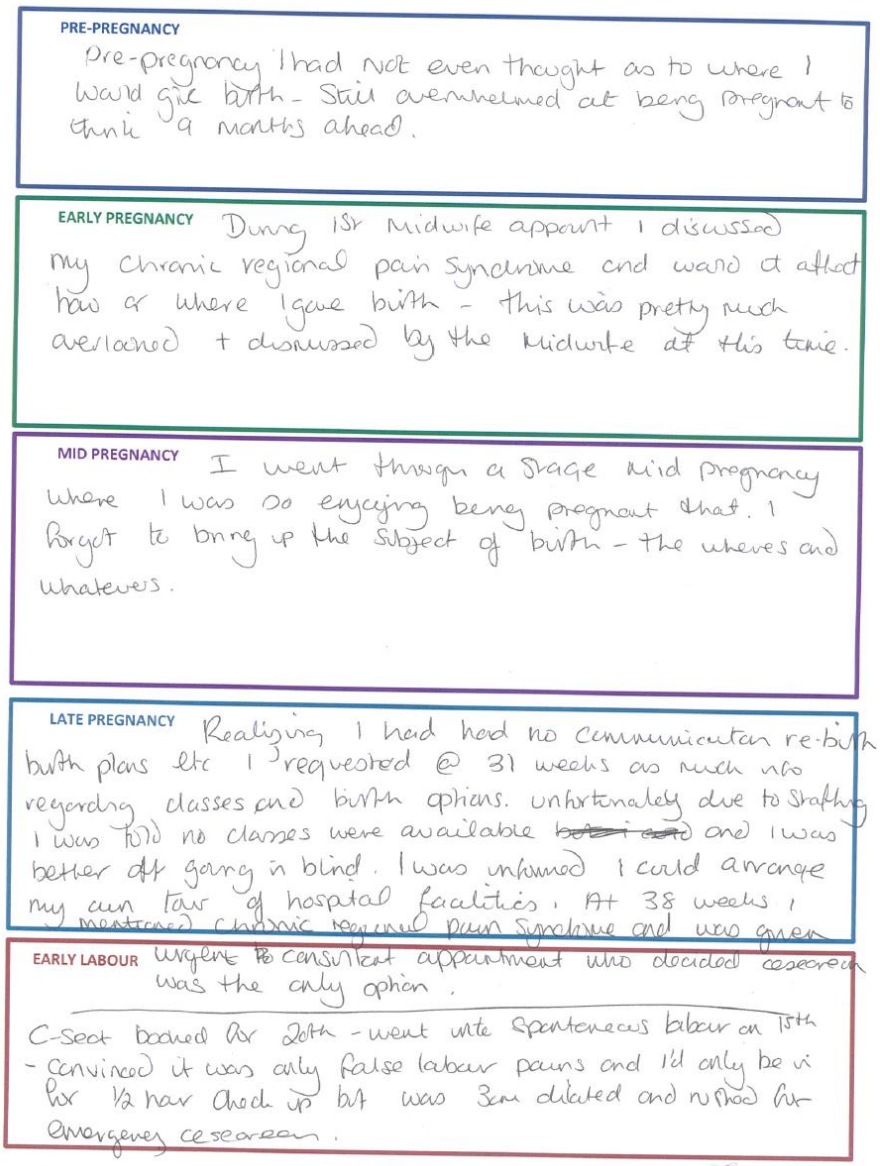
Ideal offer of home birth

Quote (Either sticker or your own experience) e.g.	The reason why you feel this is a perfect example of an active offer for home birth
Woman – 36 weeks pregnant "My husband would have thought 'They know best' and we'd have gone down the same route (hospital birth) as everybody else if my Midwife hadn't been so positive"	Midwife positively offered a home birth with a good outcome.
Woman – 36 weeks pregnant "My Midwife asked 'Where do you want to give birth?', and I thought 'Wow, that's actually an option'... and she gave me all this information about what having a home birth would entail"	If this was the first time home birth had been discussed it was late. However, if it was the continuum this is very positive.
Community Midwife at 36 week birth plan discussion "What makes you want to come here (Midwifery Led Unit) rather than giving birth at home?	Positive open, leading question. which explores a women choice.
Community Midwife "I give all women information about home birth"	Fully good Midwife.

Offer could be improved:

Community Midwife at 36 weeks birth planning visit "You were high risk at the start of your pregnancy but now you're low risk so you can choose between home, midwifery led unit or Labour Ward"	The choice of a home birth should have been offered sooner and even if the woman was high risk + wanted to birth at home the opportunity to involved the whole team has been missed and her choice, or awareness of choice limited.
Partner of Woman - 36 weeks pregnant "I get the impression it wouldn't be too much of an inconvenience if we chose a home birth"	The home birth service could have been clearly explained and backed up with information. Staff constraints + escalation may have had an impact on this statement
Woman – 35 weeks pregnant "I wouldn't have a home birth in case my baby needed resuscitation...(Community Midwife) and I haven't talked about this"	Should have been discussed. Generally this should be discussed at the bookings.
Woman – 35 weeks pregnant "I don't get any vibes about how (Community Midwife) feels about home birth"	Midwives need to offer choice positively, be it hospital or home.

Appendix 20 - PSU experience of being offered a planned home birth during their pregnancies



Appendix 21 – Active offer workshop study community midwife study information pack

Midwife Participants Study Information Sheet 5.8.13 V.1

School of Healthcare Sciences

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Bangor University
LL57 2EF

Study title: The collaborative design of an active offer intervention for planned home birth by women, their partners and midwives.

Participant information sheet

You are being invited to take part in a PhD research study about the offer of home birth to pregnant women. Before you agree to take part it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take time to decide whether you wish to take part, or not.

What is the purpose of the study?

This study has been developed because research has shown that women's experiences of being offered a planned home birth vary considerably across the UK. Previous studies have found that most women actually assume that they will give birth in hospital, and that often no aspect of their maternity care prompts them to consider giving birth at home.

For midwives working to provide care to pregnant women, there is no clear knowledge about how best to offer home birth to women.

This study aims to develop an approach that midwives and women can use together to explore decision making around home birth.

Why have I been chosen?

R&D approval has been granted by BCUHB for me to approach you about taking part in this study.

You have been chosen to take part because you are a Midwife who is involved in discussing birth place options with women and partners during their antenatal care. This might be because you are a Community Midwife, or because you are involved in providing antenatal classes to women and their partners.

It is felt that your practical experience of facilitating discussions with women, and your realistic knowledge of the demands of clinical practice would be essential in the development of how a more 'active offer' of home birth could be created.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet to keep.

If you decide to take part you are free to withdraw at any time and without giving a reason.

If you decide to take part, please complete the Study Consent Form and send it to the researcher Jude Field in the stamped addressed envelope.

If I decide to take part, what would the study involve?

The study will involve attending a 2-3 hour workshop with other local midwives who are also involved in discussing birth place choices with women.

Before we meet, I would have held several workshop groups with women and their partners who had either chosen to give birth at home, or had chosen to give birth in hospital or in an MLU. I hope that we will have created an interpretation of an 'active offer' for home birth which I would like you, as midwives to consider. It would be the aim of the workshop that we work to create a version of the active offer that you feel could work in clinical practice.

At the workshop we will be using several group activities, such as creating scenarios of different pregnancies and discussing women's journeys and experiences through their antenatal and early labour care. The topics of these activities would be considering the needs and experiences of women with different social and pregnancy backgrounds and the highlighting of important points within a woman's maternity care that could be used to facilitate the offer of home birth.

Participation in any of the individual activities is voluntary, but it is not anticipated that any of the activities would cause any embarrassment. While you would be encouraged to reflect directly upon your own experiences, this is not a requirement for participation in the workshops.

Food and refreshments will be available at no expense, and you would be reimbursed for any travel expenses to the venue that you had incurred.

The session will be digitally sound recorded (either in part or in its entirety), and photographs may also be used to record parts of the session. You are able to decline consent for being recorded, photographed, whilst still participating in the workshop session, and this would be recorded on the consent form that you would be asked to complete.

I would also ask your consent for me to use anonymised quotations from the workshop in any of the publications that arise from this project. Due to the process of anonymisation, no individuals would be identifiable from these quotations.

After attending a workshop, I would ask if you would be willing to attend a further workshop style session with maternity service users.

What are the benefits or disadvantages of taking part?

The benefits are that you will be able to voice your opinions on home birth, your experiences of discussing the option of home birth with women and their partners, and be able to make recommendations that will inform the development of an active offer for home birth.

I do not anticipate any disadvantages.

Confidentiality

All data (Digital recordings, photography, and anonymised transcripts) will be securely stored at Bangor University and will only be accessed by members of the research team.

All data will be kept securely for 5 years after publication, but the original verbal recordings will be destroyed following transcription. Anonymised data may be retained and used for teaching purposes or further research during this time period.

Due to the nature of this project, the issue of disclosure of information must be specifically addressed in relation to unsafe clinical practice (NMC 2008) and child protection (Children Act 1989). If this occurs, you would be informed that confidentiality would be broken and the researcher would contact the necessary authorities.

What happens if I don't want to carry on with this study?

You can decide to withdraw from the study at any time and without giving a reason. You can withdraw by telephone, email or writing to any of the contact details listed at the bottom of this information sheet. If you do decide to withdraw all of your data will be destroyed.

Who is organising or funding this study?

This study has been organised by Jude Field, a School of Healthcare Sciences PhD student, under the supervision of Professor Jo Rycroft-Malone, Professor in Health Service and Implementation Research and Dr. Chris Burton, Senior Research Fellow at the School of Healthcare Sciences, Bangor University.

Jude Field is a Staff Midwife, working for BCUHB in Ysbyty Gwynedd, Bangor.

Who has reviewed this study?

This study has been reviewed by the Bangor University Healthcare and Medical Sciences Ethics Committee.

What will happen to the results of this research?

I plan to disseminate the findings of this research by means of:

Feedback reports to all participants

Possible publication in peer reviewed journals and on the World Wide Web

Conference presentations

It is intended that the results of these collaborative workshops will have created a clinically appropriate 'active offer' of home birth. I hope, on completion of my PhD, to be able to obtain further funding to be able to test this approach to home birth discussion in a research trial.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to Jude Field (the researcher) on the contact details provided, who will do her best to answer your questions.

If you remain unhappy, or if you have any complaints about the way the researcher carries out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Professor Jo Rycroft-Malone

Head of School, School of Healthcare Sciences

College of Health and Behavioural Sciences, Bangor University

Gwynedd LL57 2EF

Tel: 01248 383119

Thank you for taking the time to read this information sheet and for considering taking part in this study. If you would like to take part, please complete the Study Consent Form and return it to Jude Field in the Stamped Addressed envelope provided.

If you require any further information about this study please contact the researchers named below:

Jude Field - PhD Student

Email: j.c.field@bangor.ac.uk

Telephone: 01248 382802

Dr. Chris Burton –Senior Research Fellow

Email: c.burton@bangor.ac.uk

Telephone: 01248 382556

Professor Jo Rycroft-Malone – Professor in Health Services and Implementation Research

Email: j.rycroft-malone@bangor.ac.uk

Telephone: 01248 383119

Midwife Participant Study Consent Form 5.8.13 V.1

PRIFYSGOL BANGOR UNIVERSITY

Study Consent Form

Study title: The collaborative design of an active offer intervention for planned home birth by women and their partners, and Midwives.

Please initial to indicate agreement or

		Yes	No
1	I agree that I have read and understood the information sheet dated 11.7.13 for the above study and have had the opportunity to ask questions.		
2	I understand that my participation is voluntary and that I am free to withdraw -at any time via email, letter or telephone, without giving any reason, and without my legal or employment rights being affected.		
3	I agree to take part in the above named study.		
4	I consent to the workshop being digitally recorded.		
5	I consent to any photography from the workshop being used in publications arising from this project.		
6	I consent to anonymised quotations from the workshop being used in any publications arising from this project.		
7	I understand that I may withdraw my consent regarding the use of my anonymised quotations or photographs at any time before publication - via email, letter or telephone, without giving any reason, and without my legal rights or professional development opportunities being affected.		
8	I understand that confidentiality will be breached in the event disclosure of child protection or unsafe clinical practice issues		

…….. ……..……

……

Name (Participant) Signature

Date

……

……

……

Workplaces address and preferred contact number(s)

…… ……
……

Name (Researcher) Signature Date

(No.14)

Please the reverse of this form for voluntary questionnaire.

Please indicate the following to help the most appropriate workshop groups be formed:

Please indicate your responses, and all of your preference(s):

1	I would prefer to attend a workshop held:	Monday - Friday	Saturday - Sunday	9-5	Evening
2	I have attended:	More than 5 home births this year (2013)	Less than 5 home births this year (2013)	0 home births this year (2013)	

Appendix 22 – Active offer workshop study community midwife reminder letter

5.8.13 V.1

School of Healthcare Sciences

Fron Heulog

Bangor University

LL57 2EF

Study title: The collaborative design of an active offer intervention for planned home birth by women, their partners and midwives.

Participant information sheet

Two weeks ago I sent you an invitation to participate in this study, and today I would like to reiterate this invitation.

You are being invited to take part in a PhD research study about the offer of home birth to pregnant women. Before you agree to take part it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take time to decide whether you wish to take part, or not.

What is the purpose of the study?

This study has been developed because research has shown that women's experiences of being offered a planned home birth vary considerably across the UK. Previous studies have found that most women actually assume that they will give birth in hospital, and that often no aspect of their maternity care prompts them to consider giving birth at home.

For midwives working to provide care to pregnant women, there is no clear knowledge about how best to offer home birth to women.

This study aims to develop an approach that midwives and women can use together to explore decision making around home birth.

Why have I been chosen?

R&D approval has been granted by BCUHB for me to approach you about taking part in this study.

You have been chosen to take part because you are a Midwife who is involved in discussing birth place options with women and partners during their antenatal care. This might be because you are a Community Midwife, or because you are involved in providing antenatal classes to women and their partners.

It is felt that your practical experience of facilitating discussions with women, and your realistic knowledge of the demands of clinical practice would be essential in the development of how a more 'active offer' of home birth could be created.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet to keep.

If you decide to take part you are free to withdraw at any time and without giving a reason.

If you decide to take part, please complete the Study Consent Form and send it to the researcher Jude Field in the stamped addressed envelope.

If I decide to take part, what would the study involve?

The study will involve attending a 2-3 hour workshop with other local midwives who are also involved in discussing birth place choices with women.

Before we meet, I would have held several workshop groups with women and their partners who had either chosen to give birth at home, or had chosen to give birth in hospital or in an MLU. I hope that we will have created an interpretation of an 'active offer' for home birth which I would like you, as midwives to consider. It would be the aim of the workshop that we work to create a version of the active offer that you feel could work in clinical practice.

At the workshop we will be using several group activities, such as creating scenarios of different pregnancies and discussing women's journeys and experiences through their antenatal and early labour care. The topics of these activities would be considering the needs and experiences of women with different social and pregnancy backgrounds and the highlighting of important points within a woman's maternity care that could be used to facilitate the offer of home birth.

Participation in any of the individual activities is voluntary, but it is not anticipated that any of the activities would cause any embarrassment. While you would be encouraged to reflect directly upon your own experiences, this is not a requirement for participation in the workshops.

Food and refreshments will be available at no expense, and you would be reimbursed for any travel expenses to the venue that you had incurred.

The session will be digitally sound recorded (either in part or in its entirety), and photographs may also be used to record parts of the session. You are able to decline consent for being recorded, or photographed, whilst still participating in the workshop session, and this would be recorded on the consent form that you would be asked to complete.

I would also ask your consent for me to use anonymised quotations from the workshop in any of the publications that arise from this project. Due to the process of anonymisation, no individuals would be identifiable from these quotations.

After participation in a workshop, I would ask if you would be willing to attend a further workshop style session with maternity service users.

What are the benefits or disadvantages of taking part?

The benefits are that you will be able to voice your opinions on home birth, your experiences of discussing the option of home birth with women and their partners, and

be able to make recommendations that will inform the development of an active offer for home birth.

I do not anticipate any disadvantages.

Confidentiality

All data (Digital recordings, photography, and anonymised transcripts) will be securely stored at Bangor University and will only be accessed by members of the research team.

All data will be kept securely for 5 years after publication, but the original verbal recordings will be destroyed following transcription. Anonymised data may be retained and used for teaching purposes or further research during this time period.

Due to the nature of this project, the issue of disclosure of information must be specifically addressed in relation to unsafe clinical practice (NMC 2008) and child protection (Children Act 1989). If this occurs, you would be informed that confidentiality would be broken and the researcher would contact the necessary authorities.

What happens if I don't want to carry on with this study?

You can decide to withdraw from the study at any time and without giving a reason. You can withdraw by telephone, email or writing to any of the contact details listed at the bottom of this information sheet. If you do decide to withdraw all of your data will be destroyed.

Who is organising or funding this study?

This study has been organised by Jude Field, a School of Healthcare Sciences PhD student, under the supervision of Professor Jo Rycroft-Malone, Professor in Health Service and Implementation Research and Dr. Chris Burton, Senior Research Fellow at the School of Healthcare Sciences, Bangor University.

Jude Field is a Staff Midwife, working for BCUHB in Ysbyty Gwynedd, Bangor.

Who has reviewed this study?

This study has been reviewed by the Bangor University Healthcare and Medical Sciences Ethics Committee.

What will happen to the results of this research?

I plan to disseminate the findings of this research by means of:

Feedback reports to all participants

Possible publication in peer reviewed journals and on the World Wide Web

Conference presentations

It is intended that the results of these collaborative workshops will have created a clinically appropriate 'active offer' of home birth. I hope, on completion of my PhD, to be able to obtain further funding to be able to test this approach to home birth discussion in a research trial.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to Jude Field (the researcher) on the contact details provided, who will do her best to answer your questions.

If you remain unhappy, or if you have any complaints about the way the researcher carries out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Professor Jo Rycroft-Malone

Head of School, School of Healthcare Sciences

College of Health and Behavioural Sciences, Bangor University

Gwynedd LL57 2EF

Tel: 01248 383119

Thank you for taking the time to read this information sheet and for considering taking part in this study. If you would like to take part, please complete the Study Consent Form and return it to Jude Field in the Stamped Addressed envelope provided.

If you require any further information about this study please contact the researchers named below:

Jude Field - PhD Student

Email: j.c.field@bangor.ac.uk

Telephone: 01248 382802

Dr. Chris Burton –Senior Research Fellow

Email: c.burton@bangor.ac.uk

Telephone: 01248 382556

Professor Jo Rycroft-Malone – Professor in Health Services and Implementation Research

Email: j.rycroft-malone@bangor.ac.uk

Telephone: 01248 383119

Appendix 23 – Active offer workshop study previous service user study information pack

Woman and Partner Participant Study Information Sheet 5.8.13 V.1

School of Healthcare Sciences
Fron Heulog
Bangor University
LL57 2EF

Study title: The collaborative design of an active offer intervention for planned home birth by women, their partners and Community Midwives.

Participant information sheet

You are being invited to take part in a PhD research study about the offer of home birth to pregnant women. Before you agree to take part it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and take time to decide whether you wish to take part, or not.

What is the purpose of the study?

This study has been developed because research has shown that maternity service users' (women and their partners) experiences of being offered a planned home birth vary considerably across the UK. Previous studies have found that most service users actually assume that birth will take place in hospital, and that often no aspect of their maternity care prompts them to consider giving birth at home.

For midwives working to provide care to pregnant women, there is no clear knowledge about how best to offer home birth to women.

This study aims to develop an approach that midwives and maternity service users can use together to explore decision making around home birth.

Why have I been chosen?

As a recent maternity service user, your experiences of deciding on where to give birth to your baby will provide useful insights into how this important aspect of maternity care is provided. It does not matter where you decided to give birth – participation from both women and their partners who chose hospital birth, a Midwifery Led Unit birth or a home birth is encouraged and their opinions will be welcomed.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet to keep.

If you decide to take part you are free to withdraw at any time and without giving a reason.

If you decide to take part, please complete the Study Consent Form and send it to the researcher Jude Field in the stamped addressed envelope.

What would the study involve, if I decide to take part?

The study will involve attending a workshop with other women and their partners.

At the workshop we will be using several activities that are aimed at helping us to consider how home birth could best be offered to women and their families, with the aim of highlighting the important points within maternity care that could be used to facilitate the offer of home birth. The activities will involve working in groups to consider different 'scenarios' of women's experiences of maternity care, thinking about the journeys that service users experience throughout their maternity care and how different points of their pregnancy could be used to discuss and offer home birth.

Participation in any activity is voluntary, but it is not anticipated that any of the activities would cause any embarrassment. While you would be encouraged to reflect directly upon your own experiences, this is not a requirement for participation in the workshops.

Food and refreshments will be available at no expense, and you would be reimbursed for any travel expenses to the venue that you had incurred.

The session will be digitally sound recorded (either in part or in its entirety), and photographs may also be used to record parts of the session. You are able to decline consent for being recorded, photographed whilst still participating in the workshop session, and this would be recorded on the consent form that you would be asked to complete.

I would also ask your consent for me to use anonymised quotations from the workshop in any of the publications that arise from this project. Due to the process of anonymisation, no individuals would be identifiable from these quotations.

After participation in a workshop, I would ask if you would be willing to attend a further workshop style session with maternity service users and midwives.

What are the benefits or disadvantages of taking part?

The benefits are that you will be able to voice your opinions on home birth, your experiences of considering it as an option, and be able to make recommendations that will inform the development of an active offer for home birth. I do not anticipate any disadvantages.

Confidentiality

All data (Digital recordings, photography and anonymised transcripts) will be securely stored at Bangor University and will only be accessed by members of the research team.

All data will be kept securely for 5 years after publication, but the original verbal recordings will be destroyed following transcription. Anonymised data may be retained and used for teaching purposes or further research during this time period.

Due to the nature of this project, the issue of disclosure of information must be specifically addressed in relation to unsafe clinical practice (NMC 2008) and child protection (Children Act 1989). If this occurs, you would be informed that confidentiality would be broken and the researcher would contact the necessary authorities.

What happens if I don't want to carry on with this study?

You can decide to withdraw from the study at any time and without giving a reason. You can withdraw by telephone, email or writing to any of the contact details listed at the bottom of this information sheet. If you do decide to withdraw all of your data will be destroyed.

Who is organising or funding this study?

This study has been organised by Jude Field, a School of Healthcare Sciences PhD student, under the supervision of Professor Jo Rycroft-Malone, Professor in Health Service and Implementation Research and Dr. Chris Burton, Senior Research Fellow at the School of Healthcare Sciences, Bangor University. The study is part funded by a Studentship from Bangor University.

Jude Field is a Staff Midwife, working at Ysbyty Gwynedd, Bangor.

Who has reviewed this study?

This study has been reviewed by the Bangor University Healthcare and Medical Sciences Ethics Committee.

What will happen to the results of this research?

I will to disseminate the findings of this research by means of:

Feedback reports to all participants

Possible publication in peer reviewed journals and on the World Wide Web

Conference presentations

It is also intended that the anonymous ideas generated during the workshops will be discussed with Community Midwives in order to create a clinically appropriate 'active offer' for home birth. It is hoped that once created, it will be possible to test the active offer in clinical practice.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to Jude Field (the researcher) on the contact details provided, who will do her best to answer your questions.

If you remain unhappy, or if you have any complaints about the way the researcher carries out the study, you may contact the Head of School, School of Healthcare Sciences as follows:

Professor Jo Rycroft-Malone

Head of School, School of Healthcare Sciences

College of Health and Behavioural Sciences, Bangor University

Gwynedd LL57 2EF

Tel: 01248 383119

Thank you for taking the time to read this information sheet and for considering taking part in this study. If you would like to take part, please complete the Study Consent Form and return it to Jude Field in the Stamped Addressed envelope provided. If you are a member of a Facebook group, can contact me via Facebook, Bangor University email or via the postal service.

If you require any further information about this study please contact the researchers named below:

Jude Field - PhD Student

Email: j.c.field@bangor.ac.uk

Telephone: 01248 382802

Dr. Chris Burton –Senior Research Fellow

Email: c.burton@bangor.ac.uk

Telephone: 01248 382556

Professor Jo Rycroft-Malone – Professor in Health Services and Implementation Research

Email: j.rycroft-malone@bangor.ac.uk

Telephone: 01248 383119

Woman and Partner Participants Study Consent form 5.8.13 V.1

PRIFYSGOL BANGOR UNIVERSITY

Study Consent Form

Study title: The collaborative design of an active offer intervention for planned home birth by low risk women and their partners, and Midwives.

Please initial to indicate agreement:

		Yes	No
1	I have read and understood the information sheet dated 5.8.13 for the above study and have had the opportunity to ask questions.		

2	I understand that my participation is voluntary and that I am free to withdraw -at any time via email, letter or telephone, without giving any reason, and without my medical care or legal rights being affected.		
3	I agree to take part in the above named study.		
4	I consent to the workshop being digitally recorded.		
5	I consent to any photography from the workshop being used in publications arising from this project.		
6	I consent to anonymised quotations from the workshop being used in any publications arising from this project.		
7	I understand that I may withdraw my consent regarding the use of my anonymised quotations or photographs at any time before publication - via email, letter or telephone, without giving any reason, and without my legal rights being affected.		
8	I understand that confidentiality will be breached in the event disclosure of child protection or unsafe clinical practice issues.		

…… …….
……..

Name (Participant) Signature Date

Preferred contact details:
……
……

……. ……
……..

Name (Researcher) Signature Date

Please see reverse of form for voluntary questionnaire.

If you consent to take part in this study, it will help us to create workshop groups if you completed the following questionnaire:

Name

……..

Address (Including postcode)……

……..……

……

Your employment.……

…

What is your ethnic group?

“Why are we asking this?”

We are asking this because we know that certain ethnic minorities are often under-represented in maternity research and we feel that it is important to include the opinions of people from all ethnic groups if we can.

Please circle one option that best describes your ethnic group or background, or describe where this is requested:

Welsh / English / Scottish / Northern Irish / British	Irish	Gypsy or Irish Traveller	Any other White background
White and Black Caribbean	White and Black African	White and Asian	Any other Mixed / Multiple ethnic background
Indian	Pakistani	Bangladeshi	Chinese
Any other Asian background	African	Caribbean	Any other Black / African / Caribbean background

Arab	Any other ethnic group		

Please indicate your responses, and all of your preference(s):

1	Are you:	A female service user	The partner of a female maternity service user		
2	Have you or your partner:	Had a planned home birth	Planned a home birth but actually gave birth in hospital	Had a planned Midwifery Led Unit birth	Had a planned hospital birth
3	Would you prefer to attend a workshop attended by:	Female service users and their partners	Women service users only	Partners only	
4	Would you prefer to attend a workshop conducted:	In English	In Welsh		
5	I would prefer the workshop to be held:	Monday - Friday	On the weekend	Between 9-5	In the evening

Appendix 24 – Active offer workshop study previous service user Facebook invitation

Women and Partners Initial Study Information and Personal Invitation (Facebook) 5.8.13 V.1

'Dear …… / Group Member

My name is Jude Field, and I am a member of this Home Birth Group and a Healthcare Sciences PhD Student at Bangor University. I am also a Staff Midwife working part time at Ysbyty Gwynedd.

The area of research for my PhD concerns how home birth services are provided and offered to women. For midwives working to provide care to pregnant women and their families, there is no clear knowledge about how best to offer home birth to maternity service users, and research tells us that across the UK service users' experiences of being offered home birth vary considerably.

I am now hoping to recruit participants from this Facebook group for a workshop based, collaborative research project that will use the experiences that members of this group have had considering and planning home births as the basis of an 'active offer for home birth' that could eventually be developed and used by midwives in clinical practice. I anticipate that the workshops will be held in September/ October 2013, with a choice of workshops at different times and days.

If you, or your partner live in Gwynedd, Anglesey or Conwy, have had a baby in the last 5 years and may be interested in participating in this study please read the 'Study Information Sheet' that I have sent with this message. I am keen to have the views of partners represented in this study. If you would like to participate, please complete the attached 'Study Consent Form' and send it to me on a Personal Message via Facebook, or by my University email address that is written on the 'Study Information Sheet'. I have also uploaded both of these forms directly onto the groups Facebook page, and these can be printed and sent to me if you prefer.

Thank you for reading this. Please get in touch if you would like further information.

Jude Field

Appendix 25 – Active offer workshop study previous service user Face reminder message

‘Dear …../ Group Member

My name is Jude Field and I am a member of this Home Birth group and a Healthcare Sciences PhD student at Bangor University. I am also a Staff Midwife working at Ysbyty Gwynedd.

Two weeks ago I sent out an invitation to participate in a research study that I am organising, and I just wanted to reiterate that invitation to you today. In brief, my research looks at how home birth services are provided and offered to women. For midwives working to provide care to pregnant women, there is no published consolidation of evidence about how best to offer home birth to women, and research tells us that across the UK service users’ experiences of being offered home birth vary considerably.

I am now hoping to recruit participants from this Facebook group for a workshop based, collaborative research project that will use the experiences that members of this group have had considering and planning home births as the basis of an ‘active offer for home birth’ that could eventually be developed and used by midwives in clinical practice. I anticipate that the workshops will be held in September/ October 2013, with a choice of workshops at different times and days.

If you, or your partner live in Gwynedd, Anglesey or Conwy, have had a baby in the last 5 years and may be interested in participating in this study please read the ‘Study Information Sheet’ that I have sent with this message. I am keen to have the views of partners represented in this study.

If you would like to participate, please complete the attached ‘Study Consent Form’ and send it to me on a Personal Message via Facebook, or by my University email address that is written on the ‘Study Information Sheet’. I have also uploaded both of these forms directly onto the groups Facebook page and these can be printed and sent to me if you prefer.

Thank you for reading this. I will not be sending any further study invitation messages. Please get in touch if you would like further information.

Jude Field

Appendix 26 – active offer workshop study ethical approval

11th December 2013

Jude Field
1 Fron Bant
Gerlan
Bethesda
Gwynedd
LL57 3SR

Dear Jude

Re: 2013-08-02 / *The Collaborative design of an active offer intervention for planned home birth by women, their partners and community midwives.*

Thank you for submitting the requested amendments to your proposal.

Having reviewed these I am now able to give you approval for your study from the HCMS AEC.

If you require to make any amendments during the course of the study you will need to inform the committee by means of the substantial amendments form.

I wish you every success with your study.

Yours sincerely,

Dr Sion Williams
Chair, HCMS AEC

CC: Dr Christopher Burton
Professor Jo Rycroft-Malone

HCMS AEC minor amendment letter V2 July 2013

Appendix 27 – Active offer workshop study R&D approval

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Panel Arolygu Mewnol Y&D
R&D Internal Review Panel

Betsi Cadwaladr University Health Board
Ysbyty Gwynedd
Clinical Academic Office
Bangor, Gwynedd
LL57 2PW

Chairman/Cadeirydd – Dr Nefyn Williams PhD, FRCGP
Email: rossela.roberts@wales.nhs.uk
wendy.scrase2@wales.nhs.uk
sion.lewis@wales.nhs.uk
Tel/Fax: 01248 384 877

Ms Jude Field
Fron Heulog, School of Healthcare Sciences
Bangor University
Bangor
LL57 2EF j.c.field@bangor.ac.uk

7 May 2014

Dear Ms Field

Re: Confirmation that R&D governance checks are complete / R&D approval granted

Study Title	The co-creation of an active offer intervention for planned home birth by women and their partners, and midwives
IRAS reference	142227

Thank you for submitting your R&D application and supporting documents.
The above study was eligible for Proportionate Review and was reviewed by the R&D Manager and Chairman of the Internal Review Panel.

The Committee is satisfied with the scientific validity of the project, the risk assessment, the review of the NHS cost and resource implications and all other research management issues pertaining to the revised application.

The Proportionate Review Committee is pleased to confirm that all governance checks are now complete and to grant approval to proceed at Betsi Cadwaladr University Health Board sites as described in the application.

The documents reviewed and approved are listed below:

Documents Reviewed:	Version	Date
R&D Form – 142227/574071/14/532	-	03/03/2014
SSI Form – 142227/574040/6169/224560/293698	-	03/03/2014
R&D Checklist	-	-
SSI Checklist	-	-
Protocol	1	11/12/2013
Participant Information Sheet (English)	1	05/08/2013
Participant Information Sheet (Welsh)	1	05/08/2013
Participant Information Sheet - Midwife Reminder (English)	1	05/08/2013
Participant Information Sheet - Midwife Reminder(Welsh)	1	05/08/2013
Consent Form (English)	1	05/08/2013
Consent Form (Welsh)	1	05/08/2013
Bangor University HCMS provision of ethical approval	-	11/12/2013
UMAL Insurance-Professional Indemnity 2013-2014	-	15/07/2013
CV - Dr. Chris Burton	-	-
CV - CI - Jude Field	-	-
CV-Prof. Jo Rycroft-Malone	2	22/01/2014
CoS Authorisation - F Giraud	-	07/05/2014

All research conducted at the Betsi Cadwaladr University Health Board sites must comply with the Research Governance Framework for Health and Social Care in Wales (2009).
An electronic link to this document is provided on the BCUHB R&D WebPages.
Alternatively, you may obtain a paper copy of this document via the R&D Office.

Attached you will find a set of approval conditions outlining your responsibilities during the course of this research. Failure to comply with the approval conditions will result in the withdrawal of the approval to conduct this research in the Betsi Cadwaladr University Health Board.

If your study is adopted onto the NISCHR Clinical Research Portfolio (CRP), it will be a condition of this NHS research permission, that the Chief Investigator will be required to regularly upload recruitment data onto the portfolio database.
To apply for adoption onto the NISCHR CRP, please go to:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=580&pid=31979.

Once adopted, NISCHR CRP studies may be eligible for additional support through the NISCHR Clinical Research Centre. Further information can be found at:http://www.wales.nhs.uk/sites3/page.cfm?orgid=580&pid=28571 and/or from your NHS R&D office colleagues.

To upload recruitment data, please follow this link:
http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment.
Uploading recruitment data will enable NISCHR to monitor research activity within NHS organizations, leading to NHS R&D allocations which are activity driven. Uploading of recruitment data will be monitored by your colleagues in the R&D office.
If you need any support in uploading this data, please contact wendy.scrase2@wales.nhs.uk or sion.lewis@wales.nhs.uk

If you would like further information on any other points covered by this letter please do not hesitate to contact me.

On behalf of the Committee, may I take this opportunity to wish you every success with your research.

Yours sincerely,

Dr Nefyn Williams PhD, FRCGP
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Appendix 28 - Active offer workshop study PHB PSU sociodemographic characteristics

Woman or partner	No. planned home births	No. PHB but gave birth in hospital	No. planned hospital births	Employment	Postcode Social Profile	Ethnic origin (PSU identification)
Woman	1	0	1	Not disclosed	Not disclosed	White British
Woman	0	1	0	Community Investment Officer	C1C2D	White British
Partner	0	1	0	IT technician	C1C2DE	Any other White
Woman	1	0	2	Staff Nurse	C1C2D	White British
Woman	3	0	0	University Lecturer	C1C2D	White British
Woman	0	1	0	Student	C1C2D	English
Woman	1	0	0	Mother	C1C2D	Any other White
Woman	1	0	0	Project officer	Not disclosed	White British
Woman	0	1	1	FE Student	C2DE	Welsh
Woman	2	0	0	University Lecturer	ABC1	White British
Woman	1	0	0	Primary Teacher	ABC1	Welsh
Woman	1	0	0	Unemployed	C1C2D	Welsh
Woman	2	0	0	Marketing consultant	BC1C2	White British

Woman	1	0	1	Communications manager	ABC1	Welsh
Partner	0	1	0	Electrician	ABC1C2	White British
Woman	0	1	0	External funding officer	ABC1C2	White British
Woman	2	0	0	Mother	C1C2D	White British
Woman	1	0	0	Mother	C1C2D	White British
Woman	0	1	0	Unemployed	C1C2D	White British
Woman	0	1	0	Spanish teacher	C1C2DE	Any other White

Appendix 29 - Active offer workshop study Non-PHB PSU sociodemographic characteristics

Woman or partner	No. planned home births	No. PHB but gave birth in hospital	No. planned hospital births	Employment	Postcode Social Profile	Ethnic origin (PSU identification)
Woman	0	0	2	University	Not declared	White
Woman	0	0	3	Teacher	C1C2D	Welsh
Woman	0	0	1	Crime Scene Investigator	C1C2D	Welsh
Woman	0	0	1	Musician	ABC1C2	Any other White
Woman	0	0	2	University	C1C2D	White British
Woman	0	0	1	Researcher	BC1C2	Welsh
Woman	0	0	2	University Librarian	Not declared	Not declared
Woman	0	0	1	Psychologist	ABC1C2	White British
Woman	0	0	2	Administrative Assistant	C1C2D	Welsh

Appendix 30 – Draft AOPHB checklist – midwife routine practice

Draft AOPHB checklist – for use as an overall assessment of an individual midwife's practice

1. Do you routinely consider if women require any specific consideration in their home birth decision making, in relation to the 'Inclusion of diversity'?

- Do you consider if women have a social network that is unsupportive or unknowledgeable about planned home birth?
- Do you consider if women have a lack of privileged characteristics? Such as being poorly educated, unemployed, non-white, single, young etc?

2. Where a woman has not decided to birth at home:

Do you:

Do you routinely aim to:	Yes / No	If yes, how do you routinely do this?
* Offer PHB to women at the start of their pregnancy *Keep PHB a topic throughout pregnancy * Keep the decision making process flexible for women - ideally continuing until early labour where an early labour assessment (ELA) at home would be available * Ensure that an informed decision has been made where a woman makes a choice to give birth away from her home by asking her the reasons for her decision		

* Provide information about PHB in written, verbal and digital forms, in both individual and group settings, sourced from both NHS and non-NHS providers *Provide balanced information in terms of the risk and benefit focus across all birth settings *Be cognisant that women will need greater levels of information and discussion about PHB than other birth settings as PHB is likely to be less familiar than the other birth places *Anticipate and address any mixed or negative messages about PHB * Invite women who have planned and / or achieved PHBs to take part in provision of information and discussion with pregnant women		
* Ensure that PHB is visible to women within their routine care provision * Anticipate that for many women the message that they receive from their social networks and society about PHB may be inaccurate		

* Provide care in a location that facilitates the discussion of planned home birth * Raise the possibility of PHB in a subsequent pregnancy in the PN period		
* Initiate discussions and give information about the physiological birth process * Lead or link conversations to conversation about how women feel about their own ability to give birth, and care for their baby in the early post-natal period * Discuss how birth environments may influence birth experience and outcomes * Invite women who have planned and / or achieved PHBs to attend antenatal classes to demonstrate the possibility of physiological birth		
*Ask women early in their pregnancy about who is supporting them during their pregnancy, and offer to meet with them during an early routine appointment *Use meetings to obtain a picture of how they feel about PHB		

* If it is not possible to meet with a woman's significant other, employ different communication methods to engage with them *Encourage a woman and her partner to discuss PHB together, and feedback to you about their thoughts * Use information, in line with that provided to women, that has been tailored for significant others from the beginning of a woman's pregnancy *Invite women who have planned and / or achieved PHBs to take part in the inclusion process, potentially with the additional inclusion of their own significant others where this is possible		

3. If a woman has decided to birth at home:

Do you:

Do you routinely aim to:	Yes / No	If yes, how do you routinely do this?
* Provide information about PHB in written, verbal and digital forms, in both individual and group settings, and sourced from both NHS and non-NHS providers		

*Provide information that is balanced in terms of the risk and benefit focus across all birth settings *Provide information when a woman asks for it * Invite women who have planned and / or achieved PHBs to take part in the provision of information and discussion with pregnant women		
* Initiate discussions and give information about the physiological birth process * Lead or link conversations to conversations about how a woman feels about her ability to give birth, and care for her baby in the early post-natal period * Discuss how birth environments may influence birth experience and outcomes * Invite women who have planned and / or achieved PHBs to attend antenatal classes to demonstrate the possibility of physiological birth * Discuss or teach tools to support birth at home [but equally birth in any setting], such as breathing, relaxation techniques, and massage, and potentially hypnobirthing or mindfulness		
* Display a positive professional attitude about PHB		

* Demonstrate positive support for a woman's personal decision to birth at home, such as by lending or recommending home birth related information sources, such as books or DVDs; or by lending birth related items such as birth pools * Continue to challenge the assumption of institutional birth so that a woman knows she is not alone in her decision * Ensure that a woman is aware of the ability to change her decision at any point, but if this done, enquiring about her reason for this change of plan * Create the opportunity for a woman to create a social network that is supportive of PHB, for example, encouraging a woman to attend a PHB group * Continue to provide support to women who are experiencing an obstetric risk factor but still wish to continue to plan, consider planning a PHB		
* Ask early in pregnancy about who is supporting them during pregnancy, and offering to meet with them during an early routine appointment *Use meetings to obtain a picture of how significant others feel about PHB		

* Employ other communication methods if it is not possible to meet with a woman's significant other *Encourage a woman and her partner to discuss PHB together, and to feedback to you about their thoughts * Use information, in line with that provided to women, that has been tailored for significant others from the beginning of a woman's pregnancy *Invite women who have planned and / or achieved PHBs to take part in the inclusion process, potentially with the additional inclusion of their own significant others where this is possible *Remember that significant others may need input in line with the 'Creating the Conditions' stage despite a woman's decision to plan birth at home		

Appendix 31 - Draft AOPHB checklist – midwife care for individual woman

Draft AOPHB checklist – for use with individual women

1. Does this woman require any specific consideration regarding the 'Inclusion of diversity' element of the AOPHB?

- Does she have a social network that is unsupportive or unknowledgeable about planned home birth?
- Consider a lack of privileged characteristics? Such as being poorly educated, unemployed, non-white, single, young etc?

For all women consider the impact of significant others in the way that the AOPHB suggests

If yes to either of these questions, provide enhanced support for her decision making.

2. Does the woman require care according to Creating the Conditions [CC] or Positive Reinforcement [PR]? If she has not already decided she wished to birth at home, provide care according to CC.

CC – follow table *

PR – follow table *

Checklist for care according to CC

- Continue CC until the end of maternity care unless:

1. The woman decides to birth at home – provide PR according to table *
2. The woman makes an informed decision to birth away from her home

Date CC commenced: Date CC recommenced:

Date CC ceased: Date CC ceased:

Reason: Reason:

Aim	This will be achieved through:	Note when you feel you have worked towards or achieved this aim in your care provision	State how you used the elements and mechanisms noted in figure * to work towards /achieve this aim:
A woman is provided with an unambiguous, on-going offer of a planned home birth, that is initiated by her midwife	* The offer of PHB being made to women at the start of their pregnancy *Routinely keeping PHB a topic throughout pregnancy * Keeping the decision making process flexible for women - ideally continuing until early labour where an early labour assessment (ELA) at home would be available * Ensuring that an informed decision has been made where a woman makes a choice to give birth away from her home by asking her the reasons for her decision		
A woman is provided with detailed and balanced information and discussion about home birth	* Providing information about PHB in written, verbal and digital forms, in both individual and group settings, sourced from both NHS and non-NHS providers *Information being balanced in terms of the risk and benefit focus across all birth settings *Being cognisant that women will need greater levels of information and discussion about PHB than other birth		

	settings as PHB is likely to be less familiar than the other birth places *Anticipating and addressing any mixed or negative messages about PHB * Inviting women who have planned and / or achieved PHBs to take part in provision of information and discussion with pregnant women		
A woman is supported to challenge any assumption of institutional birth and what it represents	* Ensuring that PHB is visible to women within their routine care provision * Anticipating that for many women the message that they receive from their social networks and society about PHB may be inaccurate * Providing care in a location that facilitates the discussion of planned home birth * Raising the possibility of PHB in a subsequent pregnancy in the PN period		
A woman is encouraged to talk about their feelings and to learn about physiological birth	* Initiating discussions and giving information about the physiological birth process * Leading or linking conversations to conversation about how women feel about their own ability to give birth, and care for their baby in the early post-natal period		

	* Discussing how birth environments may influence birth experience and outcomes * Inviting women who have planned and / or achieved PHBs to attend antenatal classes to demonstrate the possibility of physiological birth		
A woman's significant other(s) are included in the decision making process	*Asking women early in their pregnancy about who is supporting them during their pregnancy, and offering to meet with them during an early routine appointment *Using meetings to obtain a picture of how they feel about PHB * If it is not possible to meet with a woman's significant other, employing different communication methods to engage with them *Encouraging a woman and her partner to discuss PHB together, and feedback about their thoughts * Using information, in line with that provided to women, that has been tailored for significant others from the beginning of a woman's pregnancy *Inviting women who have planned and / or achieved PHBs would be invited by midwives to take part in the inclusion process, potentially with the additional inclusion of their own significant others where this is possible		

Checklist for care according to Positive Reinforcement

- Continue PR until the end of maternity care unless:

1. The woman makes an uninformed decision to birth away from home – provide CC according to table *
2. The woman makes an informed decision to birth away from her home

Date PR commenced: Date PR recommenced:

Date PR ceased: Date PR ceased:

Reason: Reason:

Aim	This will be achieved through:	Note when you feel you have worked towards or achieved this aim in your care provision	State how you used the elements and mechanisms noted in figure * to work towards /achieve this aim:
A woman is provided with detailed and balanced information and discussion about home birth	* Providing information about PHB in written, verbal and digital forms, in both individual and group settings, and sourced from both NHS and non-NHS providers *Information being balanced in terms of the risk and benefit focus across all birth settings *Providing information when a woman asks for it		

	* Inviting women who have planned and / or achieved PHBs to take part in the provision of information and discussion with pregnant women		
A woman is encouraged to talk about her feelings and to learn about physiological birth	* Initiating discussions and give information about the physiological birth process * Leading or linking conversations to conversations about how a woman feels about her ability to give birth, and care for her baby in the early post-natal period * Discussing how birth environments may influence birth experience and outcomes * Inviting women who have planned and / or achieved PHBs to attend antenatal classes to demonstrate the possibility of physiological birth * Discussing or teaching tools to support birth at home [but equally birth in any setting], such as breathing, relaxation techniques, and massage, and potentially hypnobirthing or mindfulness		
A woman is provided with reassurance and support for her decision making	* Displaying a positive professional attitude about PHB * Demonstrating positive support for a woman's personal decision to birth at home, such as by lending or recommending home birth related		

	information sources, such as books or DVDs; or by lending birth related items such as birth pools * Continuing to challenge the assumption of institutional birth so that a woman knows she is not alone in her decision * Ensuring that a woman is aware of the ability to change her decision at any point, but if this done, enquiring about her reason for this change of plan * Creating the opportunity for a woman to create a social network that is supportive of PHB, for example, encouraging a woman to attend a PHB group * Continuing to provide support for a women who is experiencing an obstetric risk factor but still wishes to continue to plan, or is still considering planning a PHB		
A woman's significant other(s) are included in the decision making process	* Asking early in pregnancy about who is supporting them during pregnancy, and offering to meet with them during an early routine appointment *Using meetings to obtain a picture of how significant others feel about PHB		

	* Employing other communication methods If it is not possible to meet with a woman's significant other *Encouraging a woman and her partner to discuss PHB together, and to feedback about their thoughts * Using information, in line with that provided to women, that has been tailored for significant others from the beginning of a woman's pregnancy *Inviting women who have planned and / or achieved PHBs to take part in the inclusion process, potentially with the additional inclusion of their own significant others where this is possible *Remembering that significant others may need input in line with the 'Creating the Conditions' stage despite a woman's decision to plan birth at home		

Appendix 32 – The draft AOPHB intervention

The proposed intervention is called the 'Active Offer for Planed Home Birth', and uses the acronym 'AOPHB'. It has been designed in light of the constituting elements of my four main findings. My intention in developing this intervention is that providing an active offer of planned home birth would position midwives to increase the demonstration of midwifery support for planned home birth, replicate the supportive social capital that most of the women who currently plan to birth at home receive and empower more women to engage in home birth decision making. In doing so the goals of the AOPHB are:

1. To enable more women (a high percentage of women) to have made an informed decision about whether to birth at home
2. Ideally, an increase in the number of women who do decide to give birth at home

The proposed AOPHB is a 'complex intervention' because it is an 'intervention with several interacting components' (MRC 2006). Rogers et al (2005) concluded that multiple-component interventions are more successful than single component interventions when attempting to influence birth place choices. The thesis this far has focused upon how the interactions that take place between women and midwives may influence planned home birth decision making [underpinned by the subjective and objective dimensions that Cardinal and Suave have outlined (2010)]. However, while this process does have a substantial role within the AOPHB intervention, the multiple components take a wider scope - being either 'midwife and employing organisation' focused – [which will also be underpinned by the prerequisite dimension (Cardinal and Suave, 2010)], or 'service user' focused. This approach is similar to the approach taken within the Baby Friendly Initiative (UNICEF ref) and is suggested to be more effective in increasing the inclusion of 'patients' in decision making than employing an intervention that focuses on either healthcare professionals or patients alone (Légaré et al 2015). Within the midwife and employing organisation focused interventions there is an additional component focused on student midwives if the organisation provides clinical placements. Within the service user focused interventions there are components focused on women, and also those on their significant others.

The reporting approach used within this outline:

The TIDieR checklist has been used in this outline to ensure that adequate consideration has been paid to the initial design of the AOPHB intervention, and that sufficient detail has been given to describing the AOPHB to allow understanding of how the intervention is intended to be implemented.

The TIDieR checklist was originally designed to enable researchers 'to describe interventions in sufficient detail to allow their replication'. However, in this application of the checklist it has been used within this chapter to describe the pilot AOPHB intervention prior to its implementation. The checklist consists of twelve points, but because the AOPHB is at an early stage of development, only the first to ninth stages of the checklist have been used. This has meant that points ten, eleven and twelve have not been commented on as these report the way in which the intervention was implemented.

The suggested AOPHB components focused on midwives and their employing organisation:

AOPHB components that are focused on the employing organisation:

(a) Audit of current organisational practice in the offer of PHB against the AOPHB standards

Prior to implementation of the AOPHB it is suggested that an audit of the current way that PHB is offered within the service is undertaken so that context specific areas where care is already provided in line with the AOPHB, and where care is not being provide in line with the AOPHB are highlighted. Areas where care is not being provided in line with the AOPHB will potentially be areas of implementation challenge within the organisation and could then be focused upon within the appropriate elements of the AOPHB intervention. NICE (2007) states that audit can be a positive way of generating change.

The audit process would involve use of a proforma and require

- Talking with midwives about their current practice in relation to each of the two stages of the AOPHB using the checklist included in chapter 7
- Looking at existing organisational information provision re. all birth place options
- Looking at the organisation's current planned and achieved PHB rate, including the socio-demographic profile of the women who currently make this choice within the organisation's service users
- Talking with women and significant others about the care they received in relation to planned home birth decision making

(b) Employing organisation's intranet uploaded with AOPHB podcast for professionals

A professional focused podcast [created by the AOPHB author] would be embedded into the organisation's intranet on the relevant service pages. The podcast would outline to staff what the AOPHB is and how it is justified in terms of the evidence base; and explain that the AOPHB has been adopted within the organisation. The podcast would address the potential implementation challenges that are anticipated could be experienced in relation to either of the AOPHB stages.

NICE (2007) state that videos can be used as educational tools for healthcare workers, and the Centre for Disease Control [CDC] states that podcasts are a social media intervention that is both low in cost and time to create (CDC 2011).

(c) Link to the AOPHB website on the employing organisation's intranet

The AOPHB requires that a link to the AOPHB website [that would be maintained by the AOPHB authors] would be provided from within the employing organisation's intranet. Midwives and student midwives would then be able to access this site when they wished to do so. It is suggested that is intervention component would increase the credibility of the AOPHB within the employing organisation by the inclusion of content that demonstrates the successful implementation of the AOPHB.

The following table suggests how AOPHB components a to c relate to the stages of the AOPHB and address the identified potential implementation challenges that midwives within an employing organisation may experience, and how these components aim to address them:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges:
Creating the Conditions	Initiate the unambiguous, on-going offer of a planned home birth	Motivation – priorities and commitments	•Concern about potentially being viewed as having coerced women to discuss home birth against their will •Developing the routine practice of exploring a woman's decision making for institutional birth without the feeling that they are being disrespectful of their decision
	Provide detailed and balanced information and discussion about home birth	•Motivation – priorities and commitments •Practicalities – time to do this in routine practice	•Routine provision of info where a woman or significant other may not appear receptive
Positive Reinforcement	Provide detailed and balanced information and discussion about home birth	•Motivation – priorities and commitments •Practicalities – time to do this in routine practice	•Women who are planning a home birth require the information they request at times to suit them, not pre-scripted content at pre-scripted time points in pregnancy
	Reassurance and support	•Motivation – priorities and commitments •Practicalities – time to do this in routine practice	•Service users who are planning a home birth require continued reassurance and support for their decision making
Both stages	All domains	•Motivation – priorities and commitments •Acceptance and beliefs – will this be useful	•Sufficient time to perform the extra discussion and activity required, such as more detailed discussion about home birth and holding specific home birth groups

(d) Identification and use of an Opinion Leader within the Health Board to lead and promote the AOPHB

Within clinical practice, an opinion leader – perhaps a Consultant Midwife with a suitable remit, local home birth lead or midwife who is respected locally for her planned home birth experience, would be identified. There is no clear evidence of what the most effective way to identify an opinion leader is, with some studies using a sociometric approach and others applying an informant method (Flodgren et al 2011). However, there is some evidence to suggest that opinion leaders do promote evidence-based practice (Flodgren et al 2011).

The Opinion Leader would be engaged to:

- use their influence to engage and support other midwives in implementing the AOPHB within their practice (NICE 2007)
- provide the annual AOPHB updates
- co-ordinate the annual AOPHB audit process (HQIP 2015)

The following table illustrates the ways in which the identification and use of an Opinion Leader within the employing organisation could address the identified potential AOPHB implementation challenges that midwives within an employing organisation may experience:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges:
All	All	•Motivation – priorities and commitments •Acceptance and beliefs – will this be useful •Skills – confidence in communication skills •Practicalities – time to do this in routine practice	•Engaged in reinforcing the message that the provision of the AOPHB is good practice and that is the current practice standard •Feedback to midwives, via audit and verbal re the experiences and outcomes of women and significant others re the AOPHB •Offering to support midwives in particular scenarios, examples of how AOPHB has been successfully used in practice

(e) Annual audit

Once the AOPHB has been implemented for a year within an employing organisation an annual audit of the standard of implementation that has been achieved within the organisation, and outcomes of the AOPHB in terms of informed decision making about PHB and PHB rates would be conducted.

The annual audit process would use a proforma and involve:

- Talking with midwives about their recent practice in relation to each of the two stages of the AOPHB
- Looking at the current organisational information provision re. all birth place options
- Review of handheld notes re. completion of the AOPHB documentation
- Looking at the organisation's current planned and achieved PHB rate, including the socio-demographic profile of the women who currently make this choice within the organisation's service users

- Talking with women and significant others about the care they received in relation to planned home birth decision making

The BFI (UNICEF) uses an ongoing audit process to assess the adherence to the BFI Standards, and reviews clinical notes, assesses midwives' breastfeeding knowledge and skills, and interview women about their experience of breastfeeding / infant feeding support.

(f) Audit data uploaded to the intranet demonstrating on-going benefits and outcomes of the AOPHB

The initial and annual organisational assessment audit results would be uploaded to the intranet at the start of AOPHB implementation. This would enable midwives and student midwives to access these when they wish to do so. This will enable the results of the audit to be disseminated to individual midwives, and other staff employed within the maternity service (HQIP 2015).

The following table suggests how the annual AOPHB audit, and its eventual placement on the employing organisation's intranet [components e and f] would overcome potential barriers to the implementation of the AOPHB by midwives within the organisation:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges:
Creating the Conditions	Initiate the unambiguous, on-going offer of a planned home birth	Motivation – priorities and commitments	•Concern about potentially being viewed as having coerced women to discuss home birth against their will •Developing the routine practice of exploring a woman's decision making for institutional birth without the feeling that they are being disrespectful of their decision
	Provide detailed and balanced information and discussion about home birth	•Motivation – priorities and commitments •Practicalities – time to do this in routine practice	•Routine provision of info where a woman or significant other may not appear receptive
Positive Reinforcement	Provide detailed and balanced information and discussion about home birth	•Motivation – priorities and commitments •Practicalities – time to do this in routine practice	•Women who are planning a home birth require the information they request at times to suit them, not pre-scripted content at pre-scripted time points in pregnancy

	Reassurance and support	•Motivation – priorities and commitments •Practicalities – time to do this in routine practice	•Service users who are planning a home birth require continued reassurance and support for their decision making
Both stages	All domains	•Motivation – priorities and commitments •Acceptance and beliefs – will this be useful	•Sufficient time to perform the extra discussion and activity required, such as more detailed discussion about home birth and holding specific home birth groups

AOPHB components that are focused on individual midwives:

(g) Initial AOPHB training programme

The initial AOPHB training would be delivered to small groups of midwives, and would last approximately four hours. NICE (2007) state that small educational meetings, such as training courses, are often used to educate health professionals about developments in their fields.

The training would be facilitated in the midwives' usual working environment by a member of the AOPHB team or a trained facilitator from the employing organisation [possibly the identified the opinion leader].

The initial AOPHB training would aim to do two main things:

1. Inform the midwives about the purpose and content of the AOPHB

• Why the AOPHB is felt to be necessary within their organisation (based on organisational audit findings) and the in UK (discussion of national decision making experiences and PHB rates). (Feedback audit results [component a]). Use examples of where care according to AOPHB standards has/ has not been provided and the resultant birth place.

• Reinforce message that AOPHB is now expected standard of care within their organisation – show intranet podcast (component b)

• The component parts of AOPHB ('Creating the Conditions' and 'Positive Reinforcement')

• The supporting elements on the AOPHB [employing organisation and individual midwife focused components, and woman and significant other focused components].

2. Train the midwives in the provision of care according to the AOPHB

• Explore provision of each stage of the AOPHB in terms of overall aim of each stage, and the constituting domains. This would include time to discuss and address concerns/challenges that the midwives perceive to exist

- Practice using the AOPHB in terms of scenarios (relevant to existing organisational systems) – e.g. initial consultation visit scenarios in terms of assessment of AOPHB stage required, on-going care in terms of care required, scenarios re continuing the AOPHB when caring for women on another midwife's caseload, scenarios about the inclusion of significant others, scenarios around discussing birth experiences where the need for referral regarding trauma is highlighted.

- Highlight support available within their organisation through the Opinion Leader(s)

(h) Annual AOPHB update

The annual AOPHB training would be delivered to small groups of midwives, and would last approximately 1.5 hours. NICE (2007) state that small educational meetings, such as training courses, are often used to educate health professionals about developments in their fields.

The training would be facilitated in the midwives' usual working environment by the employing organisation's opinion leader (NICE 2007).

The update would aim to:

- revisit and reinforce the use of the AOPHB process within clinical practice
- address ongoing challenges
- inform the midwives of the annual audit findings [component e] (NICE 2007, HQIP 2015)

The following table suggests the way that the AOPHB components g and h aim to address the potential implementation challenges that may arise for midwives working within an employing organisation:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges:
All	All	•Motivation – priorities and commitments •Acceptance and beliefs – will this be useful •Skills – confidence in communication skills •Practicalities – time to do this in routine practice	•Engaged in reinforcing the message that the provision of the AOPHB is good practice and that is the current practice standard •Inform midwives audit and verbal re the experiences and outcomes of women and significant others re. the AOPHB •Allow midwives to work through particular scenarios that they may find challenging / departure from current practice •Highlight support available within organisation

(i) AOPHB documentation in handheld notes

Documentation that highlights the AOPHB two stage process would be created by the AOPHB author and included within the maternity handheld notes that are used by the employing organisation. The documentation would act as a prompt for a midwife to clearly categorise a woman according to

which stage of the AOPHB she requires, and to provide the relevant components of the AOPHB throughout pregnancy (NICE 2007). Documentation would also be included within the postnatal notes to ensure that the PN elements of the AOPHB are also provided to women.

Additionally, the documentation would facilitate continuity of AOPHB care where continuity of carer during the antenatal period was not provided to women, or where a woman is referred to a home birth team on deciding she would like to birth at home.

The following table suggests how the AOPHB documentation may assist midwives in overcoming some of the challenges to the implementation of the AOPHB within their clinical practice:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges:
All	All	•Motivation – priorities and commitments	•Visual reinforcement / reminder of the message that the provision of the AOPHB is good practice and that is the current practice standard •Visual reminder of the component elements of the AOPHB in terms of stages / domains

(j) Interaction with previous service users who have received the AOPHB

THE AOPHB will ensure that midwives are in contact with woman and significant others who received the AOPHB and chose to birth at home. Women and their significant others would be invited to attend the antenatal class sessions where home birth is discussed, and the monthly home birth groups that women and their significant others will be invited to as part of the AOPHB.

The following table suggests how midwives interacting with service users who have experienced the AOPHB may assist them to overcome some barriers to the implementation of the intervention:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges by:
All	All	•Motivation – priorities and commitments •Acceptance and beliefs – will this be useful	•Regular reinforcement / reminder of the message that the provision of the AOPHB is good practice and that it is useful for women and their significant others

Student midwife focused interventions:

Where student midwives attend a practice placement where the AOPHB has been implemented by the employing organisation, they would be able to receive a student midwife focused AOPHB intervention.

Three educational components would be implemented within the pre-registration education programme:

(k) A programme of classroom sessions

AOPHB teaching sessions would be included within the 3 years of pre-registration midwifery training where HEIs use placements within employing organisation who have implemented the AOPHB. This approach has been used within midwifery training for other subject areas, such as mental health where sessions have been pre-created by a charity (MIND), or infant feeding (BFI). A framework could be provided to the HEI to allow them to create a curriculum that maps to the AOPHB process (BFI).

The training would be held within the individual HEI setting, and facilitated by a HEI employer using the guidance notes provided with the framework / pre-created sessions.

(l) Documentation of x5 episodes of care provided according to the AOPHB

Each student midwife would need to provide evidence of five episodes of care that they have provided in line with the AOPHB. The documentation for this would be provide by the AOPHB alongside the training materials. These would be assessed by their midwifery mentor (who herself has been trained in providing care according to the AOPHB).

The BFI process requires student midwives to record antenatal conversations and clinical skills during their training, so this process is accepted within clinical practice amongst students and midwives (BFI).

Working alongside students who are also providing care in line with the AOPHB as part of their training may also serve to motivate Midwifery Mentors to provide this style of care.

(m) Attendance at least one PHB during training

Student midwives would be required to attend at least one planned home birth as part of their pre-registration midwifery training, in order to complete the AOPHB training. Research suggests that student midwives being exposed to home birth prior to qualification results in them being more favourable towards home birth once registered (Vedam et al 2010).

AOPHB components focused on women:

(n) Care for women according to the required 'Creating the Conditions' and 'Positive Reinforcement' AOPHB stages

Midwives would use their AOPHB training (components g & h) and the AOPHB documentation (component i) to provide women with care according to the stage of the AOPHB that they require. This includes an automated 'do not reply' email / text service that women would provide their details for, and which would convey messages that are in line with the AOPHB stage that they require – such as information about physiological birth, water birth, the benefits of home birth for women requiring the 'Creating the Conditions' stage, and videos of home births and ideas for home birth preparation for women requiring the 'Positive Reinforcement' stage. The email 'package' would be pre-designed [and updated as required] by the AOPHB author so as to be easy for midwives to initiate. It would also include provision of a discussion sheet that women will be encouraged to use with their significant others to discuss planned home birth with them.

The suggested structure is designed to address each of the domains that are contained within the two stages of the AOPHB.

(o) Service user focused AOPHB podcast uploaded to the employing organisation's website and social media pages

A service user focused podcast [created by the AOPHB author] would be embedded into the organisation's website on the relevant service pages. The podcast would outline to service users what the AOPHB is and how it is justified in terms of the evidence base; and explain that the AOPHB has been adopted within the organisation.

The following table suggests the barriers to implementation that women who receive the AOPHB may experience, and how the intervention has been designed to overcome these barriers:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges by:
Creating the Conditions	All	•Awareness and knowledge – do they know about PHB, and the reason for guidance re PHB? •Acceptance and beliefs – credibility of the PHB system that are being told about •Motivation – potential benefit of PHB	•Saying why the organisation has adopted the AOPHB and why it is important to make an informed decision about PHB. •Say approach considers the support that significant others might need if a woman they are supporting would like to consider giving birth at home •Include pregnancy experiences where women have responded to CC and considered / decided upon PHB. •Highlight that PHB is an option in this health board. • Midwife will sign post service users that she has contact with to this video

Positive Reinforcement	All – especially 'Support and Reassurance' domain	•Acceptance and beliefs – credibility of the PHB system that are being told about	•Reassurance for service users who would like to plan a PHB that they will receive a positive response and proficient service if they say to their midwife that they wish to birth at home •Say approach considers the support that significant others might need when a woman they are supporting decides to birth at home

(p) Woman focused AOPHB resources and invitations to AN classes (active birth classes, home birth groups, and parentcraft classes) publicised on organisation website and social media pages

Women focused resources, such as the discussion sheet mentioned above in relation to components n & o, and invitations to the various groups that constitute the AOPHB group activities would be advertised on the organisation website and social media pages, in addition to being mentioned by their midwife. This would allow women to access these invitations independently of their midwifery care, and view them as part of the maternity service's widespread clinical strategy.

Engagement in numerous classes, in addition to the routine antenatal appointments, will ensure that women continue to receive contact and positive input about planned home birth from their midwife despite there being up to sixteen weeks between appointments [between sixteen weeks and twenty-eight weeks gestation] for multiparous women with a healthy pregnancy (NICE AN guidance).

The following table illustrates how this component of the AOPHB aims to overcome the implementation barriers that women may experience:

Related to AOPHB stage:	Related to domain of the AOPHB stage:	Barriers	Aims to address these potential implementation challenges by:
Creating the Conditions	All	•Awareness and knowledge about physiological birth •Awareness and knowledge – do they know about PHB, and the reason for guidance re PHB? •Acceptance and beliefs – credibility of the PHB system that are being told about •Motivation – potential benefit of PHB	•Addressing potential resistance to the AOPHB from women who have a lack of previous knowledge / confidence about their ability to give birth safely without intervention •Addressing potential resistance to the AOPHB from women who have a lack of previous knowledge / support about PHB •Addressing potential barriers created by significant others' lack of information / support about PHB •Creation of a social network that supports PHB

			•Midwife will sign post service users that she has contact with to these webpages
Positive Reinforcement	All – especially 'Include of significant others'	•Awareness and knowledge – do significant others know about PHB, and the reason for guidance re PHB? •Acceptance and beliefs – credibility of the PHB system that significant others are being told about •Motivation – potential benefit of PHB for the woman significant others are supporting	•Preparation for PHB •Creation of social network that supports PHB •Addressing potential barriers created by significant others' lack of information / support about PHB •Midwife will sign post service users that she has contact with to these webpages

(s) Women interacting with service users who have received the AOPHB

Women will be invited to attend parentcraft classes, and home birth group meetings (component p) so as to interact with women who have received the AOPHB and birthed at home. This component is included to facilitate women to develop, or enhance, their supportive social networks as evidence suggests that this would be facilitative for women requiring either the 'Creating the Conditions' or 'Positive reinforcement' stages of the AOPHB.

(u) Midwives lend resources for planned home births to women who wish to birth at home
Midwives will be able to lend women home birth related resources, such a books and DVDs about home birth preparation and birth pools. This will act as a supportive process in line with the 'Positive Reinforcement' stages 'Support and Reassurance' domain. Anecdotal reports have suggested that the lending of resources such as birth pools has increased the home birth rate in some areas. It is acknowledged that it may not be financially possible for birth pools to be lent by all midwifery teams, and so this idea is extended to include the lending of other items as this is suggested to be helpful or demonstrate support to women.

Significant other focused AOPHB components:

(q) Care for significant others according to the required AOPHB stage
Midwives would use their AOPHB training (components g & h) and the AOPHB documentation (component i) to provide significant others with care according to the stage of the AOPHB that the pregnant woman requires. In particular:

- A discussion sheet would encourage significant others to talk about home birth – either as a way of encouraging both woman and significant other when neither are considering this option, or where a woman would like to birth at home and needs to discuss this with their significant other. This would specifically address the 'Challenge the assumption of institutional birth' and 'Include significant others' domains within 'Creating the Conditions', and the 'Include significant others' domain within the 'Positive Reinforcement' domain.
- An automated 'do not reply' email / text service that women would provide their details for, and which would convey multi-media messages that are in line with the correct AOPHB stage – such as information about physiological birth, water birth, partners' experiences of home birth for significant others supporting women requiring the 'Creating the Conditions' stage, and information and videos of home births', and significant others involvement and preparation for home birth where a woman is requiring the 'Positive Reinforcement' stage.

The use of emails or texts (CRISP 2013) is a well-recognised approach as reminders or motivational messaging (Hall et al 2015).

(r) Significant other focused AOPHB resources and invitations to AN classes publicised on organisation website and social media

Significant other focused resources, such as the discussion sheet mentioned above in relation to components n & o, and invitations to the various groups that constitute the AOPHB group activities would be advertised on the organisation website and social media pages, in addition to being mentioned by their midwife. This would allow significant others to access these invitations independently of any midwifery care, and view them as part of the maternity service's widespread clinical strategy.

(t) Significant others interacting with service users who have received the AOPHB

Significant others will be invited to attend parentcraft classes, and home birth group meetings (component p) so as to interact with women who have received the AOPHB and birthed at home. This component is included to facilitate significant others to develop, or enhance, their supportive social networks as numerous sources within the scoping review [Chapter 4] have suggested that partners, and other family members have benefited from attending home birth groups as a result of meeting others who have birthed at home.