

What are women's views on homebirth? A study to inform the development of practical strategies that will promote birth at home as a choice for low-risk, multiparous women

Jo Naylor-Smith

A thesis submitted to the University of Birmingham for the degree of Master of Health Research (MRes)

College of Medical and Dental Sciences
School of Health and Population Sciences
University of Birmingham

September 2014

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Abstract

The aim of this qualitative study was to investigate women's views about homebirth, what influences their choice of place of birth, and the support and information they need to consider homebirth as a safe and realistic option.

The main themes identified in a critical literature review informed the topic guide for 6 focus groups undertaken with 28 women. Potential participants were identified by leaders of local mother and baby groups who used posters to promote the study. The study sample was women who had all had at least one baby in the last year, and recent experience of local maternity services.

Framework Analysis was used to identify deductive and inductive themes in the data, and the findings from this phase of the study were discussed as part of a focus group with 8 members of the Homebirth Team at the local Trust.

It was found that the women needed more information about the practicalities and experience of homebirth and trust in the service, before making a decision about home birth. It was observed that the views of other mothers shared in the group discussion influenced women's views on place of birth. These results have implications for practice with regard to how information is presented to mothers, and the involvement of health professionals in helping mothers make decisions.

I would like to dedicate this thesis to my parents, Wendy and Roland Smith. Their consistent, non-judgemental love and support has allowed me to grow and achieve my potential, even though it has taken a long time for me to believe in myself as they always have.

Acknowledgements

I would like to thank Birmingham Women's NHS Foundation Trust for the opportunity to undertake this postgraduate study, and the National Institute of Health Research for their generous funding.

Vital administrative support has been provided by Anne Walker and Emma Broglia. Their patience and skill in achieving in minutes what would have taken me hours has been very much appreciated.

The support of Dr Beck Taylor, in the co-facilitation of the focus groups and more essentially as a critical friend has brought a positive element to this journey that I didn't anticipate, but has been a pleasure.

I would like to especially thank my supervisors, Dr Sara Kenyon, Dr Karen Shaw and latterly Dr Alistair Hewison who have supported me throughout this study. Karen and Sara have been dedicated in their provision of knowledge, reassurance and support, and have been patient and available to me above and beyond their academic responsibility. Alistair's contribution of an objective view in the final months of this study has been invaluable.

Finally I would like to thank my partner, Kevin Boyle, his love and pride in seeing me achieve makes the hard work and dedication worthwhile.

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1. BACKGROUND

The need to increase choice for pregnant women, including place of birth (PoB) is a national health priority which should inform the development of services outlined in Changing Childbirth (Department of Health (DoH), 1993), endorsed by other DoH policy publications (DoH 2004, 2007). More than 97% of women gave birth in an OU (OU) and national homebirth rates are 2.3%, with a regional range of 0.4%-9% of all births (Birthchoice UK, 2011).

Until the publication of The Birthplace Study (BECG, 2011), there was a lack of good quality evidence demonstrating the safety of homebirth. The need for more robust evidence surrounding the relative safety of birth outside of an OU was further highlighted by the National Institute of Clinical Excellence (NICE) within its review of the Intrapartum Care Guidelines in 2007.

Retrospective studies (Mori et al, 2007, Wax et al, 2010), published after the NICE Intrapartum Care Guidelines (2007) claiming homebirth was significantly less safe than OU birth, were widely criticised in 2010 (Cohain, 2010, Hart, 2010, Klien) for their lack of rigour and generalizability. Furthermore, they demonstrated the political divide between obstetricians, midwives and women's groups promoting natural birth. All highlighted the need for more evidence on the safety of homebirth.

The hierarchy of evidence (Sackett, 1986) suggests that the most robust evidence is obtained from systematic reviews, followed by randomised control trials (RCT). However, the Cochrane Review undertaken by Olsen and Clausen's (2012) identified only 2 trials that met their inclusion criteria, however, only one trial including 11

women delivered outcome data and was reported. The evidence from this trial did not allow substantive conclusions to be drawn, due to its moderate quality and small sample size. Olsen and Clausen (2012) suggest that such a RCT with sufficient numbers of participants is unlikely to be undertaken due to the present maternity service infrastructure being unable to support the large number of homebirths it would require, and women would be reluctant to be randomised.

The Birthplace Study (BECG, 2011), a prospective cohort study of 64,538 low-risk women, represents the most robust evidence to date of the relative safety of homebirth for the babies of all low-risk¹ multiparous² women when compared with OU birth.

The study found that although the risk of a poor outcome for babies born at home for nulliparous³ women was increased, the absolute risk was low. Care providers are now able to promote homebirth as it has been demonstrated that multiparous women giving birth at home have no difference in adverse perinatal outcomes compared to women giving birth in an OU.

The Birthplace Study (BECG, 2011) also demonstrated that homebirth was associated with less intervention⁴ and increased numbers of women having a normal⁵ birth. Transfer rates into the OU were reported as 45% for nulliparous and 12% for multiparous women.

¹ Defined by national clinical guidelines (NICE) as women free of medical and obstetric complications when they go into labour

² planning their second or subsequent baby

³ planning their first baby

⁴ e.g. emergency caesarean section

⁵ defined as birth without any of the following interventions: induction of labour, epidural or spinal analgesia, general anaesthetic, forceps or ventouse, caesarean section or episiotomy

The West Midlands has a homebirth rate of less than 1% of all births (Birthchoice UK), and a higher than the national average birth rate which is continuing to rise (Office of National Statistics (ONS), 2011), resulting in demand for birth in obstetric or Midwife-led maternity units exceeding capacity citywide.

With an attempt to increase its homebirths, an objective to embrace the national choice agenda and reduce the demand on its maternity beds, Trust A has been successful in its bid to secure commissioning for a dedicated Homebirth Team (HBT). The aim is to provide caseload midwifery and homebirth support for 3% of women requesting Trust A to provide care within the next 3 years.

The challenge for the HBT is to promote homebirth as a safe and realistic choice, necessitating a change in culture from the current situation where OU birth is the reality for the majority of women.

Although The Birthplace Study (BECG, 2011) provides evidence of the comparative safety of homebirth to birth in OU, it does not address how women make their choice of PoB and how this is influenced.

- This study plans to address this knowledge gap by undertaking a systematic literature review regarding women's views of their choice of PoB, identifying key themes in the published literature using Centre for Reviews and Disseminations' (CRD) core principles, with the quality of the evidence critically appraised using the Critical Skills Appraisal Programme (CASP)
- Undertaking focus groups with women and Health Care Professionals (HCP's) from the HBT at Trust A. Themes identified from the women's

groups will be fed back to the HCP's to explore the practical strategies that might be developed as a result.

- Analysis of the data will be undertaken using a framework method (Ritchie and Spencer, 1995) which identifies both deductive and inductive themes.
- A summary of the results will be provided with suggestions for practical strategies to be taken forward by the service and further research detailed.

2. REVIEW OF THE LITERATURE

2.1 Introduction

Decisions about health care for individual patients and public policy should be informed by the best possible evidence. Reviewing current evidence in any subject area is achieved by conducting a systematic review of the existing literature to identify, critically appraise and summarise all relevant studies to make the available evidence more accessible (CRD, 2009). Systematic reviews should report on the method and strategy of searching used for it to be credible and repeatable (Bowling, 2009) along with identifying and recording the evidence base about the subject being reviewed. This creates an opportunity to demonstrate where knowledge is lacking and guide future research (Booth, Rees and Beecroft, 2010).

This review aims to provide a critical synthesis of published research into the views of women on choice, and their influences in their decision making around PoB.

2.2 The Review question

What does the evidence inform us about women's views on their choice of place of birth?

2.3 Search Methodology

To ensure best practice for this comprehensive critical literature review, CRD's guidance (2009) for undertaking reviews in healthcare was used and their core principles adhered to. To identify the most appropriate literature for the review, during the initial search it was recognised that it was necessary to include authoritative literature reviews (of which there are 3) to ensure all the key papers in this area were considered. To ensure that a critical appraisal was undertaken and the quality of the evidence was systematically evaluated the CASP assessment tool was used.

This tool uses checklists appropriate to the type of study⁶ citing questions to determine quality, enabling each study to achieve a score out of 10, the highest indicating the most robust quality of evidence.

An electronic search of the following databases was conducted in order to identify original studies:

- MEDLINE
- CINHAL
- PUBMED
- EMBASE
- COCHRANE
- MIDIRS

Although the main focus of the review is the views on decision making and choice of PoB for low-risk, multiparous women, it was considered that using these as limiters may make the search too specific as these factors may not be mentioned in the title or abstract. The initial selection criteria were broad to ensure all potential studies were included and assessed for their relevance.

The key words and predetermined search terms⁷ used were: Place of birth, homebirth, obstetric unit birth, hospital birth, choice, decision making, views and opinions.

The initial selection was based on the article titles, and then all the duplicates were excluded, the abstracts were assessed for relevance to the subject. Articles that were clearly unsuitable were excluded, and the full text versions of the studies that appeared relevant from the abstract were obtained and assessed.

⁶ E.g. qualitative, quantitative, review etc.

⁷ Mesh headings

Manual searches were completed by following up citations from the studies that appeared to be relevant, and these additional studies were assessed through the system detailed above.

The following inclusion and exclusion criteria were applied:

Inclusion Criteria

1. Primary research studies and literature reviews written since 1993, which was the date of publication of *Changing Childbirth* (DoH), putting choice of PoB on the national agenda for the first time.
2. Published in the English language.
3. Quantitative, qualitative or mixed method studies to maximise transparency and minimise bias (Polit, Beck and Hungler, 2001).
4. Focus on women's choice and decision making around choice of PoB.
5. Context of developed countries, as defined by the High Income Index, (Worldbank, 2012).

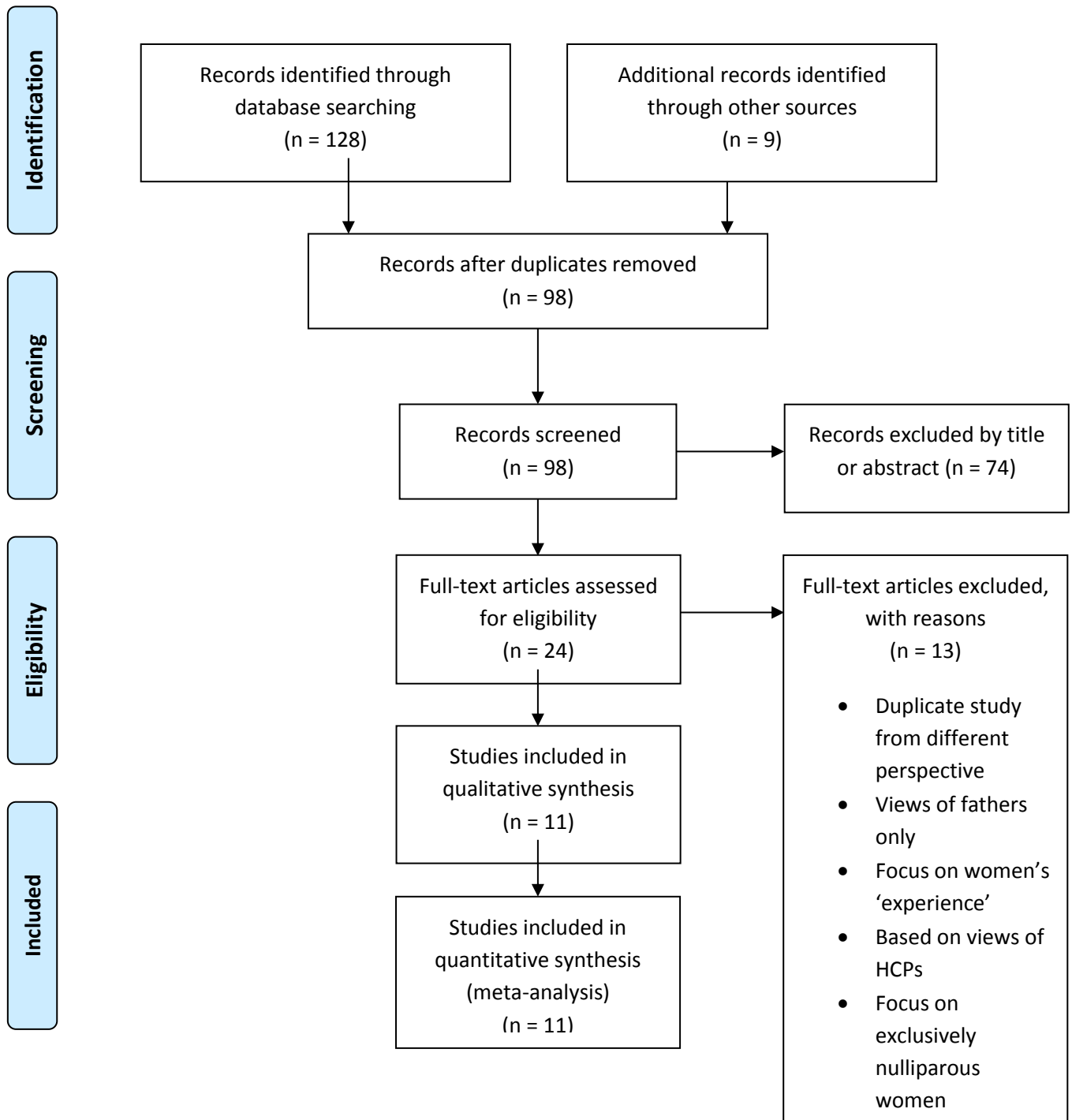
Exclusion Criteria

1. Personal accounts. Sackett (1986) suggests that these are very low on the hierarchy of evidence.
2. Health promotion leaflets for both Health Care Professionals (HCPs) and women.
3. Opinion articles or editorials written by HCP.

The search was recorded by using a PRISMA flow diagram, (Moher et al, 2009), (Figure 1) and an extraction table was compiled to summarise, synthesise and critically appraise the studies. This structured integrative literature review approach

was used to identify themes and devise a thematic narrative to establish what is both known and unknown about the subject.

Figure 1 PRISMA 2009 Flow Diagram (Moher et al, 2009)



2.4 Critical Analysis of body of literature

2.4.1 Quality

The studies identified from the critical literature review (n=11) were, in general, low to medium quality, qualitative studies using small numbers of women, or literature reviews. There were no studies that specifically focussed on low-risk, multiparous women's views on choice of PoB. Although 'OU birth' and 'Hospital birth' combined with 'choice' or 'decision making' were used as search terms, no studies with these phrases in the title were found, however, 'homebirth' combined with the same limiters produced 5 studies. It can be surmised from this there is less evidence about why low-risk, multiparous women choose OU birth than there is about why they choose homebirth, suggesting the need for more comparative studies.

The majority of the studies included (n=5) (Table 1) considered retrospective accounts of the decision making process of women who had chosen to have a homebirth for their first or subsequent babies. Although these views provide insight into the provision of choice and subsequent decision making for these women, they are essentially self-selecting and interested in homebirth, therefore not representative of the general low-risk multiparous population. These studies also neglect to provide insight into why women choose to give birth in an OU, rather than at home.

Table 1. Participants who had chosen exclusively to homebirth (n=5)

Research Title/Author/Country of Origin	Research Methodology	Conclusion	Quality score (CASP)
Negotiating control and meaning: homebirth as a self-constructed choice in Finland. Krisi Viisainen (2001) Finland	Unstructured interviews with 12 couples plus 9 individual Finish women who had planned a homebirth in previous 3 years.	'Natural Birth' holds various meanings to different Finnish women, and medical management of childbirth is culturally variable, as its resistance to it.	7/10
Multiparous women's confidence to have a publically- funded homebirth: A qualitative study. Catling-Paul, C., Dahlen, H. and Homer, C.C.S.E (2011) Australia	10 multiparous, English speaking women from one OU in Australia interviewed postnatally using semi-structured interviews.	Women who had already experienced a natural birth had confidence in their ability to give birth at home. They searched for information, considered risks and were influenced by their previous birth experience, family support and their own self-confidence.	6/10
Homebirth experience 1: decision and expectation. Alison Andrews (2004) Wales	Semi structured interviews of 8 multiparous women who were planning a homebirth.	The decision to have a homebirth was based on the expectation of normality, calm and control. Additional factors were previous birth experience, concerns over childcare and the desire for a calm environment.	2/10
Factors influencing multiparous women to choose a homebirth - an exploratory study Ashely, S & Weaver J (2012) England	Semi structured interviews with 8 women who chose homebirth after a previous OU birth.	Four themes emerged as influencing women to have a homebirth: the midwives role, anticipated experience, risk and control. To birth at home is an individual and complex decision, and is based on previous birth experience and influence of others.	4/10
Why homebirth? A qualitative study exploiting women's decision making about place of birth in two Canadian Provinces. Murray-Davis et al (2012) Canada	Qualitative, Grounded theory approach using semi structured interviews of 34 women.	Women in 2 different provinces of Canada approach decision making around choice of place of birth in a similar fashion from which a decision making framework can be devised.	4/10

Further records were identified that considered the views of women on PoB⁸ (Table 2) but did not separate the data to identify the parity or risk status of the women participating.

Table 2. Multiparous and nulliparous women's views on choice of place of birth (n=4)

Research Title/Author/Country of Origin	Research Methodology	Conclusion	Quality Score (CASP)
'Choice' and Place of Delivery: a qualitative study of women in remote and rural Scotland. Pitchforth et al (2008) Scotland	Qualitative study – 12 community based focus groups of women who had recently had experience of Maternity services.	Provision of maternity services may not be sufficient to convince women they have choice, and a more critical approach to the use of choice as a service development and analytical concept should be developed.	6/10
Women's perceptions of their right to choose the place of childbirth: an integrative review Hadjigeorgiou, E et al (2010) Worldwide	Integrative literature review.	There is widespread evidence that women worldwide wish to exercise their choice of place of birth, however, the medical model is still a powerful influence in many countries. The lack of informed choice for women reveals the need for improvement in communication between Health Care Professionals and women.	5/10
Place of birth: can 'Maternity Matters' really deliver choice Alison Edwards (2008)	Summary of literature.	Implementing choice of place of birth is a complex concept and women have to deal with a myriad of influences from the institution, Health Care Professionals and others around them.	6/10
Women's views of the place of confinement. Simon Fordham (1997)	Postal Questionnaire (Likert scale) of 340 20-40 year old women from one surgery (some exclusions).	Women have varied views on choice of place of birth and more accessible information is needed for them to make an informed and free choice.	3/10

The studies detailed in Tables 1 and 2, multi-national research was included, which although providing insight in pregnant women across the world's thought processes

⁸ without specifically focussing on homebirth

when choosing their PoB, also negatively affects the relevance and transferability to a UK context, due to cultural and health system differences.

The most relevant studies (Table 3) were conducted in the UK and included exclusively multiparous women⁹. However, they did not separate out high and low-risk women, so their results although the closest to the research question, should be interpreted within this boundary.

Table 3. Multiparous, High and Low-risk Women – Choice of Place of Birth (n=2)

Research Title/Author/Country of Origin	Research Methodology	Conclusion	Quality Score (CASP)
To what extent are women free to choose to give birth? How discourses of risk, blame and responsibility influence birth place decisions. Coxon, K, Sandall, J and Fulop, N. (2013). England	Prospective Longitudinal narrative study of 82 high and low-risk nulliparous and multiparous women from 3 maternity services in. Data on Multiparous women reported separately.	Cultural and social factors explain the high uptake of OU birth, and high level support for alternative settings for birth will only be affective if they were positioned as culturally normative and acceptable practice.	8/10
Factors influencing multiparous women who choose a homebirth -a literature review. Ashely, S & Weaver, J (2012) Multi-national	Literature Review.	Persistent themes in the literature were related to control of the birth, risks and safety, homebirth as a lifestyle choice and the influence of Midwives.	7/10

2.5 Themes

2.5.1 Expectation of birth in an Obstetric Unit (OU)

Choosing PoB, is arguably the most important decision a women will make during her pregnancy, yet it is taken for granted that birth ought to take place in an OU

⁹ Coxon et al (2013) reported data separately for nulliparous and multiparous women

(Pitchforth, 2008, Coxon et al, 2013) as this is the 'norm' (Ashely and Weaver, 2012a).

Homebirth is not a true choice for all women, due to maternity infrastructure, culture and education (Ashley and Weaver, 2012a) limited by belief that birth only takes place in an OU (Hadgigeorgiou, 2010). Although the evidence to support the perception that birth in an OU is safest for low-risk women is minimal (Savage, 2007, in Edwards 2008) women who have a choice, opt for OU birth 'just in case' (Kightly, 2007 in Edwards, 2008, Coxon et al, 2013). Women also have to demonstrate commitment and determination in order to succeed in challenging the culture of medicalised birth and the unsympathetic views surrounding this (Andrews, 2004).

The evidence is conflicting regarding whether nulliparous or multiparous women are most open to the idea of birth in different settings; Coxon et al (2013) suggests nulliparous women make the most use of alternative places of birth, where in an earlier review of the literature Edwards (2008) states multiparous women are more likely to do this. In the context of her literature review, Edwards (2008) does concede that most of the women in the studies she reviewed had only experienced birth in an OU, which could influence the results.

2.5.2 'Adaptors' or 'Active Choosers' (Pitchforth et al, 2008)

To make an informed decision about their PoB, women need to understand that they do have a choice (Edwards, 2008, Ashley and Weaver, 2012), which is not the case for all women (Pitchforth et al, 2008).

Choice has been part of the Midwifery agenda since Changing Childbirth was published in 1993 (DoH) but the reality of choice is not always communicated to

women. In her study of choice of PoB for women in remote rural Scotland, Pitchforth et al (2008) concluded:

‘Understanding “choice” from the perspective of women who currently have more than one option of where to deliver provides valuable insight, particularly at a time when policy statements are emphasising the need to increase and ensure option for place of birth for all women in the UK’ p47

Choice is a complex concept and can be experienced and implemented in various ways (Pitchforth et al, 2008). It has been suggested that real choice is exclusive to the better educated (Viisainen, 2001, Murray-Davies et al, 2012) with middle-class values (Edwards, 2008) influenced by socio-economic status (Coxon et al, 2013), with women from ethnic minorities experiencing less choice, mainly because they were unaware of what was available (Edwards, 2008). In their review of the literature studying multiparous women choosing a homebirth, Ashely and Weaver (2012b) reported that the aspiration of choice was common to all women, and its’ restriction undermined the women’ confidence to give birth.

The concept of ‘Adaptors’ and ‘Active Choosers’ was presented by Pitchforth et al (2008) describing the way women engaged with choice, and represents the choice strategies they adopted. The ‘Adaptors’ generally implemented their right to choose by trusting the advice of their carers, especially for their first birth The ‘Active Choosers’ used more active language referring to ‘putting my foot down’ and having to ‘fight for what you want’.

It is important to acknowledge that with choice there comes responsibility and the provision of choice for women should not take such precedent in their maternity experience that it becomes a burden (Pitchforth et al, 2008).

2.5.3 Role of HCPs in influencing decisions on choice of place of birth

The available literature surrounding choice of PoB and decision making of women to birth outside an OU demonstrates the often negative influence Midwives and Obstetricians have on facilitating true choice for women. Women report hostility from HCPs if they challenge their expectation of control (Andrews, 2004, Edwards, 2008) and if choice is 'granted' a pressure from HCP on women to 'make the right choice'.

The restriction of choice can take several formats, with HCPs failing to present all alternatives and actively discouraging birthplace choices which they do not feel comfortable to support (Pitchforth et al, 2008). Midwives are the facilitators or barriers to informed choice (Ashley and Weaver, 2012a), however, choices offered can be restricted by core provision, staff conflict or lack of training provision (Edwards, 2008).

Women stated they wanted consistent information from HCP (Ashley and Weaver, 2012a) and if this is received then it enhances the credibility of both Midwives and Obstetricians (Pitchforth et al, 2008). There was a perception from women that HCPs present information in a way that they choose, and can be 'deliberately coercive, particularly with the promise of a 'healthy baby' (Levy, 2004, in Edwards, 2008). Midwives have been found to be deliberately vague in their provision of unbiased information (Hadjigeorgiou et al, 2010) and women suspect they invent complications in order to prevent homebirth (Viisainen, 2001).

The rationale for women's choices in childbirth has been assessed by how closely they follow either a medical or natural model of care. Both Viisainen, (2001) and Coxon et al (2013) found that women rarely embrace either of these models in its entirety, preferring to construct their own reality between available medical

knowledge and their own idealised expectations of birth. This is demonstrated in Viisainen's 2001 study conducted in Finland, a culture and system where birth outside of an OU is not supported. Women used the expertise of HCP to ensure that their pregnancy was medically uncomplicated, and then at a late stage arranged a homebirth with no expectation of support from their original HCPs and without consultation to avoid confrontation. Although this behaviour was observed in a culturally different landscape to the UK, it demonstrates how if choice is restricted, some women will manipulate the system in order to locally reconstruct an option that is acceptable to them.

2.5.4. Importance of clear information for women

One of the persistent themes identified in the literature is women's need for clear and complete information to assist their decision making around PoB. Although Fordham (1997) suggest that women have little knowledge of the potential benefits and constraints of different places of birth, this could be explained in that his questionnaire was sent to all women aged 20-40 years in his practice, irrespective of their experience or engagement of maternity care. It can be concluded, however, that women do encounter barriers in searching for information about PoB, and that most information available concentrates on safety, with the voices and opinions of women remaining unheard (Hadjigeorgiou et al, 2010, Murray-Davis et al, 2012).

If midwives do provide information about choice of PoB, it is disputed whether it can ever be completely clear, as it is delivered within tight timescales with minimal time allocated for questions, and women report being overloaded with information, therefore reluctant to ask for more (Edwards, 2008).

The best support for women wanting to discuss alternative PoB appears to be group support found in antenatal classes or classes specific to homebirth, where information is shared (Murray-Davis et al, 2012) and 'like-minded people solidified their confidence to pursue a homebirth' (Catling-Paul et al, 2010).

2.5.5. Perceptions of 'Natural Birth' and 'Control'

Women can perceive birth as a 'risky life event' which they will be lucky if it turns out well, which can be perceived as a negative view of a natural process (Savage 2007 in Edwards, 2008), although women who had had a previous 'natural' birth appeared more reassured in their abilities to achieve this again in the future (Murray-Davis et al, 2012).

Women's definition of 'natural' and 'control' in terms of PoB contrasts depending on where their preference is to birth their babies. Women's belief in their ability to achieve a 'natural' birth can be compromised if they consider an OU an unsafe environment for a baby to be born (Coxon et al, 2013). Their worries are multifaceted, but include separation from their families, loss of privacy and trust in their bodies and a compromised birth experience for their baby (Viisainen, 2001). For women electing to birth in an OU, they feel uncertain about 'natural' birth and the availability of medical technology secures a 'safe and clean' birth, which can, for them be perceived as 'natural' (Coxon et al, 2013). The women in Viisainen's study (2001) also felt that the only way to maintain control over the birth process and therefore reduce interventions, was to give birth outside an OU, however, all the women interviewed had either experienced or previously planned a homebirth, so their experiences were not representative of all women.

2.6 Summary

All the findings from studies reviewed need to be accepted in the context that there are no comparable studies that purely concentrate on low-risk, multiparous women's views on choice of PoB, therefore providing justification for further research with this sample of women. This means that no direct comparisons or insight can be drawn from this systematic review which must be considered in context of the cultural and system boundaries of the individual countries.

The research considered suggested that culturally, women believe that birth in an OU is the default option and the interaction with HCPs and the information that is provided and available to them emphasises this belief. Women value choice, and will adapt their justifications for their decision of where to give birth according to their own internal belief system regarding their ability to maintain control and achieve a 'natural birth'.

There is no specific evidence informing why multiparous women with a low-risk pregnancy choose to give birth in an OU¹⁰, consequently insight into the thought process of low-risk multiparous women's is not well understood and this leads to uncertainty about how they can be supported in this process by HCPs.

¹⁰ As there were only studies available which considered the decision making process for women who had chosen homebirth.

2.7 Conclusion

The aims of this study are to:

- understand women's current views about homebirth and what influences their decision making
- identify their perceptions of the barriers and supporting factors surrounding homebirth

With an objective to:

- inform the development of practical strategies that will promote birth at home as a choice for low-risk, multiparous women.

The research question to answer the aims and objective is:

What are women's views on homebirth? A study to inform the development of practical strategies that will promote birth at home as a choice for low-risk, multiparous women.

The review of the literature was used to inform the development of a topic guide for the focus groups with women (Appendix 1).

It is important to consider the views of a diverse range of multiparous women in their natural setting, as merely eliciting the opinions of women who are white professionals, older than 30 years and most likely to give birth at home (BECG, 2011, Brintworth and Sandwell, 2013) will contribute little in the way of new knowledge.

Participants will also be asked for their views on how the HBT can effectively communicate the benefits of homebirth to women, and what support and unmet

information needs they may have. This information will be collated and shared with the HBT and from it practical strategies to engage women will be formulated which have the benefit of stakeholder involvement.

3. METHODOLOGY AND STUDY DESIGN

3.1 Introduction

This qualitative study used a sample of pre-existing groups (mother and baby and HBT) to address the research question. The preparation and process of conducting the focus groups is described, along with examples of the support materials used.

Issues of reflexivity and reliability were considered, acknowledging the potential for bias and the involvement of the Research Team, along with providing participants with the opportunity to comment on the analysed data.

A framework analysis method (Richie and Spencer, 1994) was utilised in order to make sense of the data, using deductive and inductive themes. Framework analysis was chosen as it is a rigorous and systematic method, which offers clarity, transparency and an audit trail and is particularly suited to theme based analysis (Ward et al, 2013).

3.2 Methodology

When planning this study, positivism was considered as a dominant philosophy in common with other quantitative health care research. Positivism assumes that social phenomena can be measured objectively through observation, as human behaviour is a reaction to external stimuli (Bowling, 2009). In this study, women's choice of PoB is influenced by social norms, experience of themselves and others, and information provided. Therefore a social constructionist approach, which explores the stereotypes that humans use to understand reality as they see it (Schneider and Sidney, 2009) was required.

The Researcher needed to be aware of the subjectivity of her approach, as a Midwife working at the Trust A, the requirement for critical self-reflection on both the research

methods and the interpretation of data is essential (Topping, in Gerrish and Lacey, 2010). For the Researchers' influence and assumptions to be scrutinised, it is essential the research and its analysis was carried out in a systematic way with descriptive observations of what was said, done and seen, documented and reported along with the interpretation of their meaning and influence on original assumptions (Topping, in Gerrish and Lacey, 2010, Bowling 2009).

A qualitative research method was chosen as appropriate for this study as it explores complex phenomena (Tong et al, 2007) and attempts to take a holistic perspective to reveal the complexities of human behaviour. This was applicable to discover what women's motivations are for choosing or rejecting homebirth in order to use these views to devise practical strategies to encourage low-risk, multiparous women to consider birth at home as a realistic option.

Data was gathered using focus groups, which have become increasingly popular as a method for investigating public attitudes to health behaviours and quantifying the outcomes and quality of the care that NHS Trusts deliver (Robinson, 1999, Tong et al, 2007). The use of pre-existing groups was particularly appropriate in this study as they are a form of group interview which generate data by capitalising on the interaction between participants who are articulating opinions both individually and collectively (Kitzinger, 1995). Therefore they were useful for accessing views and opinions from women, specifically about reasons for choice of PoB.

Collecting data in a setting that is familiar to the participants¹¹ means a more relaxed research atmosphere can be developed resulting in an increased opportunity to obtain more detailed and sensitive information (Bowling, 2009).

However, focus groups as a method of data collection have specific advantages and disadvantages, which needed to be considered and discussed with the Research Team before this method was agreed to be appropriate.

An advantage of focus groups is they are an effective and efficient data gathering method as several participants' views are collected concurrently (Morgan, 1998, Robinson, 1999, Bowling 2009) and extreme views are 'weeded out' as natural quality controls from other participants operate (Robinson, 1998). A safe and comfortable environment can be created (Nicolson and Anderson, 2003) facilitating equality in expression of participants with difficulties with literacy with all participants having the opportunity to contribute in their own words (Robinson, 1999 and Goodman and Evans, in Gerrish and Lacey, 2010). Focus groups give the facilitator the opportunity to clarify issues and achieve a more subtle interpretation of the data when non-verbal events are observed, as well as using group dynamics to establish shared and consistent views (Robinson, 2009).

Since confidentiality cannot be guaranteed in a public setting, this can be considered as a disadvantage of focus groups; however, this can be managed by establishing ground rules at the beginning of the group. There is a challenge with focus groups that skilled facilitators are required to ensure the group is not dominated by one person or view, with less articulate or quieter participants not contributing (Nyamathi

¹¹ Local Children's centres for the Women, the HBT Base for the HCPS

and Shular, 1990, Robinson, 1999, Bowling, 2009). Another disadvantage of the data obtained from focus groups is in its interpretation, which is potentially open to bias of those undertaking the analyses as the Researcher tends to write themselves into the accounts rather than let the data speak for itself (Barbour and Barbour, 2002). To minimise this possibility, training was provided by the lead supervisor to those facilitating the focus groups, and a de-briefing session held following them. Also possible biases in interpretation were minimised by the rigour of framework analysis undertaken and experienced Researchers checking the emerging themes (see later section for more detail).

This study used pre-existing groups for data collection. Kruger (1998) suggested that as these groups can be characterised by having their own pre-existing dynamics, this could be considered a potential for bias. In contrast to this view, Kitzinger (1994) felt that better quality, naturally occurring data can be achieved by the use of pre-existing groups as they have the unique ability to comfortably challenge each other's views and recollection of events.

The optimum number of participants in a focus group is 5 to 12 (Nyamathi and Schuler, 1990) as this enables every member to contribute comfortably and achieves adequate diversity in terms of age, social class and ethnicity (Goodman and Evans, 2010).

Although the actual number of attendees for both groups was unpredictable, the pre-existing mother and baby groups were selectively sampled as their normal cohort number was within the optimal parameters. To adequately consider the views of participants of differing ages, social classes and ethnicity, 5 women's focus groups

were held in different areas of the city. The number of focus groups was reviewed after all data has been collected and analysed to make sure that data saturation had been reached, and no new themes or perspectives requiring further exploration have emerged (Procter et al, 2010).

As described earlier, the purpose of the HCP's focus groups was to discuss the findings of the women's groups to devise practical strategies based on the women's comments that the HBT could transfer into practice. The HBT comprises of 15 members, including a Consultant Midwife, Midwives and Midwifery Assistants. A smaller proportion of the HBT were on duty and consented to attend the focus group, therefore this sample size was also within the optimal number.

3.3 Method

The focus group participants were recruited by the identification of a 'gate keeper'¹², which enabled the Researcher to gain admission (Glesne and Pseche, 1992, cited in MacDonal and Fudge, 2001). For the women's groups the Researcher met with the group leader initially to explain the study and then subsequently when the date of the group meeting was agreed. At this meeting the Researcher left a poster to display (Appendix 2), and a participant information leaflet (PIL) to be distributed to potential participants. For the HCP's focus groups similar arrangements were made, however, in this case by email between the Researcher and the Consultant Midwife. The PILS (Appendix 3 and 4) were given to the potential attendees of the regular group one to two weeks before the focus group was planned to take place. Since both the poster and the PIL displayed the Researcher's contact details, the potential participants had

¹² For the women's groups this was the group leader of the stay and play group, for the HBT this was the Consultant Midwife

an opportunity to contact her before they attended if they had any questions or concerns, although none did.

The Women's focus groups were facilitated by 2 Researchers; the Principal Researcher, a Midwife who was able to use her professional experience to recognise and explore issues relevant to homebirth, and an experienced co-facilitator who took notes and supported the process. The focus groups were planned to last up to an hour, and participants brought their babies who were welcomed into the group and encouraged to play as normal (see section 5.4).

For the women's focus groups a topic guide was prepared informed by the review of the literature (see Appendix 1) which consisted of a list of key questions relating to the aims and objectives of the study, although the order in which they were asked varied as they were designed to probe the participants' meanings (Britten, 1995) and encourage, rather than stifle debate. Although in general most participants contributed equally in the focus groups, there were some, who despite subtle encouragement from the facilitator¹³ did not. This was particularly noticeable in the groups where all the participants were from an Asian background and 2 women brought their husbands, and women who attended alone and were observed to be talkative before the group then failed to participate (see section 5.3).

For the HCP's focus group a topic guide (Appendix 5) generated from the women's views was used, in order to capture the HCP's views of the themes generated. The topic guide needed to be carefully designed and structured and flow from a well-

¹³ In the form of smiling and eye contact

designed research question (Freeman, 2006) in this case to stay true to the purpose of this study to put women's views at the heart of the research.

The focus groups were recorded using audio digital recorder and the second Researcher took accurate notes including verbal and non-verbal events (Robinson, 1999). The digital recordings were securely stored in an audio file on a password protected computer which was only accessed by the Researcher then transferred by a secure digital link to a professional transcription service. Once transcribed the records were checked for accuracy before the digital file was destroyed and all data extracts were anonymised. The transcripts will be stored in a locked cabinet at the University of Birmingham for 15 years in line with its Data Protection policy.

All participants of the women's focus groups were offered the opportunity to receive a letter thanking them for attending the group and a 1 page, plain English summary (Appendix 6) of the findings from the 5 groups. The majority of the women exercised this option.

3.4 Sample & Sampling Strategy

The women's sample was selected by sourcing venues where mothers of babies under a year meet regularly. The cohorts of mothers, by definition of their membership of these groups, were multiparous and could potentially use the homebirth service for future births. Although the members of these groups were not all designated as 'low-risk' for a future pregnancy and therefore did not entirely fit the identified profile for this study, by examining the views of this sample, the experiences and perspectives of women who would not be considered suitable to deliver their babies at home were also analysed.

Basic demographic details (Appendix 7) of the participants in this group were collected with a definition of whether they would categorise themselves as low or high-risk for any future pregnancy. This data was analysed separately and contrasted to establish whether each group's views were universal or specific to their risk status. As risk factors can be transient during pregnancy and birth, this comparison may have provided further rich data and insight into women's views into choice of PoB.

For the HCP focus group the HBT were asked to contribute, since they would be instrumental in delivering any practical strategies developed from the study.

Demographic details were also collected from this group (Appendix 8), to establish their job role and number of years' experience in the NHS to put their comments into context.

3.5 Issues of reliability, validity or qualitative rigour

Since intense reflection can promote making meanings of the data and its effective generalisation, qualitative Researchers must be immersed in their data (Polit and Beck, 2010). This was achieved by the same Researcher facilitating all of the focus groups and checking all the transcriptions for accuracy before coding. The Principal Researcher was supported at the focus group venues by two different co-facilitators, which provided diverse perspectives and facilitated a critical approach to the data.

The need for a high level of reflexivity in the conduct of this study was important to ensure it was not adversely influenced by a number of factors. For example, the Principal Researchers' previous experience and assumptions which can influence the data collected (Mays and Pope, 2000). The Researcher is a female, white, Midwife at Trust A with a professional interest in homebirth, therefore a transparent level of self-

reflection was required to demonstrate her '*situatedness so as not to become an adverse bias*' (Stige et al, 2009 p1509).

The data was coded by the Researcher, with the transcripts also independently reviewed by her research supervisors in order for different viewpoints to be offered to ensure one perspective did not dominate (Gale et al, 2013). This form of Researcher triangulation can generate a wider and more sophisticated understanding of the phenomenon being studied (Tong et al, 2006). To minimise the potential for bias, the analysis needed to be systematic and verifiable, providing a trail of evidence increasing the extent of the dependability of the evidence (Rabiee, 2004) therefore a framework method (Richie and Spencer, 1994) was utilised.

Providing a summary of findings to the women with the opportunity for them to respond with comments is both a form of 'respondent validation' which can assist in refining explanations of the data (Barbour, 2001) and an opportunity to check the accuracy of the data. The Researcher needed, however, to be aware that the participants may be viewing the findings from their own individual perspective, without considering that they are an overview for the wider audience (Mays and Pope, 2000) therefore their comments need to be viewed in this context.

3.6 Ethical Issues & Ethical Approval Process

Favourable ethical opinion for this research was gained from the Integrated Research Application System (IRAS) (see Appendix 9), along with the University of Birmingham (sponsor ERN_14-0393), the Local City Council¹⁴ and Trust A¹⁵.

¹⁴ Responsible for the Children's Centres where the focus groups were held

¹⁵ Where the HBT is based and the Researcher is employed as a Midwife

When undertaking any form of research, it is essential that the Research Team considers the prevention of harm to the participants and their communities by the research process or any resulting publications (Stige et al, 2009). Participants must feel 'safe' when contributing to the discussion as it has been observed that the variation in purpose between focus groups and therapy groups can sometimes be confused¹⁶ (Owen,2001). Focus groups are a complex phenomenon, with participants sometimes revealing more in a group situation than they would in an individual interview (Owen, 2001). The subject of this study was unlikely to be upsetting to participants, however, if any signs of distress had been observed by the Researchers this would have been discussed with the woman¹⁷, with the offer of onward referral or support, although this was not necessary at any of the focus groups held.

Written consent (Appendix 10 & 11) was obtained from all participants at the beginning of the focus groups along with the participants' authority to use anonymised quotations. The influence of group dynamics cannot be underestimated, so the right to withdraw from the study at any time was explained at the onset (Robinson, 1999) and detailed on the consent form, PIL, along with the request that the participants maintain the confidentiality of the group.

Researcher safety was considered, but not felt to be a risk as 2 Researchers¹⁸ attended each focus group and debriefed afterwards.

¹⁶ Especially by women

¹⁷ And the group leader if the woman consented

¹⁸ The principle Researcher and a more experienced colleague or Academic Supervisor

3.7 Data Analysis

Framework analysis (Richie and Spencer, 1994) was chosen as a data analysis tool as it provides a logical sequence of steps which result in clearly structured outputs of reduced data that identify commonalities, differences and the relationship between them enabling conclusions to be drawn about the themes (Gale et al, 2013).

Since the Researcher was inexperienced in analysis, a worked example (Gale et al, 2013) was closely followed with information about thought processes and decisions recorded to demonstrate the transparency of decisions made in an audit trail (Ward et al, 2013) (Appendix 12 and 13).

This approach enabled the Researcher to work through key stages of data analysis (see section 4.4). A deductive approach was initially used to detect evidence of themes identified in the systematic literature review, with emerging themes then identified and synthesised with the original themes to demonstrate new ideas and knowledge.

Since the existing evidence specific to the review question was limited and of poor quality, a combined deductive/inductive approach was employed in order to *'leave space to discover other unexpected aspects of the participants' experience or the way they assign meaning to the phenomena'* (Gale et al, 2013 p3). As qualitative research often produces fragmented data, this prescriptive system was particularly suitable, and was chosen in preference to a grounded theory approach which may not have adequately demonstrated the influence of culture on the interaction of participants (Morse, 2008).

3.8 Summary

By using focus groups of women and HCPs in pre-existing groups to produce data analysed by framework analysis, this qualitative study aimed to identify and build on key themes addressing the question of what influences women's choice of PoB, what their views are on homebirth and what strategies can be used to address any unmet needs surrounding this subject.

4. RESULTS

4.1 Introduction

In this chapter the results of the data collected from the women's focus groups are presented. To give context to the study, the women's and HCP sample is described, and the analysis methods are detailed to provide transparency and rigour.

An explanation of the similarity of the opinions of women who were defined as either high or low-risk is also offered in order to bring clarity to results in terms of the study cohort (see section 4.7).

4.2 Study Sample (Women)

Data was gathered from 28 participants from 5 focus groups held at local Children's Centres in June and July, 2014 (see Table 4). At 2 groups fathers attended either alone or with their wives, and although the study was explained to them and they were invited to listen to the discussion, consent was not taken for them to contribute. The exception to this was focus group 4 where a father translated for his wife who spoke poor English.

Table 4 - Women's Focus Groups

	Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4	Focus Group 5	Total
No. of participants	6	7	2	5	8 (plus 3 refusals to consent)	28
Length of audio recording (mins:secs)	36:55	37:55	23:52	24:43	23:16	146:41
No. pages of transcript data ¹⁹	17	26	16	15	19	103

¹⁹ A small amount of data was impossible to transcribe due to the background noise of the babies

4.3 Maternal Characteristics

Of the 28 women who participated all were multiparous, with 75% of the participants having a single child, with the remaining 25% having 2 children or more. The participants were asked to describe themselves as low or high-risk as defined in the table below.

Table 5 - Definitions of Risk Factors

	Mother's Health	Babies Health
Low-risk	Midwife-led antenatal care Normal BMI (Body mass index) No additional care required relating to physical, mental or social health. Vaginal delivery (including use of epidural, forceps, ventouse and episiotomy)	Born after 37 weeks gestation. Normal birth weight for mother.
High-risk	Consultant led antenatal care. Health problem that could affect mother or baby during pregnancy or birth (e.g. diabetes, high blood pressure, epilepsy, obesity, severe asthma, psychiatric disorders) At least one caesarean section, or excessive bleeding or tearing after vaginal birth	Born before 37 weeks gestation. Weight less than 2.5kg Weight above 4.5kg Previous stillbirth or neonatal death.

The majority of the women (57.1%) categorised themselves as 'Low-risk' on their completed demographics form (see Appendix 7)²⁰ therefore fitted the criteria of this study. The views of the remaining 12 women (42.9%) were collected and analysed separately in order to recognise synergy and contrast in the views of the 2 groups of women (see section 4.7).

²⁰ Since the women self-rated their risk category and the research team did not have access to their medical records the accuracy of their self-assessment cannot be verified.

The largest ethnic group was white, making up 57.1% of the sample population, with the second largest being the Pakistani group at 14.3%, followed by Black or Black British (10.7%).

Of the women who disclosed their age (92.9%), 53.8% were 16-29 years of age, with the remainder (46.2%) over 30 years, with a mean age of the women who disclosed their age of 29 years and 9 months.

The characteristics of the study sample are set out in Table 6.

Table 6 - Maternal characteristics

Variables		n=	Frequency %
Risk Factor	High-risk	12	(42.9)
	Low-risk	16	(57.1)
Ethnic Origin	White	16	(57.1)
	Mixed	1	(3.5)
	Black or Black British	3	(10.7)
	Asian or Asian British – Indian	1	(3.5)
	Asian or Asian British – Pakistani	4	(14.3)
	Asian or Asian British – Bangladeshi	1	(3.5)
	Asian or Asian British – Any other Asian	1	(3.5)
	Other (Egyptian)	1	(3.5)
Age (years)	16-29	14	(50)
	30+	12	(42.9)
	Did not disclose	2	(7.1)
	Mean age (disclosed)	29yrs 9mths	
Parity	1	21	(75)
	2	5	(17.9)
	3+	2	(7.1)

4.4 Data Analysis (Women)

Data was analysed using a framework method (Richie and Spencer, 1994) following the guidelines of a worked example produced by Gale et al (2013).

A combined approach of deductive and inductive analysis was taken. With specific issues identified in the systematic review identified deductively, whilst allowing for other unanticipated elements of the women's experience to emerge (Gale et al, 2013).

4.4.1 Transcription and familiarisation with the data

The digital audio recording of each focus group was sent securely to a transcription company, and the Researcher listened to the audio recording and read the transcripts simultaneously, stopping the recording to make any amendments in terms of accuracy, or fill in any gaps. Since digital audio recording also picked up the noise of the babies playing, this was challenging, however, the Researcher was able to fill in some of the gaps from memory, and with the aid of the contemporaneous notes taken by the co-facilitator. This process also ensured that the Researcher was immersed in the data and fully familiar with the content of each of the focus groups.

4.4.2 Coding

To achieve open coding, the Researcher coded the transcript (Appendix 12), underlining interesting words and passages and using the left-hand side of the transcript to label the content, and the right-hand side to make notes and observations. Since some themes were already predetermined by the literature search, these were coded with subthemes relevant to the evidence already recorded.

4.4.3 Developing a working analytical framework

Since the deductive themes were already defined, emerging themes had been discussed prior to analysis with the 2 co-facilitators²¹ and preliminarily identified in the co-facilitators contemporaneous notes taken during the focus groups. The Researcher reviewed the codes and notes applied to the transcript and established which were meaningful and common to all groups and applied working titles to each one. A paper framework matrix was devised (see 4.4.5) to ensure consistency and organisation of the data so large amounts can be viewed at one time.

4.4.4 Applying an analytical framework

At this point in the analysis the use of the CAQDAS package NVivo version 8 was considered. However, as the quantity of data was manageable and the Researcher was suitably familiar with its layout, a decision was taken to proceed by hand. Initially, data relating to the original themes (deductive) was identified; taking each theme and giving it an individual colour code, then the Researcher used highlighter pens underlining relevant phrases or comments with a corresponding colour. Once this was complete for the deductive themes, the emerging themes (inductive), which had been previously identified, were colour coded in the same way.

4.4.5 Charting data into the framework matrix

In order to summarise the data, a framework matrix was used (Appendix 13). A separate sheet was used for each theme, with one row per focus groups and columns divided into high, low, and unknown²² risk statuses. The corresponding data was transferred into the appropriate columns, leaving a final column for comments and observations made by the Researcher, and synthesising the co-facilitators notes

²¹ One of which was the Researchers Academic Supervisor

²² Comments that could not be attributed to a specific participant in the transcription phase

from each focus group. Once completed this framework matrix was sent to the co-facilitators, for them to comment on content, definition of the inductive themes and accuracy of attribution of the participants views. After receipt of this feedback the framework matrix was reviewed and amended accordingly.

4.4.6 Interpreting the data

Once the data was summarised and divided into themes, recoding subthemes²³ by colour was undertaken, in order to aid efficient interpretation and clear presentation. Quotations that provided evidence of each subtheme were identified to add context and rich data to each thematic description.

4.5 Deductive Themes

The following themes are defined as deductive, i.e. they are defined as codes that were preselected based on the systematic review of the literature, previous theories or the specifics of the research question (Gale et al, 2014).

4.5.1 Expectation of birth in an OU

The evidence suggested that it is taken for granted that birth ought to take place in OU (Pitchforth, 2008, Coxon et al, 2013) and this was confirmed in the focus groups. Most women talked about their 'assumption' that they would give birth in an OU, often recalling that they had no discussion about this with HCPs. For some there was no discussion required:

'you go to hospital to have your baby' M, 35, HR (High-risk)

'it was assumed by everybody like myself and my loved ones that it would be in hospital... it wasn't really discussed' C,29,LR (Low-risk)

²³ Either taken from the literature review for deductive themes, or emerging themes from the data

Strong cultural norms also played a part for many in contributing to their expectation that birth must take place in hospital:

'I've never heard of it (homebirth) it's not common, none of my family or my sister have had that experience or anyone I know has needed to consider it' N, 24, LR

As identified in the literature review, many women felt that birth carries significant risk and is safest in an OU, identifying their main concern being an 'emergency' or 'something going wrong'. There was a strong feeling that the availability of specialist medical equipment and a medical team including doctors was essential for all births whether they were straightforward or not.

'if all goes wrong I'm a trolley away from a C-Section if necessary' C,40,HR

Since all the women in the study were multiparous, it was difficult to determine whether they, or nulliparous women were most open to the idea of alternative places of birth as identified by Coxon et al (2013), contradicting Edwards (2008). When women reflected on their decision making for their first pregnancies, there was a strong sense that the fact that they were nulliparous made them disregard birth in any other venue than the OU:

'As a first time mum I would never have had a homebirth because I didn't know what was coming, I wouldn't have felt safe enough' Unidentified

'It was kind of set that it would be here (hospital) because it was my first' G, 25, LR

4.5.2 'Adapters or Active choosers'

The evidence suggests that to make an informed decision about PoB, women need to both understand they have a choice and have it offered to them. It was evident from the participants that, although most were aware that they had choice, they interpreted this as 'which hospital' and considered locality, familiarity, reputation and

where their friends/family had received care, instead of thinking about alternative places to birth their babies:

'my husband did some research on google and found Trust A had a good reputation' C, 40, HR

'I wanted to go to Trust A. That's where I went, it's the nearest one' M. 35, HR

As identified by Viisainen, (2001) Murray-Davies et al (2012), Edwards (2008) and Coxen et al (2013), it was evident that choice was influenced by ethnicity, with women who classed themselves as white being much more aware of their choices than women from ethnic minorities²⁴ who were mainly unaware that choice of PoB was available.

'I was given the option of a homebirth but preferred hospital as it's my first baby and I didn't fancy it at the time' C, 32, LR (White)

'I didn't think you were allowed that, they didn't mention that' R, 28, LR (Bangladeshi)

'not a choice to choose where to have my baby, there isn't options for me' A, 25,HR (Egyptian)

There was evidence of both 'Adapters'²⁵ and 'Active Choosers'²⁶ in many of the focus groups. Sometimes the 'Adapters' appeared to feel frustrated when they made their choice of PoB and either a temporary change in their risk status or restrictions because of service provision meant that their wishes were not always respected:

'I chose hospital birth and to have a waterbirth but couldn't the first time as my blood pressure was too high and the second time it was being used' K, 21, HR

²⁴ 42.9% of participants

²⁵ implement the right to choose by trusting their carers

²⁶ fight for what they want

'Active Choosers' were also evident, although less common however, they were only found in the white population of participants who contributed:

'Trust A doesn't allow you to labour in water (after previous caesarean section) so I switched to Trust B' S, 39, HR

'I was under a consultant but I was healthy and hadn't had any issues' M, 28, HR (Planned homebirth)

As discovered by Pitchforth et al (2008) 1 woman acknowledged that although she had choice and exercised it, she was confused and burdened by the extra pressure and responsibility it gave her:

'it felt quite a strange process to be the person controlling it...it's quite complicated actually, being given the choice was almost something you didn't want as a pregnant woman. Because the last thing you want is to make a choice to the detriment of your child' S,39, HR

4.5.3 Role of HCP in influencing decisions on choice of place of birth

The literature describes the negative influence that HCP can have on facilitating true choice for women when considering PoB. Data from the focus groups, however, suggested HCPs have minimal influence on women's choices, with most preferring to rely on the experience of close friends and family and information gained from antenatal classes and the media:

'I think I was aware of homebirth as an option, but certainly not from a health care professional' R, 36, LR

There was, however, some evidence of hostility from HCPs if their expectation of control was challenged, which was also shown in the studies by Andrews (2004) and Edwards (2008):

'They didn't really want me to have one (homebirth) There was quite a lot of negativity. And in fact even though my husband phoned to say I was in labour they said 'we haven't got the staff. Can you get into hospital'.....I just felt no-one approved' M, 28, HR

There were many reported examples of midwives restricting women's choice by not presenting all the alternatives:

'Midwife wrote in green book that my baby would be at the Trust A' A, 25, HR

'they just gave us directions how to get there, we weren't given any options' S, 29, HR

The participants provided no evidence that consistent information enhanced the credibility of HCPs (Pitchforth et al, 2008), and very little that they were deliberately vague or invented complications in order to prevent homebirth (Viisainen, 2001).

There was one example of HCPs being coercive in the way they presented information (Levy, 2004, in Edwards, 2008):

'we knew each other anyway as I had the same Midwife she said I could have delivery suite or birth centre, or you can have homebirth...then she looked at me and smiled and said 'Yes well.....' M, 35, HR

Evidence of women constructing their own reality between available knowledge and their own idealised expectations of birth (Viisainen, 2001, Coxon et al, 2013) was only found in 2 women, 1 planning a homebirth against medical advice and one wanting to labour in water after a previous caesarean section. Both sought advice and guidance from HCPs and synthesised this with their own intrinsic knowledge and made their decisions based on this.

4.5.4 The importance of clear information for women

There were many examples from the focus groups that women valued the information sharing and group support found in antenatal classes and meeting with groups of 'like-minded people' (Catling-Paul et al, 2010). This type of information sharing was suggested frequently as an appropriate vehicle for providing women with clear information that was experiential and not exclusively focussed on safety:

'I think it would be nice to meet someone who did homebirth, not just a person who gave birth but someone who also was there and delivered because you get a little information' K, 21, HR

Although many women stated antenatal classes as the main provider of knowledge²⁷ of PoB, the 'hospital tour' was highlighted as a rich source of knowledge and a pivotal point where decisions are made:

'They took us round delivery suite and the birth centre, but I don't remember anything about homebirth' S, 23, LR

One example however,, demonstrated the importance of having 'like-minded' advocates for the different birthplace choices, as if women cannot identify with the women discussing it, this can influence their choice:

'I went to some of those pregnancy yoga classes – 'hippy dippy ones' and probably it wasn't for me, but I know a lot of them were either considering or having homebirths. And I just didn't feel it was for me.' C, 33, LR

Some participants do confirm Edwards' (2008) view that if HCPs do provide information about PoB it is as part of a cascade of information which overwhelms women and they are reluctant to ask questions:

'my Midwife did have a vague discussion about place of birth towards the end of my pregnancy' C, 33, LR

'I was given a leaflet by somebody, but I confess I didn't really read it' R, 36, LR

The use of leaflets, as demonstrated above, was for most ineffectual, a few women could recall being provided with a leaflet about choice of PoB, however, they were generally disregarded. The exceptions to this were 2 women²⁸, stating that as they

²⁷ Other than friends and family

²⁸ Both of Asian ethnicity, but attended separate focus groups

did not have close family or friends around them, they did read leaflets to fill this knowledge gap.

4.5.5 Perceptions of ‘Natural Birth’ and ‘Control’

The majority of women who participated in this study did perceive birth as a risky event (see section 4.4.2), but as they had all given birth, there was some evidence (as found by Caitling-Paul, 2010) that they would have confidence in their bodies ability to achieve a ‘natural’ birth again.

There was evidence in the data of women having different definitions of ‘natural’ depending on their preference of PoB. The overwhelming majority felt that the availability of medical technology secures a ‘safe and clean’ birth, which for them can be perceived as ‘natural’ (Coxon et al, 2013).

‘Hospital is the natural thing’ R, 28, LR

Women, who believed in their ability to give birth outside of the OU, however, did put a different emphasis on ‘natural’:

‘More natural not having machines...constantly beeping’ G, 25, LR

‘Because in the last days normal ladies have babies at home especially if they have their mum with them...it is more safer because there is bacteria in hospitals and she can catch it because she’s too weak’ A, 25, HR

4.6 Inductive Themes

Inductive themes were generated from the data from open²⁹ coding and then followed by a refinement of these themes (Gale et al, 2013).

4.6.1 What does homebirth look like?

For many of the women participants, homebirth as a concept was totally unfamiliar, mainly due to the lack of information provided or available to them. Because they had

²⁹ unrestricted

no point of reference and didn't know what homebirth 'looked like' their perception and questions demonstrated that if they did consider it as an option they had very little knowledge on which to make an informed choice:

'I don't even know if you have a homebirth where do you give birth? Do you choose a room; do you....in a bed? I've got absolutely no idea' C, 32, LR'

A few women associated homebirth with waterbirth, but this was not perceived as practical or was associated with increased inconvenience and cost:

'I always wanted a waterbirth, so I knew a homebirth wouldn't be feasible. I know you can but it's a lot of hassle' J, 32 HR

'If you want to have a waterbirth at home, do you have to hire your own pool? So it becomes really expensive. Unattributed

There were some women who were concerned about environmental factors that would affect them being comfortable to remain at home to birth their babies:

'I wouldn't want to be sitting in a pile of guts on my living room carpet and then cleaning it up' M, 35 HR

There was a difference of opinion between 2 women about the memories having a baby in your house would leave, for the women and future generations:

'my husband was born at home, it's always been talked about in a positive way. I think there's something quite nice about the fact he was born at home' J, 32, HR

'I didn't want a homebirth because I didn't want to walk into a room and think I had my baby there...the reality is it wasn't a pleasant experience to remember and I'm really glad I didn't have that experience at home' R, 32, LR

An association was drawn by a few women from ethnic backgrounds with the practicality of homebirth and the availability or willingness of close relatives to support the mothers during and immediately after birth:

'My mum isn't with me; it will be difficult for me to have a homebirth' A, 25, HR

'And what happens with the mother-in-law, does she have to get involved with the birth and clear up afterwards?' R, 28, LR

Immediate postnatal care of the women and their babies was also something that greatly concerned many of the participants, as they were unsure how much support and time they would get from HCPs after the birth:

'Is there a dedicated length of time that people spend with you before they leave you for their next customer? The last thing you want is ...you've got this baby and you're at home sitting in the mess and they say 'Right okay, well, I'll see you in community in a weeks' time' M, 35, HR

'once the baby is born will they just leave?' R, 28,LR

One of the positive aspects of homebirth highlighted by several women was the guarantee of 1 to 1 care from the Midwife, although this was usually associated with a poor experience in an OU:

'when you're having a homebirth you've got that attention haven't you, they don't have to rush out of the room to go to someone else' S, 23, LR

'You're in your own environment without the external influences like being short staffed' C, 33,LR

A few women from 1 focus group discussed the use of national television documentaries to directly promote homebirth³⁰ and many suggested the televisions in antenatal clinic would be an appropriate medium to provide visual information about the reality of homebirth.

4.6.2 The importance of postnatal care

When asked about what women would find worrying about homebirth, it was clear how much the majority of women valued the aftercare provided in the OU, and they voiced concerns that this would not be replicated at home. They particularly valued

³⁰ Suggested "One Homebirth Every Minute"

the breastfeeding support they received from the OU Midwives and support staff, and the reassurance that they were observed regularly and there was someone to call if they were concerned:

'They were so supportive, coming round and helping to breastfeed' C, 32, LR

'but then what do I do with his first nappy, because it was just like tar. They were brilliant. So if you have that level of support in the home who's available, who's on the end of the phone, but more importantly who's staying there while you get those questions done? C, 40,HR

4.6.3 Trust and confidence in the maternity system

When discussing choice of PoB, several participants raised concerns about whether they had enough trust in maternity services to deliver a safe and responsive homebirth service. Most of the opinions raised were based on the mother's previous either good or bad experience of maternity care. An example of this was the benefit some women saw in having continuity of carer during pregnancy if being cared for by the HBT, as this was seen as valued and an improvement on the current system:

'I've heard you have your own Midwife all the way through and my Midwife went off on maternity leave and I had about 9 different midwives throughout' C, 32,LR

'it would be better if there was just one (Midwife) and someone you could go to, but I just felt like no-one was there at all' S, 32, LR

Confidence was, however,, generally low relating to the practicalities of supporting homebirth, as there was some concern that there would not be the appropriate resources invested:

'I just don't think there's enough money. I don't think it would happen. It's just so underfunded and not enough staff. I just couldn't trust it I wouldn't' C, 32, LR

A few women, some with experience of homebirth, and some contemplating it, were also concerned about the negative response they felt they would get when they called the OU to ask for a Midwife to come to their home when they believed they were in labour:

'Obviously we're often told 'oh yeah, it'll be available. And often they say to you've got to come into the hospital I'm afraid' M, 28, HR

'If you want to have a homebirth and they discuss you coming into hospital they discourage you to do it again I suppose' N, 24, LR

Some women also used knowledge gained from friends and family, to describe their real concerns about the baby being born before the Midwife arrives at their home:

'That's the only anecdotal stories I've heard about homebirth, the gas and air hasn't turned up, the Midwife hasn't turned up....' S, 39, HR

'The baby comes and it's not breathing in the first instance, what do you do if the Midwife isn't there?' M, 28, HR

4.6.4 Shift in perceptions of homebirth

In all the focus groups, when homebirth was first discussed, there was a general suspicion and palpable negative views, and these are noted in many of the themes above. However, women from ethnic minorities, whether in groups where this ethnicity was homogenous, or in mixed ethnicity groups, were most likely to shift their perception of the practicality and desirability of homebirth by the end of the session, while this was not observed in many women from a white background:

'Only in critical cases should go to hospital. It is the nature of people. Nature is best' A, 25, HR, Egypt

'if they told me about it because I had quite an easy birth, I would have preferred to have it out of hospital' N,24, LR, Pakistani

4.7 Difference in views of women who were low and high-risk

When planning the study the intention was to analyse both sets of data separately and compare and contrast the themes and outcomes. During the focus groups, the Researcher was not definitively aware of the risk status of the women, as the demographics form was completed at the end of the session. Although some risk statuses became obvious to the Researcher³¹ during the group as the women referred to their birth experiences³² these did not appear to define the women's views or their ability to consider all places of birth, whether or not they were appropriate to them. Therefore, it became clear that the risk status of the women was largely irrelevant to the majority of the participants views, as women who were low-risk up until they gave birth, and then, for instance, had a caesarean section, could clearly and articulately recall their thought process during their pregnancy relevant to choice of PoB. For clarity when presenting the data, and quotations have been labelled as from women who were either low-risk (LR) or high-risk (HR) however, for all of the themes evidence can be found from both of these samples.

4.8 Study Sample (HCP)

A different approach was taken with this group as the purpose was to explore the HCPs views of the themes emerging from the focus groups with women and to ensure the link was made between research and practice rather than explore the HCPs views on PoB. This engagement with the team who will implement the strategies was designed to increase the likelihood that they will be effectively

³¹ As a clinician

³² Stating that they were consultant lead, indicating high-risk, or they gave birth in the birth centre, indicating low-risk

transferred into clinical practice, and also to identify any emerging training needs for the HCPs.

Data was gathered from a focus group of 8 HCPs³³ with a total of over 80 years' experience working in the NHS (see Table 7). The Researcher, supported by a co-facilitator and Research Supervisor presented the background, methods and results of the study, using quotations from women who attended the focus group to demonstrate the deductive and inductive themes. The participants were then asked to discuss the key findings and suggest practical strategies to address the gaps in knowledge that the women articulated.

Table 7 - HCP Characteristics

Role	Band	Years NHS experience
Consultant Midwife (HBT)	8b	20
Consultant Midwife (Normality)	8b	31
HBT Manager	7	6
HBT Midwife	6	21
HBT Midwife	6	3
Maternity Support Worker	3	3
Maternity Support Worker	3	<1
Student Midwife	n/a	3 rd year

4.9 Data Analysis (HCP)

The analysis of the data produced from the HCP focus group followed the same process as described in section 4.4. A deductive approach using the themes that emerged from the focus groups was used in order to focus the results on the development of practical strategies to address the opinions and knowledge gaps expressed by the women. All quotations below are from Consultant Midwives and

³³ From the HBT

Midwives from the HBT, however, they are not reported separately in order to protect their identity.

4.9.1 Many women did not recall HCPs discussing choice of place of birth in an effective or systematic way, if at all, and the leaflets they were given were in general not read

There was a strong feeling that it was the responsibility of the local Community Midwives to offer homebirth³⁴ to women at their first appointment '*plant the seed*', then frequently throughout their pregnancy, as a '*drip drip*' approach. There was a suggestion that the structure of the antenatal notes did not encourage this:

'When you're doing the booking interview you've got a little tick box and it says 'place of birth'....once its' ticked it never gets revisited'

The HCPs felt that their capacity to interact with all women to discuss PoB was a challenge:

'and it's how do we see all of these women, to suggest it to them'

Even though most the women participants said they felt that leaflets were disregarded and ineffective, the HBT felt it would be beneficial to redesign their existing leaflet to make it more user friendly.

4.9.2 Women report a desire to know more about the practicalities of homebirth

Data from the focus groups has suggested that women would like to know more about the practicalities of homebirth. The HCPs felt that once they met women and explained them to them, the women were often keen to go ahead. Women attending the focus groups were a general multiparous population with no stated interest in

³⁴ As opposed to choice of place of birth

homebirth and it may be that the HCP did not appreciate the women they see are self-selecting³⁵.

There was a discussion about how more information might be given to women and the influence of television. It was agreed by the Team that television programmes did not always represent homebirth in its entirety. There was discussion about the possibility of making a DVD showing the practicalities of homebirth, and either giving this to women or playing it in the background at venues where women receive ultrasound scans or antenatal care.

There was an acknowledgement that the leaflet given women about homebirth talked more about risk, which is important, but that it should also include information about the practicalities:

‘what’s really important to women is, is this going to make a mess on my carpet’

4.9.3 Women would like information about the experience of homebirth

The focus groups have suggested that women would like more information about the experience of homebirth. There was discussion about how women compare OU birth to their perceptions of homebirth and whether they felt this would have made their experience significantly better:

‘I think it goes in two completely different ways doesn’t it, because some women go ‘I’ve had an awful experience I’ll have it at home next time and it’s going to be different’ And some women go ‘that was an awful experience, how bad would it have been at home?’

³⁵ They had asked to see a Midwife from the HBT

4.9.4 Women are not sure if the homebirth service is reliable and safe

The view that women worried about the reliability and safety of the homebirth service was attributed to those women who knew that historically, the homebirth service had a reputation for being sporadic and understaffed. This fact was believed by the HBT to be perpetuated by the Community Midwives, by how they represent the service and in their relationships with the women on their caseloads:

‘quite a few Community Midwives said, well, I’ll believe it when I see it’

‘that speaks loudly and directly about the relationship actually, or the lack of relationship that’s there and the continuity of care perhaps isn’t there’

There had been some work done in the community to promote the HBT as a specialist, community team who were not a resourced to be used when the OU got busy. It was suggested that there was more work to be done about educating women and GP’s about the geographical boundaries of the service and when it was most appropriate to contact the Team in order to ensure they attend women in labour at the right time.

4.9.5 Group discussion about place of birth appears to open up debate

The finding that women appear to be more open to thinking about the different places of birth if it is discussed in a group environment was one the HCPs had identified themselves by attending local Children’s Centres and holding tea parties:

‘more as a social event, come and see your Midwife, come and ask questions, come and meet other women who are having a baby’

The Team did not appear to reflect that the women who attend these groups are self-selecting³⁶ and suggested that all women should be sent a 'compulsory' appointment to attend a group session to help them decide their PoB, with a woman there who had had a homebirth sharing her experience.

There was a concern among the HCPs that if homebirth information was distributed too widely and effectively to all women, there would be a volume of requests beyond their resources, and from women who were at increased risk when a birth outside the OU would not be advocated:

'say for example you did something like that on Baby TV³⁷ and suddenly you got 7000 women wanting to give birth at home.....Do you think if it was moved that you did a group session that actually you would attract more people who were unsuitable?'

4.10 Summary

The analysis of the data collected from 28 women and from 5 focus groups suggests that many of the themes identified in the systematic literature review remain pertinent to multi-parous women when considering how they chose their PoB for their present child(ren) and the decisions they would make in future pregnancies. New emerging themes present opportunities for potential development.

The information from the HBT demonstrated how HCP's can demonstrate hostility if their expectation of control of women is challenged (Andrews, 2004, Edwards, 2008). The Researcher was surprised that, having introduced the context of the study as women's views being fundamental, the majority of the discussion was about the HCP's anecdotal experiences.

³⁶ Already open to the idea of birth outside the OU

³⁷ Educational information and advertisements, displayed via a television in Antenatal clinic

5. DISCUSSION

The aim of this study was to explore women's views of homebirth, and to develop practical strategies to promote birth at home for low-risk, multiparous women.

5.1 Overview of significant findings

From the analysis and synthesis of the deductive and inductive themes that emerged, the following significant findings were identified:

- Many women do not recall HCPs talking through choice of PoB in an effective or systematic way, if at all, and leaflets were often not read.
- Women reported a desire to know more about the practicalities of homebirth.
- Women would like information about the experience of homebirth.
- Women aren't sure the homebirth service is reliable and safe.
- Group discussion about homebirth seems to seem to open up debate.

5.2 Findings in relation to aims, questions and literature

5.2.1 The reality of choice of place of birth

Choice of PoB for all women has been on the national agenda since Changing Childbirth (DoH, 1993). Internationally the Millennium Development Goal to reduce of maternal mortality by $\frac{3}{4}$ and increase births attended by a skilled birth attendant are due to be achieved by 2015, making research evidence about PoB extremely relevant (Sandall, McCandlish and Bick, 2012).

Most women who participated in the focus groups were aware they had choice, but choice is not an equitable concept, and it was found that some women had more choice than others (Jomeen, 2007). An example of this is some women (from an

ethnic background) felt they were told by HCPs where to give birth, whilst others undertook research on the internet. This could be an example of Midwives restricting information due to their own personal experiences (Jomeen, 2007) or stereotyping women in order to protect them from what they considered to be inappropriate requests (Kirkham et al, 2002) believing that some women reject homebirth and prefer to give birth in an OU with a doctor.

Although in this study many women specifically from an ethnic background suggested that choice wasn't offered to them and they appeared content with this, by the end of the focus groups some appeared more dissatisfied with their restriction of choice, and more open to consider homebirth, contrary to Kightley's (2007) assertion.

The principle of 'informed choice' can only be upheld if all women are presented with all options available to them, including birth at home if choosing to have their baby in the OU. By not offering informed choice, women are being denied the opportunity to be empowered and their ability to exercise autonomy and self-determining behaviour is compromised (Madi and Crow, 2003, Mander and Melender, 2009). Some women queried whether they considered choice to be a positive thing, citing the confusion and burden of responsibility it placed on them, suggesting that Midwives should resist offering a 'minefield of choices' but assist them in making the choices that will result in them having a satisfactory childbirth experience (Davis, 2003).

The members of the HBT believed a Midwife from their specialist team was best placed to properly inform women about homebirth, but did discuss how this may be difficult to achieve based on their limited resources. This conversation could be considered to be shared decision making which is a philosophy and a process

requiring partnership between patients and professionals to make decisions about care where there is one good way forward (The Health Foundation, 2012). However, for this process to be effective the HCP needs to provide complete and unbiased evidence based information, and data from the focus groups with women suggested that this was not the reality for many women.

There was reference by the HCPs of a 'tick box' culture, where once PoB was discussed by the community Midwife, a box in the woman's notes would be ticked and the discussion was not revisited. This demonstrates a bureaucratic tendency in healthcare designed to '*ensure that professionals conform to a relatively protocol driven model*' (McCourt, 2006 p1317), and encourages avoidance of emotional engagement and a focus on efficiency (Finlay and Sandall, 2009). This gap in the way information was delivered to women by the Community Midwives and the HBT needs to be addressed if genuinely informed choice about PoB is to be achieved.

5.2.2 Women wish to know more about the practicalities of homebirth

The focus group data indicated that women wanted to know more about the practicalities of homebirth particularly with regard to safety, and how giving birth in their home environment would be managed in practical terms.

It was expected that women would express their concerns about the safety of homebirth, as has been well documented elsewhere (Hadjigeorgiou et al, 2011, Ashley and Weaver, 2012, Coxen et al, 2013) and considered in both the systematic literature review and results section of this study 'Expectation of Birth in an OU'.

The limitations of leaflets noted in the focus groups with the women were not identified by the HCPs. There is a tendency within maternity to give leaflets with the

belief that this will open up choice, however, there is evidence that this is not the case (Kirkham and Stapleton, 2001). Leaflets are tools for conveying information, however, although this is essential to achieve informed choice (Kirkham and Stapleton, 2001), the importance of an open discussion should not be underestimated.

Since the women who took part in the focus groups booked for their pregnancies, Trust A has introduced a leaflet 'Planning where to have your baby' (Trust A, 2012) which is designed to be given to every woman at the booking appointment, along with an explanation from the Community Midwife. The introduction of this leaflet and its impact on women's knowledge has not been evaluated; therefore the participant's feedback from these focus groups on the usefulness of leaflets needs to be considered.

The need for more information about the practical and environmental factors surrounding homebirth and worries about postnatal care has not been found in published literature. The HBT expressed surprise when presented with this finding, however, as the focus group purposively sampled women who had not previously considered homebirth, in contrast to the women the team usually meet, this could explain the difference in their responses.

Since all³⁸ the women in this study had given birth in an OU, this for all but 2 of them is their only experience of intrapartum and postnatal care. However, women having their second or subsequent babies are still influenced by the experience of friends and family (Coxon et al, 2013) and this was vocalised by many participants in the

³⁸ The one woman in the focus group who had experienced homebirth had had three previous hospital deliveries

focus groups. Since the majority of women in the UK have would have been born to mothers who were also born in an OU (Kightley, 2007) there would be a gap in their historical knowledge of the practicalities of homebirth. As found by Mander and Melender (2007) many women cited television as an important source of information however, they did not seem to recognise that the births in some instances may have been 'sensationalised' in order to make it compulsive viewing;

'found I watched a lot of One Born Every Minute and it tends to panic you a little bit so you don't want to go with a homebirth' S,23, LR

Since straightforward homebirth is rarely covered by documentary or soap operas, women's knowledge can be skewed if television is an influencing factor in their birth place choices.

Women were, almost without exception, positive about their experience of postnatal care in the OU, and the fact that this care could not be replicated in a home environment was of great concern to them.

There was agreement between the women and the HCPs that an experiential DVD, played in antenatal and scan clinics would be effective in introducing women to the concept of homebirth without requiring any commitment or expressed interest from them, and this may be something that could be explored.

However, it is delivered, increasing the number of women considering homebirth will require engaging low-risk, multiparous women and is a major organisational change that is likely to require additional training and/ or support for the staff involved.

5.2.3 Women need reassurance that the homebirth service is reliable and safe

The HBT at Trust A was formed at a time when the existing homebirth service was perceived as poor by women and HCPs alike. The women's concerns mainly involved a Midwife not being available to attend them at home and their being asked to attend the OU, or give birth at home without medical assistance.

The reasons that the previous homebirth service was perceived as unreliable are multifaceted, and although the Trust has moved on from this system, Community Midwives who used to exclusively provide this service and are now the gatekeepers and still actively involved in delivering the service alongside the HBT. In McCourt et al's analysis of the Birthplace organisational case studies (2012), there was found to be a lack of experience and confidence among Community Midwives delivering homebirth, which may have impacted on the Trust's ability to provide the homebirth service.

The HBT were aware that in order to make the service effective, they needed to foster a better working relationship with their community colleagues:

'we need to do something to work with the Community Midwives. I think as they start to trust us as a team and they actually start seeing us being a real option...and then they feel better about recommending to women the HBT'

In order to offer an insight into understanding both these teams' perspectives, and move forward to achieve effective teamwork further research using co-production could be considered (Hewison, Gale and Shapiro, 2012). Using practitioners as recipients, co-production could potentially be useful in understanding the perspectives of both teams, and agreeing synergies and priorities of how evidence can be transferred into practice.

5.2.4 Group discussion appeared to open up debate about homebirth and shift opinion

Group discussion as a vehicle for change was identified from the data in two specific areas. Firstly, women said they thought that attending group sessions discussing PoB would be, for them the most acceptable way for them to receive this information. Secondly during the discussion of PoB in the focus groups, there was a tangible shift in the attitudes of the participants to homebirth and their acceptance of it as a possible choice increased.

The women focus group participants said that they would prefer to learn about homebirth from 'experiential' accounts of women and Midwives who had personal and professional involvement with homebirth. There were many accounts from women stating that they obtained most of their information from antenatal classes, and the 'hospital birth tour'³⁹ was cited as the pivotal moment where the decision about PoB was made. This is not a new finding with Leap (1996) attributing part of the 60% homebirth rate achieved by the South East London Midwifery Group Practice to women returning to their antenatal groups with their babies and sharing their birth stories. Women also rated other women's recommendations as one of the most widely valued information sources when choosing where to have their babies (Thompson and Wojcieszek, 2012).

The HCPs expressed concerns about a group approach to information giving, feeling that women who were not classed as 'suitable' for homebirth would start to request it in large numbers. The data from the women's groups indicated a universal desire for a conversation about PoB, even if because of their risk status their recommended options were limited. There is a perceived link between choice and quality of

³⁹³⁹ At TRUST A now only open to women who attend antenatal classes due to resourcing pressures

experience and the recognition that pregnancy and childbirth are a psychological, as well as a physical experience (Jomeen, 2007).

If information about choice of PoB is to be delivered in this way, it will take a major organisational shift, however, this is what the data indicates.

5.3 Evaluation of Methods

This qualitative study used focus groups to obtain data from low-risk, multiparous women about their views on homebirth and how practical strategies could be devised to promote this as a realistic choice. The findings were then presented to the newly formed HBT at Trust A for their comments in order to engage them with the data and give them the opportunity to suggest practical strategies to take this forward.

It was observed in the women's focus groups that the familiarity of the women with each other and the interaction of their babies appeared to encourage meaningful contribution suggesting that Kitzinger's views about pre-existing groups providing good quality, naturally occurring data (1994) were most accurate in this study. The inevitable background noise of babies playing did present challenges in the exact transcription of the data and attributing it accurately to the correct participant when the Researcher was checking it.

There were no comments returned from the one page summary sent to the women who submitted their contact details. This could be interpreted that the women were happy with the content, or that they were not sufficiently motivated to respond.

Although the focus group with the HCPs provided rich data, it was not in the context of the purpose of the study. This may be explained in that the focus groups were structured differently to the women's by asking the HCPs to consider the women's

opinions rather than offering them an opportunity to comment on the research question. This approach may have generated more suggestions for practical strategies, but would not have taken the feedback from the women into account; therefore any suggestions would not have the benefit of the women's input, which was central to this study

In retrospect the inclusion of a focus group with the Community Midwives would have enhanced the depth of the findings of this study, however, when this became apparent, it was not practical due to ethical and time restraints.

5.4 Limitations

Focus group number 4 was attended by two men, accompanying their wives to the mother and baby group for the first time. It is possible that the attendance of the men in this group had an effect on the contribution of some of the other women participants, who after initially being quite vocal, did not contribute to the discussion.

Although all women who took part in the focus group were multiparous, this study did not succeed in obtaining views solely for women who would be considered 'low-risk' for a future pregnancy (see section 4.7).

In the HCP focus group the Maternity Support Workers did not contribute so their views are not represented. This may reflect the need for separate engagement with this group it is possible that issues of experience, power and confidence may have hindered their involvement in open discussion. The views of the Community Midwives, who are the gatekeepers of referral to the HBT, were not included (see recommendations).

The Researcher was also known to some of the HCPs as a senior colleague, and

this may have had an effect on their contributions if they were unclear of her role in the focus group

6. CONCLUSIONS AND RECOMMENDATIONS

This study has considered in depth women's views on homebirth, and has discovered some powerful new themes that lay the foundations for the Homebirth Steering Committee to devise practical strategies for promoting birth at home as a realistic choice.

The information gaps women have identified in understanding the practical and experiential elements of homebirth, their reluctance to trust the system to be safe and reliable, provide key opportunities for Trust A to provide women with the information they require making homebirth seem attainable. Women have stated rather than using leaflets which they generally find inadequate if not discussed, that they would like the information delivered in a group session with women and midwives who have experienced homebirth. The women's focus groups demonstrated that even though they were not promoting homebirth and were conducted with women who did not have an expressed interest in homebirth, a positive shift of opinion is possible when other women share their views and experiences.

The new findings detailed in this study contribute to the existing body of evidence as they were not found as definitive themes in the systematic literature review. This gives the HBT at Trust A the opportunity to uniquely shape its service to respond to women's views.

- That women need to understand more about the practicalities and experience of homebirth before it can be a real option for them.
- Women need reassurance that postnatal care at home will be equally safe as it is in the OU.

- That women need reassurance that the homebirth service is safe and reliable.
- That group discussion about homebirth opens up debate.

Recommendations for practice:

- All women should equitably be offered all options of PoB and be advised which would be considered appropriate to them⁴⁰ and why. The format and timing of this needs to be planned, delivered and evaluated taking into account the views of the women from this study and in consultation with both the HBT and the Community Midwives to ensure seamless inter-professional working.
- Group discussion with women and HCPs experienced in birth options including homebirth is women's preferred vehicle to receive this information; therefore a plan to deliver this is worth further investigation.
- In order for confidence to be restored in the homebirth service performance statistics⁴¹ could be displayed prominently in community clinics or on the Trust A website.
- In order to consider homebirth as a reality, women need to be given more information in a format that is most effective and acceptable to them. One suggestion is DVD's available in environments where they receive ultrasound scans or antenatal care, or informal discussion groups offering information on all places of birth. This information needs to contain essential safety information, but must give equal weight to the practicalities, experience, retrospective data illustrating reliability of the service and the provision of postnatal care.

⁴⁰ Taking into account their risk factors

⁴¹ No. of homebirths booked and attended, No. of babies born before a Midwife arrives

Recommendations for further research:

- The HBT could be given a further opportunity to comment in the women's views after further focussed explanation as the initial focus group did not generate the information anticipated.
- Community Midwives need to be given the opportunity to comment on this study and further research in a co-production design may be beneficial in order to begin understand their views and agree a way for both teams to work together for the benefit of women in their care.
- Further investigation into the use of leaflets as an effective vehicle to impart information together with a structured discussion with a HCP may be considered.

Word Count 15,978 – 1,019 (tables & diagrams) = 14,959

Appendix 1: Women's Focus Groups Topic Guide

FOCUS GROUP TOPIC GUIDE - WOMEN

Facilitator's welcome, introduction and instructions to participants:

Welcome and thank you for agreeing to take part in this focus group. You have been asked to participate as your point of view is important.

Introduction:

This focus group discussion is designed to understand your views on homebirth and to explore if there is any more information or support you would like, to think about having your baby at home. The focus group discussion will take about an hour, however, if you need to attend to your baby, use the toilet or leave early please feel free to do so. We are not expecting a fire alarm practice today, however, if the fire alarm sounds please leave by the doors marked fire exit.

We will record the discussion and once transcribed the all the participant's names will be removed so quotes from the discussions can be used in reports but no-one involved will know who said what. If you change your mind about taking part in the study you can do so without giving a reason, however, due to the nature of the focus group your data will still be used up to the point of withdrawal but no direct quotations will be used.

Confidentiality:

We and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however, please try to answer and be as involved as possible.

How the group will run:

- So we don't miss any important points, we ask participants to speak one at a time.
- There may be a temptation to jump in when someone is talking but please wait until they have finished
- We are interested in your views, so there is no right or wrong answer
- You do not have to speak in any particular order
- You do not have to agree with the views of other people in the group, in fact we are very interested in the range of different views on homebirth.
- Does anyone have any questions?
- Ok let's begin

Warm up – ice breaker

- It would be very helpful if everyone tells us their first name and if your baby has done anything new or funny in the last few days

Introductory question

I am just going to give you a couple of minutes to think about your views on homebirth. Is anyone happy to share what their immediate thoughts are?

Guiding Questions

1. Did you think about the different places you could have your baby?
2. Did any health professionals discuss choice of place of birth with you?
 - If so who and at what point during your pregnancy?
 - Was it helpful? Did you need any more/different information?
3. Did you discuss where you intended to give birth to your baby with family and friends?
 - Did their views influence your choice?
4. What factors did you consider when you chose to have your baby/babies either in hospital or at home? (e.g safety of both you and your baby, surroundings, knowing who was going to look after you)
5. Do you think there are any good things about homebirth? If so what to think they are?
6. Is there anything that you feel is worrying or negative about homebirth?
7. Can you think of any information you would need to make you consider homebirth in the future?
 - How would this information best be communicated to you? (e.g. discussion/leaflets/dvd's/socialmedia/one-to-one or group discussion)
8. What would be important to you that a HBT offers? (e.g. /known Midwife/1-1 support in labour/guarantee to attend/removal of clinical waste)

Concluding question

Of all the things we've discussed today, is there one thing about your experience of pregnancy and child birth that would make you consider a homebirth if you had future children?

Conclusion

- Thank you for participating.
- Your opinions will be very useful in informing the HBT the kind of service you want.
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please feel free to speak to me at the end of the group or contact me via telephone or email
- We would like to remind you that any comments featuring in this report will be anonymous, and it will be appreciated if any opinions expressed are not discussed outside of this group.
- We will be sending you a summary of the views expressed today and at other focus groups, your thoughts and comments will be very welcome

Thank you

Appendix 2: Women's Focus Groups Poster

What do you think of homebirth?

What information and support do women need to make homebirth a choice they would consider?

I need your help. I am doing a study looking at how women feel about giving birth at home, and what issues are involved in making that decision, and I would like to know your views.

I am interested in everyone's opinions, whether you are interested in homebirth or not, as this will help us develop a new homebirth service for local mums and babies.

As part of your usual Mother and Baby group I will be holding/leading a small group discussion on:

Date:

Time:

It would be fantastic if you would join in the discussion and give me your views. Refreshments will be provided and babies welcome!

Please feel free to contact me to find out more:

Researcher 1

Midwife & MRes Student
University of Birmingham

Tel: 07755 123456

email: Researcher1@bham.ac.uk

Appendix 3: Women's Participant Information Leaflet

Participant Information Leaflet for Women

What are women's views on Homebirth? A study to inform the development of practical strategies to promote birth at home as a choice for low-risk women having their second and subsequent babies.

Study Lead: Researcher 1

Thank you for your interest in this focus group study to explore the views of women about homebirth.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read this information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you want to take part.

What is the purpose of the study?

The aim of the study is to find out how women feel about giving birth at home. Recently published evidence (The Birthplace Study, 2011) suggests that for low-risk women having their second or subsequent baby giving birth at home is as safe as it is in hospital for the baby. This group of women were also more likely to have a 'normal birth' at home without an epidural or medical interventions like a caesarean section or episiotomy than women who gave birth in hospital, and their need to be transferred to hospital during labour was 12% (about 1 in 8)

We are interested in what women think about this and what makes them choose to give birth in hospital or at home and what their information and support needs are. We would like to talk to women having their second or subsequent babies whether their pregnancy is classed as complicated or not. This is so we can compare their views, and gain understanding about how to support them if their pregnancy becomes complicated and they have to think again about their choice of place of birth.

This information will be used by the new Homebirth Team at Trust A to develop and improve their services.

Why have I been chosen?

We are asking you to take part in a small focus group because you have had a baby recently, live close to Trust A and attend one of the several mother and baby groups where we are holding these focus groups. We are interested in everyone's views, whatever their previous birth experience was like and regardless of whether they are planning more children in the future or not.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide to take part you are still free to change your mind at any time and you do not have to give a reason. If you decide not to take part, or decide to withdraw from the study at any time your data will still be used up to the point of withdrawal but no direct quotes will be used in any reports or publications.

What will happen to me if I take part?

Myself and another Researcher will attend your regular Mother and Baby group on the date advertised, and the focus group will take place there. Immediately before the focus group I will talk to you about the project and answer any questions you may have. You can then decide whether or not you want to take part. You will then be asked to give your written consent to take part in the focus group, and for a few brief details about your age, how many children you have and your ethnicity, along with some basic medical details. The focus group will take about an hour, and refreshments will be provided. Your babies will be welcomed too and we will manage the meeting around their needs.

During the focus group you will have the opportunity to talk about your views on giving birth at home, for example:

- How did you choose where to have your last baby?
- Did anyone, such as Midwives, partner, friends or family, influence that decision?
- Do you think there are any good things about homebirth?
- Is there anything that you find worrying about homebirth?
- Is any more information and support in choosing your place of birth needed, and how and when would you like this to be given to you?

We are interested in everyone's views no matter what your experiences.

The focus groups will be audio recorded so we have an accurate record of what was said, and the second Researcher will take notes. If there are any questions you would prefer not to answer, then you do not have to and you are free to change your mind at any time. We will not put your name on the recording. The audio files from the focus groups will be typed up on a computer. Your name will not appear on the transcript. We will not tell anyone involved in the hospital what any individual participant said, but anonymous quotes may be used in reports to illustrate the findings. The hospital team will only see a summary of the results.

Once all the information collected has been analysed, we will send you a summary of the findings. You will be very welcome to comment on these findings, which we can include in the final report to the HBT to shape and improve their service.

What are the possible risks or benefits of taking part?

We do not expect there to be any risks involved in taking part in this study, but benefits of taking part include giving you the opportunity to influence the development of Birmingham Women's Hospitals homebirth service. You can choose to leave the study at any time, however, if you withdraw after the focus group has taken place it will be impossible to exclude your comments due to the difficulty of removing an individual's contribution to the focus group.

Will my taking part in the study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. All information that leaves the Research Team will have your name removed so that you cannot be recognised from it. We are following the government's strict rules about how information like this has to be stored to keep it secure and we may need to keep it for up to 15 years.

What will happen to the results of the study?

We will produce a report of our findings which we can send you if you request it, and we may also publish the results of the findings in medical journals and at conferences. The results of the study will also be written up as part of the Researchers Masters in Research (MRes) thesis. You will not be identified in any report or publication. It may be quite a while before we present information in this way.

Who is organising and funding the research? Who can I contact if I need more information?

The research is part of my Masters in Research which is funded by the National Institute for Health Research.

I am based at the University of Birmingham. My contact details are on the back of this leaflet and you are very welcome to contact me with any queries.

Thank you for taking the time to read this information.

Who can I contact if I need more information?

If you have any questions about the study you can contact me (Jo Naylor-Smith) directly (either by phone, text or email) using the contact details below.

Contact Details

Researcher:

Researcher 1

Trial Office:

Room 123
Public Health Building
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Phone Number:

07755 12345

E-mail Address:

Researcher 1@bham.ac.uk

Appendix 4. Participant Information Leaflet - HCP

Participant Information Leaflet for Healthcare Professionals

What are women's views on Homebirth? A study to inform the development of practical strategies to promote birth at home as a choice for low-risk women having their second and subsequent babies.

Study Lead: Jo Naylor-Smith

Thank you for your interest in the focus group study exploring the views of women about homebirth.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read this information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you want to take part.

What is the purpose of the study?

The main aim of the study is to find out how women feel about giving birth at home. Recently published evidence (The Birthplace Study, 2011) suggests that for low risk women having their second or subsequent baby giving birth at home is as safe as it is in hospital for the baby. This group of women were also more likely to have a 'normal birth' at home without an epidural or medical interventions like a caesarean section or episiotomy than women who gave birth in hospital, and their need to be transferred to hospital during labour was 12% (about 1 in 8)

We are interested in what women think about homebirth and what makes them decide whether to give birth in hospital or at home and if there is any further information and support they would like in making this choice. We are interested in the perspective of both high and low risk multiparous women so their responses can be compared and we will gain insight in how to support women whose risk factors change in pregnancy and they need to reconsider their choice of place of birth.

After we have held focus groups with women and collated their views we would like to meet with you to refine and prioritise their recommendations. This will give you the opportunity to have a say in the development of the homebirth service, how the women's

recommendations are implemented into practice and identify any emerging training needs you may have.

Why have I been chosen?

We are asking you to take part in this focus group because you are part of the homebirth team at Trust A and are instrumental in its' development. We are keen to find out what you think.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide to take part you are still free to change your mind at any time and you do not have to give a reason. If you decide not to take part, or decide to withdraw from the study at any time it will not affect your job in any way. However, your data will still be used up to the point of withdrawal but no direct quotes will be used in any reports or publications.

What will happen to me if I take part?

Myself and another researcher will arrange to hold a focus group with you and our colleagues at your place of work. Before this if you have any questions you can contact me directly (either by phone, text or email), and I (Researcher 1) will get in touch with you by phone. Immediately before the focus group I will talk to you about the project and answer any questions you may have. You can then decide whether or not you want to take part.

The focus group will take about an hour, and refreshments will be provided. We are interested in everyone's views and it is important everyone participates and expresses their views during the focus group.

During the focus group we will take the opportunity to discuss with you our findings from the women's focus groups, and you will have the chance to comment on these. We are interested in your opinions about the practicalities of the strategies suggested and how these can best be implemented.

The focus groups will be audio recorded so we have an accurate record of what was said, and the second researcher will be taking notes. If there are any questions you would prefer not to answer, then you do not have to and you are free to change your mind at any time. We will not put your name on the recording. The audio files from the focus groups will be typed up on a computer however, your name will not appear on the transcript. We will not tell anyone involved in the hospital which Healthcare Professional said what and the hospital team will only see a summary of the results.

What are the possible risks or benefits of taking part?

We do not expect there to be any risks involved in taking part in this study, but benefits of taking part include giving you the opportunity to influence care for women in the future. Please be assured that you do not have to answer any questions that you are uncomfortable with, and you can cease to participate at any time. If you do choose to withdraw from the study after the focus group has been held, it will be impossible to exclude your comments due to the difficulty of removing an individual's contribution to the focus groups.

At the end of the focus group we will check you are still happy for us to use the information you provided. The results from the study will help us understand your views and provide important information to help the homebirth team develop the service for women in the Birmingham area in the future.

Will my taking part in the study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. All information that leaves the research team will have your name removed so that you cannot be recognised from it. We are following the government's strict rules about how information like this has to be stored to keep it secure and we may need to keep it for up to 15 years.

What will happen to the results of the study?

We will produce a report of our findings which we can send you if you request it, and we may also publish the results of the findings in medical journals and at conferences. The results of the study will also be written up as part of the Researchers Masters in Research (MRes) thesis. You will not be identified in any report or publication. It may be quite a while before we present information in this way.

Who is organising and funding the research?

The research is part of my Masters in Research which is funded by the National Institute for Health Research.

I am based at the University of Birmingham. My contact details are on the back of this leaflet and you are very welcome to contact me with any queries.

Thank you for taking the time to read this information.

Contact Details

Researcher:

Researcher 1

Trial Office:

Room 123
Public Health Building
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Phone Number:

07755 12345

E-mail Address:

Researcher 1@bham.ac.uk

Appendix 5. Topic Guide – HCP

FOCUS GROUP TOPIC GUIDE – Health Care Professional

Facilitator's welcome, introduction and instructions to participants

Welcome and thank you for agreeing to take part in this focus group. You have been asked to participate as your point of view is important.

Introduction:

This focus group discussion is designed to understand your views on the strategies women have suggested in order encouraging low risk, multiparous women to consider a homebirth. The focus group discussion will take about an hour. We will record the discussion and once transcribed the data will be anonymised so quotes from the discussions can be used in reports but no-one involved will be identifiable. If you wish to withdraw from the study you can do so without giving a reason, however, due to the nature of the focus group your data will still be used up to the point of withdrawal but no direct quotations will be used.

Confidentiality:

You should try to give your views on the women's suggestions as truthfully as possible, it is not essential for everyone in the room to agree. We and the other focus group participants would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however, please try to answer and be as involved as possible.

How the group will run:

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking but please wait until they have finished.
- We are interested in your views, so there is no right or wrong answer
- You do not have to speak in any particular order
- You do not have to agree with the views of other people in the group
- Does anyone have any questions?
- OK, let's begin

Warm up – ice breaker

It would be very helpful if everyone tells us their name and what they think is the best thing about homebirth.

Researcher to outline back ground and method of study and themes derived from women's focus groups

Discussion

I'd like to discuss the themes one by one and come up with some practical strategies to address them together

Do these suggestions mean that you will need any additional training or support – if so how would you want this to be provided?

Conclusion

- Thank you for participating.
- Your opinions will be very useful
- We hope you have found the discussion interesting
- If there is anything you are unhappy with or wish to complain about, please feel free to speak to me at the end of the group or contact me via telephone or email
- We would like to remind you that any comments featuring in this report will be anonymous, and it will be appreciated if any opinions expressed are not discussed outside of this group

Thank you

Appendix 6. Letter of thanks and summary to women



UNIVERSITY OF
BIRMINGHAM

**College of Medical and
Dental Sciences**

School of Health and
Population Sciences

Head of School
Professor of Policy and Public Health
Jayne Parry
MD FFPH

<Name>
<Address Line 1>
<Address Line 2>
<Address Line 3>
<Address Line 4>
<Date>

Dear <Name>

Re Research project: What are women's views on homebirth? A study to inform the development of Practical strategies to promote birth at home as a choice for low-risk women having their second and Subsequent babies

Thank you for attending the recent focus group relating to the above study. Your attendance and contribution was greatly appreciated and will help the Homebirth Team at Birmingham Women's Hospital to shape and improve their service. You provided your contact details so that I could send you a summary of the data collected and provide you with the opportunity to comment on the content should you wish to. Please be aware that the summary is of the comments and views collected from a diverse range of 28 women over 5 focus groups. They may not represent your views as an individual or from the group you took part in, however, they are the most common opinions that came up across the range of focus groups.

If you would like to contact me to respond to the summary, please do so before 12th September 2014, so your comments can be considered for inclusion of the final report.

Once again I would like to thank you for your time and contribution to this Study.

Yours Sincerely,

Researcher 1 BSc(Hons) RM
Email: Researcher1@bham.ac.uk
Tel: 07755 12345

Summary Report of the focus groups about women's views of homebirth

Confirmation of what was already known:

1. Women generally expected to give birth in hospital as it was felt that this was the safest place to be in case something went wrong. They remember little discussion with Midwives and Doctors, and they chose 'which hospital' rather 'where to give birth' based on location, reputation and experience of friends and family.
2. For women to make a choice of where to give birth, they firstly have to understand that choice is available to them. This knowledge varied greatly between the different women we met, with women from different ethnic backgrounds experiencing choice differently. With choice comes responsibility, and some women struggled with this
3. Most information about where to give birth came from group discussions, antenatal classes and the 'Birth tour' and leaflets were often not read
4. Women think differently about 'natural' childbirth means depending on where they intend to give birth.

New ideas gained from the focus groups

1. Women don't know the risks connected with homebirth, what will actually happen and what to expect from the experience. Some women were concerned about the potential mess it may leave, whether their relatives would be expected to help and the negative memories birth at home may leave with them. Women did, however, see homebirth as a way to guarantee one to one care from their midwife.
2. It was strongly expressed that the postnatal care provided in hospital was very important, and women worried how they would get the same care and support in their own homes
3. Some women raised concerns about whether they had enough trust that a safe homebirth service could be provided, where Midwives and equipment were there in time for every birth. There was a view that not enough money was invested in the maternity system, so they may be promised a homebirth, but be asked to travel to the hospital in labour because there wasn't a midwife to go to them.
4. Most women stated they wouldn't want to have a homebirth at the beginning of the discussion, however, after hearing others views, some women's opinions shifted closer to thinking that they may wish to consider birth at home in the future.

Next Steps

1. This results of the study will be written up as part of my Masters in Health Research thesis
2. A report will be written and taken to the Homebirth Steering group, who will decide how these new ideas can be taken forward

Appendix 7: Demographics form for Women's Focus Groups

When completed: 1 for participant; 1 for Researcher

Women's Focus Group Participant Demographics

This will help us make sure that we have spoken to a wide range of women with different experiences of pregnancy and childbirth. All details provided will be kept confidential to the Research Team

FirstName:		Age:				
Address:	<i>(Optional)*</i>					
Ethnicity						
	White		Asian or Asian British – Chinese			
	Gypsy traveller or Irish Traveller		Asian or Asian British – Any other Asian			
	Asian or Asian British – Indian		Black or Black British			
	Asian or Asian British – Pakistani		Mixed			
	Asian or Asian British – Bangladeshi		Other (please specify)			
How many children do you have? (circle one)						
1	2	3	4	5	6	7+
Which of the following BEST describes you?						

Please tick if **ALL** statements below apply to you: ☐

1. Antenatal Care mainly by a Midwife throughout your pregnancy
2. You are of normal weight and had no additional care during pregnancy relating to your physical, mental or social health
3. All your babies were born after 37 weeks of pregnancy and were of normal birth weight for you
4. All your births have been 'normal' (including quick labour and use of epidural, forceps, ventouse and episiotomy)

OR - Please tick if **ANY** of the statements below apply to you: ☐

1. Your antenatal care was mainly by doctors at the hospital
2. You have a health problem that could affect your or your babies health during pregnancy and birth (eg diabetes, high blood pressure, epilepsy, obesity, severe asthma, psychiatric disorders)
3. You have previously had a baby born before 37 weeks of pregnancy, or a baby weighing below 2.5kg(5½lbs) or above 4.5kg(10lbs)
4. You have had a stillbirth, or a baby that died shortly after birth
5. You have had a least one caesarean section, or had problems with excessive bleeding or tearing after a 'normal' birth

*Address only required if you wish to receive a one page summary of the focus group findings.

Appendix 8. Demographics form HCP

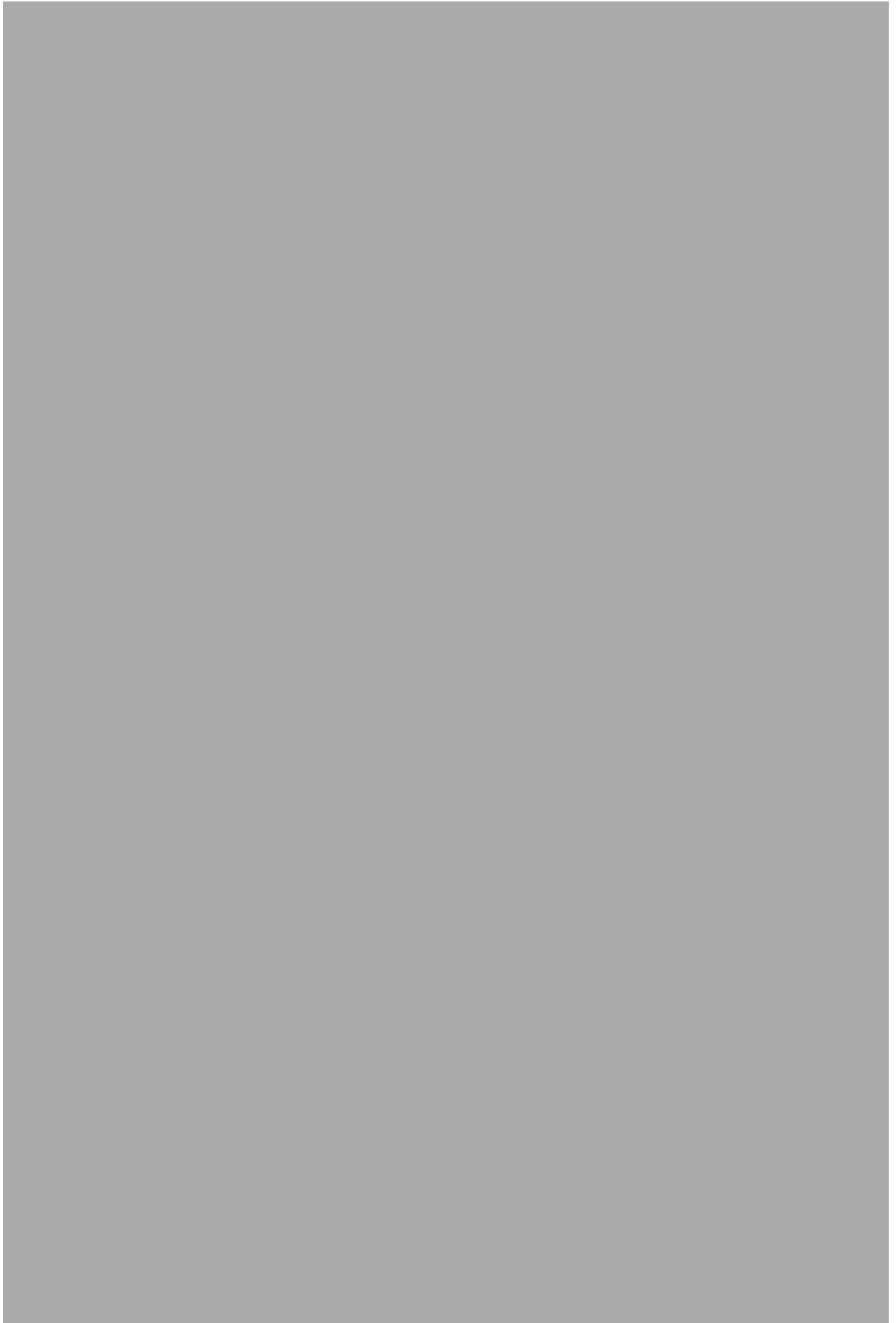
Focus Group Participant Demographics

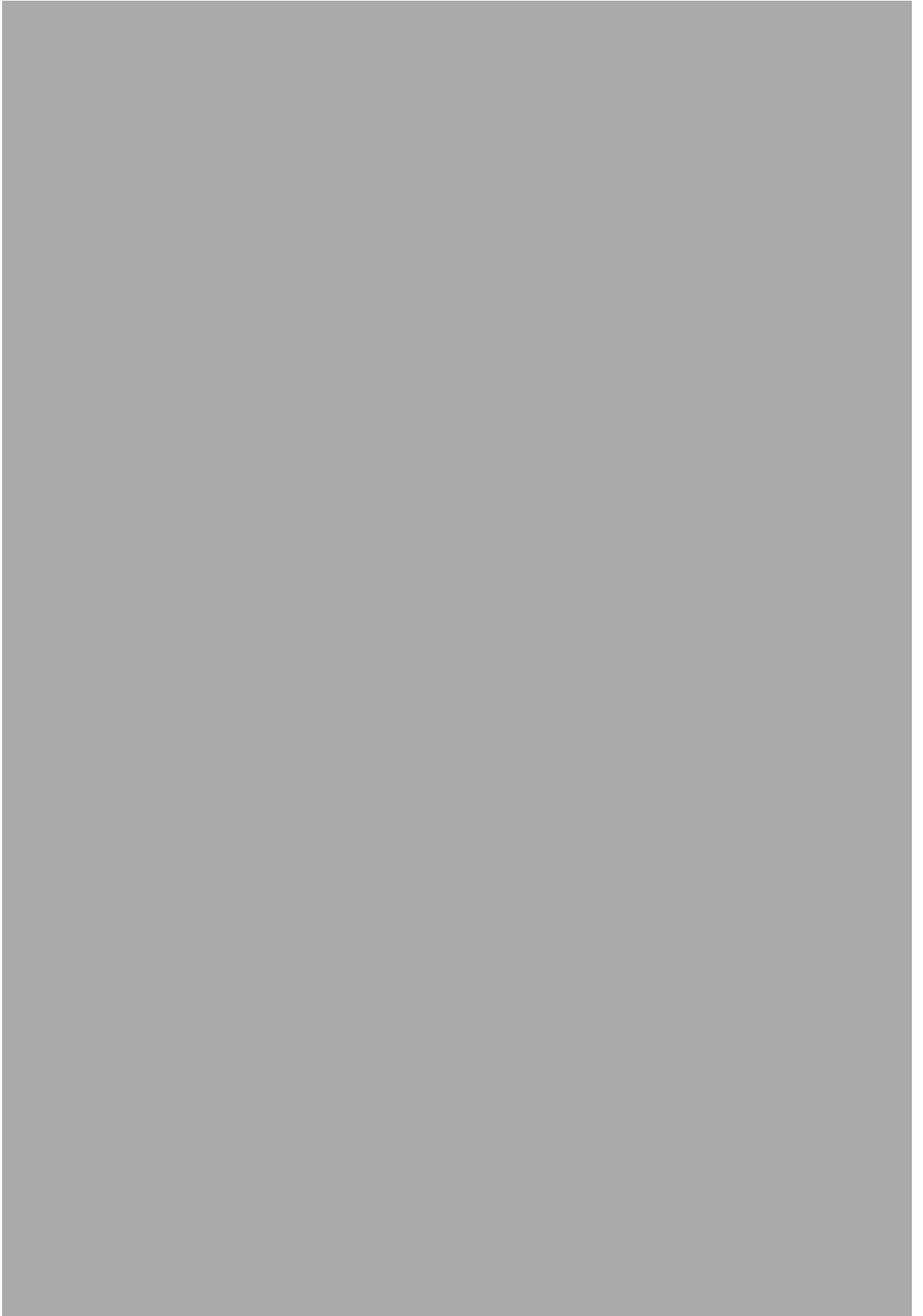
Health care Professionals

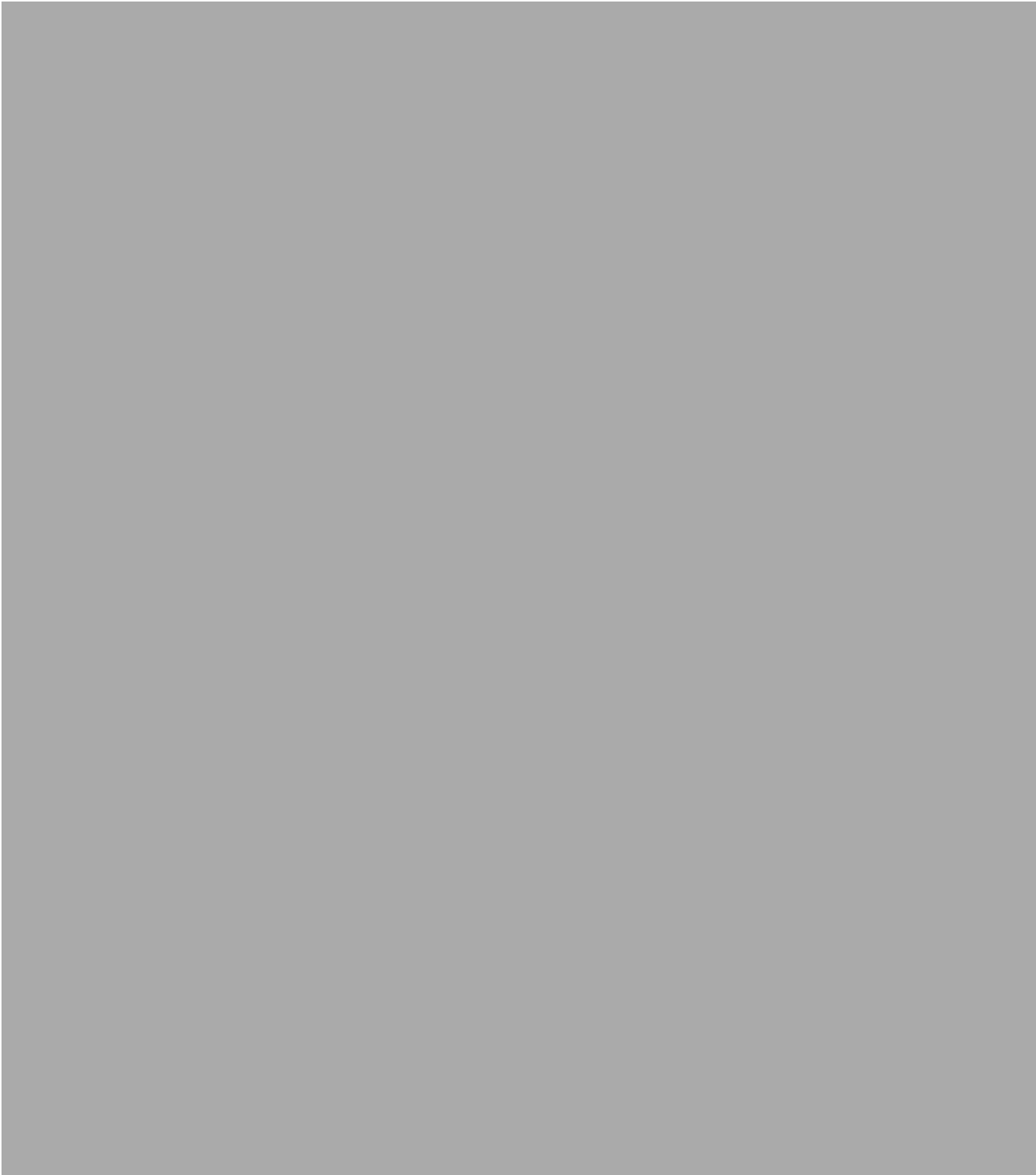
Name:	
Job title:	
Band:	
Number of years qualified/ working in the NHS:	
Date:	

Appendix 9: Ethical approval from NHS Health Research Authority









Appendix 10: Womens Focus Groups Consent Form

Consent Form for Women's Focus Groups

What are women's views on Homebirth?

A study to inform the development of practical strategies to promote birth at home as a choice for low-risk women having their second and subsequent babies.

Project lead: Researcher 1

Supervisors: Dr Supervisor 1 & Dr Supervisor 2

Please complete in ballpoint pen:

- | | Please Initial
(do not tick) |
|--|---------------------------------|
| 1. I confirm that I have read and understood the information sheet (Version 2 - 2.06.2014) for the above study and have had the opportunity to ask questions | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason | <input type="checkbox"/> |
| 3. I agree to the focus group being audio digitally recorded | <input type="checkbox"/> |
| 4. I agree to anonymised quotations being used in reports of the study. | <input type="checkbox"/> |
| 5. I understand that relevant sections of my identifiable data collected during the study may be looked at by appropriate individuals from the University of Birmingham, where it is relevant to my taking part in this research. The Sponsor may appoint a third party to access my indentifiable data.. I give permission for these to have access only to the records relevent to the study, but not to my or my childs general NHS records | <input type="checkbox"/> |
| 6. I agree to take part in the above study. | <input type="checkbox"/> |

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix 11. HCP Focus Group Consent Form

Consent Form for Healthcare Professionals Focus Groups

What are women's views on Homebirth?

A study to inform the development of practical strategies to promote birth at home as a choice for low-risk women having their second and subsequent babies.

Project lead: Researcher !

Supervisors: Dr Supervisor 1 & Dr Supervisor 2

Please complete in ballpoint pen:

*Please initial
(do not tick)*

1. I confirm that I have read and understood the information sheet (Version 2 – 2.06.2014) 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. ☐
3. I agree to the focus group being audio digitally recorded. ☐
4. I agree to anonymised quotations being used in reports of the study. ☐
5. I understand that relevant sections of my identifiable data collected during the study may be looked at by appropriate individuals from the University of Birmingham, where it is relevant to my taking part in this research. The Sponsor may appoint a third party to access my identifiable data. I give permission for these to have access to my records relative to this study. ☐
6. I agree to take part in the above study. ☐

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

When completed: 1 for participant; 1 for researcher

Appendix 12: Example of use of CASP* tool to appraise the quality of a paper

Place of birth: can 'Maternity Matters' really deliver choice Alison Edwards (2008) BJM Vol 16, No 12 771-775

Question No.	Question	Answer	Justification
1	Was there a clear statement of the aims of the research?	No	No identified research question, aims or objectives.
2	Is the qualitative methodology appropriate?	Yes	Birth narratives were identified as a medium to empower women and provide rich data for the researchers. The most effective way to achieve this was by using qualitative methods
3	Was the research design appropriate to address the aims of the research?	No	Semi-structured interviews were used but there is no justification of this as a data collection method or any alternatives considered
4	Was the recruitment strategy appropriate to the aims of the research?	No	Although the recruitment strategy was described, there is no discussion or acknowledgement that the women were self-selecting on 2 counts: <ul style="list-style-type: none"> • They had chosen to either plan or have a home birth • They had responded to information sheets provided by Midwives Self-selection could affect their contribution and their views were not representative of all women
5	Was the data collected in a way that addressed the research issue?	Yes	Data collection was described and a copy of the interview guide provided
6	Has the relationship between researcher and participants been adequately considered?	No	No evidence that researcher bias was considered is included.
7	Have ethical issues been taken into consideration?	No	Paper states 'following ethical approval' women were approached by midwives and given an information sheet and consent form. There is no evidence of how ethical standards were maintained or if issues of consent and confidentiality were discussed with the participants
8	Was the data analysis sufficiently rigorous?	Can't Tell	The analysis process is described and referenced, with the adapted method detailed in a text box

			within the paper. However, it states that this was conducted by the author and there is no evidence of reflexivity or any consideration of potential bias and influence of the author during this phase.
9	Is there a clear statement of findings?	No	Themes were identified, although it is unclear whether these were inductive or deductive to the research question. There was little discussion of evidence against the researchers arguments, and in the conclusions the findings were related to operational targets, which had not been mentioned in the background to the research
10	How valuable is the research?	No	There are no recommendations for further research, or explicit information on how the findings can be transferred into other populations.
		2/10	

*Reproduced from the CASP Qualitative Research checklist 31.05.2013

Appendix 13: Example of open coding of transcript

Coding Labels	Transcript	Notes and ideas
Expectation of Birth in OU(location and reputation)	K: I didn't really get any more than that really, homebirth wasn't really mentioned, but because we live close to Trust A and it's such a good hospital, we chose there.	Limitation of options given by HCP. Homebirth excluded
Active Chooser	GF: Okay. Lovely. Anyone else have any experience of that? J:I was under consultant care, so I wanted - for my first - I wanted to go in the Baby Centre, the Birthing Centre, and they agreed that I could, and my second I couldn't, and I didn't have any choice but to be in the hospital GF: Okay. Anybody else:	Although HCP's views challenged in first instance, Adapter in 2 nd pregnancy
Expectation of Birth in OU(location)	C: I chose Trust A because it's closest to me and my mother in law works there as well. GF: Okay. So that was practical for you that you knew somebody that was there. And you were choosing a specific hospital as opposed to a place of birth in terms of considering other things?	
Expectation of Birth in an OU	F: Yes. GF: Okay. Anybody else want to talk about their place of birth, where they decided to have their baby? Or if they decided to actively	'Which hospital' instead of Choice of place of birth
Expectation of birth in OU	C2: I think we'd always thought we were going to use Trust A. My husband did some research and found - on Google - found it had a really good reputation. But I always knew that I was going to have a hospital birth. I wasn't going to have a homebirth for my first one because I'm a bit risk averse. And then through the pregnancy, because I've got rheumatoid arthritis which sometimes flares up, I was then under a consultant so there was kind of no choice. But I was perfectly happy with that, to be honest with you.	Independent research rather than relying on HCP
Importance of clear information		
Expectation of Birth in OU (Safety)		
Adapter		

Appendix 14: Example of Framework Matrix

Deductive Theme 1. Expectation of birth on an OU

Focus Group	High Risk	Low Risk	Risk Status Not Known	Comments/observations
1	<p>-HB not mentioned-chose Trust A as live near & good hospital (p4)</p> <p>-I was under consultant care- I didn't have any choice but to be in hospital (p4)</p> <p>-choosing a specific hospital rather than place of birth(p4)</p> <p>-I always knew I was going to have a hospital birth because I'm a bit risk averse (p5)</p> <p>-I spoke to people who were complimentary about Trust A – when I'd seen it I thought it would be a nice place to have it (p5)</p> <p>-I knew homebirth wouldn't really be feasible (p6)</p> <p>-only considered 'which' hospital as worried something may go wrong – I knew there were doctors next door to birth centre (p8)</p> <p>-‘if all goes wrong I'm a trolley away from a C-Section if necessary’ (p12)</p>	<p>-I chose trust A because it was closest to me (p5)</p> <p>-was given option of homebirth but preferred hospital as first baby & ‘didn't fancy it at the time (p6)</p> <p>-went to birth centre in case anything goes wrong you're in the hospital (p9)</p> <p>-Its only if something goes wrong you need hospital (p10)</p>		<p>-Decision making is multi-factorial but primarily motivated by minimising risk</p> <p>-Women see birth as having significant risk and that hospital is ‘safest place’</p> <p>-perceptions of risk based on own/others experience & television</p> <p>-hospital is seen as normal/usual PoB for women – choice re-enforced by HCP if choice is not offered</p> <p>-Hospital has facilities to ‘manage if things go wrong’ Reference to ‘fear’ ‘horror stories’ & ‘what if’</p>

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