Experiences of Women and Other Birthing People Who Make Non-Normative Choices in Childbearing

A Constructivist Grounded Theory

Anna-Marie Madeley

RM, BSc (Hons), MSc, PGCertTHE, FHEA

Thesis Submitted to the Open University for the Degree of Doctor of Philosophy

October 2023
Abstract

The thesis aimed to explore why and how participants construct non-normative choices in the context of pregnancy and childbearing, alongside the underlying social processes participants navigate within UK maternity systems. Non-normative choices include outside-of-guideline care, declining routinely offered care and interventions or requesting care outside sociocultural norms. Such choices represent a critical test against which claims of women-centred care and authentic informed decision-making can be tested. To date, emphasis on empirical research in this area has primarily focussed on clinician-based understandings of supporting non-normative choices and women’s experiences of more extremely positioned, mostly intrapartum choices. These have often excluded service users’ voices within more nuanced choices across the childbearing continuum, situated firmly within consent, autonomy, and agency issues. By exploring these issues, the thesis will present a constructivist grounded theory exploring the social processes experienced by and affecting women’s experience in making non-normative choices, offering a substantive theory to explain how women’s reproductive identity shapes and informs non-normative choice-making. I present how non-normative choices represent a strategy by which, in the presence of institutional and systemic identity threat, reproductive identity is expressed, reinforced, or defended through common strategies, represented in the QuEEN model of common strategies for reproductive identity reinforcement and defence.

The thesis will argue that contrary to choices being seen as ‘non-normative’ within contemporary maternity care, women view their choices as normative within their unique contexts and that a paradigm shift is required to reframe how non-normative choices are viewed. Rigid, risk-based systems of care designed to categorise women throughout their pregnancy journey work directly against aspirations for personalised care planning and frameworks of choice, reinforcing the urgent ongoing need for emphasis on personalised care within the UK maternity system to achieve equitable and safe perinatal outcomes in the presence of facilitative choice and relational care models.
Acknowledgements

First and foremost, I cannot expressly strongly enough the support and guidance offered to me over the last three years by my exceptional supervisors, Professor Sarah Earle, Professor Lindsay O’Dell and Dr Sally Boyle. Your confidence in my abilities to get to this point never wavered, treating me with firm patience and gently guiding me through areas of literature and academic spaces I feared initially to tread. The PhD process is a chaotic and exhilarating experience, and your advice to trust the process remained invaluable – and accurate! I could not have done this without you and will forever be grateful. I also offer sincere thanks to the Open University Faculty of Wellbeing, Education and Language Studies for funding my studentship,

I want to express my undying gratitude and love to my family, who, despite the last three years being incredibly challenging, have consistently encouraged me to continue – we can have that holiday now. To Michelle – you have been with me from the beginning of everything, and I am proud to have you walk alongside me.

I am indebted to Bella, Carolyn, and Claire, my (almost) silent advocates who always showed so much interest in my work and career. I blame all of you for getting me here in the first place. To Belle, my PhD buddy on the other side of the world, and all the other PhD Midwives whom I have the pleasure of knowing, I draw strength from your commitment towards improving the childbearing outcomes and experiences worldwide.

Special thanks go to Freddie, John, Brian, and Roger. You will likely never know how I have leant on your body of work to keep me on an even keel and grounded; you are my safe space to which I return daily- thank you.

Finally, I want to express my deepest thanks to each participant in my study who shared their stories with me. You are the reason I do my job and will continue to do so, using everything I have learned in this process to continue to improve care for those with similar stories.
Declaration of Authorship

I declare that this thesis has been composed solely by myself and that it has not been submitted, either in whole or in part, in any previous application for a degree. Except where otherwise acknowledged, the work presented is entirely my own.
Page Intentionally Blank
# Table of Contents

ABSTRACT .......................................................................................................................... I

ACKNOWLEDGEMENTS ..................................................................................................... III

DECLARATION OF AUTHORSHIP ...................................................................................... V

TABLE OF CONTENTS ......................................................................................................... VII

LIST OF FIGURES .............................................................................................................. 16

LIST OF TABLES .................................................................................................................. 18

ACRONYMS AND ABBREVIATIONS .................................................................................. 19

GLOSSARY AND KEY DEFINITIONS ................................................................................ 21

CHAPTER 1 INTRODUCTION TO THESIS ........................................................................... 26

1.1 Introduction ..................................................................................................................... 26

1.2 Professional and Personal Influences and Reflexive Positionality .............................. 26

1.3 A Note on the Language Used in this Thesis: .............................................................. 29

1.4 Research Aims, Objectives and Research Question ..................................................... 30

1.5 Organisation of the Thesis ............................................................................................ 31

CHAPTER 2 THESIS BACKGROUND AND CONTEXT ......................................................... 33

2.1 Introduction ..................................................................................................................... 33

2.2 Maternity Choice in the United Kingdom ..................................................................... 34
2.3 Medicalisation, Institutionalisation and Risk ................................................................. 37

2.4 What Women Want ........................................................................................................ 42

2.5 Making Non-Normative Choices – Situating the Study ................................................ 43

2.5.1 Normativity and Non-Normativity ............................................................................ 43

2.5.2 The Legal, Ethical and Moral Status of Non-Normative Choices ............................. 43

2.5.3 Who Makes Non-Normative Choices in the United Kingdom? ............................... 45

2.6 Thesis Definition of a Non-Normative Choice ............................................................. 47

CHAPTER 3 META-ETHNOGRAPHIC SYSTEMATIC LITERATURE REVIEW .......... 48

3.1 Introduction ....................................................................................................................... 48

3.2 Review Question, Aim and Objectives ........................................................................... 49

3.2.1 Why Choose a Qualitative Meta-Synthesis of the Literature? ................................. 49

3.2.2 Meta-Ethnographic Methodology .............................................................................. 51

3.3 Phase 1: Getting Started ............................................................................................... 54

3.3.1 Refining the research question ................................................................................. 54

3.4 Phase 2: Deciding what is relevant to the initial interest .............................................. 56

3.4.1 Search Strategy .......................................................................................................... 56

3.4.2 Inclusion and Exclusion Criteria .............................................................................. 60

3.5 Phase 3: Reading the Studies .......................................................................................... 62

3.5.1 Data Extraction .......................................................................................................... 62

3.6 Phase 4: Determining How Studies Are Related .......................................................... 62

3.6.1 A Note on Constructs ................................................................................................. 63

3.7 Phase 5: Translating Studies Into One Another ............................................................. 63

3.8 Phase 6: Synthesizing Translations .............................................................................. 64
CHAPTER 4 RESEARCH DESIGN AND METHODOLOGY .............................................. 86

4.1 Introduction ........................................................................................................ 86

4.2 Revisiting the Research Question, Aims and Objectives .................................. 87

4.3 Research Paradigm ............................................................................................. 87

4.4 Philosophical Positioning - Constructivist Epistemology and Relativist Ontology. .......... 88

4.5 Approaches to Grounded Theory (GT) ............................................................... 89

4.6 Research Methodology ....................................................................................... 89
4.7 Glaserian/ Classical Grounded theory (CGGT) ................................................................. 90
4.8 Straussian Grounded Theory (SGT) .................................................................................. 90
4.8.1 Symbolic Interactionism ...................................................................................................... 91
4.9 Constructivist Grounded Theory (cGTM) ............................................................................ 92
4.9.1 Literature Reviews in Grounded Theory and the Use of Meta-Ethnography .................. 93
4.9.2 Patient and Public Involvement and Engagement (PPIE) and Co-Design ...................... 94
4.10 Research Methods ............................................................................................................. 96
4.10.1 Ethical Approvals and Considerations ............................................................................ 96
4.10.2 Consent and Right to Withdraw ...................................................................................... 97
4.10.3 Confidentiality and Anonymity ...................................................................................... 97
4.11 Recruitment and Sampling Strategy .................................................................................. 98
4.11.1 Social Media-Based Recruitment .................................................................................... 98
4.11.2 Inclusion and Exclusion Criteria .................................................................................... 99
4.11.3 Sample Size .................................................................................................................. 100
4.11.4 Purposive Sampling ...................................................................................................... 101
4.11.5 Theoretical Sampling ................................................................................................... 103
4.12 Data Generation Methods ................................................................................................ 106
4.12.1 Reflexivity: Trustworthiness and Transparency ............................................................... 108
4.12.2 Preparing for Interviews ............................................................................................... 110
4.12.3 Interview Method and Technique .................................................................................. 112
4.12.4 Transcription of Interviews .......................................................................................... 113
4.12.5 Memo Writing and Field Notes ..................................................................................... 114
4.12.6 Synthesized Member Checking ...................................................................................... 118
4.13 Data Analysis .................................................................................................................... 121
4.13.1 Initial Coding ........................................................................................................... 121

4.13.2 Focussed Coding .................................................................................................... 123

4.13.3 Constant Comparative Analysis ............................................................................. 123

4.14 Introducing the Participants ....................................................................................... 126

4.14.1 Participant Characteristics and Biographies ........................................................... 126

4.14.2 Participant Biographies ......................................................................................... 128

4.15 Conclusion .................................................................................................................. 132

CHAPTER 5 THE SUBSTANTIVE THEORY ........................................................................... 133

5.1 Introduction .................................................................................................................. 133

5.2 The Substantive Theory .............................................................................................. 135

5.3 Conclusion .................................................................................................................. 141

CHAPTER 6 CONSTRUCTING REPRODUCTIVE IDENTITY .............................................. 142

6.1 Introduction .................................................................................................................. 142

6.2 Experiencing Normative Expectations of Childbearing ............................................. 143

6.3 Embodied Reproductive Influences .......................................................................... 148

6.4 Professional Influences ............................................................................................. 150

6.5 Intergenerational Influences ..................................................................................... 153
6.6 Conclusion .......................................................................................................................... 157

CHAPTER 7 ENTERING THE SYSTEM ....................................................................................... 158

7.1 Introduction .......................................................................................................................... 158
7.2 Deconstructing Reproductive Identity .................................................................................. 159
7.2.1 Categorising and Labelling ............................................................................................. 159
7.2.2 Controlling Risk ............................................................................................................. 165
7.2.3 Fetal Centring .................................................................................................................. 169
7.3 Expecting Compliance ......................................................................................................... 172
7.3.1 Enforcing Timetables ...................................................................................................... 175
7.4 Amplifying Actions .............................................................................................................. 178
7.5 Conclusion .......................................................................................................................... 187

CHAPTER 8 NAVIGATING THE SYSTEM ....................................................................................... 188

8.1 Introduction .......................................................................................................................... 188
8.2 Evaluating Information and Knowledge .............................................................................. 189
8.2.1 Information seeking ........................................................................................................ 189
8.2.2 Weighing Evidence ......................................................................................................... 194
8.2.3 Privileging Embodied Knowledge ................................................................................. 196
8.2.4 Predicting and Planning (Acts of Preparedness and Strategising) ................................. 199
8.3 Needing Community ........................................................................................................... 200
8.3.1 Seeking Community, Allies and Advocates ................................................................. 200
8.3.2 Sharing Community Values and Philosophies .............................................................. 205
8.3.3 Hidden Communities ..................................................................................................... 206
8.4 Engaged in a Battle .............................................................................................................. 209
8.4.1 Battling with the System .............................................................. 209
8.4.2 Pushing Back ............................................................................ 210
8.5 Doing Nothing ............................................................................. 214
8.5.1 Quitting the System ................................................................. 214
8.5.2 Playing the Game ...................................................................... 215
8.5.3 Negotiating .............................................................................. 216
8.5.4 Achieving the Choice ................................................................. 217
8.5.5 Complying (Giving Up) ............................................................. 218
8.6 Conclusion .................................................................................. 222

CHAPTER 9 RECONSTRUCTING REPRODUCTIVE IDENTITY ..................... 223
9.1 Introduction .................................................................................. 223
9.2 Adjusting to New Identity ............................................................. 224
9.2.1 Blaming Myself ....................................................................... 224
9.2.2 Coping with trauma ................................................................. 226
9.2.3 Planning the Future ................................................................. 227
9.3 Becoming Part of the Community ................................................ 231
9.3.1 Sharing Experiences (Advocating) ........................................... 233
9.4 Professional Advocacy and Identity ............................................. 235
9.5 Conclusion .................................................................................. 239

CHAPTER 10 DISCUSSION ................................................................... 240
10.1 Introduction ................................................................................. 240
10.2 Reproductive Identity ................................................................. 241
10.3 Medicalisation and the Institution as a Source of Identity Threat .... 246
10.4 Strategies For Identity Expression, Reinforcement and Defence ................................. 256

10.5 Conclusion .................................................................................................................. 267

CHAPTER 11 CONCLUSION AND RECOMMENDATIONS ............................................ 268

11.1 Introduction ................................................................................................................ 268

11.2 Summary of this Study ............................................................................................. 269

11.3 Study Strengths and Limitations ............................................................................. 271

11.3.1 Strengths ............................................................................................................... 271

11.3.2 Limitations ............................................................................................................ 272

11.4 Original Contributions and Implications of this Study ....................................... 273

11.4.1 Methodological and Theoretical Contributions ................................................ 273

11.4.2 Clinical Implications ......................................................................................... 275

11.4.3 Political Implications ......................................................................................... 276

11.5 Recommendations for Future Research, Policy, and Practice ............................ 278

11.6 Reflections on the Study ......................................................................................... 282

11.6.1 Concluding Thoughts ......................................................................................... 285

REFERENCES ................................................................................................................... 286

APPENDIX 1 –RELEVANT PUBLICATIONS AND WORKS ARISING OUT OF THESIS. 322

APPENDIX 2 - META ETHNOGRAPHY: EXAMPLE ITERATION OF SEARCH STRATEGY
........................................................................................................................................ 326

APPENDIX 3 – META ETHNOGRAPHY: CHARACTERISTICS OF INCLUDED STUDIES
........................................................................................................................................ 329

APPENDIX 4 – META ETHNOGRAPHY: TABLE OF CONSTRUCTS ................................. 335

APPENDIX 5 – RECRUITMENT PROCESS CHART ....................................................... 340

xiv
List of Figures

Figure 1  PRISMA 2019 Flow Diagram (Moher et al., 2009) .......................................................... 68

Figure 2 Social Media Accounts (l. Twitter  r. Instagram) .......................................................... 99

Figure 3 Inclusion and Exclusion Criteria .................................................................................. 100

Figure 4 Examples Social Media Recruitment Posts (l. Twitter  r. Instagram) .......................... 101

Figure 5 Recruitment Response Rates and Actions Throughout The Project .............................. 103

Figure 6 Diagram Representation of Method Process ................................................................. 105

Figure 7 Example of Reflexive Memo in NVIVO ....................................................................... 111

Figure 8 Example of Immediate Post-Interview Notes (Faye) .................................................. 112

Figure 9 Example Handwritten Field Notes from Interview With Participant 2 .......................... 115

Figure 10 Memo Framework ....................................................................................................... 116

Figure 11 Example of Analytical Memo in NVIVO .................................................................. 116

Figure 12 Example of Analytical Memo in NVIVO .................................................................. 117

Figure 13 Example of Consecutive Methodological Memos. ..................................................... 117

Figure 14 Adapted Process for Synthesised Member Checking .................................................. 119

Figure 15 Example of the Member Checking Form Accessed by Participants. .............................. 120

Figure 16 Diagrammed Non-Normative choices ...................................................................... 126

Figure 17 Typology of Non-Normative Choices Represented in Data ...................................... 131

Figure 18 Substantive Theory Model .......................................................................................... 140

Figure 19 Constructing Reproductive Identity Concept Diagram ............................................... 156
List of Tables

Table 1 Approach to Meta-Ethnography .............................................................................. 53

Table 2 SPIDER Framework .......................................................................................... 56

Table 3 Search Term Development - First Iteration ......................................................... 57

Table 4 Search Term Development - Final Iteration ......................................................... 59

Table 5 Meta-Ethnography Studies - Eligibility Criteria .................................................... 61

Table 6 Information Sources .......................................................................................... 67

Table 7 Interview Recording Method and Sampling Type .................................................. 108

Table 8 Participant Demographics .................................................................................. 127
<table>
<thead>
<tr>
<th>Acronym/Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU</td>
<td>Alongside Midwifery Unit (Birth Centre)</td>
</tr>
<tr>
<td>ARM</td>
<td>Artificial Rupture of Membranes</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-Retro Viral therapy</td>
</tr>
<tr>
<td>ANNB</td>
<td>Antenatal and Newborn Screening Programme</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>CEMACH</td>
<td>Confidential Enquiry into Maternal and Child Health</td>
</tr>
<tr>
<td>CEMD</td>
<td>Confidential Enquiry into Maternal Deaths UK</td>
</tr>
<tr>
<td>CGGT</td>
<td>Classical Glaserian Grounded Theory</td>
</tr>
<tr>
<td>cGT/cGTM</td>
<td>Constructivist Grounded Theory/ Constructivist Grounded Theory Methodology</td>
</tr>
<tr>
<td>CLC</td>
<td>Consultant Led Care</td>
</tr>
<tr>
<td>CMACE</td>
<td>Centre for Maternal and Child Enquiries</td>
</tr>
<tr>
<td>CO</td>
<td>Carbon Monoxide</td>
</tr>
<tr>
<td>CoC</td>
<td>Continuity of Care/ Carer</td>
</tr>
<tr>
<td>CTG</td>
<td>Cardiotocograph</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>EDD</td>
<td>Estimated Date of Delivery, based on scan</td>
</tr>
<tr>
<td>ELCS</td>
<td>Emergency Lower-section Caesarean Section</td>
</tr>
<tr>
<td>FMU</td>
<td>Freestanding Midwifery Unit (also Birth Centre)</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GT/GTM</td>
<td>Grounded Theory/Grounded Theory Methodology</td>
</tr>
<tr>
<td>HBAC/HBAC2</td>
<td>Home birth after caesarean section/ Homebirth after 2 caesarean sections</td>
</tr>
<tr>
<td>HCP</td>
<td>Healthcare Professional</td>
</tr>
<tr>
<td>HSIB</td>
<td>Healthcare Safety Investigation Board</td>
</tr>
<tr>
<td>Hx</td>
<td>History</td>
</tr>
<tr>
<td>IA</td>
<td>Intermittent Auscultation</td>
</tr>
<tr>
<td>IOL</td>
<td>Induction of Labour</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra-Uterine Death</td>
</tr>
<tr>
<td>LMS/LMNS</td>
<td>Local Maternity System/ Local Maternity and Neonatal System</td>
</tr>
<tr>
<td>MBRACCE</td>
<td>Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries</td>
</tr>
<tr>
<td>MLC</td>
<td>Midwifery Led Care</td>
</tr>
<tr>
<td>MLU</td>
<td>Midwifery Led Unit</td>
</tr>
<tr>
<td>MRCS</td>
<td>Maternal Request Caesarean Section</td>
</tr>
<tr>
<td>MTP</td>
<td>Maternity Transformation Programme</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NIMACH</td>
<td>Northern Ireland Maternal and Child Health</td>
</tr>
<tr>
<td>NIPT</td>
<td>Non-Invasive Perinatal Testing</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>NPEU</td>
<td>National Perinatal Epidemiology Unit</td>
</tr>
<tr>
<td>OGTT</td>
<td>Oral Glucose Tolerance Test</td>
</tr>
<tr>
<td>OU</td>
<td>Obstetric Unit</td>
</tr>
<tr>
<td>OV</td>
<td>Obstetric Violence</td>
</tr>
<tr>
<td>PO</td>
<td>Per Oral, swallowed via mouth</td>
</tr>
<tr>
<td>PPH</td>
<td>Post Partum Haemorrhage</td>
</tr>
<tr>
<td>(P)PROM</td>
<td>(Premature) Prolonged Rupture of Membranes</td>
</tr>
<tr>
<td>PR</td>
<td>Per Rectum, administered into rectal passage</td>
</tr>
<tr>
<td>PV</td>
<td>Per Vaginum, administered through vagina</td>
</tr>
<tr>
<td>QES</td>
<td>Qualitative Evidence Synthesis</td>
</tr>
<tr>
<td>RCM</td>
<td>Royal College of Midwives</td>
</tr>
<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
</tr>
<tr>
<td>SGT</td>
<td>Straussian Grounded Theory</td>
</tr>
<tr>
<td>SMC</td>
<td>Synthesised Member Checking</td>
</tr>
<tr>
<td>SROM</td>
<td>Spontaneous Rupture of Membranes</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
<tr>
<td>UKMidSS</td>
<td>United Kingdom Midwifery Study System</td>
</tr>
<tr>
<td>VBAC/ VBAC2</td>
<td>Vaginal Birth after Caesarean/ Vaginal Birth after 2 Caesarean births</td>
</tr>
</tbody>
</table>
## Glossary and Key Definitions

<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alongside Midwifery Unit</td>
<td>Midwifery-led birthing facility located on the same site or hospital as an obstetric unit. Care is provided by midwives alone.</td>
</tr>
<tr>
<td>Antenatal/Antepartum</td>
<td>Period of pregnancy before the onset of labour and birth</td>
</tr>
<tr>
<td>Birth worker</td>
<td>A generic umbrella term used by some to describe anyone who provides various levels of perinatal support and care. Includes midwives, obstetricians, doulas, lactation consultants, maternity support workers, psychologists, counsellors etc.</td>
</tr>
<tr>
<td>Born Before Arrival</td>
<td>The birth of a baby before arrival either at the hospital or before the arrival of a midwife.</td>
</tr>
<tr>
<td>Childbearing Continuum</td>
<td>Period including conception, pregnancy, labour, birth and postnatally</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>A model of care provides a named midwife or team of midwives providing all antenatal, intrapartum, and postnatal care to one woman.</td>
</tr>
<tr>
<td>Doula</td>
<td>A layperson provides non-medical support through pregnancy, labour, birth and postnatally in whole or part.</td>
</tr>
<tr>
<td>Freebirth</td>
<td>Labour and birth, where women have chosen not to have the assistance of a without medical or midwifery attendance. It is also called unassisted birth.</td>
</tr>
<tr>
<td>Freestanding Midwifery Unit</td>
<td>Midwifery-led birthing facility not located on the same site or hospital; care provided by midwives alone. Transfer to an obstetric unit is usually by ambulance or care.</td>
</tr>
<tr>
<td>Grand Multiparous</td>
<td>A woman who has had either≥ 4 or ≥ 5 births after the age of fetal viability (definitions vary)</td>
</tr>
<tr>
<td>Gravida/ Gravidity</td>
<td>The number of times a woman has been pregnant regardless of when birth occurred. Expressed as GX; therefore, G4 =Pregnant 4 times.</td>
</tr>
<tr>
<td>Guideline</td>
<td>Formalised, evidence-based, assisted decision-making tool guiding clinical recommendations and pathways about a specific situation or condition. Not mandatory.</td>
</tr>
<tr>
<td>Homebirth</td>
<td>Labour and birth at home</td>
</tr>
<tr>
<td><strong>Induction of Labour</strong></td>
<td>Process of mechanically or chemically inducing labour to begin artificially</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Informed Choice</strong></td>
<td>Process of making a choice based on information, knowledge, and experience</td>
</tr>
<tr>
<td><strong>Informed Consent</strong></td>
<td>The ethical principle requires saying yes (or no) before intervention, treatment, or examination. From an assumed position of mental capacity, it must be voluntarily given and informed (benefits, risks, alternatives, personalised and based on materiality). It can be verbal or written, explicit or implied.</td>
</tr>
<tr>
<td><strong>Intrapartum</strong></td>
<td>The period from the onset of labour to the completion of the third stage of labour.</td>
</tr>
<tr>
<td><strong>Kiwi/ Ventouse</strong></td>
<td>Instrument used for a vacuum-assisted birth.</td>
</tr>
<tr>
<td><strong>Local Maternity System or Local Maternity and Neonatal System</strong></td>
<td>A group drawn from providers, commissioners, local authorities and service users (MVPs) who work in partnership to deliver maternity and neonatal transformation under the Maternity Transformation Programme</td>
</tr>
<tr>
<td><strong>Maternity Transformation Programme (MTP)</strong></td>
<td>NHS England - National programme of work implemented to achieve the vision of Better Births (Cumberlege Report). It has 10 work streams, which include increasing choice and personalisation.</td>
</tr>
<tr>
<td><strong>Medical Model of Childbearing</strong></td>
<td>A philosophy and ideology that positions pregnancy and birth as pathological until after the event and that the process requires monitoring and medical management to remain safe.</td>
</tr>
<tr>
<td><strong>Midwife</strong></td>
<td>Autonomous expert professional suitably qualified and registered to provide support, care and advice during pregnancy, childbirth, and postpartum.</td>
</tr>
<tr>
<td><strong>Multigravida</strong></td>
<td>A woman who has been pregnant more than once</td>
</tr>
<tr>
<td><strong>Multiparous</strong></td>
<td>A woman who has given birth to more than one viable pregnancy</td>
</tr>
<tr>
<td><strong>National Institute for Health and Care Excellence</strong></td>
<td>The organisation draws together the best available evidence and provides national advice, quality standards and guidance for public health and social care use.</td>
</tr>
<tr>
<td><strong>Neonatal</strong></td>
<td>The period immediately post-birth concerning the baby (Neonate)</td>
</tr>
</tbody>
</table>
| **Non-Normative choice** | An autonomous decision made by women deemed to have the capacity to do so, made at any point along the childbearing continuum, which reflects one or more of the following elements:
- Desiring care outside of established guidelines or medical recommendations would not routinely be offered as a choice.
- Withholding consent to any routinely offered intervention which is offered as a choice.
- Moving outside cultural, social, or familial expectations and non-medical ‘norms’ |
| **Obstetric Unit** | Clinical location in which care is provided by a team of obstetricians, midwives, neonatologists, anaesthetists, etc., for women at high risk of complications during labour and birth. Diagnostic, medical and emergency services, including theatre, obstetric, neonatal, and anaesthetic care, are available 24 hours a day on-site. |
| **Obstetrician** | A doctor specialising in obstetric and high-risk care throughout pregnancy and birth. |
| **Parity** | The number of times a woman has birthed a live neonate at any gestation or at $\geq 24$ weeks gestation, regardless of viability. Expressed as $P^{x}x$: so $P^{2}x^{1} = 2$ births after 24 weeks or live births, with 1 birth before 24 weeks not living (miscarriage). Stillbirths would be included in the large number and documented on notes. |
| **Parturition** | The act of birthing, childbearing |
| **Placentophagy** | The oral consumption of one’s placenta post-birth. |
| **Planned Caesarean Birth** | The preferred term for a caesarean birth replacing maternal request or elective caesarean section |
| **Policy** | Mandatory procedure for requirements within an organisation. It is not appropriate to dictate recommendations for clinical care. |
| **Polyhydramnios** | An excess of amniotic liquor |
| **Post Partum Haemorrhage** | Obstetric emergency. In the UK, loss of 500mls of blood from the genital tract (or any amount accompanied by signs of clinical shock) within 24
hours of the birth of the neonate (primary) or up to 6 weeks postpartum (secondary). It can be minor, moderate, or significant (>1000mls).

<table>
<thead>
<tr>
<th><strong>Post Term/ Dates Pregnancy</strong></th>
<th>Also referred to as late-term. A pregnancy that extends beyond 14 days (total 294 days) after the estimated date of delivery (EDD).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Postpartum/Postnatal</strong></td>
<td>The time immediately following childbirth</td>
</tr>
<tr>
<td><strong>Primigravida</strong></td>
<td>A woman pregnant for the first time</td>
</tr>
<tr>
<td><strong>Primiparous</strong></td>
<td>A woman who has birthed once</td>
</tr>
<tr>
<td><strong>Puerperal</strong></td>
<td>Related to the period after childbirth, within which time a woman’s body returns to its pre-pregnancy state</td>
</tr>
<tr>
<td><strong>Puerperium</strong></td>
<td>A period after childbirth, usually around six weeks within which time a woman’s body returns to its pre-pregnancy state</td>
</tr>
<tr>
<td><strong>Shared Decision Making</strong></td>
<td>The practice of collaborative decision-making is where clinicians support women to make informed choices about their care. A misnomer, as decision-making, is not legally or ethically shared unless capacity is in question (see supported decision-making)</td>
</tr>
<tr>
<td><strong>Shoulder Dystocia</strong></td>
<td>Obstetric emergency. A vaginal cephalic birth that, after the birth of the head and failed gentle axial traction, requires additional manoeuvres to assist in the birth. It occurs when the anterior fetal shoulder impacts the maternal symphysis pubis.</td>
</tr>
<tr>
<td><strong>SIGN</strong></td>
<td>Scotland Specific clinical guidelines development, equivalent to NICE</td>
</tr>
<tr>
<td><strong>Social model of childbearing</strong></td>
<td>Alternatively, the midwifery model of childbearing is a philosophy and ideology that positions pregnancy and birth as normal, physiological event that only requires intervention in the event of deviation from those processes.</td>
</tr>
<tr>
<td><strong>Standard Operating Procedure</strong></td>
<td>Standardised set of systematic procedure to be followed in each circumstance</td>
</tr>
<tr>
<td><strong>Supported Decision Making</strong></td>
<td>More accurate and largely preferred term for the process currently described as ‘Shared Decision Making.’</td>
</tr>
<tr>
<td><strong>Syntocinon Intravenous Infusion (IVI)</strong></td>
<td>An intravenous infusion of synthetic oxytocin used for induction or augmentation of labour which is titrated until uterine contractions reach 3-4 in 10 minutes</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Unplanned Caesarean Birth</strong></td>
<td>Preferred term for a caesarean birth replacing emergency caesarean section</td>
</tr>
</tbody>
</table>
Chapter 1 Introduction to Thesis

1.1 Introduction

This thesis offers the findings of a constructivist grounded theory study examining why and how women construct their decisions to make non-normative choices along the maternity continuum, exploring what might motivate and drive those decisions. In doing so, the thesis examines women’s experiences navigating the maternity care system within the United Kingdom, presenting the underlying social processes and offering an explanatory substantive theory grounded in the data. This chapter introduces the motivations for undertaking this study, exploring my personal and professional influences and reflexive position. I will then present the thesis structure and a note on the use of language in this thesis. Finally, I will present the overall research aims, objectives and research question.

1.2 Professional and Personal Influences and Reflexive Positionality

When undertaking any research, particularly in this thesis, addressing positionality outside of an objective stance must be acknowledged. Indeed, a researcher's positionality interacts and intersects with reflexivity (Bukamal, 2022). I have woven discussions of reflexivity throughout this thesis; however, it is necessary to introduce a discussion of my own professional and personal influences, which have concurrently informed and guided my doctoral journey, including methodological considerations.

I qualified as a midwife in 2012 with no aspirations to be anything other than a safe, evidence-based clinician, supporting women at one of the most vulnerable times to have a safe, fulfilling, and positive experience. As a student midwife, I developed a strong ethos and philosophy for supporting and advocating choice alongside a strong sense of responsibility for protecting women’s autonomy, however challenging these might be for others, an ethos I have taken throughout my career.

Undertaking this study has forced me to confront elements of my reproductive journey that laid the ground for the study and my whole ethos as a midwife and researcher. I came to midwifery in my late twenties, having had what I initially reflected as a normative pregnancy and birth. I followed the rules and timetables and instructions from midwives and obstetricians, and conformed to what my parents, siblings, and friends implicitly expected of me. While I had always been interested in childbirth as a process, the experience would unexpectedly change my life. Many discuss childbirth as transformative; indeed, for me, it was, but not in the conventional, empowering, life-
defining way. My first pregnancy and birth exposed me to the impersonal conveyor belt of modern maternity care, feeling somewhat thrown to the wolves in exploring my options alone, with little to no practical guidance from my midwives and obstetric team. I went to antenatal classes as was the expectation, where a rosy picture was painted for me of the normative expectations that would guide the rest of my pregnancy and birth. While I would like to say that nothing could have prepared me for the experience of labour and birth, I still believe that there was much that could have, but nothing was offered that did. My experiences were complex and followed a personal experience that I felt was humiliating and shameful, so much so that in consultation with my supervision team I have decided not to share the full details here. I have, however, journaled and reflected extensively about the experience. I found my loss of control and autonomy profoundly distressing in a way that, at the time and until my midwifery education, I could not articulate. I was abandoned and blamed by the system I trusted to care for me. I had no relationship with the faceless clinical staff. Strangely, I remain grateful for these experiences because they were the catalyst for pursuing a midwifery career to make incremental changes that might change the experiences of women like me. It did not need to be like that.

My midwifery education was (and continues to be) a revelation. Firstly, I quickly realised that my experience was not an anomaly; many women had similar experiences, reinforcing my decision to move into the maternity space. Secondly, it turned out I was quite a good midwife and thirsty for it. I wanted to learn everything I could, including the art and science of midwifery – anatomy and physiology, care planning, law and ethics, consent and autonomy, pharmacology – anything to do with my future role. I developed an aptitude for research and evidence, spending hours searching for and evaluating every piece of research or evidence about more or less everything I could, realising that for me to advocate for women in my care authentically, I needed to be able to recall, present and critique all evidence that I, or others, were offering. I quickly built up and took into registration as a qualified midwife, a reputation for being ‘that’ midwife that others reached out to check the evidence for one intervention or another. To resolve a physiological issue or indeed for challenging practice that was not done in the interests of the best available evidence, or indeed in the absence of evidence. I hope that in my career, working clinically as a practice development midwife, senior leader, and, latterly, as an educator, I have modelled these behaviours and instilled confidence in others to advocate for women.

My MSc research (Madeley, 2018) laid the foundations for this study, exploring how midwives support women choosing homebirth in the presence of complex needs, the first study of its kind to recognise that high-risk homebirth as a phenomenon was not going away and that an evidence base needed to support safe care. This arose directly from my experiences as a clinical midwife, as I reflected on seeing more and more women declining care
and making outside-of-guidance choices than my inpatient colleagues, and the penny dropped. Women were choosing to give birth at home, outside of the system, to realise their choices; they were choosing the continuity of my team, building trusting relationships because they knew that they would have their decisions respected regardless of the outcome. I also looked after a few women who had chosen planned caesarean birth outside of guidance due to previous traumatic experiences. I soon realised that what was missing - the women’s voices. My research and others appeared to be privileging clinicians’ voices above the women's, which did not sit right with me. To remain woman-centred, we must raise their voices and advocate for their needs. It always felt so unjust and entirely counter to my midwifery ethos to work in a system that professes woman-centred care. Yet, when women attempted to express choice, they were judged, cajoled, and manoeuvred into making decisions that fit the system but not the women themselves. I always committed to practising authentically within the full scope of midwifery care as an autonomous and accountable midwife, supporting and advocating for many women making non-normative choices, declining care, or taking other paths in their maternity journey.

I remain fiercely protective of women’s right to choose, regardless of what those choices might be. Therefore, I have no philosophy nor engrained preference for one mode of birth over another, what analgesia or mode of relaxation one chooses, or where one wishes to birth their baby. I profess an philosophy of women being free to make their choices in a respectful and relational space, free from obstetric violence and with the support they want and request.
1.3 A Note on the Language Used in this Thesis.

I have used the first person in constructing this thesis for two methodological reasons. Firstly, this provides a transparent account of my choices and decisions undertaken throughout the study's inception and execution. Secondly, the use of meta-ethnography in the systematic literature review and constructivist grounded theory explicitly acknowledges the role of the researcher as a co-participant in their method, with the findings and resultant theories constructed by the researcher and the participants. By using the first person, I acknowledge this explicitly.

It is necessary to recognise that some decisions regarding language and terminology surrounding childbirth require clarification due to their subjective and often controversial nature. I have adopted the broad principles of the recommendations of the Re:Birth report (RCM, 2022c) for the use of language (e.g. birth rather than delivery or section, planned/unplanned caesarean instead of maternal request or emergency, spontaneous vaginal birth) unless the language represents a verbatim quote from a participant. Furthermore, I acknowledge that the term ‘woman’ does not always reflect an individual’s understanding of their gender identity (Woodward, 2011; Hoffkling, Obedin-Maliver and Sevelius, 2017), which is important in the context of a participant contributing to this study. The terms ‘patient’ and ‘service user’ were considered but rejected despite them being gender neutral as they tend to convey negative connotations of illness and the potential to render those referred to in this thesis depersonalised. Consequently in the spirit of personalisation, I refer to participant pseudonyms or explicitly to participants by their preferred gender and pronouns where necessary or referring to the participants as a whole. I have avoided disempowering language, acknowledging that each encounter along the childbirth continuum\(^1\) is unique, embodied and centred on the woman or other birthing person's experience. Examples of this include the use of ‘birth, birthed or birthing’ instead of ‘delivery or delivered’ which implies objectivity, passivity and lack of control (Hunter, 2006; Walsh, 2010).

\(^1\) For definition see Glossary and Key Definitions, p21.
1.4 Research Aims, Objectives and Research Question

The aims of this study were to:

1. Examine and explain why and how women and other birthing people construct their decisions to make non-normative choices and explain the underlying social processes that motivate and drive their decisions.

2. Examine their experiences concerning navigating the maternity care system.

The objective of the research was to:

- Generate an explanatory substantive theory about how women and other birthing people make a non-normative choice and, in so doing, explain the underlying social processes.

The research question for the study was:

“What are the experiences of women and other birthing people who make non-normative choices along the childbearing continuum in the United Kingdom
1.5 Organisation of the Thesis

Chapter 1 introduces the thesis and presents my personal and professional interests in the subject and reflexive positioning. I clarify my approach to terminology and the research aims, objectives, and research question.

Chapter 2 presents the context for my research exploring historical, modern, and institutional influences on childbearing choice in the UK. In this chapter, I introduce how I define a non-normative choice and discuss normativity, non-normativity, and the legal and ethical implications of making such choices. Finally, I present an overview of the limited UK-based evidence base outside the literature review in Chapter 3.

Chapter 3 expands upon the previous chapter by presenting the findings of the meta-ethnographic review of the literature, providing a broader international context of the phenomena represented in the literature. In this chapter, I justify the need for my research by exposing and explaining the gaps in empirical and theoretical knowledge that my empirical work fills.

Chapter 4 presents the research design and methodology and justifies the philosophical underpinning of the study and subsequent selection of the constructivist grounded theory method. Further, in this chapter, I provide a detailed account of the applied method and an audit trail satisfying the trustworthiness requirements for the constructivist grounded theory method (cGTM). In this chapter, I also introduce the participants and their non-normative choices.

Chapter 5 introduces the first of the findings’ chapters. I present the substantive theory: Theory of Reproductive Identity Expression, Reinforcement and Defence.

Chapters 6 – 9 present the final four findings chapter. In these chapters, I introduce the social processes that support the conceptualised and abstracted substantive theory. I explore participants' experiences of constructing reproductive identity, entering the system, navigating the system, and finally reconstructing reproductive identity.

Chapter 10 discusses the findings situated within broader theoretical and conceptual literature and introduces the QuEEN Model of Common Strategies for Reproductive Identity Expression, Reinforcement and Defence.

Chapter 101 summarises the research, its strengths, and limitations and offers my reflections on implications for practice. Finally, the chapter indicates recommendations for future work in this area.
This thesis includes twelve appendices, which are referenced clearly for the reader. I have also used footnotes to offer further contextual information supporting the main text and arguments.
Chapter 2 Thesis Background and Context

2.1 Introduction

The following chapter describes the main concern from which this thesis grew. First, I will offer the context of non-normative choices by briefly exploring historical, systemic, and institutional influences on the choice agenda in the United Kingdom. Second, I present normativity and non-normativity in a general context, describing the legal issues relating to specific non-normative choices in maternity care and a contextual discussion illustrating the first part of the evidence, knowledge, and theoretical gap. Finally, I will present the challenges from a legal and professional perspective of non-normative choices in the context of maternity care, reviewing the quantitative and other data outside that presented in Chapter 3 - Meta-Ethnographic Systematic Literature Review.
2.2 Maternity Choice in the United Kingdom

“Article II: Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care... Article VII: Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion.” (White Ribbon Alliance, 2011, p. 35)

The term ‘woman-centred care’ has become the embodiment and cornerstone of personalised maternity care since its explicit introduction in the Changing Childbirth Report (DoH, 1993) and subsequent adoption into Government policy in 1994. Defined by Leap (2000) and adopted globally, woman-centred care supports the notion of focussing on an individual’s ‘needs, aspirations and expectations’ as opposed to those of the institution or professionals (Leap, 2000, 2009). Within the UK, Changing Childbirth lays the foundations for a women-centred choice-based agenda in maternity care, affirming that women have ‘...unique needs...arising from her medical history...ethnic, cultural, social and family background.’ (DoH, 1993 p. 7).

This pioneering approach to improving access to and the quality of NHS maternity services in the early 1990s arose out of the findings of the Expert Maternity Group and the recommendations of the House of Commons Select Committee 2nd Report on Maternity Services (MRSC, 1992) that women should play a pivotal role in driving the maternity care they receive. Principal to women-centred care is the notion that all women should be able to choose which care they receive, where, and with whom, including ‘making a decision about her care based on her needs, having discussed matters fully with the professionals involved’ (Department of Health, 1993). Defining what choice means and how it can be authentically exercised in contemporary maternity care remains complex. A House of Commons review a decade after Changing Childbirth’s publication evaluated the extent to which choice in maternity care was being achieved, suggesting that while an overall increase in perceived ability to exercise choices existed, the extent to which this translated into feelings of control did not translate, with 60% of respondents to MRSC (1992) not always having a sense of control and a subsequent improvement in psychological outcomes (Green and Batson, 2000; House of Commons Health Committee, 2003).

The report cited the ability to provide genuine choice as a ‘luxury’ (House of Commons Health Committee, 2003, p. 3), limited to ‘articulate middle classes’ and restricted by professionals or influenced by the political climate at the time (Health Committee, 2003; House of Commons Health Committee, 2003, p. 7). Beverly Beech subsequently coined the term ‘the illusion of choice’ (House of Commons Health Committee, 2003, p. 8),
suggesting that the reality of what choices are actually offered are restricted by a framework reliant on the context of the local maternity services, attitudes and views of healthcare professionals and interestingly also dependent on socioeconomic factors, influenced by elements of inequality (Health Committee, 2003).

Since these publications, various international and domestic policy and guidance iterations have continued to present choice in childbearing as both an aspirational and a fundamental element of dignified maternity care (Department of Health, 2007; World Health Organisation, 2014; Birthrights, 2015; World Health Organisation, 2016; NHS England, 2016a; Birthrights, 2017b, 2018). The current NHS Maternity transformation programme and its commitment to improving choice through implementing the recommendations of Better Births (NHS England, 2016a, 2021c) has again reiterated the intention to deliver authentic, universal choice through personalised care at a local level, emphasising that:

“Care should be centred on the woman, her baby and her family, based around her needs and decisions, where there has been genuine choice informed by unbiased information.”

(NHS England, 2021d, p. 2)

The NHS long-term plan makes explicit expectations to improve the delivery of safer maternity services, personalised care, and shared decision-making (NHS England, 2019a) in the UK, committed to halving stillbirth, neonatal and maternal mortality, and morbidity by 2025 (discussed later in the chapter). More recently, the report into the safety of maternity services in England (HSCC, 2021) and the three-year delivery plan for maternity and neonatal services (NHS England, 2023b) have reaffirmed the necessity and requirement to listen to and work with women and their families, supporting informed choice and facilitating personalised care ‘shaped to a woman’s own risk and situation’ (HSCC, 2021, p. 46). Acknowledging risk, however, remains only part of the story, with informed consent and supported decision-making (NHS England, 2016a, 2019a, 2021d, 2021e; CQC, 2023) being critical in delivering personalisation with an individual’s needs, wants, and expectations centred in decision making, accepting that:

“Different women have different agendas about what they want to do” …[and] that the job of the clinician was to do the best possible risk assessment, communicate clearly and respect women’s autonomy”.

(Jolly, 2021, p. 46)
An explicit recognition that a ‘one size fits all’ care system cannot meet the needs of a complex society with varying health needs (NHS England, 2021a, 2021e) establishes the need for authentic personalisation of care. Recognition of individual biopsychosocial complexity is vital in this process and the context of autonomous decision-making because tensions exist between providing personalised care and managing universal safety and risk. Care pathways and recommendations are made through the evaluation and assignation of biomedical risk status and sociodemographic factors, which subsequently guide and inform increasingly standardised packages of care to which women are expected to conform. Despite this, current data suggest that women are not always given appropriate information or explanations about their care (59%); for example, only 19% of women report no choice about their preferred location for birth (CQC, 2023).

Since 2015, three high-profile investigations into failings in maternity services (Kirkup, 2015, 2022; Ockenden, 2021) have heralded some of the most fundamentally necessary changes in arrangements for maternity care. Significantly, these relate to improvements where care lacked appropriate risk assessment, care planning and escalation, inconsistent application or compliance with national guidelines and protocols, poor working relationships between midwives, obstetricians and the wider multidisciplinary team, poor clinical competence and skills, and the emergence of a culture pursuant of ‘normal birth at all cost’ (ibid 2015, p. 15). The report led to 26 national recommendations (18 local recommendations) and triggered a review of maternity services across England. The publication of the report came a year after the Secretary of State for Health announced national ambitions to reduce the rate of stillbirths in England from 4.7:1000 to 2.3:1000 by 2030, with targets of 50% reduction by 2025, with 20% by 2020 (DHSC, 2017) leading to, amongst other initiatives, the implementation of the saving babies lives care bundle (NHS England, 2016b, 2023a). The bundle is in its third iteration and seventh year at the time of writing. It requires the implementation of interventions and associated auditable metrics designed to reduce stillbirth and neonatal morbidity and mortality, each predicated on fetal surveillance, monitoring and maternal behaviour modification, including but not limited to smoking cessation, assessment, and surveillance for fetal growth restriction. The implication for women is that adherence to the bundle element is mandatory (although it is not), seemingly at odds with concurrent aspirations within the National Maternity Review (NHS England, 2016a) and the NHS Mandate (DoH, 2017), requiring measurable progress and planning in improving and facilitating choice.
2.3 Medicalisation, Institutionalisation and Risk

‘Reproductive biology is always mediated by cultural interpretations, specific material conditions and diverse social circumstances and relationships’ (Nowell, Mitchell and Kurki, 2021, p. 68)

Much is written concerning the effects of the permeation of biomedical risk discourse into elements of the modern maternity experience and the subsequent disempowerment and pathologisation of women’s bodies (Katz Rothman, 1982; Martin, 1987; Davis-Floyd and Sargent, 1997; Davis, 2021). The biomedical model of childbirth shifted parturition from a principally social context to a medicalised model (van Teijlingen, 2005), where childbearing is considered pathological until proven otherwise (van Teijlingen, 2017). Beck (1992) It suggests that his ‘risk society’, a product of modernity itself, necessitates subsequent systematic control and creation of order. Further, risk identification, mitigation, and reduction strategies are representative of the sensibilities and technocratic ideology of dominant institutions, including the medicalised one within which maternity care is currently conducted (Beck, 1992; Davis-Floyd, 2001; Chadwick and Foster, 2014; Healy, Humphreys and Kennedy, 2016a; Scamell, 2016), with definitions of what constitutes risk and safety exclusive of social, psychological and cultural considerations (Edwards and Murphy-Lawless, 2006; Peter and Wheeler, 2022).

Alaszewski (2006) suggests that technological advances alongside societal shifts towards individualisation have reached a state of being unable to control risk, significant in the context of aspirations for personalisation of care within a risk-averse maternity culture. This is supported by Malacrida and Boulton (2012), who, in exploring women’s perceptions of childbearing choice, found that a blend of competing agendas, such as technocratic approaches and organisational constraints within hegemonic maternity services affect the degree to which somebody can make choices.

Perceptions of risk are socially constructed, shaped by temporal sociocultural norms, contextually situated, variable and highly political (Beck, 1992; Tulloch and Lupton, 2003; Chadwick and Foster, 2014; Lennon, 2016); never has this been more relevant than in the context of contemporary maternity care. Despite this, institutional conceptualisations of risk tend to reflect the binary high/low-risk typology related to biomedical or obstetric risk factors identified in the NICE (2023) guidelines (Kurinczuk et al., 2015) rather than acknowledging broader psychosocial complexities of women’s health. Moreover, women’s perceptions of risk are frequently at odds with institutional notions of risk (Brown et al., 2013; Healy, Humphreys and Kennedy, 2016b; Lee, Ayers and Holden, 2016c, 2016b; Lennon, 2016; Coxon et al., 2017), comparing their circumstances to the broader recommendations of population-based empirical data and measurable outcomes for homogenous groups of people. These conditions,
therefore, present a critical tension between risk-based practices within the institution and the realisation of the choice agenda, discussed further in the following section.

Despite evidence to the contrary (Brocklehurst et al., 2011; Hutton et al., 2019; Reitsma et al., 2020), and borne out of spurious notions of improved safety within a medicalised institution (Peel and Standing Maternity and Midwifery Committee, 1971; Scamell, 2011; Scamell and Alaszewski, 2012), childbearing in the UK remains a chiefly institutional activity with contemporary figures estimating around 97.5% (NHS Digital, 2022; ONS, 2022) of births in England and Wales occurring in a hospital and therefore subject to their norms and timetables. Even when pregnancy, labour and birth happen outside of the physical constraints of the institution, the same rules and timetables are administered by healthcare professionals providing care. Women who choose to pursue pregnancy and birth outside of the institution report being subject to negative strategies (Coxon et al., 2017) despite evidence suggesting that many women choose to give birth outside of the physical parameters of the institution to avoid temporal and spatial constraints and adverse outcomes associated with being in the institution (Roth, 1963; Feeley and Thomson, 2016a, 2016b; Scarf et al., 2018; Hutton et al., 2019; Reitsma et al., 2020; Greenfield, Payne-Gifford and McKenzie, 2021a; Olsen and Clausen, 2023).

Technological advances that allow external observation and evaluation of the fetus through visual and audible aids such as ultrasound or other biomedical prenatal diagnostic technologies have increased the likelihood of survival for fetuses born early but also permitted earlier identification of conditions that might be incompatible with life, affect the quality of life or maternal conditions that can be managed and treated (Burke, 2008; Lupton, 2013; Stephenson, McLeod and Mills, 2016; Cavaliere, 2018; Favaretto, Vears and Borry, 2020; van Dijke et al., 2021; Kelly-Hedrick et al., 2023). The inference is machine-like predictability and control over women’s faulty bodies, tacit and overt deviations from socioculturally acceptable norms of pregnancy and the risky business of parturition (Martin, 1997; Davis-Floyd, 2001). Katz Rothman suggests that the ‘science and technology that society develops reflects the values of its culture’ (ibid 1990, p. 9), characterising a super valuation of a ‘fetus-first mentality’ (Milne, 2020, p. 1) and consequential maternofetal conflicts (Ohel et al., 2006; Hollander et al., 2016). The attribution of personhood upon the fetus, despite its legal position (Oakley, 1986; Oaks, 2000; Windsor, 2017), is problematic, embodying a ‘cultural creation of the unborn child’ (Katz Rothman, 1990), negating the embodied and situated nature of the pregnancy (Firth, 2009). Furthermore, fetal centring implies an expectation for women to prioritise the wellbeing of their fetus over all else; the good and sacrificial mother construct as “a mechanism through which women do what they should” (Goodwin and Huppatz, 2010, p. 4).
Contemporary drivers and government-led strategies to improve perinatal outcomes and reduce the risk of stillbirth have resulted in interventions intended to modify maternal behaviours that might risk fetal compromise (NHS England, 2023a). These include behaviours that might be met with moral or social disapproval, such as smoking, drinking, having a raised body mass index (BMI) or taking medication during pregnancy, reaffirming the super valuation of fetal well-being above that of women’s autonomy (Kukla, 2010; Lowe and Lee, 2010; Lowe, Lee and Yardley, 2010; Symon, 2018). Increased screening and surveillance reinforce this focus (Armstrong-Buissere et al., 2020; Widdows et al., 2021; NHSE, 2022; NHS England, 2023a), becoming routine and the norm despite weak evidence supporting implementation in many cases. A commonly cited example is the continued use of cardiotocography (CTG). CTG was introduced in the late 1960s to reduce fetal and neonatal mortality by identifying fetal hypoxia by identifying pathological changes in the fetal heart rate. Today, women deemed to have any biomedical risk, and some with none, are ‘offered’ CTG during labour (NICE, 2023). Evidence has shown that no discernible benefit, other than a reduction in neonatal seizures, is associated with the use of CTG compared to intermittent auscultation (Alfirevic et al., 2017; Grytten et al., 2018; Small et al., 2021) and that the reliability of interpretation of CTG traces has contributed to poor outcomes (Hernandez Engelhart et al., 2023). From a legal and litigation standpoint, CTG might be an unreliable defence (Sartwelle, 2012; Politi, Mastroroberto and Ghi, 2023). Feminist scholars have argued that the CTG reinforces a separation of the mother-fetus dyad, over-personifying the fetus and drawing focus away from the woman (Melamed, 2023), emphasised by institutional guidelines and policies for CTG and central monitoring, which studies have shown undermine women’s decision making and disempower clinical decision making (Small et al., 2022, 2023). Many have suggested that the true intention of such strategies is to reduce litigation and liability for adverse maternal and fetal outcomes (Forster et al., 2006; Symon, 2006; Tingle, 2013; Wise, 2013; Healy, Humphreys and Kennedy, 2016b; Robertson and Thomson, 2016; Scamell, 2016).

The political nature of risk management is evident within recommendations of national guidelines (NICE, 2020, 2021b, 2021c, 2023) and drivers for enhanced governance arising out of investigations into failing maternity services (Francis, 2010; Ockenden, 2021; Kirkup, 2022), safety and mortality reviews (Knight and Bevan, 2021; Knight et al., 2021; Mitchell, 2023) and national strategies for reducing perinatal mortality and morbidity (NHS England, 2023a). Many are translated into institutional arrangements for risk management in the form of

---

2 The term ‘offers’ features within all maternity guidance produced by NICE and RCOG. The word legally infers choice and is closely related to ethical principles of consent, whereby consent is solicited.
guidelines, pathways and standardised approaches to care, primarily predicated on risk-based categorisation (Scamell and Alaszewski, 2012; Frohlich and Schram, 2015; Greenhalgh, 2018) and the prediction of adverse physiological maternal or fetal outcome based on algorithmic risk assessment tools situated within population-based data (Greenhalgh, Howick and Maskrey, 2014). Returning to CTG monitoring, a clear example of the foregoing is centralised monitoring of CTG, mandated as a recommendation (Ockenden, 2021) despite evidence of its efficacy remaining largely absent (de Jonge, De Vries and Declercq, 2023).

The emergence of the evidence-based medicine (EBM) movement since the 1980s saw a move away from the historically standardised, piecemeal application of contemporary and historical knowledge and anecdote within healthcare planning towards the evaluation of evidence, shared decision making and expert and theoretical consensus reasoning (Guyatt et al., 1992; Sackett et al., 1996; Sackett, 2007; Greenhalgh, Howick and Maskrey, 2014; Copeland, 2020). EBM is not without its drawbacks, mainly favouring positivist methods and population-derived empirical data (Valkenburg, Achterhuis and Nijhof, 2003). The most common expression towards synthesis, translation and implementation of evidence-based medicine in the United Kingdom is arguably the clinical guideline, an assisted decision-making tool ideally subject to rigorous development before performance, guiding clinical recommendations and pathways (Greenhalgh, Howick and Maskrey, 2014; Prusova et al., 2014; Frohlich and Schram, 2015). Guidelines differ from policies and protocols in their application and intention (Prusova et al., 2014; Frohlich and Schram, 2015) (also see Glossary and Key Definitions). However, criticism remains around the problematic nature of ‘guideline-centred care’ (Woolf et al., 1999; Kotaska, 2011; McCartney, 2014) and the failure to view guidelines as advisory rather than strict rules (Downe, 2010; Copeland, 2020). Criticisms include blanket, non-critical and rigid adherence (Kotaska, 2011), a lack of quality evidence in development (Prusova et al., 2014; Steel et al., 2014), poor understanding of the distinction between policy, protocol and guideline3 (Frohlich and Schram, 2015), failure of guidelines to facilitate application to co and multiple morbidities (Hughes, McMurdo and Guthrie, 2013; Anjum and Mumford, 2017) and fear arising out of the medico-legal implications of non-adherence. Contemporary independent reviews of maternity services have highlighted issues of failure to follow or implement national and local guidelines (Francis, 2010; Ockenden, 2021; Kirkup, 2022); therefore, additional scrutiny that compels compliance with guidelines exists, potentially heightening clinical anxiety around guideline non-compliance in women’s choices. While most clinicians will rely upon guidelines when providing recommendations (Downe, 2010), the legal status and protection guidelines offer

---

3 See Glossary and Key Definitions
compared to clinical judgement is less well understood by clinicians and the institution in the context of legal precedent (UKSC, 2015; Sanderson v Guys and St Thomas’ NHS Foundation Trust, 2020). Furthermore, critics have argued that guidelines themselves are counterproductive to personalised care, having a significant impact on maternal autonomy and choice, frequently being implicitly coercive and lacking the necessary evidence (Wright, 2007; Kotaska, 2011; Greenhalgh, Howick and Maskrey, 2014; Prusova et al., 2014; Greenhalgh, 2018).

Where choices are made that transgress either institutional or societal expectations and norms, then the ramifications can be severe, with studies highlighting judgement on a woman’s ability and fitness to be a mother leading to vexatious referral to child social services (Feeley and Thomson, 2016a; Jenkinson, Kruske and Kildea, 2017; Holten, Hollander and de Miranda, 2018). Moreover, as Coxon et al. (2014) suggested, wider discourses around good motherhood and fetus-centric care in the event of a poor outcome lay blame at the feet of individuals rather than acknowledging the impact of institutional, cultural, economic and socio-political agendas (Healy, Humphreys & Kennedy (2016), thereby removing institutional responsibility where women resist conformity. Indeed, studies exploring clinicians’ views of supporting non-normative choices have identified healthcare professionals’ concern over litigation and regulatory action should a poor outcome occur after supporting a woman’s choice (Hollander et al., 2016; Jenkinson, Kruske and Kildea, 2017; Feeley, Thomson and Downe, 2019; Madeley, Williams and McNiven, 2019; Opdam et al., 2021; Westbury and Enion, 2021). A culture of risk hypervigilance has ramifications with restricting women’s choices (Coxon, Sandall and Fulop, 2014; Newnham, McKellar and Pincombe, 2015) and the ability of autonomous clinicians’ to support, therefore, those choices (MacKenzie Bryers and van Teijlingen, 2010).
2.4 What Women Want

There currently exists competing ideas about what is most desirable concerning pregnancy and birth experience and outcome, often with disagreement between professionals and those for whom they care. Downe et al. (2018) undertook to explore what mattered to childbearing women by synthesising 25 qualitative studies across 19 countries. Overwhelmingly, the findings supported the view that while a healthy child was a favourable outcome, so too was a positive birthing experience meeting or exceeding expectations (viewed through their socio-cultural lens), being treated with kindness, humanity and having psychosocial as well as biophysical needs met by skilled and supporting caregivers. Far from having idealistic expectations, most women pragmatically demonstrated understanding not only the extent to which pregnancy and birth are unpredictable, hard work, frightening and sometimes necessitating intervention (or where somebody requested intervention) but there was an acknowledgement that the presence of clinically and psychologically competent staff in a safe environment promotes a sense of achievement and personal control. Significantly, Downe et al. (2018) highlight that a ‘good’ experience is highly contextual to the individuals’ view of socio-cultural norms, and the meaning they assign to the experience depends on the extent to which they view pregnancy and childbirth as transformative.

Furthermore, studies have highlighted that the extent to which women feel they have control and agency over their pregnancy and birth are significant moderators in how women evaluate their childbearing experience (Cook and Loomis, 2012; Newnham, 2014; Leahy-Warren et al., 2021) and that substantial barriers exist towards shared decision-making and autonomy (Watkins et al., 2022). A broader exploration of these issues is necessary to expand the scope of knowledge and understanding to inform future clinical policy and practice. Authors of a recent critique evaluating women’s maternity care preferences found that existing research remains limited in scope, focusing on women with childbearing experiences and is limited to preferences for existing models and provisions (Bull et al., 2022).
2.5 Making Non-Normative Choices – Situating the Study

In the previous section, I examined historical, systemic, and institutional influences on the choice agenda in the United Kingdom. In the following section of this chapter, I situate the study by defining normativity and, by comparison, non-normativity concerning choice in maternity care. This provides the foundation for the thesis definition of a non-normative choice.

2.5.1 Normativity and Non-Normativity

The Oxford English Dictionary define “normative” and “normativism” respectively as that which:

“...constitutes or serves as a norm or standard; implying or derived from a norm; prescriptive” and

“Belief in or advocacy of norms, esp. with reference to the primacy or desirability of social norms.”

(Ibid 2020)

Sociologically, norms can be defined as those rules relating to an individual's acceptable conduct or behaviour that reflects the values of any given culture, be they moral, ethical or grounded in culturally held or individual beliefs (Kingdon, 2009). What constitutes normativity is socially constructed and deeply connected to temporal and spatial context. Goffman (1963) suggests that interactions within a group or in an environment socialise the individual to behave or act in a particular way in each situation. These interaction rituals (Goffman, 1967) maintain and reinforce norms, with any movement outside of these norms likely to expose individuals to accusations of non-conformity, deviance (Becker, 1963) and stigma (Goffman, 1963). This is important when considering what is considered normative in contemporary maternity care, as definitions currently rely on the mode of birth and outcome risk-based judgement of the physiological state of the pregnant woman along their pregnancy journey.

2.5.2 The Legal, Ethical and Moral Status of Non-Normative Choices

“Pregnancy and childbirth, and all of the decisions they entail, are as old as humanity itself, predating any law. The idea that the law should address a pregnancy at all, much less in a way that controls or punishes women on the basis of pregnancy, is a relatively modern contrivance”.

(Diaz-Tello and Kumar-Hazard, 2020, p. 276)
Along with beneficence, justice, and non-maleficence as a biomedical ethical principle, autonomy is inextricably associated with notions of liberty, consent, agency, and capacity. At its core, autonomy is the ability of any individual to self-govern, free from interference and limitations by others that prevent meaningful choices (Beauchamp and Childress, 1979).

The extent to which bodily autonomy is realised in pregnancy and childbirth and, by extension, interference in autonomous decision-making has been historically and geographically linked to the legal standing of the fetus (Diaz-Tello and Kumar-Hazard, 2020; Law, 2022). Within the UK, the fetus holds no rights nor legal personhood until born (C v S, 1987; Vo v France, 2004); therefore, there is no legal basis whereby fetal wellbeing supersedes the autonomy and bodily integrity of a pregnant woman, which must remain inviolate (St George's Health Care NHS Trust v SR v Collins and others ex parte S, 1998). International human rights legislation, adopted domestically, affirms these rights (Council of Europe, 1950; Human Rights Act, 1998), many of which have been tested in the European Court of Human Rights and UK courts (Re MB (Medical Treatment) [1997] EWCA Civ 3093, 1997; St George's Health Care NHS Trust v SR v Collins and others ex parte S, 1998; ECHR 2011 1/9 Case of Ternovszky v. Hungary, 2010). Women are legally entitled to make decisions about their care, including whether to receive offered interventions, accept a healthcare professional's advice, or access care, regardless of whether their choices might have a negative fetal or maternal outcome. Regulatory guidance and professional standards for clinicians reiterate these rights (NMC, 2018; GMC, 2020) intrinsically linked to informed consent (Madeley, 2022, 2023), and yet within contemporary reports of failing maternity care systems, issues of consent being overridden or lacking altogether feature consistently (Ockenden, 2021; Kirkup, 2022).

Non-consented care represents a primary example of disrespectful and abusive healthcare (Bowser and Hill, 2010; White Ribbon Alliance, 2011) with accounts of harm related to both forced intervention in the absence of consent and significantly within the context of this thesis where consent has been expressly withheld (Hodges, 2009; Bohren et al., 2015; Beck, 2018; Kingma, 2021). Consent is an ongoing process, and for it to be valid, it must be freely given, with a presumption of mental capacity (Mental Capacity Act, 2005) to make a competent decision (unless proven otherwise) and, most significantly, informed (RCOG, 2015b; Birthrights, 2017a; GMC, 2020). The landmark Montgomery ruling (UKSC, 2015) established precise requirements for personalised discussion of materiality of risk and outcome salience to guide the extent and depth of information provided, founded on understanding the pregnant women’s experiences, values, concerns and expectations. Material risk is defined as one which ‘a reasonable person in the patients' position would be likely to attach significance to’ (UKSC, 2015,
and is an important legal test embedded within UK law. This considers objective clinical risk and the woman’s personal and social circumstances, which can conflict with care recommendations.

### 2.5.3 Who Makes Non-Normative Choices in the United Kingdom?

Prevalence, incidence, and outcome data for non-normative choices are largely absent from routinely collected data in the United Kingdom and internationally, relying on phenomena-specific research (explored later in this chapter and in Chapter 3), and specific and incidental mortality and morbidity data (Hollowell et al., 2015; Rowe et al., 2015, 2018, 2020; Knight et al., 2019, 2020, 2021, 2022; Morelli et al., 2023). Attempts to explore who makes such non-normative choices have focussed on discrete phenomena such as freebirth and high-risk homebirth (see Chapter 3). A perceived rise in requests for ‘outside of guideline’ care has led to the establishment of dedicated clinics within NHS Hospital Trusts (Hattan, Flohlich and Sandall, 2016) to support evidence-based care planning; the application is not consistent, nor are there currently national drivers to support implementation or evaluation of their effectiveness, either from a service user or a provider perspective. Publications from the Royal College of Midwives (RCM, 2022a, 2022d, 2022b) provide guidance on the role of guidelines, informed consent and personalised care planning within the context of outside-of-guideline care, reaffirming legal, ethical and professional responsibilities; however, the true extent to which the phenomenon exists - outside-of-guideline care requests, declining medical advice, or declining or withholding consent to elements of care - across healthcare settings in the United Kingdom remains unclear.

Some studies have examined outcomes for women making non-normative choices, providing some insight into who is making non-normative choices and what those choices are. Sociodemographic data from the further analysis of the Birthplace Study (Brooklehurst et al., 2011; Hollowell et al., 2015) aimed to explore characteristics of 9319 higher-risk women who made non-normative choices concerning their place of birth (1489 planning birth at home, 329 planning an FMU⁴ birth and 810 planning an AMU⁵ birth ). The analysis found that, compared to women planning to birth in an obstetric-led unit, they were more likely to be white, older, affluent, married or living with a partner, multiparous, and the majority of those birthing with a postdate (see Key Definitions and Glossary) pregnancy or beyond in the planned homebirth group (Hollowell et al., 2015). While the number of

---

⁴ Freestanding Birth Unit - See Glossary and Key Definitions

⁵ Alongside Midwifery Unit - See Glossary and Key Definitions
high-risk women planning to birth in a place outside of recommendations (non-OU⁶) was small, the authors asserted that their data be considered ‘non-negligible’ (2015, p. 154), sufficient enough to suggest that women with common risk factors plan birth in locations other than OU and in particular at home. Hollowell et al. (2015) acknowledge a need to explore women’s motivations and influence on decision-making to contribute to understanding future service changes and adaptations required to meet the needs of women.

Li et al (2015) explored the perinatal and maternal outcomes in women at a higher risk of complications birthing in low-risk environments such as at home or in an MLU. The authors suggest that babies of women fitting a profile of birthing in an obstetric unit were more likely to be admitted to neonatal care than those who planned birth at home, with intrapartum morbidity and mortality statistically similar. Due to the limited number of women with risk factors birthing at home, a larger sample would be needed to confirm statistical significance, so caution is needed when interpreting these results. Women planning vaginal birth at home after previous caesarean was the focus of secondary analysis of the same study. Rowe et al (2015) reported that women in this cohort had an increased chance of vaginal birth compared to an obstetric unit, and although adverse outcomes were few, they were not ‘negligible’. They did, however, note a high transfer rate⁷. Data from the ESMiE⁸ enquiry (Rowe et al., 2020) exploring poor perinatal outcomes for a cohort of women who planned home birth against advice suggested this decision contributed to the outcome for four of fifteen women. The panel also noted that these fifteen cases had common features of (amongst clinical failings):

“the woman declining care and/or interventions when offered, including scans, induction, fetal monitoring, vaginal examinations and transfer …delays in transfer were considered to have occurred in part because the woman delayed or declined transfer” (Rowe et al., 2020, pp. 166–1670).

Why women declined and delayed is unclear; however, the authors acknowledge the benefits of supported decision-making and care planning within a respectful and open relationship and the potential for misalignment between risk understanding and tolerance towards choices between health professionals and the women.

---

⁶ Obstetric Unit – See Glossary and Key Definitions.
⁷ Rate at which woman had to be taken from home to hospital/obstetric unit in an ambulance.
⁸ UK based national confidential enquiry examining the quality of care associated with intrapartum related perinatal death in births planned in midwife led settings.
The language used to frame non-normative choices is also problematic. ‘Outside/outwith of guideline⁹’, the most commonly used, suggests a presumed authority and infallibility of guidelines, assuming compliance with recommendations and an associated implication of deviance when not complying (Becker, 1963). Similarly, the term ‘declining’ care. Therefore, these terms are potentially ‘othering’ for those making choices that do not conform to recommended care or medical advice, effectively applying unwanted labels. Furthermore, such terms exclude the broader scope of choices reflective of withholding consent to care, interventions, and routinely offered care.

2.6 Thesis Definition of a Non-Normative Choice

Given the preceding discussion, I have defined a non-normative choice, moving beyond discrete phenomena and encapsulating a broader scope of choices. My definition of a non-normative choice is as follows:

An autonomous decision made by women deemed to have the capacity to do so, made at any point along the childbearing continuum, which reflects one or more of the following elements:

- Desiring care outside of established guidelines or medical recommendations which would not routinely be offered as a choice, e.g., *home birth where the clinical recommendation is to birth in a hospital.*

- Withholding consent to any routinely offered intervention offered as a choice, e.g., *declining cardiotocograph monitoring, routine screening, or induction of labour.*

- Moving outside cultural, social, or familial expectations and non-medical ‘norms,’ e.g., *placentophagy, acceptability of receiving blood products.*

The articulation of what constitutes a non-normative choice is embedded in previous literature and is discussed in the next chapter.

---

⁹ The term ‘outwith guidelines’ has been used synonymously with ‘outside’ guidelines (Hattan, Flohlich and Sandall, 2016; Feeley, 2022) and yet have very different meanings. Outside implies a physical opposite to that which is inside, while ‘outwith’ has a more abstracted meaning (Butterfield, 2016, p. 740). Both definitions remain problematic in relation to those issues described above.
Chapter 3 Meta-Ethnographic Systematic Literature Review

3.1 Introduction

In the previous chapter, I explored the context in which non-normative choices are made in the United Kingdom by examining historical, systemic, and institutional influences on the choice agenda. I presented normativity and non-normativity in a general context and offered a review of the limited quantitative and other data available outside that shown in this chapter.

In this chapter, I present my approach to a systematic search and critical examination of existing literature using meta-ethnography, generating new theoretical and abstract insights into the phenomena arising from the extant literature. I specifically chose meta-ethnography due to its methodological congruity with constructivist grounded theory (explored further in 4.9.1), thereby elevating the purpose of the review. Meta-ethnography within this thesis provides vital information concerning empirical and theoretical gaps (Miles, 2017) while informing the development, design and interpretation of my empirical work presented in this thesis. Consistent with the method, the process and results presented in this chapter are not intended to retrieve and synthesise all that is known about the focus of a subject but to provide an interpretative account and generate new insights through emergent theory and concept generation.

Firstly, I present the review question, aims and objectives, followed by a discussion of the methodological approach and justification for using meta-ethnography in the context of the wider study. I describe the applied systematic search strategy consistent with the method and then summarise the search results. The findings of this review are presented as a series of reciprocal and refutational findings, interpreted through the line of argument synthesis statement. Finally, the chapter discusses the review findings in the brief context of more comprehensive contemporary drivers, outlining the strengths and limitations of the review, its original contribution to knowledge, and the gaps in empirical and theoretical knowledge that provides the foundation for the thesis.
3.2 Review Question, Aim and Objectives

Congruent with the chosen methodological approach to undertaking a meta-ethnographic literature review, it was necessary to develop a review question that guides the search and sets boundaries and scope for future analysis and interpretation (Atkins et al., 2008). The question this review aimed to answer is:

“What are the views, attitudes, perceptions and experiences of women and other birthing people who make non-normative choices along maternity care pathways?”

The aim of the review was to:

Establish what is known about the experiences, views, attitudes, and perceptions of women and other birthing people who make non-normative care choices during pregnancy, labour, and the puerperium.

The objective of the review was to:

- Undertake a systematic search of existing literature to complete a meta-synthesis of the literature utilising the meta-ethnographic method.
- Through this method, expose any new understandings, conceptualisations, and theories within the existing literature.
- Through this process, develop a critical understanding of the subject and an identification of gaps in knowledge within which the empirical research will be positioned and refine the overall research question accordingly.

3.2.1 Why Choose a Qualitative Meta Synthesis of the Literature?

Systematic reviews and meta-analyses are typically considered the highest quality of evidence synthesis, both methods having strong roots in quantitative research (Moher et al., 2009). Over the last two decades, systematic meta-synthesis and qualitative evidence synthesis (QES) have grown in popularity and recognition as a means of

---

10 See 2.6 for Thesis Definition of a Non-Normative Choice

11 Herewith referred to as “the maternity care continuum.”
contributing to growing bodies of evidence, especially in healthcare, for more complex enquiries and to inform evidence-based pathways and guide decision-making (Uttley et al., 2023).

The process of undertaking systematic reviews across qualitative studies has been criticised for various reasons, including, but not limited to, the diversity of design and methodologies, methodological quality, and philosophical positioning (Page et al., 2018; Moore, Fisher and Eccleston, 2022; Uttley et al., 2023). The approach mainly depends on the review's ontological position and the intended outcome of the synthesis being aggregative, narrative, interpretative or theory-generating (Toye et al., 2014; Booth et al., 2018). Toye et al. (2014) suggest a binary distinction between descriptive and aggregative reviews and those who interpret findings by conceptual or theory generation. This view is similar to that held by Gough et al. (2012), who advocate that where reviews are purely aggregative, they reflect a position of a singular reality from which an objective truth can be observed and, therefore, generalised across disciplines.

This contrasts with reviews that seek to observe complexity by embracing differing conceptualisations and interpretations, lending themselves to a more relativist approach (Dixon-Woods and Fitzpatrick, 2001; Dixon-Woods et al., 2005; Walsh and Downe, 2005). By synthesising qualitative data, the results may be somewhat reductionist; however, Walsh and Downe (2005) contend that the process could reflect new conceptualisations and insight. This position is supported by early proponents of QES; Sandelowski, Docherty and Emden (1997), who argued that for meta-synthesis to have a discernible influence outside the academic environment, it must be positioned within an interpretative framework.

Supporting this approach and in direct contrast to quantitative metanalysis, which aim to attain statistical significance and generalisability across populations, sampling, and selection of primary studies for inclusion in meta-synthesis do not always aim to be fully comprehensive and inclusive. Instead, their goal is to generate theory and new conceptualisations of often complex phenomena (Noblit and Hare, 1988). This can only be achieved where the data volume can offer an in-depth understanding of complex phenomena rather than merely representing or oversimplifying them, a common issue where significant volumes of data across methodologies exist. Frameworks for a theoretical and purposive sampling of primary literature must be employed (Campbell et al., 2003; Thorne, 2016; Glenton et al., 2022)

Nevertheless, concerns remain surrounding methodologies used to approach the process systematically as well as the ability of the synthesis to preserve the original studies' richness of data. Indeed, early critics overtly distrusted the power of interpretative and theory-generating QES to provide new insights without losing the integrity and
authenticity of the data represented in the original studies (Sandelowski, Docherty and Emden, 1997). Several authors (Tong, Sainsbury and Craig, 2007; Moher et al., 2009; France et al., 2014) have attempted to address these criticisms, notably concerning identifying suitable methodologies for review, conducting a thorough and replicable search, synthesis of data and subsequent reporting. Most prominent amongst these are the RETREAT and other criteria for the selection of synthesis methods, the Cochrane Handbook for Systematic Reviews, STARLIGHT guidelines for reporting and conducting literature searches and PRISMA reporting guidelines for systematic review and meta-analysis (Booth, 2001; Walsh and Downe, 2005; Booth, 2006a; Moher et al., 2009; Booth et al., 2018; Thomas et al., 2019). I chose to undertake this review using an interpretive rather than aggregative approach, preferring to adopt a synthesis method that allows for theorisation while remaining grounded in the data. A combination of methodological considerations and processes was considered to guide the planning and execution of this review, with meta-ethnography chosen as the overarching methodology.

3.2.2 Meta-Ethnographic Methodology

Noblit and Hare developed meta-ethnography (1988) to elevate aggregation and thematic interpretation of review data to that of theory generation through seven canonical stages (Table 1). Initially intended for ethnographic studies, the 7-stage inductive process of meta-ethnography allows for studies with methodological differences to be synthesised by constant comparison, interpretation and generation of middle-range\(^{12}\) theory grounded within the data (Green and Thorogood, 2018d).

Before the development of the meta-ethnographic method by Noblit and Hare, Glaser and Strauss identified that if theory was generated within discrete studies and not linked to others, there was a likelihood that they would be destined to remain unvisited ‘little islands of knowledge’, supporting the need for contextual, discipline-oriented application of synthesised knowledge and theory (Glaser and Strauss, 1971, p. 181).

The term ‘meta’ used within this context refers to the translation of primary studies into each other through the process outlined thus:

\(^{12}\) A middle range theory is one that seeks to partially explain a phenomenon through abstracted descriptions of phenomena observed in a social setting, explaining core relationships and mechanisms (Charmaz, 2014a), therefore consistent with substantive theory generation in constructivist grounded theory. Particularly salient in the context of healthcare research as middle range theorising aims to bridge empirical data, grand theories and day to day operations (Kislov et al., 2019).
<table>
<thead>
<tr>
<th>7 Phase Meta-ethnography (Noblit and Hare, 1988)</th>
<th>Description</th>
<th>Corresponding Elements (France, Cunningham, et al., 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting Started</td>
<td>Initially identifying the interest and focus for the synthesis</td>
<td>Refining review questions, aims, and objectives</td>
</tr>
<tr>
<td>2. Deciding what is relevant to the initial interest</td>
<td>The identification and selection of studies are subject to the synthesis.</td>
<td>Search Strategy, Search Process, Study sampling, selection and screening</td>
</tr>
<tr>
<td>3. Reading the studies</td>
<td>Reading and re-reading the selected studies to become familiar with the content, carefully noting metaphors created during the studies' original interpretative cycles and paying particular attention to details and data to be extracted.</td>
<td>Reading the studies, Characteristics of studies, Data extraction method, process, and findings</td>
</tr>
<tr>
<td>4. Determining how studies are related</td>
<td>Establish how each selected study relates to one another by developing key elements within each discrete study, expressed as metaphors (themes, concepts, or perspectives). This produces a relationship between studies and instigates the type of synthesis that will be applied – refutational, reciprocal or line of argument.</td>
<td>Method and process of identifying relationship</td>
</tr>
<tr>
<td>5. Translating studies into one another</td>
<td>Translation (comparison) of metaphors across accounts to support the assumptions made in step 4, ensuring that core metaphors are maintained and synthesised while regarding the accounts as analogous. This process requires constant comparison with metaphors while simultaneously</td>
<td>Method and process of refutational, reciprocal and line of argument analysis and findings, including preservation of context and meaning. Interpretative meaning</td>
</tr>
</tbody>
</table>
maintaining the metaphor’s integrity for each study.

6. Synthesising translations

| Comparison of translations from stage 5 for commonality and or integration | Method for development of overarching synthesised translations |

7. Expressing the synthesis

| In a manner that is understandable for others | The outcome of the synthesised translation |

Table 1 Approach to Meta-Ethnography

Noblit and Hare (1988) initially provided no methodological guidance in applying their staged method. The process of ME, despite being presented in a linear set of steps or stages, is not intended to be undertaken sequentially but rather as an inductive and iterative knowledge synthesis, preserving the method’s roots in ethnography (Noblit and Hare, 1988). They argue that emphasis should be on detailed, thick description as this is where the interpretivist lines of argument and theory generation in context emerge, referred to as ‘webs of significance’ (Geertz, 1973, p. 5; Noblit and Hare, 1988). Meta-ethnography is a popular methodology for synthesising data in healthcare-related subjects (Green and Thorogood, 2018b). Nevertheless, as the popularity of the method has grown, criticisms have arisen related to the perceived lack of methodological rigour, trustworthiness and credibility of the final synthesis, a lack of transparency around the identification and selection of included studies and a lack of standardised reporting to preserve the context and meaning of primary data (Atkins et al., 2008; Toye et al., 2013, 2014; France et al., 2014, 2015). The eMERGe reporting guidelines were developed in response and provided standardised reporting criteria, supplementing Noblit and Hare’s seven stages (1988). This also provides a specific framework for reporting meta-ethnographic studies (France, Cunningham et al., 2019). The following review, therefore, has engaged both the seven canonical stages and eMERGe guidelines in the execution and presentation of this review.

In the following sections, I present a chronological explanation of the application of the meta-ethnographic review of the literature. In the interests of simplicity, I took a pragmatic decision to show the search results alongside the explanation of the process before presenting the full findings, which subsequently formed the basis of a peer-reviewed journal publication (Madeley, Earle and O’Dell, 2023)
3.3 Phase 1: Getting Started

3.3.1 Refining the research question

I adopted the SPIDER framework to refine the research question for the literature review guided by Cooke et al. (2012). The framework was developed in response to a review evaluating various models with specific indications based on intended user groups in systematic quantitative research (Methley et al., 2014). The aim was to develop a comparator for the PICO framework (Population, Intervention, Comparison, Outcome) to formulate questions within a qualitative context not specific to any individual user group (Cooke, Smith and Booth, 2012). Other frameworks were considered, including the PEO framework (Bettany-Saltikov, 2012), an adaptation of the PICO framework. PEO facilitates question development by succinctly identifying the population being studied (P), the exposure in question (E) and the outcome (O). I did not consider the PEO framework robust enough to capture the whole phenomena; therefore, the SPICE framework (Booth, 2006b) was then considered (Setting, Perspective, Intervention, Comparison and Outcome). This framework did not suit the direction of the search, favouring intervention-related research; therefore, I did not adopt it. The only discernible benefit of the SPICE framework over the PEO framework was in identifying the setting where the research was to take place. However, this is addressed within the SPIDER framework, which also supports the development of inclusion and exclusion criteria (Methley et al., 2014). I used the headings to generate keywords within these broad categories and then applied them in a tabular format (see Table 2).
<table>
<thead>
<tr>
<th>Sample</th>
<th>Phenomena of Interest</th>
<th>Design</th>
<th>Evaluation</th>
<th>Research Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant AND Women</td>
<td>Non-normative</td>
<td>Ethnography</td>
<td>Experience</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td>Abnormal</td>
<td>Phenomenology</td>
<td>Influences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-guideline care</td>
<td>Narrative</td>
<td>Views</td>
<td></td>
</tr>
<tr>
<td>Pregnant AND Birthing People</td>
<td>Refusal of care/ intervention</td>
<td>Narrative</td>
<td>Views</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Declined care/ intervention</td>
<td>Enquiry</td>
<td>Attitudes</td>
<td></td>
</tr>
<tr>
<td>Pregnant AND Wom?n</td>
<td>No guideline</td>
<td>Interpretative</td>
<td>Perceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Against advice/ Medical advice</td>
<td></td>
<td></td>
<td>The qualitative element of mixed methods studies</td>
</tr>
<tr>
<td></td>
<td>High risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaginal birth after caesarean (VBAC) (2, 3+)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Homebirth after caesarean (HBAC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Freebirth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multiple birth/ pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group B streptococcus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waterbirth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Raised BMI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obesity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective caesarean section/ Elective Ce?sarian</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
No fetal monitoring/ F?etal  
No AND midwives  
No AND Doctors  
At risk

<table>
<thead>
<tr>
<th>Concept 1 AND</th>
<th>Concept 2 AND</th>
<th>Concept 3</th>
<th>Concept 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant AND</td>
<td>Non-normative OR</td>
<td>Vaginal birth after caesarean (VBAC) (2,3+)</td>
<td>Experience</td>
</tr>
<tr>
<td>Women</td>
<td>Abnormal OR</td>
<td></td>
<td>Perspective</td>
</tr>
</tbody>
</table>

Table 2 SPIDER Framework

3.4 Phase 2: Deciding what is relevant to the initial interest.

It was imperative to maintain a balance to avoid unwieldy volumes of data while maintaining conceptual quality and richness in the ensuing analysis process (Ames, Glenton and Lewin, 2019). I designed the search strategy to be expansive first to assess the extent of existing information, initially obtaining all available studies that fulfilled the inclusion criteria (purposive sampling) but also to ensure that the focus of the search included the whole childbirth continuum, rather than focussing on intrapartum related phenomena alone (see Table 3 Search Term Development - First Iteration.) (McKibbon, Wilczynski and Haynes, 2006; Grant and Booth, 2009; Boell and Cecez-Kecmanovic, 2010; Gorecki et al., 2010; Harsh, 2011; Finfgeld-Connett and Johnson, 2013). I achieved this using the following search strategy, informed by STARLIGHT guidance for literature searching (Booth, 2006a).

3.4.1 Search Strategy

I devised a list of synonyms from the review question based on my knowledge of the subject, aims and objectives, sample, and the phenomena of interest. These provided the foundation of search terms. Boolean operators identified to combined terms, i.e., pregnant AND waterbirth AND out of guideline OR decline intervention. The first iteration of search terms - categorising concepts to generate combined search terms - is presented below (Table 3). Wildcards were included to ensure that common spelling differences were accounted for in databases.
Table 3 Search Term Development - First Iteration.

Text searches within selected databases established that including specific medical conditions and generic terms, including BIRTH and DELIVERY and BIRTH choice, resulted in an unmanageably large number of results, which did not address the review question. I consulted with a research support librarian to enhance and refine search terms and comment on the selected databases.

I made the following changes in discussion with my supervision team and research specialist librarian:
- Remove specific medical or physical conditions from Concept 2 for the primary search but include targeted antenatal interventions. The secondary search then included these search terms to target previously included phenomena.

- Remove search terms not recognised by databases, yielded no results, or were synonymous with other conditions, i.e., stigmatising (non-normative/abnormal) and replaced with unconventional OR alternative OR unusual.

- Reduce the number of descriptors in concept 3 to generic descriptors of pregnancy intervention, birth modes and place of birth (unless specifically defined phenomena of interest such as freebirth). I combined these with concept 2, anticipating capturing the phenomena of interest.

- Reduce the number of databases to include specifically targeted healthcare sources: PubMed/Medline/PMC, OVID/MIDIRS, CINAHL, PsychINFO and Web of Science.
I then developed the final search terms:

<table>
<thead>
<tr>
<th>Concept 1 AND</th>
<th>Concept 2</th>
<th>Concept 3</th>
<th>Concept 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant AND Women</td>
<td>Refusal of treatment or refusal of care or refusing treatment OR refusal of care OR refusal of intervention</td>
<td>Homebirth AND HBAC Freebirth</td>
<td>Experience</td>
</tr>
<tr>
<td>Pregnant AND Birthing People</td>
<td>Declining care or against medical advice or outside the guidelines OR declining Intervention OR out of guideline</td>
<td>Elective caesarean section AND Elective Caesarian</td>
<td>Perception</td>
</tr>
<tr>
<td>Pregnant AND Wom?n OR Gravid</td>
<td>High-risk pregnancy OR at-risk pregnancy OR complicated pregnancy</td>
<td>Maternal request for caesarean section AND maternal request for caesarian</td>
<td>Attitudes</td>
</tr>
<tr>
<td></td>
<td>Unconventional OR Unusual OR Alternative</td>
<td>Screening AND/OR Surveillance</td>
<td>Views</td>
</tr>
</tbody>
</table>

Table 4 Search Term Development - Final Iteration

I applied functional limiters to support the inclusion and exclusion criteria (Table 4) while retaining the original studies' context, conceptuality and authenticity (Walsh and Downe, 2005; Booth, 2006a; France et al., 2019). To ensure that the antenatal and postnatal period was included within the definition of the continuum, I undertook a combined database search with the inclusion of specific keywords to reflect antenatal, intrapartum and postnatal interventions, clinical examinations, screening and choices (McKibbon, Wilczynski and Haynes, 2006; Grant and Booth, 2009).
### 3.4.2 Inclusion and Exclusion Criteria

I developed the following inclusion and exclusion criteria informed by the review question and scope:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Period</strong></td>
<td>Published post-1990-2021 (repeated search expanded to 2023)</td>
<td>Published Pre 1990</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>High-middle income countries with analogous healthcare, midwifery and obstetric models and socio-cultural demographics to the UK</td>
<td>Low income, healthcare, midwifery, and obstetric model/socio-cultural demographic not analogous to the UK</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>English/ Translated into English/ Translatable</td>
<td>Non-English language/ Unable to translate</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>&gt;18 years pregnant women/birthing people Primiparous/Multiparous Planned birth in any setting, including planned born before arrival</td>
<td>&lt;18 years old Partners of women/birthing people Unplanned born before arrival&lt;sup&gt;13&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**Rationale**
- Changing Childbirth, published in 1993, to capture work leading to publication.
- Maximise scope and reach of findings
- Contextualise findings to similar countries.
- Socio-cultural demographic and legal application akin to the United Kingdom
- Consideration of the application of findings to UK policy and practise.
- Consistency, transparency, and accuracy
- Pragmatic time and resource considerations
- Ethical Considerations for children and capacity for decision making and
- Partners or clinicians outside of the scope
- Capture decision making

<sup>13</sup> *Born before arrival or BBA* (see Glossary and Key Definitions). Unplanned BBA associated with multiparity, precipitate labour (within 3 hours of onset of regular contractions, approx. 2:100 spontaneous onset births) (Loughney, Collis and Dastgir, 2006; Suzuki, 2015) The use of the term ‘unplanned’ here is critical as studies have shown that some women may plan for assistance to arrive after the birth as a means of rejecting medical assistance.
| Study Design | Primary qualitative studies/ including Qualitative methodology. Qualitative element of mixed methods or experimental Open-ended questions in surveys | Quantitative methodology / RCT/ | • Capture and synthesise experiential data related to the research question. • Enable synthesis |

| Types of Publications/Literature | Peer-reviewed articles, research reports, theses | Secondary Research Inc. meta-analysis and systematic review) Opinion and commentary Policy and guideline | • Quality • Comparability of data • Rigour |

| Study Focus | Views, attitudes, experiences, perspectives of choice of non-normative care pathway by women or other birthing people | Views, attitudes, and experiences of choice of non-normative care pathway by healthcare providers (i.e., obstetricians, midwives, allied health) and others, including partners | • Partners or clinicians outside of the scope • Capture decision making |

*Table 5 Meta-Ethnography Studies - Eligibility Criteria*

Consistent with the meta-ethnographic method, the sampling and selection criteria did not aim to be comprehensive but rather to retain the conceptual quality and richness of the existing data (Ames, Glenton and Lewin, 2019). I used a combination of sampling methods guided by strategies proposed by Harsh (2011). All papers considered eligible were tabulated in Microsoft Excel and reviewed (full text) against the inclusion/exclusion criteria, again with a sample independently examined by a second reviewer. No disagreements arose following the discussion; however, arrangements were in place for a third reviewer should arbitration have been necessary.
3.5 Phase 3: Reading the Studies

Noblit and Hare (1988) advocate for reading and rereading the studies to begin tentatively identifying concepts, metaphors and themes. The process of meta-ethnography is iterative, and therefore, this process continues throughout the synthesis, permitting data immersion.

3.5.1 Data Extraction

I initially extracted data from the selected studies utilising a Microsoft Excel spreadsheet. I included aims and objectives, research question, study design and methodology, methods, sampling (size and strategy), data collection method, data analysis methods and reviewer comments, guided by Downe et al. (2009). This contributed to the presentation of study characteristics (see Appendix 3) as required by eMERGe reporting guidelines and the phase 4 determination of how studies might be related methodologically, discussed in the following section (France et al., 2019).

3.6 Phase 4: Determining How Studies Are Related

Noblit and Hare (1988) assert that for translation of studies to occur, they should share the same ethnographic approach, arguing that mixing one qualitative approach with another and thus means of data analysis jeopardises the preservation of meaning grounded in the data. One major drawback of this approach is that it excludes other studies, which may generate insights and understandings on a phenomenon that might otherwise be lost. Other authors have addressed this by exploring how studies that share disparate approaches can be compared, contrasted and synthesised (Sandelowski, Docherty and Emden, 1997; Walsh and Downe, 2005; France et al., 2019). Sandelowski et al. (1997) illustrate this point by proposing that the initial step in determining relationships is to undertake a comparative analysis of methodological design characteristics to appreciate each distinct study’s attributes before moving on to relational and refutational analysis between studies. I applied this by comparing

14 Concept: “some analytic or conceptual power, unlike more descriptive themes” (Britten et al., 2002, p. 46) or “a meaningful idea that develops by comparing particular instances” (Toye et al., 2014). Concepts should explain, not describe the data (Cahill et al., 2018).
paper characteristics between the included studies focusing on data collection and analysis and methodological approaches (See Appendix 3)

3.6.1 A Note on Constructs

Noblit and Hare (1988) do not explicitly refer to the identification and use of three levels of constructs in their original text; however, developments that refine the process of meta-ethnography advocate for their use (Schütz, 1962). Constructs are defined as first order (meaning and understanding applied by the participants), second-order (concepts, themes and metaphors based on original researcher interpretation) and third-order (interpretations made by the synthesis author) (Malpass et al., 2009). Employing the use of first, second and third-level constructs helps characterise the data in a meta-ethnography (Britten et al., 2002; Sattar et al., 2021) whilst ensuring that interpretation remains grounded in the original data by preserving construct authenticity and basing the synthesis on explicitly expressed first and second-order constructs stated by the original authors (Britten et al., 2002; Walsh and Downe, 2005; Campbell et al., 2011; Toye et al., 2014; Everhart and Johnston, 2017). By adopting this approach, I negated methodological concerns around synthesising large numbers of studies and inauthentically reorganising and recoding findings (Toye et al., 2014).

3.7 Phase 5: Translating Studies Into One Another

I entered first- and second-order constructs into a synthesis template (Downe et al., 2009). I then checked each concept against the original papers’ key metaphors, phrases, ideas, and themes (see example in Appendix 4). In some cases, the original authors had not made second-order constructs explicit in terms of conceptual clarity. This is not to say that the concept was absent; quite the opposite, in that most papers demonstrated a move away from aggregation and description but merely failed to articulate an explicit concept (Toye et al., 2013). I managed this by coding significant and meaningful ideas presented within the papers and assigning a concept name to them (Toye et al., 2013).

I then entered all papers into NVIVO 12, read and reread them to identify the explicit concepts and meaningful ideas, and then coded them, ensuring that codes remained conceptual and not merely descriptive (Britten et al., 2002; Toye et al., 2013, 2014; France et al., 2019). This process also contributed to the dynamic assessment of quality. Only data that related to inclusion criteria were included in the synthesis.
All first and second-order constructs were then listed and grouped into analogous ones and dissimilar in a process described as ‘sorting …into conceptual categories…that share meaning…translating into one another’ (Toye et al., 2014 p. 31). Using a process of constant comparison, I moved back and forth, comparing and translating critical concepts within and amongst studies, systematically comparing chronologically against the original text and then to concepts across other studies for meaning (Campbell et al., 2011; Cahill et al., 2018). Where meaning was shared, these concepts were combined into groups and blended conceptual categories (Sandelowski and Barrows, 2007; Toye et al., 2014). This idiomatic and iterative translation ensured that the key concepts remained grounded in the data, retaining conceptual meaning while also beginning to form the basis of reciprocal translation (similarities across studies) or refutational translation (differences or incongruities) (Toye et al., 2014, p. 31) This process formed the basis for synthesising translations, the next phase of analysis.

3.8 Phase 6: Synthesizing Translations

Synthesised translation is the penultimate phase of Noblit and Hare’s (1988) method, and I achieved this through developing and constructing third-order constructs, representing my interpretation of the synthesised first and second levels (Walsh and Downe, 2005). By iteratively returning to the data, repeating phases three to six and translation through writing, I was able to develop an integrated line of argument synthesis, thus elevating the interpretative relationship between reciprocal and refutational findings, or ‘storyline’ (Campbell et al., 2011; Cahill et al., 2018), offering new interpretation and conceptualisations of the data.

3.9 Phase 7: Expressing the Synthesis

The following section offers a summary of the review results and the reciprocal and refutational findings. Finally, the argument synthesis line is presented, completing the canonical phase cycle.
3.10 Summary of Results

I registered the meta-ethnographic systematic review with PROPERO International Prospective Register of Systematic Reviews on 15th November 2022, ID number CRD42020223097.

I completed the initial literature search between the 1st and 18th of December 2020 (Booth, 2006a; Moher et al., 2009; France et al., 2019). I then repeated this in July 2023 to ensure I captured any additional studies published since the initial search. One study, reported across two papers, was located but did not fit geographical inclusion, so I excluded both papers. They are, however, cited in the discussion (see 3.12).

The following presents the process and results of the database and other information sources searched:

<table>
<thead>
<tr>
<th>Database/Source</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CINAHL</td>
<td>Complete search strategy applied with no adaptations; 389 titles fulfilled search criteria. All were title and abstract, and then full text screened against inclusion and exclusion criteria, resulting in 8 papers.</td>
</tr>
<tr>
<td>Pubmed/MEDLINE/PMC</td>
<td>Complete search strategy applied with minor synonym adaptations; 216 titles fulfilled search criteria. All were title and abstract, and then full text screened against inclusion and exclusion criteria, resulting in 9 papers. ¹⁵</td>
</tr>
<tr>
<td>OVID/MIDIRS</td>
<td>Complete search strategy applied with minor adaptations for synonyms; 266 titles fulfilled search criteria. All were title and abstract and then full text screened against inclusion and exclusion criteria, resulting in 2 papers.</td>
</tr>
<tr>
<td>PSYCHInfo</td>
<td>Complete search strategy applied with no adaptations; 389 titles fulfilled search criteria. All were title and abstract, and then full text screened against inclusion and exclusion criteria, resulting in 4 papers.</td>
</tr>
</tbody>
</table>

¹⁵ Where duplicates were noted across all further searches, known to be have already been obtained in previous searches, these remained within results to duplicate screen later in process.
<table>
<thead>
<tr>
<th>Database</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web of Science</td>
<td>Complete search strategy applied with no adaptations; 461 titles fulfilled search criteria. All were title and abstract, and then full text screened against inclusion and exclusion criteria, resulting in 1 paper.</td>
</tr>
<tr>
<td>CINAHL/PUBMED/MEDLINE/PMC/OVID/MIDIRS/PSYCHInfo</td>
<td>Combined database search using a full search strategy, applying specific search terms to include specific antenatal, intrapartum, and postnatal interventions, clinical examinations, screening, and choices. This search yielded a total of 688 results. All were title and abstract screened against inclusion and exclusion criteria, resulting in 14 papers, 6 remained after full-text screening.</td>
</tr>
<tr>
<td>EthOS</td>
<td>No results located with reference to the search criteria.</td>
</tr>
<tr>
<td>ORO</td>
<td>No results located with reference to the search criteria.</td>
</tr>
<tr>
<td>Citation Search</td>
<td>42 papers identified by checking reference lists of all the papers that let the first screening. 38 papers, however, were noted to be duplicates of those previously located and, therefore, were eventually excluded however, 3 remained.</td>
</tr>
<tr>
<td>Hand Search</td>
<td>A title search of the previous 10 years utilising search terms was undertaken for the following journals:</td>
</tr>
<tr>
<td></td>
<td>• BMC Pregnancy and Childbirth</td>
</tr>
<tr>
<td></td>
<td>• BMC Reproductive Health</td>
</tr>
<tr>
<td></td>
<td>• Australian Journal of Midwifery</td>
</tr>
<tr>
<td></td>
<td>• Australian Nursing and Midwifery Journal</td>
</tr>
<tr>
<td></td>
<td>• European Journal of Midwifery</td>
</tr>
<tr>
<td></td>
<td>• British Journal of Midwifery</td>
</tr>
<tr>
<td></td>
<td>• Evidence Based Midwifery</td>
</tr>
<tr>
<td></td>
<td>• Journal of Midwifery and Women’s Health</td>
</tr>
<tr>
<td></td>
<td>• Women and Birth</td>
</tr>
<tr>
<td></td>
<td>• The Practising Midwife</td>
</tr>
<tr>
<td>Media and Network</td>
<td>A request was sent on 9\textsuperscript{th} December 2020 through JISC Midwifery research group to identify any papers and grey literature that may have been missed in the</td>
</tr>
</tbody>
</table>
database searches. 16 responses were received, with recommendations for papers, all of which had already been obtained via database searches.

| Professional Individual Contact | Individual contact was made with 4 researchers who authored papers within the results. Author searches was also undertaken via ResearchGate. This method yielded no results. |

Table 6 Information Sources

The database, hand, citation, and other searches yielded 2476 papers. Saturation occurred once the database searches yielded no new hits; this happened soon after completing database searches.

After removing duplicates (n=69), the remaining 2407 publications were title and abstract screened by me against the inclusion and exclusion criteria (Table 7). I imported studies fulfilling the inclusion criteria to Zotero reference management software (Corporation for Digital Scholarship, 2020) for full-text screening. A second reviewer met with me to sample and confirm rigour in the process, enhancing the credibility and confirmability of this search element.
Figure 1. PRISMA 2019 Flow Diagram (Moher et al., 2009)

Noblit and Hare (1988) intended that meta-ethnography be utilised to synthesise small numbers studies, although they do not quantify ‘small numbers’. Campbell et al. (2011) suggest that the ≤40 studies would reflect the upper limit. Considering this and the selected studies' methodological and subject-specific heterogeneity, 33 papers fell within these parameters.

### 3.10.1 Screening for Quality

Quality assessment of studies features in most reporting guidelines for any meta-synthesis - including meta-ethnography - however, there remains controversy concerning this necessity. Noblit and Hare (1988) and Sandelowski (1997) reject the view that any assessment of quality is necessary in favour of data inclusivity indeed,
to exclude studies as a result of methodological flaws risks excluding insightful and valuable data (Campbell et al., 2003; Toye et al., 2014). Quality assessment can be considered an artefact of the quantitative foundations of synthesis and systematic review method (Mays and Pope, 2000) to identify sources of bias, assuring internal validity and, thus, the truthfulness of the findings. This is problematic concerning synthesising studies outside of the objectivist epistemology as it assumes a truth to be discovered and apportions a value judgement on the text, the exclusion of which may be detrimental to the richness of the data extracted for synthesis. Moreover, this is a particular consideration when synthesising studies across methodological disciplines. Despite this, the inclusion of quality assessment remains within eMERGe reporting guidelines for meta-ethnography (France et al., 2019). I considered and applied the broad principles of quality assessment, and where I identified methodological or reporting issues, this has been reported upon (Walsh and Downe, 2005; Joanna Briggs Institute, 2020).

3.10.2 Summary of Study Characteristics

The review includes a total of 33 papers representing 25 studies. Relevant extracted study characteristics and detail is presented in Appendix 3. Methodological approaches were diverse and comprised of thematic analysis (21), grounded theory (3), phenomenology (3), thematic framework analysis (2), interpretative phenomenological analysis (2), and explorative descriptive analysis (2). Similarly, data collection and analysis techniques varied, including16 semi-structured interviews (30), diaries (1), narrative accounts (2), surveys (2), and focus groups (3). In total, studies from seven countries were represented in the synthesis: the United Kingdom (12), Australia (10), Netherlands (4), Sweden (3), Norway (2), Iceland (1), Ireland (1). Finally, the aims of the studies were compared and summarised concerning their corresponding paper:

- Exploring motivations, experiences and decision-making processes for birthing at home in the presence of obstetric or medical risk factors (Lee, Ayers and Holden, 2016c, 2016b, 2016a; Lee, Holden and Ayers, 2016; Hollander et al., 2017; Holten, Hollander and de Miranda, 2018)
- Freebirthing (Feeley and Thomson, 2016b, 2016a; O’Boyle, 2016; Plested and Kirkham, 2016; Lindgren, Nässén and Lundgren, 2017; Henriksen et al., 2020)

---

16 Semi-structured interviews were mostly used, with some papers reporting the use of a combination of data collection methods for example semi-structured interviews informed by the results of narrative accounts, diaries, surveys and focus groups, or vice versa. The numbers above therefore may represent several techniques used in one paper.
• A combination of both freebirthing and homebirth in the presence of complex needs (cited above).

• Exploring refusal of recommended care, including declining discrete routine or recommended interventions or treatment, including induction of labour for postdate pregnancy (Jenkinson et al., 2016; Jenkinson, Kruske and Kildea, 2017; Roberts and Walsh, 2019)

• HIV treatment in pregnancy (McDonald and Kirkman, 2011).

• Motivations for declining routinely offered screening (Liamputtong et al., 2003; de Zulueta and Boulton, 2007; Gottfreðsdóttir, Björnsdóttir and Sandall, 2009; Wätterbjörk et al., 2015; Crombag et al., 2016; Bakkeren et al., 2020)

• Requesting care outside of current medical recommendations or guidelines, such as water vaginal birth after caesarean (McKenna and Symon, 2014)

• Motivation for caesarean birth in the absence of clinical indication (Weaver, Statham and Richards, 2007; Fenwick et al., 2010; Sahlin et al., 2013; Tully and Ball, 2013; Eide, Morken and Bærøe, 2019).
3.11 Synthesis Findings

The following section presents the findings of the meta-ethnographic review as synthesised translations of 33 papers representing 25 studies. Where appropriate, verbatim quotes from original papers are included to illustrate first, second and third-level constructs.

Firstly, this section introduces the three reciprocal findings identified across the papers:

- *Influences and Motivations for a Non-Normative Choice* (explores individual accounts, justifications, and motivations for making non-normative choices)
- *Barriers and Conflict* (explores institutional and systemic barriers and conflicts when making or which might influence non-normative choices)
- *Knowledge as Empowerment* (describes how women engaged with and utilised knowledge to assert control and autonomy in making non-normative choices.

Secondly, the one significant refutational finding identified through analysis is presented:

- *The Middle Ground* (explores how some women experienced facilitative care).

Finally, I offer the line of argument synthesis.
3.11.1 Reciprocal Finding 1: Influences and Motivations for a Non-Normative Choice

This finding explores individual accounts, influences, and motivations for making non-normative choices. Five sub-findings were identified in the review and discussed next: Philosophy, values, and beliefs; Socio-cultural influences; Risk interpretation and safety; Ambivalence; and Fear and (re)traumatising choices.

Philosophy, Values, and Beliefs

Much of the literature (n=19) addressed either in whole or in part the question of why women make non-normative choices, the answer noted to be complex. A dominant motivation for making non-normative choices was decisions that accorded with personal views of pregnancy and birth as a normal, physiological event that ‘imprints on one’s life’ (Jackson, Schmied and Dahlen, 2020, p. 7). The act of pregnancy and childbirth for some women was therefore laden with personal cultural, religious, and societal significance (Lee, Ayers and Holden, 2016a), many defining the safest childbearing experience as dependent on the degree to which their values, beliefs and needs were met, including experiencing control and autonomy (Jackson, Schmied and Dahlen, 2020).

Women often made choices that promoted the physiology of birth or in response to previous experiences of childbearing (Feeley and Thomson, 2016b; Lee, Ayers and Holden, 2016a), and for some, this was an “undisturbed natural birth” (Hollander et al., 2017, p. 5), outside of the hospital (Keedle et al., 2015; Lee, Ayers and Holden, 2016a; Hollander et al., 2017; Rigg et al., 2017; Holten, Hollander and de Miranda, 2018; Jackson, Schmied and Dahlen, 2020), without a regulated birth worker or obstetrician (Feeley and Thomson, 2016b; O’Boyle, 2016; Plested and Kirkham, 2016; Lindgren, Nässén and Lundgren, 2017; Holten, Hollander and de Miranda, 2018, 2018; Jackson, Schmied and Dahlen, 2020). Some placed value on achieving a vaginal birth as an optimum outcome, while for others, there was a high personal value on the emotional and psychological significance of the childbirth experience rather than on other physical birth outcomes. For example, McKenna and Symon (2014, p. 23) reported that, for women who chose to give birth at home after a previous caesarean birth, the “psychological benefits were of even greater significance ... than the beneficial physical outcomes”. Equally, some women expressed that they always knew that vaginal birth would not be an option for them, therefore pursuing a planned caesarean birth (Sahlin et al., 2013). A participant declining HIV antiretroviral treatment in pregnancy asserted that doing so reduced the psychological distress of being reminded that she was suffering from an illness that she felt stigmatised her daily (McDonald and Kirkman, 2011), further supporting the notion that valuing psychological safety played a crucial role in motivating non-normative choices.
**Socio-Cultural Influences**

Societal expectations influenced many women’s non-normative choices, notably in studies exploring screening and antenatal pathways. In the study of Non-Invasive Prenatal Testing (NIPT) (Bakkeren *et al.*, 2020), participants reported feeling socially obliged to accept screening as the culturally accepted norm, regardless of their views or expectations.

Socio-cultural influences also impact non-normative choices. When offered a termination, some participants reported a sense of suspicion, believing the offer was linked to a societal desire only to produce ‘perfect children’ (Bakkeren *et al.*, 2020, p. 117) or a means of ‘clearing the human race’ (Wätterbjörk *et al.*, 2015, p. 1235); this typically resulted in a rejection of the offer. Discomfort in making decisions which women regarded as interfering with a higher power, or ‘playing God’ (de Zulueta and Boulton, 2007; Bakkeren *et al.*, 2020, p. 117) was sometimes noted in accounts of prenatal screening, again leading to a rejection of the intervention. The perceived societal imperative to produce only ‘perfect’ children and the value placed on the lives of disabled people (Liamputtong *et al.*, 2003) also influenced women to decline or avoid screening. Conversely, a healthy baby was noted to be a motivator for making non-normative choices, including declining screening, refusing HIV antiretroviral medication (de Zulueta and Boulton, 2007; McDonald and Kirkman, 2011) or requesting caesarean birth in the absence of medical indication (Weaver, Statham and Richards, 2007), wishing to avoid perceived risks of associated with what was being offered.

Some women felt that rejecting vaginal birth was stigmatised, characterised by multiple accounts of being accused of being ‘too posh to push’ when choosing caesarean birth without clinical indication (Tully and Ball, 2013, p. 106). Participants in Sahlin et al. (2013) study reported that they felt subject to an assumption that “*a real women will give birth naturally, vaginally*” and thus, to choose otherwise in the absence of indication could, as the authors suggest, be perceived as being “…*unwomanly… not good enough, provocative and a way of cheating*” (Sahlin *et al.*, 2013, p. 450).

Being pregnant was likened by women to being viewed as public property, feeling judged against what is considered socially and morally acceptable. Therefore, women felt they must publicly regulate their intentions, disclosures, and choices to avoid stigmatisation and judgement from society and local communities. They responded by concealing non-normative pregnancy and birth intentions or avoiding public disclosure of non-normative decisions. Typical examples were intentions to freebirth or homebirth with complex biopsychosocial
needs (Keedle et al., 2015; Feeley and Thomson, 2016b, 2016a; O’Boyle, 2016; Lindgren, Nässén and Lundgren, 2017; Henriksen et al., 2020)

Risk Interpretation and Safety

The review suggests that individual subjective perception of risk determined choices, despite this sometimes being at odds with clinicians’ perception and presentation of risk. Women came to their pregnancies clearly, understanding that childbearing is not inherently risk-free. They often postulate that complications will arise regardless of the extent or nature of risk assessment and measures designed to reduce or mitigate it, including surveillance, intervention, or examination. Choices for mode and place of birth presented frequent instances of discordant risk evaluation, presentation and choices between women and clinicians. Women’s perception of risk included a personal evaluation of the acceptability of material risk17 applied to their own, often complex situations (Fenwick et al., 2010; Jackson, Dahlen and Schmied, 2012; Crombag et al., 2016; Feeley and Thomson, 2016a; Lee, Ayers and Holden, 2016c; Hollander et al., 2017; Eide, Morken and Bærøe, 2019).

Studies reported that rather than providing reassurance, the potential for emotional and psychological distress arising from accepting screening and surveillance, motivated choices as avoidance strategies. Concerns regarding the physical risk of invasive screening (Liamputtong et al., 2003; Gottfreðsdóttir, Björnsdóttir and Sandall, 2009) and psychological risks of ‘knowing’ the outcome of screening were examples of perceived potential adverse consequences. The act of declining an intervention, screening or even information related to them appeared to be employed as a psychologically protective behaviour that reinforced personal notions of achieving a worry and stigma-free childbearing experience (Liamputtong et al., 2003; Crombag et al., 2016; Bakkeren et al., 2020).

Many expressed concern over contemporary childbearing as being over-medicalised (Liamputtong et al., 2003), judging unnecessary interventions to be of a higher risk of realising iatrogenic harm than the consequences of their own choices (Jackson, Dahlen and Schmied, 2012; Lee, Ayers and Holden, 2016a, 2016c; Holten, Hollander and de Miranda, 2018). Concerns were reported to lead to the rejection of healthcare systems and

---

17 Material risk is defined as one which “a reasonable person in the patients position would be likely to attach significance to” (UKSC, 2015, p. 15) and is an important legal test embedded within UK law. This takes into both consideration of objective clinical risk and the woman’s own personal and psychosocial circumstances, which can conflict with recommendations for care.
recommendations. Therefore, the perception of risk and safety was a complex mix of physical and psychological factors. Women expressed the need for both psycho-emotional and physiological protection across studies, acknowledging that contemporary maternity care tends to focus on physiological safety and outcomes at the expense of a positive, fulfilling birth experience, which many women desired (de Zulueta and Boulton, 2007; McKenna and Symon, 2014; Lee, Ayers and Holden, 2016a; Plested and Kirkham, 2016; Hollander et al., 2017).

The studies did not imply that women were naïve in their decision-making; many expressed the intention to accept responsibility and accountability for the consequences of their choices (Jackson, Dahlen and Schmied, 2012; Lindgren, Nässén and Lundgren, 2017; Rigg et al., 2020), with safety as a principal consideration (Lee, Ayers and Holden, 2016a) despite how others may view their choices.

**Ambivalence**

Women sometimes expressed ambivalence “as a supporting factor in balancing social and emotional dilemmas” (Crombag et al., 2016, p. 11). This was evident in studies that focused on planned caesarean birth in the absence of medical indication. A disconnection from the birth process as holding any special or significant meaning (i.e. being considered a rite of passage) was expressed by some participants as “struggling to articulate any personal meaning” (Fenwick et al., 2010, p. 397), framing their mode of birth choice as a means to an end to birth a healthy baby. One participant stated, “I wanted the baby more than giving birth to it if that makes sense.” (Weaver, Statham and Richards, 2007). This view was again evident in a similar study where a participant stated, “...I don’t see the process of birth as some kind of big payoff for me. I’ll do anything, c-section or whatever, in order to get a healthy baby” (Weaver et al., 2007, p.35).

Some women expressed fear towards vaginal birth or stating that they felt it to be unnatural or unpleasant (Eide, Morken and Berørte, 2019), “frightening, unpredictable and dangerous”(Fenwick et al., 2010, p. 396), or describing a sense of “sheer terror” (Ibid. p296). Accounts of fear of vaginal birth were complex and multi-factorial, including reflective accounts from family members’ own traumatic experiences of childbirth (Weaver, Statham and Richards, 2007; Fenwick et al., 2010). Some women considered caesarean birth safer than vaginal birth (Sahlin et al., 2013) or felt compelled to relinquish responsibility for decisions to their obstetric team, seeking emotional, physical and psychological safety by abdicating their decision-making. One participant stated, “I trusted them. I handed control of myself over to them. I was completely in their hands” (Fenwick et al., 2010, p. 398). While this might reflect a technocratic society (Fenwick et al., 2010), women who viewed vaginal birth as
dangerous and retaining more risk than they were prepared to accept viewed caesarean birth as safeguarding their values and beliefs, in the same way, women who declined intervention did.

Moreover, this refutes any notion that women who make non-normative choices do so only by rejecting the biomedical model. Instead, they privilege embodied and tacit knowledge and experience to make an informed decision. Indeed, in the case of women seeking complex homebirth (Lee, Ayers and Holden, 2016c), contact with clinicians was increased antenatally for reassurance purposes, providing a sense that when the time came to birth, the risk of complications remained low because “I just felt looked after, that if anything were gonna happen, then they’d spot it” (Ibid 2016c, p. 52).

Fear and (Re) Traumatising experiences

Fear was a recurring category across studies and a common motivator for women declining medical advice or rejecting normative pathways. A combination of nuanced, complex and varied reasons includes historical sexual assault (Feeley and Thomson, 2016b), dissatisfaction with previous episodes of inpatient medical care in child and adulthood, as well as obstetric care (Sahlin et al., 2013; Henriksen et al., 2020) and active avoidance of a system that they perceived may traumatis e or re-traumatis e them should they engage with the recommended care pathways either in part or whole was also noted (Jackson, Dahlen and Schmied, 2012; McKenna and Symon, 2014; Feeley and Thomson, 2016b; Hollander et al., 2017; Rigg et al., 2017; Jackson, Schmied and Dahlen, 2020). Therefore, a previous reproductive or other traumatic experience was a noteworthy, but not isolated, factor influencing non-normative choices.

Accounts of avoidance of a traumatising system featured in studies of caesarean birth in the absence of obstetric indication (McKenna and Symon, 2014), water birth after caesarean birth (Keedle et al., 2015) and freebirth and high-risk home birth (Feeley and Thomson, 2016b; Jenkinson, Kruske and Kildea, 2017; Henriksen et al., 2020; Jackson, Schmied and Dahlen, 2020). The included studies that describe how women seek to avoid a repeat of previous poor experiences. They did this via choices for the mode or location of birth and presence (or not) of attendants, aiming to, as illustrated by a participant in Eide, Morken, and Bærøe’s study (2019, p. 4), avoid ‘being back on that butcher’s bench’. Some women who considered their previous caesarean birth traumatic expressed a strong desire to birth vaginally (McKenna and Symon, 2014; Keedle et al., 2015), believing that previous interventions and care contributed to them requiring a caesarean birth in the first place, while equally, traumatic institutional experiences also influenced the choice to reject any clinical intervention or attendance (Feeley and Thomson, 2016b; Jenkinson, Kruske and Kildea, 2017; Henriksen et al., 2020; Jackson, Schmied and Dahlen, 2020).
Declining recommended care or removing themselves from the institution altogether was therefore often used as a strategy to avoid repeating similar outcomes or experiences with choice of location, a means by which women sought to reclaim control, otherwise felt to be lost due to power imbalances (Feeley and Thomson, 2016b; Lee, Ayers and Holden, 2016b).

3.11.2 Reciprocal Finding 2: Barriers and Conflict

This finding describes institutional and systemic barriers that influence non-normative choices. The sub-findings discussed below are an inflexible, fearful, risk-averse system, Policy, procedure and guidelines and Institutional manifestation of fear.

An Inflexible, Fearful, Risk Averse System

The review exposed criticisms of the inflexible nature of institutional systems within which maternity care is offered. Routine screening and surveillance, examinations and interventions intended for the estimation and subsequent removal, or mitigation of risk were evident across accounts of dissatisfaction with care and distrust of healthcare providers. These sentiments appeared rooted in perceptions of risk mitigation measures being prioritised over women's autonomy and choice, with routinisation, over medicalisation, and reliance on guidelines noted to be exemplars of power and control (de Zulueta and Boulton, 2007) with an emphasis on standardised rather than personalised care. Blanket application of guidelines and inflexible systemic approaches towards choices that fall outside of defined parameters limit the ability of clinicians to support non-normative care choices (Hollander et al., 2017; Rigg et al., 2017).

Policy, Procedures, and Guidelines

The inflexible system manifested as increasing tension between woman-centred, personalised care and the risk-averse, biomedical model of childbirth, where strict adherence to guidelines was expressed as ‘rules to be followed’, inaccurately assuming this would minimise institutional and individual medicolegal and reputational risk. Women distrusted institutions where the protection of clinicians and the system superseded supporting women’s choices (Lee, Ayers and Holden, 2016b; Plested and Kirkham, 2016; Hollander et al., 2017). One participant explained, “It was invasive, intrusive, and my well-being as a mother was secondary to achieving timelines of the hospitals’ protocols” (Rigg et al., 2017, p. 88).
**Institutional Manifestations of Fear**

Therefore, clinician and healthcare provider fear, particularly concerning women making non-normative choices and the potential consequences in relation to outcome, was viewed as a dominating discourse. How facilitative clinicians are concerning non-normative choices appeared to be directly related to the acceptability of the choice being made and how likely it would result in a negative outcome.

The institution considered women making various non-normative choices to be taking a step too far (Lee, Ayers and Holden, 2016b), described as “drawing lines in the sand” (Jenkinson, Kruske and Kildea, 2017, p. 8) when women did not comply with clinical recommendations and pathways (Plested and Kirkham, 2016; Jenkinson, Kruske and Kildea, 2017). Examples of escalating institutional actions included women not feeling listened to, the misrepresentation or manipulation of risk information, and continued and repeated unwanted conversations (Feeley and Thomson, 2016b; Jenkinson et al., 2016; Hollander et al., 2017; Jenkinson, Kruske and Kildea, 2017; Rigg et al., 2017, 2020; Roberts and Walsh, 2019) and the widely recognised phenomena of “shroud waving” (Plested and Kirkham, 2015, p30); which refers to constant reference to the death of the fetus, baby or mother regardless of the accuracy of the likelihood, should recommendations not be followed.

Reports of obstetric violence and threatened assault were also noted (Jenkinson, Kruske and Kildea, 2017). Women gave accounts of aggressive interactions with clinicians, claiming loss of identity, dehumanisation and infantilisation, being ignored and treated like “a piece of meat” (Keedle et al., 2015, p.5), experiencing impersonal, traumatising episodes of care (Rigg et al., 2017) and being viewed and referred to through the lens of a health condition, rather than as an individual (McDonald and Kirkman, 2011).

Studies also noted consistent questioning of women’s capacity, both from a mental health perspective and a perceived moral judgement about their likely ability to be a ‘fit’ mother, labelling women as reckless or deviant in their decision-making (Feeley and Thomson, 2016a; Roberts and Walsh, 2019). This sometimes resulted in an inappropriate and vexatious referral to children's social services (Feeley and Thomson, 2016b; Plested and Kirkham, 2016; Hollander et al., 2017). Holten, Hollander and de Miranda (2018, p.1) define interactions with healthcare providers described in this section as ‘defining moments’, influential in determining and influencing further non-normative choices.
3.11.3 Reciprocal Finding 3: Knowledge as Empowerment

This finding describes how women engaged with and utilised knowledge to assert control and autonomy in making non-normative choices.

Seeking and Evaluating Knowledge

A key observation across the studies was women’s knowledge seeking to support and rationalise individual choices. Women reported using a variety of sources and strategies to mobilise “becoming an expert” (Jackson, Dahlen and Schmied, 2012, p. 9) regardless of the nature of the choice (de Zulueta and Boulton, 2007; Bakkeren et al., 2020). These sources of information were evident when accepting or rejecting apparent medical expertise (Hollander et al., 2017; Eide, Morken and Bærøe, 2019; Roberts and Walsh, 2019; Henriksen et al., 2020).

As noted previously, women drew upon their own and familial experiences to inform their choices alongside expressions of instinctual and embodied assumptions of their perceived ability (or inability) to give birth. Some used information from previous pregnancies and reproductive episodes to make decisions about screening and surveillance in current pregnancies, declining additional information altogether (Wätterbjörk et al., 2015).

Women across the studies were engaged in extensive sourcing and interpretation of complex and sophisticated evidence, including, but not limited to, medical and scientific journals, primary research, and social media sources, all of which served to inform and legitimise their choices. Social media, in particular, enabled engagement with communities that reflected their situations and philosophies (Lee, Holden and Ayers, 2016; Roberts and Walsh, 2019; Henriksen et al., 2020). Jackson, Schmied and Dahlen (2020) reported that for some women in their study, this was the first time that the full range of birthing options available to women were discovered:

“I just became more informed about my other choices ... [and this] just blew open a whole new world for me around another choice” (HB04). (Jackson, Schmied and Dahlen, 2020, p. 8)

Very few studies identified clinicians and institutions as primary or trusted sources of information, with women acknowledging their intuitive and embodied knowledge as superior (Hollander et al., 2017). A range of knowledge-seeking behaviours were exhibited to corroborate or contradict clinical advice, particularly about risk evaluation. Women rejected information considered unhelpful or not applicable to their individual context (Keedle et al., 2015; Lee, Holden and Ayers, 2016).
Some women were reported to be selective in drawing upon information, particularly minimising information that did not accord with their own beliefs, values, and philosophies or that might create anxiety, preferring to accept and trust lay information that supported their understanding and approach to birth. One participant illustrated this: “If something’s made sense to me, and my logic and my beliefs and my kind of philosophy” (Lee, Holden and Ayers, 2016, p. 3). This might appear to represent confirmation bias, a well-documented phenomenon in health information-seeking behaviours (Meppelink et al., 2019; Forgie et al., 2021).

**Operationalising Knowledge**

Women reported being ‘armed’ with knowledge as a means of contingency planning for interactions with clinicians. This frequently involved negotiation with and subversion of the system to avoid further intrusion, resistance or opposition from healthcare providers (Feeley and Thomson, 2016a; Jackson, Schmied and Dahlen, 2020; Rigg et al., 2020). Studies highlighted how avoidance strategies and tactics were employed. While some women completely disengaged with services, many studies highlighted how subversion manifested, for example, by avoiding induction of labour for postdate pregnancy18 (Roberts and Walsh, 2019) or free birthing practices, as one participant explained:

“...my tactic with the midwives that we called three or so days later was to be very agreeable, be very kind of apologetic... that 'we're not being contrary or irresponsible, it just kind of happened like this, and it was all ok, and you know, saved the placenta for you to check and do all the checks to show 'we've nothing to hide” (Feeley and Thomson, 2016a, p. 19)

Newly obtained knowledge was therefore used as a mechanism to support, inform, and facilitate choices.

**3.11.4 Refutational Finding 1: The Middle Ground**

Only one significant, short refutational finding was identified through analysis: ‘the middle ground’. The middle ground refers to how avoidance strategies and tactics utilised by some women were not always necessary. Participants reported finding a ‘middle ground’ which enabled clinicians to work with women and facilitate their needs. The middle ground was described in various ways, but central to the discussions was a valuing of women’s

---

18 Postdate pregnancy: A pregnancy lasting past 42 weeks of gestation. Induction of labour offered between 41 and 42 weeks of pregnancy in the absence of other risk factors in order to reduce the likelihood of perinatal fetal morbidity, meconium aspiration and caesarean section, although no statistically significant differences observed in neonatal unit admissions (Gülmezoglu et al., 2012; NICE, 2021d).
childbearing journey through reinforcing and enabling values and beliefs and thus supporting non-normative choices (Fenwick et al., 2010; Crombag et al., 2016; Jenkinson et al., 2016; Jenkinson, Kruske and Kildea, 2017; Rigg et al., 2017; Roberts and Walsh, 2019)

3.11.5 Line of Argument Synthesis Statement

The purpose of line of argument synthesis within meta-ethnography is to provide an interpretive lens through which to draw inferences resulting from the preceding steps and determine what can be said of the “whole, based on selective studies of parts” (Noblit and Hare, 1988, p. 62). This element closely aligns with grounded theorising and provides a methodological and conceptual link between this meta-ethnographic review and the empirical work within this thesis. My line of argument synthesis statement is presented here, following the general principles of Glaser and Strauss (1967), presenting theorisation and conceptualisation that both “fits” and “works” (Glaser and Strauss, 1967, p. 3; Noblit and Hare, 1988) establishing “structures of signification” (Geertz, 1973b, p. 27).

This meta-ethnography suggests that the reality of making non-normative choices is complex, with choices informed by individual and contextual biopsychosocial factors, including the degree to which personal significance is attached to pregnancy and birth, control, and bodily autonomy. Women’s non-normative choices are influenced by their direct and indirect experiences of maternity care or negative views of health professionals and health institutions. Non-normative choices may also result from a pushback against a risk-averse and (re)traumatising system; however, this is not the sole dominant motivator. Non-normative choices are rarely arbitrary or inconsequential for women, nor do they make such choices naively; indeed, women understand and retain personal responsibility for any implications of their choices. Indeed, there is no evidence that women prioritise birth experience over physical maternal or fetal safety; however, psychological, and emotional wellbeing is also an important outcome for women. The institution remains a central source of conflict and resistance because many women believe that inflexible guidelines and institutional fear are prioritised over their needs and choices. The non-normative choice could, therefore, be considered a physically and psychologically protective behaviour.

3.12 Discussion

This systematic meta-ethnographic literature review offers insight into the views, attitudes, perceptions, and experiences of women who make non-normative childbearing choices while simultaneously exposing empirical knowledge gaps. The review developed and drew upon my new formal definition of a non-normative choice in childbearing that included three distinct elements, each of which is discussed in turn below:
3.12.1 Desiring Care Outside of Established National or Local Guidelines or Medical Recommendations

Twenty-three of the papers, representing the results of 13 studies, focused on choices which addressed several aspects of care perceived to be ‘outside-of-guideline’ or against the medical recommendation, many of which are not routinely offered as a choice, and then usually within the intrapartum period, i.e., freebirth, homebirth in the presence of complexity, maternal request caesarean birth or requesting more intervention. Data which might inform broader policy, including the incidence, prevalence and outcomes for women who make non-normative choices, is limited, although as interest in the subject grows, so does the evidence base (Hollowell et al., 2014; Rowe et al., 2015). Development of research in this area may be related to increasing concern from institutions striving to understand how and why women make choices to support personalised care planning, for example, the request for homebirth to avoid unnecessary interventions or discussions around discrete interventions such as vaginal examinations (Hauck et al., 2020) or concern regarding the medicolegal ramifications for the institution and biopsychosocial consequences for women and their families.

Existing evidence has focussed on how healthcare providers facilitate non-normative choices rather than the views and experiences of women making the choices (Madeley, 2018; Feeley, Thomson and Downe, 2020; Larner and Hooks, 2020; Price, 2020; Feeley, Downe and Thomson, 2021). This literature broadly supports the refutational findings of this review, namely that facilitative encounters with midwives and the experiences of institutional arrangements for supporting choice are otherwise described as a ‘middle ground’. Unfortunately, this also positions clinicians’ voices as central in supporting women to make non-normative choices. As this review has demonstrated, women making non-normative choices do not always regard healthcare providers as a source of authoritative knowledge (Davis-Floyd and Sargent, 1997). It is also unclear if clinicians’ approaches to supporting non-normative choices correspond with the needs and preferences of the women themselves. This is a significant unexplored dimension in the literature that the rest of the thesis aims to address, women’s voices being vital in underpinning further evidence.

3.12.2 Withholding Consent to Any Routinely Offered Intervention, Screening, or Treatment

The review noted the lack of evidence around withholding consent to any routinely offered intervention as a choice or choices outside cultural, social, or familial expectations and non-medical norms. The review did, however, include some accounts of declining screening technologies, testing and treatment for HIV and prenatal
fetal anomaly screening, induction of labour and declining interventions such as cardiotocograph monitoring during a planned vaginal birth after caesarean and induction of labour after 42 weeks (Jenkinson, Kruske and Kildea, 2017), although these were not extensively addressed. While the number of studies in this review suggests a sizable body of existing literature, particularly within the UK (12), its focus remains narrow. It fails to address more comprehensive experiences that reflect the entire childbearing continuum. Further research is required to fill this empirical and theoretical gap in knowledge (Muller-Bloch and Kranz, 2014) to generate insights into the experiences of making choices across the pregnancy continuum, for example, antenatal testing, vaginal examinations, fetal monitoring and surveillance technologies, acknowledging that women will at some point decline or withhold consent for any of these.

3.12.3 Moving outside Cultural, Social or Familial Expectations and ‘Norms’

Broader insights into the complex biopsychosocial influences and motivations before pregnancy, as well as the wider social processes that contribute to non-normative choices, are limited, representing both a knowledge and theoretical gap in the literature concerning the third element of the review definition; those that reflect moving outside cultural, social, or familial expectations and norms. Few of the papers in the review included women from Black, Asian, and other ethnic and cultural backgrounds, representing a population knowledge gap (Miles, 2017). It is a noteworthy finding warranting further exploration because while perinatal morbidity is improving globally, there are still poorer outcomes in the United Kingdom for Black, Asian and other ethnic background women than their white counterparts (WHO et al., 2019; Knight et al., 2021). It was also unclear from the studies reviewed the extent to which lesbian, bisexual, pansexual, queer, transgender, and non-binary participants contributed to data. It is not clear from the studies reviewed how diversity of any kind influenced non-normative decision-making. This is important considering the emergence of evidence during the Covid-19 pandemic that women from minoritized communities were more likely to consider freebirth (Greenfield, Payne-Gifford and McKenzie, 2021b) and that choices that might be deemed non-normative might be made in response to the likelihood of discrimination and poor outcome (LGBT Foundation, 2022).

Ten papers across the sample represented data from four single studies, although they reported different elements of those studies. It was necessary to include all such studies to preserve the depth and richness of data (Jackson, Dahlen and Schmied, 2012; Feeley and Thomson, 2016b, 2016b; Jenkinson et al., 2016; Lee, Ayers and Holden, 2016c, 2016b, 2016a, 2016a; Jenkinson, Kruske and Kildea, 2017; Jackson, Schmied and Dahlen, 2020). Within the UK, this represents a narrow field of enquiry, which, when considering the overall findings of this review, reveals a significant knowledge gap that supports the need for further research.
3.12.4 Strengths and Limitations of the Review

A strength of this review is the development of the formal definition of non-normative choice (see 2.6), representing an original contribution to knowledge moving forward through the thesis. As with any meta-ethnography, the search strategy may have yielded an unmanageable number of papers, presenting a risk of under-interpretation and a tendency towards sweeping generalisations (Sattar et al., 2021). A strength of the review has been avoiding this by remaining rigorous and reflexive in the systematic application of the search strategy while maintaining clear definitions and boundaries for inclusion throughout. Contemporary methodological guidance enhanced this process (France et al., 2019; Sattar et al., 2021) while remaining true to the original method (Noblit and Hare, 1988). Another strength has been the publication of a paper based on this chapter, subject to two cycles of rigorous peer review before publication in an leading international journal (Madeley, Earle and O’Dell, 2023).

A strength common to meta-ethnography is the synthesis of potentially unwieldy amounts of data with clearly defined parameters while maintaining overall conceptual quality and richness. Such an approach offers new insights into healthcare experiences from practitioner, patient and service user experience to inform policy, practice and future research (Sattar et al., 2021). A strength of this review has been the meta-ethnographic approach reflecting a systematic and comprehensive search strategy and subsequent synthesis, enabling an early original contribution to knowledge through the line of argument synthesis and identifying gaps in the existing literature to inform the rest of the thesis. Moreover, using meta-ethnography in the context of the constructivist grounded theory method contributes to the overall unique methodological contribution of the thesis (see 11.4).

A common limitation of any systematic review is the potential for excluding relevant work. While traditional systematic reviews aim to be fully comprehensive, meta-ethnography does not; therefore, this is not a limitation. As discussed previously, the systematic search was repeated in July 2023 to satisfy myself that any missing studies published since the initial search were captured. A limitation of the study is that I could only include papers written in English, and this body of work may not adequately address issues of diversity and inclusion. Traditionally, meta-ethnographies were criticised for a loss of integrity and authenticity concerning the primary studies included (Sandelowski, Docherty and Emden, 1997); however, I have again been guided by the eMERGe reporting guidelines developed to address this critique.
3.13 Summary and Conclusion

The findings of this review have identified that limited work on this subject from the perspective of women’s experiences has been undertaken in the context of the United Kingdom. Where evidence exists, the focus is on a narrow demographic field, with little attention paid to more expansive types of experiences and choices, particularly those that do not represent intrapartum episodes of care. Anecdotally, a perceptible increase in the incidence of women making non-normative choices across the UK and national drivers for personalisation and choice representing fundamental tenets of future safe and respectful maternity care demands an urgent need for evidence, with non-normative choices representing a test towards the authenticity of maternal choice, autonomy and genuine personalised care (Jenkinson, 2017; Anon, 2022). While the findings of this review add to the emerging body of evidence, I have identified significant empirical and theoretical gaps in the literature that this study will address, further justifying the need to examine and explain why and how women construct their decision to make non-normative choices, explain the underlying social processes that motivate and drive the decisions and examine their experiences with navigating the maternity care system within the United Kingdom.

The following chapter presents the rationale for selecting the constructivist grounded theory method as an appropriate methodology to answer the research question, address its aims and objectives and offer an explanation and audit trail of the applied method.
Chapter 4 Research Design and Methodology

4.1 Introduction

In the previous chapter, I demonstrated a gap in knowledge that this study aimed to fill. This chapter will outline the rationale for selecting constructivist grounded theory (cGT) as an appropriate methodology to answer the research question and address its aims and objectives. I provide a brief overview of the philosophical and theoretical foundations of all schools of grounded theory, highlighting the key similarities and differences justifying the decision to use constructivist grounded theory. This chapter goes on to discuss data generation and analysis. I provide a detailed account of these methods, including practical and institutional management of ethical considerations, reflexivity, and methodological rigour. Finally, I introduce the participants in anticipation of the findings in chapters 5-9.

While this chapter presents the methodological application of constructivist grounded theory in a linear fashion, this is not the case in practice. The method's application, consistent with constructivist grounded theory is inductive and, therefore, cyclical. This is reflected in some overlaps in discussion.
4.2 Revisiting the Research Question, Aims and Objectives

The research had two aims:

- Examine and explain why and how women and other birthing people construct their decisions to make non-normative choices and explain the underlying social processes that motivate and drive the decisions.
- Examine their experiences in relation to navigating the maternity care system.

The objective of the research was to:

- Generate an explanatory substantive theory about how women make a non-normative choice and, in so doing, explain the underlying social processes.

The broad research question for the study was therefore:

“*What Are the Experiences of Women and Other Birthing People Who Make Non-Normative Choices Along the Childbearing Continuum in The United Kingdom?*”

4.3 Research Paradigm

To justify my chosen method and as a novice researcher, I must address my assumptions and beliefs concerning the nature of reality, the construction of knowledge, and the implications of being an insider researcher. As discussed in Chapter 1, my interest in this subject was borne out of my clinical experiences as a midwife, supporting and facilitating choices considered non-normative in clinical practice and witnessing first-hand the conflict and subsequent impact of such requests on clinicians and women alike. These experiences were fundamental in uncovering the lack of literature available to support clinical practice when choices arise and an appreciation of the lack of understanding of the motivations and processes involved in making non-normative choices. My academic background and qualifications in evidence-based healthcare highlighted the missing pieces of a jigsaw that, in my opinion, required addressing (Green and Thorogood, 2018a). As highlighted in Chapter 2, little quantifiable data is routinely collected to account for the vast range of non-normative choices. It is unclear if there is an appetite for this to become a key metric in contemporary maternity care despite anecdotal evidence
suggesting that non-normative choices are increasing. Women make non-normative choices - and will continue to do so. Therefore, their voices are crucial to understanding their motivations and how they experience exercising choices in contemporary maternity care. To this end, considering the research aims and objectives, a qualitative approach is adopted to understand experiences related to making non-normative choices and how they are enacted within the system.

4.4 Philosophical Positioning - Constructivist Epistemology and Relativist Ontology.

Much emphasis within contemporary maternity research favours objective empiricism, situated within a framework of quantifiable data, aiming to predict and reduce maternal and fetal morbidity and mortality through remedying pathology (Renfrew et al., 2014). This positivist philosophy is predicated on a realist epistemology, assuming a stable, predictable truth generalisable across populations and free from the influence of society; in other words, ‘value-free’ inquiry (Green and Thorogood, 2018d). This is perhaps exacerbated by the overreliance on misinterpretations of the concept of evidence-based medicine (EBM) (Sackett, 2007), including the injudicious application of evidence hierarchies (Green and Thorogood, 2018a) and experimental knowledge (Greenhalgh, Howick and Maskrey, 2014), despite experiential and clinical judgement being explicitly included within early founding principles (Guyatt et al., 1992). Such approaches may account for the ‘what’ but fail to incorporate the ‘whys’, the latter being critical to understanding the subjective and complex nature of human experience which a relativist ontological position favours.

Due to the individual, contextual and temporal nature of decision-making processes, choices are made in the presence of multiple constructions of an individual’s reality, which constructivist grounded theory views as conditional with a presupposition of indeterminate fluidity (Charmaz, 2017). This reflects and favours an ontologically relativist approach, explicitly rejecting the notion of absolute truth (Lincoln, Guba and Lynam, 2005). Higginbottom and Lauridsen (2014) propose that a constructivist philosophy is most closely aligned to nursing (and by default, midwifery) since the subjective experience of service users and personalisation of care within contemporary healthcare forms a central tenet of modern healthcare transformation (NHS, 2019; NHS England, 2021a).

Constructivism involves a process whereby single, discrete events become the foundations for decisions. While similarities may exist, each decision is grounded firmly in the views, attitudes, beliefs and experiences of the
individual from whom the choices originate (Charmaz, 2014a). Similar experiences within a cohort of participants can result in different interpretations of meaning, suggesting multiple understandings of realities constructed and viewed through a moral, cultural and societal reference framework and employing historical influences (Guba and Lincoln, 1985; Corbin and Strauss, 2008). Oakley (1983) supports the notion that childbirth has a social and personal experiential element and one situated within a medical framework. Indeed, research focusing on birth experience suggests that perceptions of childbearing can have far-reaching implications, including the well-being and future health of the complete family unit (World Health Organisation, 2005; Hauck et al., 2007; Cook and Loomis, 2012).

4.5 Approaches to Grounded Theory (GT)

Historically, the development of classical Glaserian grounded theory (CGGT) was to legitimise qualitative research by employing a flexible yet rigorous methodological process, set against and being comparable to the predominance of objectivist approaches to research while retaining explanatory power, the potential to construct an abstracted theory that explained social processes (Glaser and Strauss, 1967). Grounded theory is a pioneering method that has undergone over fifty years of development and modification, leading to three main approaches that share similarities but differ in critical ontological, epistemological, and methodological applications. Grounded theory (GT) methodologies all form a framework of principles that facilitate a systematic approach to inductive data collection and analysis, resulting in an abstracted theory (Charmaz, 2014a; Urquhart, 2022). All grounded theory approaches, therefore, share similarities with concurrent data collection, coding, constant comparison, abstraction, theoretical sampling, development of concepts and categories, memoing, theoretical saturation and integration, and construction of theory; however, there are critical differences in approaches. Higginbottom and Lauridsen (2014) suggest that when selecting an approach to grounded theory, the researcher must consider their worldview and its congruence between schools of grounded theory.

4.6 Research Methodology

A qualitative approach was considered the most suitable in identifying the most appropriate methodology for my research. The meta-ethnographic literature review indicated that while there appeared to be some knowledge concerning the lived experience of discrete episodes of non-normative choice, little is known about the inherent social processes within the phenomena across the childbearing continuum. While I initially favoured an interpretative phenomenological analysis (IPA) approach exploring lived experience, I decided very early that
such an approach would not provide the in-depth explanatory understanding of the phenomenon required (Green and Thorogood, 2018d). IPA would have helped to understand the subjective lived experiences of participants; however, it was unlikely to provide explanatory power deeply connected to the data. Moreover, I wished to explore the phenomena more abstractly and conceptually- exposing and evaluating the social processes in question - to develop an applied substantive theory. The following section briefly overviews the primary schools of grounded theory, examining why the constructivist grounded theory method was the most appropriate to answer the research question.

4.7 Glaserian/ Classical Grounded theory (CGGT)

This ground-breaking approach extolled by Glaser and Strauss (1967) both situated and directed grounded theory towards aligning with positivist research (Rieger, 2019). This approach assumes detached objectivity between the researcher and the participant throughout the process, including avoiding preconceived ideas and knowledge surrounding the phenomena (Rieger, 2019). Some reject this notion of objectivity as being, amongst other issues, naïve to the core of qualitative research and displaying a power imbalance favouring the researcher's knowledge by ‘elevat(ing) their own assumptions and interpretations to an objective status’ (Bryant and Charmaz, 2007; Rieger, 2019, p. 5).

CGGT was, therefore, initially rooted in positivism, later argued to have post-positivist elements (Charmaz, 2014a). This supported a critical realist ontological perspective that an objective reality exists, but how individuals perceive it is flawed and needs interpretation (Strauss and Corbin, 1994; Annals, 1997; Lincoln, Guba and Lynam, 2005). Both CGGT and later, early Straussian grounded theory (SGT) assume a position whereby objective truth already exists within the article of study, passively residing within an unconscious reality, having laid undiscovered until the investigator discovers it within the data or subsequent analysis (Crotty, 1998; Charmaz, 2006).

4.8 Straussian Grounded Theory (SGT)

Developed out of both a pragmatist and symbolic interactionist approach, Straussian grounded theory (SGT) modified CGGT to provide a more structured and well-described approach to grounded theory, acknowledging the construction of individual reality, leaning towards a more constructivist approach (Strauss and Corbin, 1990). Strauss, later joined by Corbin in the development of late SGT, considered individuals as active agents in their lives who create social structures through actively engaging in processes, rejecting a more Glaserian approach of
individuals passively affected by broader social structures. Active engagement through language and action supports notions of autonomy and agency through meaning-making and problem-solving within social processes. This reflects the influence of pragmatism and symbolic interactionism, which later informed their approach to the grounded theory method. Neither classic Glaserian grounded theory (Glaser and Strauss, 1967) nor modified (Straussian) grounded theory (Strauss and Corbin, 1990) explicitly acknowledge the effect of the researcher on the interpretation of data, something that constructivist grounded theory would later not only recognise but actively seek to include within the process of analysis and interpretation as a vital component of the method (Charmaz, 2000, 2006).

4.8.1 Symbolic Interactionalism

Symbolic interactionism (SI) as a theoretical framework derives from pragmatism, initially arising out of the works of eminent American philosophers Charles Sanders Peirce, William James, John Dewey and later Herbert Mead (Charmaz, 2014a; Cersosimo, 2023). At its heart, pragmatism is the view of society and the application of knowledge by individuals gained through experience and an individual’s interpretation of reality. Pragmatism rejects truth as universal and redirects attention towards how individual truth is constructed and where this occurs within society, centralising the relationship between action, thought and knowledge, the latter being itself a social product (Charmaz, 2014a; Cersosimo, 2023).

Symbolic interactionism, strongly associated with the work of Mead (1934) and Blumer (1969), developed this pragmatist tradition by emphasising social processes and actions, acknowledging how interactions between individuals define and redefine understandings and personal meaning construction of the social world, acknowledging how this then influences one’s life. Moreover, a key characteristic and tenet of SI has been considering the ‘agentic actor who interprets his or her situation’ (Charmaz, 2014a, p. 265). Because of this, SI proposes that meaning-making is dynamic, unique and unpredictable at an individual level, with how individuals perform actions, in turn, influencing behaviours and responses, moderated by individual interpretation and meaning of that interaction, its context and temporality (Kuhn, 1964; Blumer, 1969). SI theories support how social interactions at an individual or societal level set expectations for behaviours and norms (Stryker, 1968, 1980), which serves its intended purposes (Kuhn, 1964). Because of this, any methodology underpinned by symbolic interactionism aims to view the world from the perspective of the studied individual, engaging with how that individual makes sense of, draws meaning from and categorises the world.
4.9 Constructivist Grounded Theory (cGTM)

Once again, building upon symbolic interactionist foundations and Strauss and Corbin’s version of grounded theory (Strauss and Corbin, 1990), Charmaz developed constructivist grounded theory. If we acknowledge, as Charmaz states, ‘social reality is multiple, processual and constructed’ (Charmaz, 2014a, p. 13), then the researcher cannot be considered neutral nor objective; indeed, the researchers’ actions and interpretations form part of that construction. Furthermore, the meanings attached to the data are co-created by participants and the researcher, with the researcher (as author) presenting their own constructed interpretation of the studied phenomena. As Charmaz (2014a) states, the researcher is not authoritative in presenting the data but is a ‘passionate participant’ themselves. This requires an explicit acknowledgement of the researcher’s subjectivity, privileges, and preconceptions and how these contribute to interpreting participants’ experience (Charmaz, 2000, 2006, 2014b); the research itself is regarded as a social construct (Birks and Mills, 2011; Charmaz, 2014a). Constructivist grounded theory methodology (cGTM) considers the researcher the primary instrument in data collection, analysis, interpretation and construction, as these rely on the interaction between participants and researcher (Charmaz, 2014a). Indeed, as Guba and Lincoln (1985) stated:

‘[the] investigator and object of investigation are…linked so that the “findings are literally created as the investigation proceeds”’ (Ibid 1985, p. 207)

As discussed in Chapter 1, I came to the research process as a midwife and mother with both personal and professional experience in navigating contemporary maternity systems and supporting women (successfully and unsuccessfully) to do so, explicitly making non-normative choices. Indeed, it was professional interest in the phenomena that led to the study itself; it would have been naive in these circumstances to propose that as a researcher, I could be completely objective and ‘bracket’ assumptions, experiences and a priori knowledge as is the convention in a Glaserian approach (Glaser and Strauss, 1967; Glaser, 1998a). Rather than considering this a limitation, Charmaz (2006, p. 10) proposes this as a benefit in that the researcher ‘construct[s] our grounded theories through both our past and present involvement and interactions with people, perspectives and research practices’. Furthermore, engaging with my subjective experiences, knowledge, and expertise promoted phenomena-based context and theoretical sensitivity (see 4.13.5) within the data (Charmaz, 2006; Corbin and Strauss, 2008). This enables the generation of a substantive theory grounded in data emerging from thick description.
Therefore, a constructivist grounded theory approach is chosen as an appropriate method of answering the research question while simultaneously allowing for flexibility in approach with explicit acknowledgement of my subjective positionality, its purpose being to understand how individuals experience a phenomenon by systematically and simultaneously collecting, coding, and analysing data. The aim is to generate a substantive theory (or middle-range theory\(^{19}\)) related to the explicit and implicit social processes inherent to the phenomena being studied (Glaser, 1998a; Charmaz, 2014a; Birks and Mills, 2015).

### 4.9.1 Literature Reviews in Grounded Theory and the Use of Meta Ethnography

Classical grounded theory extolled the virtues of not engaging with related literature not to impose existing theory onto data generation, contaminate or influence interpretation or affect theory generation. This remains one of the most debated areas by grounded theorists. Glaser and Strauss (1967) initially suggested that literature should be only reviewed after analysis to ensure that this preconceived and generated knowledge does not contaminate theory generation and analysis. Glaser maintained this view and proposed that only theoretical literature outside the studied field be reviewed to maintain a ‘theoretical sensitivity’ against which the emerging theory can be compared (Glaser, 1998b). This stance assumes that the researcher is devoid of life or professional experience that may influence analysis, a view challenged by Strauss, who initially advocated Glaser’s observations but later distanced himself from this process and, alongside Corbin, acknowledged that rather than contaminating the data, experience and prior knowledge lends itself to theoretical sensitivity by applying that knowledge to the phenomena under scrutiny, enhancing sensitivity and encouraging a critical standpoint (Strauss and Corbin, 1990, p. 42, 2015).

Researcher objectivity is explicitly rejected within constructivist grounded theory with Charmaz (2014a), suggesting a researcher-led approach to engagement with the literature, providing that reflexivity is maintained. Considering Glaser’s famous proclamation that ‘all is data’ (Glaser, 1998a, p. 8; Glaser and Holten, 2004), I made a pragmatic decision to undertake a meta-ethnography of the literature (see Chapter 3). Meta ethnography and its seven canonical steps described in Chapter 4 (Noblit and Hare, 1988) are similar methodologically to grounded theory, synthesising studies employing constant comparison, interpretation and generation of theory grounded within the data (Doyle, 2003; Campbell et al., 2011). The results of the meta-ethnography, alongside reflexive techniques, are a strength of this study, enriching and informing the empirical data generation and analysis and

\(^{19}\) Previously defined
enhancing theoretical sensitivity (see 4.13.5). Moreover, meta-ethnography enhances the credibility and resonance of the final substantive theory, simultaneously offering a unique methodological contribution (see 11.3.1 and 11.4.1).

4.9.2 Patient and Public Involvement and Engagement (PPIE) and Co-Design

A contemporary focus and cultural shift towards PPIE and co-design in healthcare research acknowledges the potential for transformative research in relevance, quality, and application, with guidance from the UK suggesting that research should be undertaken with and by patients (Hayes, Buckland and Tarpey, 2012; Greenhalgh et al., 2016; Hoddinott et al., 2018). Demonstrable elements of PPIE and co-design are also now evaluated by funding organisations and high-impact journals (Smits et al., 2020; Karlsson and Janssens, 2023). Nevertheless, barriers exist to the design and implementation of PPIE and co-design. There were two critical barriers to the conventional application of PPIE and co-design relevant to this research. Firstly, the study was time and resource-limited, restricting the ability to apply pre-study planning for PPIE and co-design, a well-acknowledged issue in all doctoral work, particularly healthcare research (Troya et al., 2019). Secondly, as previously highlighted, grounded theory is an appropriate method for exploring phenomena about which little is known. Moreover, traditional grounded theory methods discourage engagement with literature and, by inference, those with a knowledge of the phenomena, representing a methodological barrier towards PPIE and co-design. Here, I contend that the application of cGT has removed this barrier, characterising a concession towards PPIE and co-design. cGT, by explicitly recognising and acknowledging the importance of co-created knowledge generation in its process, incorporates the fundamental principles of PPIE and co-design in the rigorous application of its method, demonstrated robustly in this study. For example:

- Application of purposive and theoretical sampling techniques, concurrent analysis and constant comparison, emphasising the co-creation of knowledge between the participants and the researcher (Charmaz, 2014a, 2017)
- The use of synthesised member checking (see 4.12.6) further enhances the co-created nature of theoretical development and analysis.

Therefore, formal engagement with patients and the public for the initial co-design activities was not undertaken. However, this is not considered a limitation of the study (see also 11.3.2), nor did it have a negative effect on the substantive theory or model, quite the converse, taking into consideration the forgoing discussions.
4.10 Research Methods

The following section presents the method for undertaking the study in line with the constructivist grounded theory methodology and illustrates the audit trail for conducting the analysis in this thesis.

4.10.1 Ethical Approvals and Considerations

Ethical implications were considered throughout the design and conducting of this study (Green and Thorogood, 2018c). A favourable opinion was sought from The Open University Human Research Ethics Committee (HREC) and granted on 10th August 2021, reference number MADELEY/4062, alongside a data impact assessment and entry onto the information asset register (IAR) reference number 3306150, reviewed and approved on 6th Sept 2021. An amendment to ethical approval and DPIA was sought and granted on 5th May 2022 and 25th May 2022, respectively, for the use of transcription services.

As an NMC registrant, I retain a professional responsibility under the Code (Nursing and Midwifery Council, 2018) to safeguard those under my care, including research participants. I adhered to all applicable research and professional guidelines concerning ethical research conduct and dissemination and legal and statutory frameworks (BSA, 2017; Nursing and Midwifery Council, 2018; Open University HREC, 2020, 2020). I ensure that I uphold and safeguard the participants' dignity, safety and rights to minimise and mitigate the likelihood of harm arising from the research process (BSA, 2017; Nursing and Midwifery Council, 2018).

Given the nature of the phenomena, it was foreseeable that participants might become distressed discussing complex or emotive episodes of care. As part of the ethical approval process, routes for referral were established with support networks, counselling, and further information as a means of mitigation and offered to all participants in writing by email following each interview. Immediate actions were continually considered during interviews, remaining responsive to cues of distress or difficulties, employing pauses and breaks, and broader transferrable midwifery skills, remaining respectful, compassionate, and responsive. As well as participant distress, there was always the potential for researcher distress and compromised safety. I mitigated this through engagement with reflexive and reflective techniques, institution-wide guidelines for safety (lone working, health and safety), regular supervisory support, and PGR support systems where appropriate (Open University, 2020; Open University HREC, 2020). Moreover, as a midwife registrant, I have access to a professional midwifery advocate outside of the research process, whom I could have called upon for support if necessary.
4.10.2 Consent and Right to Withdraw

Consent must be fully informed and freely offered. Thus, I explicitly sought this in writing before data collection. Prospective participants were provided with an information sheet (Appendix 7), developed in line with institutional guidance and approved as part of the ethics submission (Open University, 2019). Participants completed the consent form (Appendix 8) and returned it to me by email (one participant) or on a confidential and secure Microsoft forms link (thirteen participants). I securely stored these in line with the data management plan for the study. Before commencing an interview, consent was verbally reaffirmed and recorded. No one withdrew from the study post-interview; however, two potential participants booked over the data generation period but failed to join the interview. I sent follow-up emails on both occasions but received no reply. I sent further emails thanking them for their interest in participating and confirming that their details would be removed per the data management plan. The ethical principle of consent is an active and ongoing process; therefore, I advised participants that participation remained voluntary and that they had a right to withdraw at any point up until the destruction of the data (Open University, 2019, 2021). During the interview process, I monitored participant distress. One participant became upset during an interview, recalling her experience. I stopped the interview and asked if she wished to continue. She decided to carry on, and the interview was completed. I sent a follow-up email post-interview, ensuring that support networks were signposted. I reaffirmed consent while submitting responses for participants who contributed to synthesised member checking (see 4.12.6) (Open University, 2019).

4.10.3 Confidentiality and Anonymity

Following the Data Protection Working Party (2014) principles, I anonymised personal data and pseudonyms were assigned alphabetically. Each participant was offered the opportunity to select their pseudonym. Mander (2023) suggests that social constructionism acknowledges individuals' importance attached to their names, often aligned with their salient and central identities. It might, therefore, be argued that imposing or altering identity might impact the research experience. This was supported by participants in this study who chose names they reported held personal meaning, for example, Kali.

Conversely, asking participants to consider choosing their pseudonyms potentially risked them selecting names or initials close to their own, inadvertently risking reidentification. To this end, I asked participants to choose a name if they wished, but in alphabetical order according to their participation. All participants decided to take up this offer. I applied pseudonyms immediately post-interview so that personal identifiers and information not required for the research process could be removed or destroyed as soon as possible (Open University, 2021).
4.11 Recruitment and Sampling Strategy

Sampling in qualitative research aims to identify a sample that can yield the data needed to answer the research question (Green and Thorogood, 2018a). Within grounded theory, and cGT specifically, the sample must be based on those who can enable theory development, seeking accessible data in areas where the researcher is likely to find it (Glaser and Strauss, 1967; Charmaz, 2014a). I achieved this by developing inclusion and exclusion criteria (Table 5) to inform initial purposive and theoretical sampling, which are explained later in this chapter.

4.11.1 Social Media-Based Recruitment

This study was partially conducted during a global pandemic, which afforded both restrictions and opportunities in recruitment and data generation planning. When planning the study, it was unclear how much restrictions on travelling and meeting with participants might affect the research; therefore, I planned recruitment and data generation to accommodate ongoing social restrictions on travelling and meeting. Social media as a recruitment tool has not only been shown to be an effective recruitment tool during the COVID-19 pandemic; it is recognised in terms of its ability to reach a wider geographical spread (Quan-Haase and McMay-Peet, 2017; Green, Fernandez and MacPhail, 2021; Archer-Kuhn et al., 2022) while simultaneously ensuring that hidden and hard to recruit communities are more likely to be reached (Barratt et al., 2015; Sandhu, Brady and Barrett, 2023), potentially therefore improving diversity in recruitment (Agyepong, 2020).
Limitations also exist. Those with limited access to social media, access to technology digital literacy issues may affect uptake (INVOLVE, 2014; Gelinas et al., 2017) and potential ethical issues surrounding negotiating recruitment within closed social media groups. No such problems arose within the context of this study.

4.11.2 Inclusion and Exclusion Criteria

I developed inclusion and exclusion criteria, considering the phenomenon in question, data gaps noted within the meta-ethnography and ethical considerations. For example, it was important that the study did not influence any immediate healthcare choices; therefore, participants were only recruited if they had completed and been discharged from any episode of maternity care to ensure that the research did not unintentionally influence a change in decision regarding care or treatment as a patient because of reflection as part of the study, considering that some women may be choosing to resist or request care outside of recommended guideline or protocol or identification and recruitment of participants remained independent of the NHS.

Figure 2 Social Media Accounts (l. Twitter r. Instagram)
<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Women and other Birthing people aged &gt;18 years.</td>
<td>• Women and other Birthing people aged &lt;18 years.</td>
</tr>
<tr>
<td>• English speaking Women and other Birthing people</td>
<td>• Non-English-speaking Women and Birthing people</td>
</tr>
<tr>
<td>• Women and other Birthing people who have completed and been discharged from any</td>
<td>• Women and other Birthing people who have made choices not considered non-normative.</td>
</tr>
<tr>
<td>maternity care episode.</td>
<td>• Women and other birthing people still within a defined maternity care episode.</td>
</tr>
<tr>
<td>• Experience making a choice that could be considered non-normative in a previous</td>
<td>• Women and other Birthing people outside of the demographic criteria</td>
</tr>
<tr>
<td>pregnancy within the last five years in England, Scotland, Wales, or Northern Ireland.</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3 Inclusion and Exclusion Criteria

4.11.3 Sample Size

Defining an appropriate sample size within qualitative research is complicated, with many conflicts within the literature regarding how many participants are enough. This is further compounded in GT as it aims to reach theoretical saturation (Charmaz, 2014a). Theoretical saturation in both theory and data has been a fundamental consideration within the constant comparative method, continuously working back and forth between and adding data until concepts are saturated, relationships established, and no further material added to the developing theory (Charmaz, 2014a; Malterud, Siersma and Guassora, 2015). Corbin and Strauss (2008) suggest that theoretical saturation within a grounded theory study is achieved where exploration of the phenomenon has led to a sufficiently broad extent that facilitates deep understanding. Theoretical saturation and sufficiency are discussed in more detail later in the chapter (see 4.13.6).

It is also essential to consider that qualitative research aims to achieve concept transferability rather than generalisability (Sandelowski, 2008; Brinkmann and Kvale, 2015); therefore, a representative sample is unnecessary. During the process of obtaining ethical approval, I provided an estimation of sample size; however,
the grounded theory method meant I could not be more specific, only being able to confirm the sample size once theoretical sufficiency was reached (see 4.13.6) (Dey, 2007; Charmaz, 2014a). A maximum of 20 participants was mooted initially with the understanding that an amendment to ethical approvals would be required if more participants were later needed. (Mason, 2010). Due to the overwhelming response of potential participants, I easily reached an appropriate sample size demonstrated through theoretical sufficiency within categories and concepts (see 4.13.6), with 14 participants recruited for the study.

Recruitment and sampling comprised two distinct but inductive processes. The first round comprised initial purposive and snowball sampling and the second theoretical sampling.

4.11.4 Purposive Sampling

The initial sampling strategy aimed to cast a wide enough net to allow for refinement of scope while targeting an appropriate sample who are likely to shed light on the phenomena and help develop the theory, informed by the inclusion criteria (Glaser, 1992). Therefore, initial purposive sampling was driven by the study’s aim, the meta-

Figure 4 Examples Social Media Recruitment Posts (l. Twitter r. Instagram)
ethnography results, and my midwifery knowledge and clinical experience (Glaser and Strauss, 1967; Charmaz, 2014a; Morse, 2021). Initially, recruitment was via request for voluntary participation across selected social media (Twitter, Facebook, and Instagram), professional networks and community groups, charities, and networks. I created social media profiles for the project to share recruitment materials (see Fig 3). I made preliminary informal enquiries with prospective facilitators who could assist in sharing recruitment materials while seeking ethical approval. These included moderators and admin of closed social media groups, including those related to birth planning (e.g., freebirth and homebirth), and cultural and social groups (LGBTQ+ groups, black and minority ethnic women support groups). Once I had shared materials across social media, these individuals shared them within their networks.

I first published recruitment adverts on 8th September 2021 via social media and internet-based professional and midwifery networks (Fig 4). Approaches were made to me within the first week by organisations, publications, and midwifery networks who I had not initially approached, requesting permission to share materials, which I agreed to, clearly caveating that at no point should it be shared within the context of the NHS. I shared a further call for participants during theoretical sampling on 6th April 2022.

Ninety-seven prospective participants responded via email to discuss the study within the first week, the volume of which was unanticipated but welcomed as the pool of prospective participants meant that rich, thick data was more likely to be obtained. Once I received an enquiry, I sent the prospective participant an email with a participant information sheet, guidance on how to volunteer for the study and a reply link on Microsoft Forms. Each participant was invited to forward the invitation email to other people they thought might be interested in participating and who also fulfilled the inclusion criteria. This snowballing technique benefitted the study in anticipating potential recruitment limitations through social media and resulted in a large pool of prospective participants; however, this was not needed, given the overwhelming response. I only recruited one participant in this manner. Participants then responded by completing the form on the secure link providing primary demographic and special category data\(^{20}\), including name, address, contact details, age, occupation, ethnicity, and

\(^{20}\) Ethnic background, gender identity and sexual orientation are considered under UK GDPR to be special category data and therefore processing required consideration within the ethics application in line with Open University ethics guidance (Crane, 2018a, 2018b; Open University, 2019; Open University HREC, 2020).
gender identity, sexual orientation, and best time to contact. Additionally, participants were invited to briefly describe their non-normative choices to assist in purposive and later theoretical sampling.

After I reviewed information submitted by prospective participants and confirmed that they fulfilled inclusion criteria, I identified individuals to invite to take part in an interview, informed by the study’s aims and objectives, demographics, nature and spread of the non-normative choices and application of my insider knowledge of the maternity care system (Charmaz, 2012). I sent an invitation to interview via email with a copy of the participant information leaflet. I then proceeded to book online interviews.

Figure 5 Recruitment Response Rates and Actions Throughout the Project

4.11.5 Theoretical Sampling

Theoretical sampling (TS), as a convention in GT, aims to sample to develop categories by narrowing focus, refining categories and concepts, establishing links between categories through abductive reasoning and supporting the emerging theory (Draucker et al., 2007; Charmaz, 2012). (Charmaz, 2014a) suggests that TS can be used both at early stages and later in a study and is supported by the researchers ‘theoretical sensitivity’,

103
described as the ability to demonstrate conceptual and abstract connections between phenomena, developing understanding, identifying gaps in knowledge and expressing interpretative explanation (Glaser, 1978; Charmaz, 2014a). Typically, this occurs when a tentative understanding of and sensitivity to developing theory or lines of inquiry emerge (Glaser, 1978). When to move from purposive to theoretical sampling is primarily a subjective decision by the researcher (Draucker et al., 2007). I decided to move from purposive to theoretical sampling after discussing preliminary findings that informed initial category development with my supervision team in late 2022. The developing categories then guided my invitation to interview, selecting participants likely to confirm, hone and expand gaps within the developing categories, refining the interview guide to reflect the pursuit of lines of theoretical enquiry.

This theoretical sampling phase occurred over a more extended period in the study compared to the purposive phase (se as categories and concepts became clearer. For example, I conducted Nellie's interview eight months after my penultimate interview as I was deliberately seeking deviant or negative cases and felt I was missing data concerning caesarean birth.
Figure 6 Diagram Representation of Method Process (Adapted from Charmaz, 2000; Charmaz, 2014a; Higginbottom and Lauridsen, 2014)
4.12 Data Generation Methods

Mindful that the range, depth, quality and relevance of data is the crux of credibility concerning any grounded theory study and acknowledging that the richness of data, and thus the strength of the grounded theory, relies on the ‘thickness’ of description (Geertz, 1973a; Charmaz, 2000), I considered a variety of data collection methods for this study.

Constructivist grounded theory, in particular, acknowledges the position of the researcher’s relationship to data acquisition as a data collection instrument (Corbin and Strauss, 2008; Birks and Mills, 2015). Therefore, as a researcher, I directly engaged with the source of data (participant) to generate rich data for analysis, including participants’ views, perspectives and experiences (Charmaz, 2014b; Birks and Mills, 2015). I therefore consider that data are generated rather than passively collected. Data generation is and should remain largely contextual about the phenomena being studied and should consider not only the participants’ viewpoints but also logistical considerations such as study timeframes (Charmaz, 2014a; Timonen, Foley and Conlon, 2018).

Specific data generation methods can elicit the data required to answer the research question. Qualitative interviewing is the most used data generation method in grounded theory. However, other methods include focus groups, observation methods, textual and visual sources such as social media, historical documents and narratives (Foley and Timonen, 2015; Strauss and Corbin, 2015; Timonen, Foley and Conlon, 2018). I decided that in-depth interviews were the most appropriate method of data generation, guided by Charmaz’s approach (2014b). Interviews were considered a suitable method for this study as they offered a focused discussion as well as flexibility to be guided by the participant, allowing me to retain study focus and become part of the interpretative dialogue (Brinkman, 2005; Brinkmann and Kvale, 2015; Hammersley and Atkinson, 2019), further developing concepts and theory.

Therefore, this study’s primary data generation method was via recorded semi-structured interviews supplemented by extensive field notes and memos. Participants were offered the option of recording their interview audio-visually on Microsoft (MS) Teams or audio alone (MS Teams or Dictaphone).
<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Method of recording interview</th>
<th>Date of Interview</th>
<th>Sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela</td>
<td>Video and Audio</td>
<td>6(^\text{th}) October 2021</td>
<td>Initial Purposive</td>
</tr>
<tr>
<td>Bella</td>
<td>Video and Audio</td>
<td>14(^\text{th}) October 2021</td>
<td>Initial Purposive</td>
</tr>
<tr>
<td>Caleb</td>
<td>Video and Audio</td>
<td>21(^\text{st}) October 2021</td>
<td>Initial Purposive</td>
</tr>
<tr>
<td>Darcie</td>
<td>Video and Audio</td>
<td>5(^\text{th}) November 2021</td>
<td>Initial Purposive</td>
</tr>
<tr>
<td>Esmie</td>
<td>Video and Audio</td>
<td>22(^\text{nd}) November 2021</td>
<td>Initial Purposive</td>
</tr>
<tr>
<td>Faye</td>
<td>Audio Only</td>
<td>25(^\text{th}) January 2022</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Grace</td>
<td>Audio Only</td>
<td>3(^\text{rd}) March 2022</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Hazel</td>
<td>Video and Audio</td>
<td>28(^\text{th}) March 2022</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Imogen</td>
<td>Audio Only</td>
<td>30(^\text{th}) March 2022</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Jade</td>
<td>Audio Only</td>
<td>30(^\text{th}) March 2022</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Kali</td>
<td>Video and Audio</td>
<td>6(^\text{th}) April 2022</td>
<td>Theoretical</td>
</tr>
<tr>
<td>Leah</td>
<td>Video and Audio</td>
<td>11(^\text{th}) April 2022</td>
<td>Theoretical</td>
</tr>
</tbody>
</table>
Video calling retained preference over telephone interviews as it also captures non-verbal cues and communication (also reflected in field notes and memos). However, I needed to consider that not all participants (especially those without access to technology, IT literacy or confidence) could utilise video calling. For one participant, it was necessary to revert from MS Teams audio visual to telephone interview due to connectivity issues. Two participants chose audio only (one telephone and one video software audio) to maintain anonymity.

### 4.12.1 Reflexivity: Trustworthiness and Transparency

Reflexivity can be defined as a critical reflection on a-priori biases and theoretical presuppositions through considered awareness of the researcher within the research process (Engward and Davis, 2015). While reflection is somewhat second nature as a healthcare professional, being a mandated element of clinical and other practise (NMC, 2018), reflexivity remains distinct, requiring an individual to remain transparent and evaluate the impact of decisions within, and relationships across, the entire research process. A reflexive approach aims to address biases and potential limitations, improving overall rigour. Reflexivity demands that the researcher engage with an internal dialogue concerning the impact of previous experience, knowledge, philosophies and assumptions that influence the research process from an experiential, interpretative and decision-making perspective (Charmaz, 2014b; Berger, 2015). Charmaz explicitly acknowledges that exploring personal positioning through reflexivity shapes the research process, providing insight into how the researcher represents the research (Charmaz, 2006, 2014a). She asserts that:

‘People bring their situations into the interview which can form an unstated backdrop for negotiating the content and conduct of the interview...differences in gender, age, status and experience may result in interactional power differences (author emphasis).’ (Ibid 2014b, pp. p72-73)
This is important in cGT given the positioning of the researcher as the data generation, interpretation and theory construction instrument (Charmaz, 2014a, 2017); therefore, it was crucial first to acknowledge my subjectivity and positionality (previously discussed in 1.2) and the influence this may have on the relationship between me as a researcher with participants and the data. Models to support reflexivity in grounded theory are available. The Alvesson and Skolgberg (2009) model, for example, is commonly used and employs four levels of guided reflexivity to address implicit and explicit influences: problematising collected empirical data, engagement with the interpretative act, clarification of the political-ideological context and consideration of questions of representation and authority (Engward and Davis, 2015). Charmaz (2014a) fully endorses applying a reflexive approach in constructivist grounded theory but does not explicitly mention nor require the use of a model of reflexivity. This is likely due to reflexivity being a core element of cGT, with inherent activities such as memoing and constant comparison essential to applying the methodology. For two key reasons, the prescriptive use of a reflexive model such as Alvesson and Skolberg (2009) was not used. Firstly, when setting aside the methodological motivations for applying a structured reflexive process, the most common usage is in the provision of an account that satisfies reporting criteria for qualitative methods, the complexity and problematic nature of engaging such standardised criteria having already been discussed earlier in this thesis relating to meta-ethnography (Dixon-Woods et al., 2004; Tong, Sainsbury and Craig, 2007; Berthelsen, Grimshaw-Aagaard and Hansen, 2018). Critics have suggested that this can lead to the uncritical application of reflexive models within qualitative research in an attempt to prove legitimacy rather than a truly engaged process of reflexivity (Gentles et al., 2014). Secondly, the congruence of grounded theory as a method, and explicitly within constructivist grounded theory with its roots in symbolic interactionism, towards reflexivity being inherent when conducted appropriately. Finally, and most importantly, despite the absence of explicit application of a model such as that described by Alvesson and Skolberg (2009), the robust reflexive processes described throughout this thesis are aligned to the constituent elements (also refer to 11.4 and 11.5).

I also needed to anticipate and control for adverse effects that my insider status as a midwife might have had on the study, both in respect of an assumed midwife-patient relationship, but interestingly, where participants shared my profession – a midwife-midwife relationship. Several definitions of insider status exist; however, most share commonality as the ‘insider’ being one which ‘shares particular attributes with the study participants’ (Bukamal, 2022, p. 335). This could include sex, gender, ethnicity and class (Berger, 2015). In the context of this study, my insider status was afforded to me by being a midwife. Such a status has both advantages (access to the field, rapport building, knowledge and understanding of the culture and phenomena, identifying the domain and context
of the research) and disadvantages (subjectivity vs. objectivity, power relationships between researcher and participants) (McDermid et al., 2014; Berger, 2015; Bukamal, 2022). I observed both. For example, being an insider researcher did help me with sharing recruitment materials across social media networks as former colleagues assisting with dissemination across their networks. However, my insider status may have presented a barrier when seeking to access women. For example, I found it difficult to access potential participants who had or were planning a caesarean birth outside of medical indication. It is possible that my position as a midwife created this challenge. However, I have been unable to ascertain precisely why this was so difficult. From the study's inception and throughout, I sought to address potential ‘insider’ issues (Bukamal, 2022), especially concerning creating and maintaining boundaries between being a midwife and a researcher. I channelled all communications through my Open University email account, on which I used the designation ‘doctoral researcher’ rather than any reference to my profession. I did not hide my profession nor publicise it; if asked, I was happy to disclose this, doing so on many occasions in interviews. Notably, some participants asked me direct questions about my background and interest in the subject before interviews, and I honestly and factually answered any questions asked, assuring transparency.

By maintaining a reflexive approach, the process towards the substantive theory development meant that while I drew upon a priori knowledge and experience, it did not force the data and findings, ensuring it remained grounded in the data (Charmaz, 2000; Gentles et al., 2014). I maintained reflexivity in various ways. Reflexive memos were written throughout the research process (Figure 77), predominantly within NVIVO, either as part of the project journal, within concept/category memos or as standalone reflexive memos. During interviews, I immediately handwrote thoughts and reflections (Fig 8) and had regular reflexive discussions. An additional layer of reflexivity occurred during coding. During transcription, my questions, comments, and discussions were coded to separate interviewer questions and later interrogated within reflexive memos and integrated into categories to expose underlying assumptions and biases. Charmaz suggests that such results, alongside interview data, emphasise the co-constructed interview conversation and substantive theory (Charmaz, 2014b).

4.12.2 Preparing for Interviews

Before each interview, I reviewed the information provided and documented brief notes guided by the reflexive template proposed by Miles and Huberman (1994). I prepared initial pre- and post-interview thoughts within a participant-specific memo. This purpose was to clarify any underlying assumptions that might influence data generation. As a novice researcher, the template proved helpful until the prompts within the template became
second nature. I ensured all necessary equipment was available and working; the email confirming the interview asked participants to ensure they were in a quiet and comfortable place, free from interruptions. All participants chose their interview times, with four conducted in the evening.

Figure 7 Example of Reflexive Memo in NVIVO
<table>
<thead>
<tr>
<th>What was the key issue that struck me in the interview?</th>
<th>Faye didn’t want to be widened but was happy to be recorded. She lives in an identifying place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anything else that was interesting, illuminating or important?</td>
<td>When talking about how the consultant was trying to get her to come in, she talks very clearly about how everything was fine, the midwife thought it was fine and yet she was being defined as a risk factor. Previous citation at the exclusion of everything else, being reduced to just being as risk factor.</td>
</tr>
<tr>
<td>- Self blame when choices were not respected rather than blaming HCPs, lots of interpretation and beating self up. This then leads to being adamant that non-normative choice is the way to go despite how unlike it may seem - control again.</td>
<td></td>
</tr>
<tr>
<td>- Interactions between the midwife and the woman - acting as an intermediary.</td>
<td></td>
</tr>
<tr>
<td>How did the interviewee behave?</td>
<td>Difficult to assess visually but was very articulate, felt almost resigned to the difficulties she faced.</td>
</tr>
<tr>
<td>How did I behave?</td>
<td>At one point Faye asked me if I had given birth. She did this to explain how the fetal ejection reflex felt - she assumed a vaginal birth but though this question was interesting, I was unsure whether to firstly disclose but secondly, what else the purpose of the question might be.</td>
</tr>
<tr>
<td>Do I have any questions, hunches or alternative explanations for differences or gaps?</td>
<td>This constant act of negotiation and balance between HCPs and her.</td>
</tr>
<tr>
<td>- Exasperation why the evidence just doesn’t align with behaviours.</td>
<td></td>
</tr>
<tr>
<td>- The degree to which woman define what is non-normative. They don’t actually see their choices as such.</td>
<td></td>
</tr>
<tr>
<td>- Having to fight for anything.</td>
<td></td>
</tr>
<tr>
<td>How do I feel about the interview?</td>
<td>Was interesting to have come hunches confirmed. Also this back and forward between HCPs.</td>
</tr>
<tr>
<td>Topics for subsequent interviews</td>
<td>What influenced knowledge of childbearing</td>
</tr>
<tr>
<td>- The position of the individual as a reproductive being.</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 8 Example of Immediate Post-Interview Notes (Faye).**

### 4.12.3 Interview Method and Technique

As interviews are intended to be a ‘gently guided, one-sided conversation’ (Charmaz, 2014b, p. 56), with the participant leading the exploration, I used an interview schedule initially based on the phenomena, aims and objectives (see Appendix 9). Ethical conduct requires that interview questions reflect the interests of the participant rather than the interviewer’s perspective (Green and Thorogood, 2018c); therefore, I started interviews with open questions, followed by prompts. As I developed a deeper understanding of the evolving concepts and categories, the interview guide became more refined, supported by prompts and probes, and the discussions became more specific and structured, evolving with increasing theoretical sensitivity to support theoretical sampling and conceptual development.
I used follow-up questions to clarify, explore, and understand how participants constructed meaning from their experiences. When asking potentially sensitive questions, I ensured that participants could decline to answer, thus confirming ongoing consent (see Appendix 9). An outline of actions to take was explicitly outlined in the interview guide to anticipate and prepare for the likelihood of participant distress or an emotional response (Dempsey et al., 2016). (Elmir et al., 2011; Dempsey et al., 2016).

Once I completed the interview, I thanked the participant, advised them on the next steps regarding member checking and selecting a pseudonym (if they wished), and followed this up with a thank you email. Each interview ranged from between 35 to 90 minutes in length. I retained all records per the data management plan and Open University regulations, with only anonymised transcripts retained once a pseudonym had been assigned.

### 4.12.4 Transcription of Interviews

Transcription as an element of the research is often either overlooked or ignored in terms of its influence on the theoretical development of a study and vice versa or choices not made explicit within methodological explanations (Lapadat and Lindsay, 1998). Often considered in qualitative research as an integrated, methodological process, which is an act of interpretation and representation (Lapadat, 2000; Oliver, Serovich and Mason, 2005; Bucholtz, 2007), the act of transcription should be considered alongside methodological considerations. The choice to transcribe verbatim interviews and the extent to which transcription includes what is not said is primarily dictated by the theoretical approach used by the researcher to achieve the ‘theoretical goals and definitions’ of the research (Ochs, 1979, p. 44).

Bucholtz (2007) suggests that researchers either favour transcription practices that reflect a naturalised approach to elucidate the spoken word (use of punctuation and paragraphing not present in speech) or a denaturalised (retaining pauses, filler words21, hesitations and pauses), guided by their methodological approach and epistemological standpoint. Approaches to transcription that aim to reflect objectively accurate representations and accounts of recorded interviews are situated firmly in a positivist paradigm (Lapadat and Lindsay, 1998; Lapadat, 2000). Jaffe (2007) argues that whoever performs transcription is influenced by their preconceived ideas, assumptions, and biases; therefore, they will always retain a degree of interpretation. Indeed, separate individuals can hear and interpret source audio data differently (Stelma and Cameron, 2007). Transcription, therefore, is not

---

21 Words such as ‘erm’, ‘err’ and ‘umm’
a reflection of the natural world but rather ‘theoretical constructions’ (Lapadat, 2000, p. 208), establishing a connection with the denaturised approach to transcription and, amongst other methods, constructivist grounded theory (Ochs, 1979; Lapadat and Lindsay, 1998; Charmaz, 2000). Transcripts, therefore, do not need to be undertaken by the researcher, nor, in the spirit of constructivist grounded theory, should they be shared with participants to check for accuracy (Charmaz, 2014a).

I initially planned to undertake all transcribing, believing that it was necessary to remain immersed in the data. Further advantages included reflecting on the interview technique and maintaining a reflexive approach. Once I had transcribed eight interviews, I found that the process of transcribing lent little to the analysis – as well as being hugely time-consuming. So, in consultation with supervisors (and a minor amendment to the ethical approval and data management plan), I made a pragmatic decision to engage a transcription service, ensuring familiarity with data by re-listening to the interview once the transcript was received, with corresponding memoing and journaling to support theoretical sensitivity and reflexivity; this also enabled me to correct any minor transcription errors.

### 4.12.5 Memo Writing and Field Notes

I took field notes to provide me with an observational narrative concerning setting, context and observations during the entire research process as well as interviews (tone, coherence, pace, silences, gestures, engagement, verbal and non-verbal clues, impressions) (Montgomery and Bailey, 2007; Foley and Timonen, 2015). They also provided a stepping-stone to memo construction and reflexivity. Field notes were generated as electronic and handwritten diaries and journals before, during and after interviews. I scanned handwritten field notes, added them to NVivo within reflexive and analytical memos linked to individual participants, and integrated them into the theory-building process.

Memos are considered a vital element of any grounded theory method; Glaser initially described them as ‘theoretical notes about the data and the conceptual connections between categories’ (Glaser, 1978, p. 60). Memos serve not only as a record of the developing codes, establishing and mapping connections between codes and representing a transformation from descriptive field notes making ‘theoretical leaps’ (Glaser, 1998a; Montgomery and Bailey, 2007; Birks, Chapman and Francis, 2008, p. 68). Birks and Mills (2015, p. 40) describe memos as the ‘critical lubricant of a grounded theory machine’. Memoing occurred throughout the process (Fig 6) and provided a creative means of exploration, interpretation, and (re)orientation (Corbin and Strauss, 2008; Charmaz, 2014a; Birks and Mills, 2015). I categorised each memo labelled with a date of entry and either methodological, theoretical, reflective, or analytical (Fig 10).
I created memos for individual participants and categories and an overarching project journal memo to document contemporaneous processes, decisions, thoughts, reflections, and events during the research process. Again, each entry was dated and labelled according to the memo framework. Through this process, I could document my analysis while critically engaging with my thoughts, feelings, hunches, and a-priori knowledge. To begin with, I found the memoing process daunting, trying initially to be too formal, noting that I was editing them as if writing an academic paper. As the research progressed, I became freer in my memo writing, akin often to a stream of consciousness. On one occasion, thoughts came to me as I was driving, so I found myself dictating a memo on more than one occasion. This was a crucial stage in my analysis as I discovered that memos later became analytical anchor points upon which I could track the category development process, constant comparison (Thornberg, 2012) and critical decisions throughout the study (Charmaz, 2006). Examples of memos are provided in Figures 7, 10, and 12.

![Figure 9 Example Handwritten Field Notes from Interview with Participant 2](image)
Figure 10 Memo Framework

Methodological Memo (MM)
Designed to capture methodological decision making, process and reflections.

Theoretical Memo (TM)
Designed to capture decision making and thought processes including ideas, instincts, gut feelings within the data. Also used to explore referential explanations and link to existing literature to develop emerging, concepts and categories.

Reflective Memo (RM)
Utilised to capture the process from novice researcher to grounded theorist, develop a reflective voice and expose, analyse and articulate positionality throughout the research process.

Analytical Memo (AM)
Designed to capture emerging ideas around, categories and codes, patterns, connections and recurring concepts.

Figure 11 Example of Analytical Memo in NVIVO

021222 AM
When rejecting surveillance there is often not an outright rejection of the technology, rather a movement towards arranging and controlling their own through private care or by picking what elements of the offered intervention they wished to receive. This occurred with Kali and ONE OTHER where they took control by paying privately. In all cases this is justified by the participants clearly stating that they evaluated both the intra and the intervention/surveillance held any meaning or value to them as a person and family unit but also applying their knowledge - either embodied or research to refute the need. This rejects the notion of the offered interventions and surveillance being personalised, but rather blanket applied. There was also a degree of predication - 'what if' and sequence of if they found something, the likely cascade of intervention was then a key motivator in delisting the initially offered intervention.

what is it that makes some interventions or choices acceptable to the participant and others not?
I think this whole process is about deconstructing and rebuilding reproductive identity through the short amount of time/limitation of pregnancy. This is likely why there are familial influences because that is the building blocks of identity - not wanting to be like or wanting to be like parents? Also might be why some midwives cross the line of conflict and straddle the process and find themselves 'mired in the issues'. Current system isn't in a position to recognize nor support this transition and the transition can look very different for everyone - some may be actively wishing to change their reproductive identity dependent on the groups/subcultures within which they not only subscribe but wish to be part of, but some want to hold on to their past experiences and mimic it, retaining a level of authority and this is why they become activists, want to change the system. It might also be why there is often a dissonance in HCPS - some will choose a section because that's how their experiences shape their outlook and they identify with this reproductive identity, same with rejecting all or some medical intervention. This of course is at odds with the structure of modern maternity systems whose aim is to produce a live baby at the end and a physically well mother - with value and moral judgements over what is the 'ideal pregnancy and birth outcome' at odds with individuals who are striving to carve their own reproductive identity. This might explain why IVF couples are seen as 'special' and offered intervention - but when they decline or push back, they are labeled as deviants. The individual labeling of deviancy (self) serves to align themselves with the groups that support their transition from one reproductive identity to another, hence the 'badge of honor' process, ut also acknowledges that the individual is prepared to blindly follow the structure of guidelines an process just to obtain the institutionally assigned label of the 'good mother'. The construction of the initial reproductive identity is an amalgam of external and internal influences which at the point of conception form how material expectations of pregnancy and birth at that point might be prepared and executed, regardless of planned or unplanned for conception. Professional values can plug into this and where there is dissonance because of background, some NN choices represent a means of influencing a holding onto the previous reproductive identity or developing a new one. Whilst there are elements of control where previous trauma exist, this isn't always the reason for the choices. There are variables that might influence the approach to the reproductive identity - the rapidity or extent to which deconstruction of the initial identity occurs, when the fetus becomes personified by the individual (and how at odds or not this is with the system), influences of the tribe etc. Where identity is being imposed by the

Figure 12 Example of Analytical Memo in NVIVO

27/04/22 MM

Applied for ethics amendment to use transcription service. Agreed by School - methodology chapter being written to reflect the nature of interviewing and the alignment of naturalism/denaturalism with having transcripts prepared for you.

4th May 2022 MM

Title of 'a good pregnancy and birth' changed to 'defining a good pregnancy and birth'. This is to reflect Glaser (1992) assertion that in order to focus on processes that describe occurrences with social activities, this should end with 'ing' - thus renaming whilst exploring the properties and boundaries of this means. Abandonment changed to 'Encountering Abandonment'. I initially was going to use the word 'experiencing' however this felt passive and as if the women did not respond. Merely experiencing something didn't feel right - I can't explain it at them moment - It was something done too them with little response whereas 'encountering' implied that this was a catalyst for further action. See the memo for Encountering Abandonment.

Figure 13 Example of Consecutive Methodological Memos.
4.12.6 Synthesized Member Checking

Guba and Lincoln (1985) suggest that member checking can enhance the rigour of qualitative inquiry. I used synthesised member checking as a means of theoretical sampling by eliciting further data and clarifying resonance with participants, a process strongly aligned with constructivist principles (Birt et al., 2016). Following the broad tenets of synthesised member checking (SMC) (Birt et al., 2016, p. 1806) (Fig 14) at the point of category synthesis, I offered participants the opportunity to comment on resonance, recognition of personal experience in my interpretation and any further data that they felt might be included. I integrated the returned data into the coding cycle (Harvey, 2015). This method more closely aligns with eGT techniques described by Charmaz (2008) as ‘testing’, allowing the opportunity to reflect and contribute further data (Birt et al., 2016).

I developed a synthesised member checking document (see Appendix 12) and sent it to participants who expressed an interest in undertaking this process on 7th December 2022. Participants responded via a Microsoft Forms link to three guided questions:

- Having read the synthesised summary, do you have any immediate thoughts or comments you wish to make?
- Having read the synthesised summary, does this reflect elements of your experience? Please explain your answer.
- Having read the synthesised summary, is there anything you want to add? Please explain your answer.

I allowed eight weeks for responses, sending a follow-up email at the four-week mark to remind participants to respond if they wished. Seven responses were received and integrated into the coding and theorising cycle.
Figure 144 Adapted Process for Synthesised Member Checking
Responses to the synthesised member checking overwhelmingly confirmed that the developing substantive theory had fit, grab, and relevance and that explanation of actions and behaviours resonated with participants (Glaser, 1978, 1992, 1998b).

Figure 155 Example of the Member Checking Form Accessed by Participants.
4.13 Data Analysis

Data analysis is an iterative, cyclic and highly reflexive process (Glaser, 1978; Strauss and Corbin, 1990). Data analysis was conducted concurrently with data collection concordant with the principles of cGT, informing theoretical sampling and informed by memo-writing. Strauss and Corbin (1990) suggest that the researcher must employ creative, analytical skills to succeed in the process, with cGT requiring flexibility in approach to ensure that theory remains grounded in data.

4.13.1 Initial Coding

According to Charmaz (2006), coding provides the critical connection between the generation of data and the emergence of a substantive theory. I began analysis during and immediately post-interview, where I noted reflections, impressions, observations, body language and use of verbal expression and keywords spoken by participants in a handwritten field note journal. I subsequently scanned these entries into NVivo for inclusion in the analysis. One of the aims of initial coding is to inductively generate as many ideas as possible from the initial data. I coded each interview as soon after transcription as possible using the coding feature of NVivo. NVivo allowed me to assign each participant a case classification, which further assisted in comparing across participants (see. 4.14)

I carefully coded each transcript until I could move to focused and theoretical coding. I did this by fracturing the data word by word, line by line and incident by incident (see below), extracting and assigning codes indicating potential meaning and actions within the data, articulated as gerunds22. I generated a vast number of initial codes, which was expected and encouraged by Charmaz (2014a). As analysis of each transcript progressed, more than one code could be assigned to one line and vice versa, with each line of text, compared to and contrasted with previously coded data, capturing the complex nature of meaning being assigned to the same line or text. Some codes were assigned to different lines of text that I interpreted as having the same meaning or action. This process assisted me in identifying key features within participants' accounts, especially processes, actions, feelings, events, and commonalities across accounts. I named codes to express meaning explicitly shared by participants or how I interpreted the text critically as the researcher.

22 Words ending in “ing”, verbs used as nouns. Emphasises social process, develop abstraction and sustain analysis grounded in data (Glaser, 1978; Barks and Mills, 2015)
Charmaz argues that in-vivo coding, in particular, characterises the social world in which the participant operates, especially concerning organisational and institutional settings, providing metaphorical insight crucial to this study (Charmaz, 2014a). Capturing the specific language and terms participants used uncovers participants’ understandings and assignation of meaning, described by Charmaz as ‘symbolic markers’ (Charmaz, 2014a, p. 134). Where possible, therefore, I coded using language that closely reflected the data and participants’ own words (‘in-vivo’ codes), capturing the participant’s voice as well as, in many cases, revealing the participant's viewpoint, keeping the action alive and being driven by data interaction (Strauss and Corbin, 1990; Corbin and Strauss, 2008). Charmaz (2014a) also advocates using “incident with incident” coding, which in the context of this study had the benefit of comparing similar and different non-normative choices across participants related to context and content. This also helped me identify codes that I could elevate to abstract categories and focused coding.

Once I completed the initial coding across the purposive sample, I returned to earlier transcripts to compare and contrast newer codes in later interviews. This process was lengthy and often laborious until categories were developed and refined; however, I often returned to Charmaz’s (2006) guiding principles for coding to provide reassurance to firstly trust the process and secondly not despair at the seemingly unwieldy spread of code by code and line by line processes that had fragmented the data. These principles are:

- Remain open.
- Stay close to the data.
- Keep codes simple.
- Construct shortcodes.
- Preserve actions.
- Compare data with data.
- Move quickly with data. (Ibid 2006, p. 48)

Through initial coding, particularly moving quickly through the data (as Charmaz recommends), I began to see tentative processes and gaps in the data where I could employ focused coding and theoretical sampling. Moreover, by coding the data swiftly while simultaneously memoing reflexively, I could better avoid ‘forcing’ the data and, therefore, be assured that interpretation arose from critical analysis rather than ‘pet’ coding (Glaser, 1992; Charmaz, 2006, 2014a).
4.13.2 Focussed Coding

Focussed codes provide empirical substance (Glaser, 1978) by synthesising and providing conceptual direction to the analysis, distilling and refining initial codes by identifying the most important threads and emphasising a more theoretical direction to analysis (Charmaz, 2014a). This did not preclude me from moving back to initial coding; quite the contrary, I had to go back to initial coding on several occasions to follow leads and hunches uncovered by constant comparison. Through this process, I elevated some codes, forming the basis of concepts and, latterly, categories and subcategories, later informing theoretical sampling. Moreover, through constant comparison, some codes were recategorised as I compared them to others, then collapsed, condensed, refined and focussed them to allow for richer explanatory and descriptive power of the process in question (Charmaz, 2006).

4.13.3 Constant Comparative Analysis

I used constant comparison from the beginning of the data generation process, with the explicit aim of iteratively identifying similarities and differences within and between data and making sense of data conceptually and analytically (Glaser and Strauss, 1967; Charmaz, 2006). I achieved this by comparing existing codes with new codes, incidents by incidents across interviews, between categories and with theoretical memos (Charmaz, 2006, 2014a). As the analysis progressed, going back and forth in the data, refining categories, and later helping with the integration of and sensitisation to broader theoretical literature, which assisted in the development of the substantive theory (Charmaz, 2006, 2012).

4.13.4 Integrative diagramming

During the constant comparative analysis, I started to engage with diagramming at the suggestion of my supervision team. Initially, I was sceptical of the value of diagramming; however, it soon became apparent that at this stage of the analysis process, diagramming would be a valuable method of sorting and analysing data, specifically concerning action causes and consequences. Its use in grounded theory is widely recognised (Charmaz, 2014a; Birks and Mills, 2015; Bryant and Charmaz, 2020); however, no one method is encouraged (Sal Moslehian, Tucker and Kocaturk, 2022). Indeed, I found diagramming incredibly useful when attempting to view the social processes I suspected were forming and, as Charmaz suggests, ‘check on the fit between [the] emerging theoretical framework and the empirical reality it explains’ (Charmaz, 2000, p. 516). Utilising semantic relationships for connecting concepts and categories (Spradley, 1979) further assisted in abstracting, theorising,
and developing the substantive theory while exposing further gaps in the boundaries and properties of emerging theoretical categories.

4.13.5 Theoretical Sensitivity

Theoretical sensitivity is the ability to take the concepts grounded in data and relate them to wider theoretical and conceptual models (Birks and Mills, 2015). I used theoretical memos to move from description within participants' accounts to high-level abstraction and theorisation, supported by constant comparative analysis and diagramming. Theoretical sensitivity in this study was later influenced by my clinical experience, professional curiosity, and a priori knowledge, all accounted for within memos. Moreover, using the understandings arising from the meta-ethnographic review of the literature and broader theoretical literature served as integral conceptual and theoretical sensitisers in developing advanced data analysis. Both Charmaz (2014a) and Thornberg (2012) share similar views about rejecting the traditionalist presupposition of literature being methodologically problematic. Thornburg asserts that engaging with these sources to develop theoretical sensitivity produces an ‘informed grounded theory’ moving away from Glaserian ‘received theory’ (Glaser and Strauss, 1967; Glaser, 1978; Thornberg, 2012).

4.13.6 Theoretical Coding, Saturation, and Sufficiency

Finally, in conjunction with theoretical sampling, I used theoretical coding to draw connections between the focussed codes and develop a framework with explanatory power while seeking theoretical sufficiency, higher-level abstraction, and theorisation. I grouped focussed codes, then condensed and integrated them into explanatory and conceptual categories, rendering the “familiar…unfamiliar and new” (Thomas, 1993; Birks and Mills, 2015). I could then clearly start identifying properties, boundaries and gaps within categories that needed further exploration.

Much debate exists within the grounded theory literature regarding the definition and application of theoretical saturation, related to the properties of a category being fully defined with no new data (Glaser and Strauss, 1967) and the point in coding where no new codes emerge (Birks and Mills, 2015; Urquhart, 2022). Consensus remains elusive, with many questioning whether saturation is possible at all (Braun and Clarke, 2021), criticising theoretical saturation as an artefact of positivist classical methods and, therefore, counterproductive to the principles of constructivist research regarding the subjectivity of data (Dey, 1999, 2007). Dey (2007) further argues that grounded theory is better served through the application of ‘theoretical sufficiency’ avoiding the risk of treating grounded theory methods as a ‘recipe’ to be followed (Dey, 2007; Charmaz, 2014b, p. 215). Moreover,
the potential remains for ceasing the process too early, rendering the analysis and theorisation superficial and descriptive (Glaser, 1992). Issues surrounding logistical constraints of the research process, timescales and resources suggest the need to make pragmatic decisions when the researcher judges’ theoretical sufficiency to have been reached.

Mindful of this criticism, I adopted the principles of theoretical sufficiency, making a judgement of adequacy within the properties of the theoretical categories once I yielded no further new data and the social processes described within the categories provided thick explanatory power (Dey, 2007; Charmaz, 2014c). The remaining iterative approach by analysing data supported this process, maintaining conceptual density and relationships (Charmaz, 2014c). Storyline analysis and development were also crucial in this process (see below), alongside the final iterations of diagramming, which shaped the final theory.

4.13.7 Storyline Development

Strauss and Corbin (1990, p. 116) define a storyline as the ‘conceptualisation of the story’, explained by them as ‘a descriptive narrative about the central phenomenon’. This process of abstraction from story to storyline ‘tells the story analytically’ (Strauss and Corbin, 1990, p. 120), allowing the researcher to explain the phenomenon while presenting its constituent parts coherently (Birks and Mills, 2015). Writing the storyline eventually became the basis of the emerging social processes and substantive theory in Chapters 5-9.

4.13.8 Theoretical Integration and Scaling Up the Theory

I moved on to scaling up the developing substantive theory by connecting each substantive theoretical category to subcategories based on the theoretical codes, representing action-based dimensions, properties, and connections, and weaving them into the storyline. I then expanded upon and integrated theoretical memos into the theory, supported by diagrams, until I judged theoretical sufficiency to have been reached. These subsequently formed the basis of the four theoretical categories presented in Chapters 5-9, the properties and boundaries providing the explanatory power for the social process underlying the abstracted theorisation represented within the substantive theory. The processes presented in Chapters 5-9 are non-linear; however, I have structured them in this way to guide the reader through the social and psychological processes that explain the substantive theory presented in Chapter 5 (Glaser, 2002). Diagrams are also provided to support the text and demonstrate the complexity of relationships between categories within the theoretical concepts.
4.14 Introducing the Participants

4.14.1 Participant Characteristics and Biographies

Data were drawn from interviews with fourteen participants. The following presents an overview of participants’ biographies and an overview of the non-normative choices represented across the data. Demographic data were used in the initial stage of purposive sampling (see Table 8). I collected characteristic and demographic information and provided granular data to contextualise experiences and support theoretical sampling. I initially diagrammed details of the non-normative choices (Fig 16), later collating them into a collated typology (Fig 17).

Figure 16 Diagrammed Non-Normative Choices
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Geographical location</th>
<th>Relationship status</th>
<th>Current Occupation</th>
<th>Education</th>
<th>Gravida/Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela</td>
<td>35</td>
<td>F</td>
<td>Mixed White/Chinese</td>
<td>England</td>
<td>Married</td>
<td>Midwife</td>
<td>MSc</td>
<td>G1 P1</td>
</tr>
<tr>
<td>Bella</td>
<td>38</td>
<td>F</td>
<td>Black Caribbean</td>
<td>England</td>
<td>Relationship</td>
<td>Education</td>
<td>MSc</td>
<td>G3 P2*1</td>
</tr>
<tr>
<td>Caleb</td>
<td>24</td>
<td>M</td>
<td>White British</td>
<td>England</td>
<td>Single</td>
<td>Student</td>
<td>BA</td>
<td>G1 P1</td>
</tr>
<tr>
<td>Darcie</td>
<td>32</td>
<td>F</td>
<td>Mixed Black Caribbean/White</td>
<td>England</td>
<td>Married</td>
<td>Education</td>
<td>BSc</td>
<td>G1 P1</td>
</tr>
<tr>
<td>Esnie</td>
<td>39</td>
<td>F</td>
<td>White Irish</td>
<td>England</td>
<td>Relationship</td>
<td>Birth keeper</td>
<td>BSc</td>
<td>G2 P2</td>
</tr>
<tr>
<td>Faye</td>
<td>38</td>
<td>F</td>
<td>White</td>
<td>Scotland</td>
<td>Married</td>
<td>Homemaker</td>
<td>BA</td>
<td>G4 P2</td>
</tr>
<tr>
<td>Grace</td>
<td>32</td>
<td>F</td>
<td>White Jewish</td>
<td>England</td>
<td>Married</td>
<td>Commercial Manager</td>
<td>BSc</td>
<td>G3 P2*1</td>
</tr>
<tr>
<td>Hazel</td>
<td>35</td>
<td>F</td>
<td>White British</td>
<td>England</td>
<td>Married</td>
<td>Home Maker*</td>
<td>GCSE</td>
<td>G13 P11*2</td>
</tr>
<tr>
<td>Imogen</td>
<td>32</td>
<td>F</td>
<td>White British</td>
<td>England</td>
<td>Married</td>
<td>Not employed</td>
<td>BSc</td>
<td>G1 P1</td>
</tr>
<tr>
<td>Jade</td>
<td>34</td>
<td>F</td>
<td>White British</td>
<td>England</td>
<td>Relationship</td>
<td>Public Sector</td>
<td>BSc</td>
<td>G3 P2*1</td>
</tr>
<tr>
<td>Kali</td>
<td>32</td>
<td>F</td>
<td>White British</td>
<td>Scotland</td>
<td>Married</td>
<td>Midwife</td>
<td>MSc</td>
<td>G3 P2*1</td>
</tr>
<tr>
<td>Leah</td>
<td>29</td>
<td>F</td>
<td>White Northern Irish</td>
<td>N. Ireland</td>
<td>Married</td>
<td>Not employed</td>
<td>PGCE</td>
<td>G1 P1</td>
</tr>
<tr>
<td>Matilda</td>
<td>30</td>
<td>F</td>
<td>White British</td>
<td>N. Ireland</td>
<td>Relationship</td>
<td>Agriculture</td>
<td>BTEC ND</td>
<td>G1 P1</td>
</tr>
<tr>
<td>Nellie</td>
<td>31</td>
<td>F</td>
<td>White British</td>
<td>England</td>
<td>Married</td>
<td>Midwife</td>
<td>BSc</td>
<td>G3 P1*2</td>
</tr>
</tbody>
</table>

*Table 8 Participant Demographics*
4.14.2 Participant Biographies

Angela is a 35-year-old mixed-ethnicity woman living in England. She is married, para 1, and works as a midwife in a highly complex NHS trust. Angela has a history of polycystic ovarian syndrome and anticipated fertility issues before pregnancy; however, she conceived quickly. Angela declined induction at 39 weeks but accepted repeated membrane sweeping and subsequent labour induction when it felt suitable for her. Angela experienced an epidural and 16hr Syntocinon infusion, followed by a trial of forceps, then a caesarean birth and minor postpartum haemorrhage. Angela subsequently breastfed and is planning to have more children.

Bella is a 38-year-old Black Caribbean woman living in England, working in education. She is in a relationship and is a para 2. Bellas's first child was born by unplanned caesarean birth six years after labour induction due to prolonged rupture of membranes and poor experience of receiving adequate analgesia and effective anaesthesia. Bella experienced uncompassionate sonography care following a miscarriage during the COVID-19 pandemic. In this pregnancy, Bella had a raised BMI, a predicted large fetus and polyhydramnios towards the end of pregnancy. She planned a VBAC with the option to change her mind about caesarean birth, withholding consent to induction of labour. Bella went on to have a caesarean birth.

Caleb is a 24-year-old white transgender man living in England. He is single, currently studying and a para 1. Caleb’s pregnancy was complicated by testosterone therapy, of which little evidence exists to inform care planning. Caleb had an uncomplicated pregnancy and birth in the hospital and would plan for a home birth if he were to conceive again.

Darcie is a 32-year-old mixed ethnicity (Black Caribbean/ white) living in England. She is married, works in education and is a para 1. Darcie experienced anxiety and depression and did not initially wish to have children. When Darcie conceived, she experienced increased anxiety around the pregnancy and was diagnosed with tokophobia exacerbated by a low-lying placenta that later moved. Darcie requested a planned caesarean, significantly reducing her anxiety. Darcie’s membranes spontaneously ruptured on her last day of work, and she

---

23 I have used terminology explicitly provided or preferred by the participants to describe protected characteristics including ethnicity, gender, sex etc. Where this was not available, I have utilised nationally available and professional guidelines for terminology (UK Gov., 2021; RCM, 2022c). Where information might compromise anonymity, details have been omitted.
decided with her midwives and obstetrician to have a vaginal birth with the option of a caesarean. Darcie went on to have a kiwi assisted birth.

*Esmie* is a 39-year-old white woman living in England. She is in a relationship and is a para 2. Esmie had some midwifery training before becoming a doula. Esmie has a raised BMI and has a clear idea of the choices she was to make during her pregnancy. Esmie withheld consent to various interventions across her pregnancy, including induction of labour, vaginal examinations and planned for placentophagy in the event of a post-partum haemorrhage. Esmie went on to have a home birth in water at 43 weeks of pregnancy.

*Faye* is a 38-year-old white woman living in Scotland. Faye is married, a homemaker and is para 2. Faye had previous weight loss surgery, and her first baby was born via unplanned caesarean birth. Faye wished to have a vaginal birth this time and planned for the birth to be at home. Faye was persuaded to transfer to the hospital in early labour, where she birthed her baby vaginally some 24 minutes after admission with no interventions or complications.

*Grace* is a 32-year-old white Jewish woman living in England. Grace works as a commercial manager, is married and is a para 2^1. Grace's first birth was with midwives outside of the NHS. In her third pregnancy, Grace did not wish to follow the timetables required by the NHS, so she booked late at 18 weeks and withheld consent to NHS scans, bloods, and routine weighing. Grace went on to have a home birth in water.

*Hazel* is a 35-year-old white woman living in England. Hazel is married, a homemaker and is para 11^2. Hazel experienced pre-eclampsia with pregnancy #5 and an unplanned caesarean at 32 weeks following induction of labour with pregnancy #6. 10 births were vaginal, in hospital and at home. Hazel withdrew from service elements throughout her pregnancies, not seeing obstetricians since #7. Hazel chose to have a homebirth for the last pregnancy. Hazel intends freebirth in the future.

*Imogen* is a 32-year-old white woman living in England. She is married and is a para 1. Imogen is a qualified midwife and works outside of the NHS. Imogen withheld consent for many interventions and screening for her and her baby once they were born. Imogen’s care was initially conducted outside of the NHS; however, she was compelled to return to the NHS late in pregnancy. Imogen went on to have a birth with forceps.

*Jade* is a 34-year-old white woman living in England. Jade is in a relationship, is a P2^1 and works in the public sector. Jade completed a midwifery degree before leaving to pursue a different career. Jade withheld consent to
various interventions and screening during her pregnancy and birth. Jade went on to have a vaginal birth in water at term+16 with no complications.

*Kali* is a 32-year-old white woman living in Scotland. She is married, a para 2 and a midwife educator. Kali wished to give birth at home but was considered at higher risk due to a fibroid. She withheld consent to routinely offered examinations and interventions, including anti-D and used complementary therapies and limited scans.

*Leah* is a 29-year-old white woman living in Northern Ireland. Leah is married and has worked in education but is currently not working. Leah is a para 1 and has a history of type 1 diabetes. Leah considered herself very healthy, an expert in her medical condition and planned meticulously for the pregnancy. She chose to have a home birth. Leah had an uncomplicated pregnancy, agreeing to growth scans and began labour at home spontaneously supported by a doula; however, she developed ketones, and progress had slowed, so she transferred to the hospital. Leah asked repeatedly for a caesarean; however, she went on to have a birth by instruments.

*Matilda* is a 30-year-old white woman living in Northern Ireland. She is in a relationship, works in agriculture and is a para 1. Matilda planned a pregnancy with homebirth and eventually intended little to no contact with formal maternity services, withholding consent to antenatal care and screening and opting for freebirth. Matilda experienced long latent labour at 44 weeks and volunteered to come to the hospital to be examined to exclude any malposition with the choice to proceed to caesarean birth rather than accept augmentation. Matilda had analgesia withheld until she consented to a vaginal examination. A caesarean was initially withheld; however, Matilda eventually went on to have a caesarean birth, subsequently withholding consent to postnatal support and neonatal screening.

*Nellie* is a 31-year-old white woman living in England. She is married, works as a midwife and is a para 1. Nellie requested a planned caesarean birth, which was facilitated outside her workplace.
4.14.3 Participant Choice Typology

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
<th>Trans</th>
<th>Gay</th>
<th>Lesbian</th>
<th>Asexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 17: Typology of Non-Normative Choices Represented in Data
4.15 Conclusion

This chapter has presented the rationale for selecting constructivist grounded theory as an appropriate methodology to answer the research question, address its aims and objectives and the methods used to generate and analyse data. I have discussed the methods used to generate and analyse data, providing a detailed account and audit trail of data generation and analysis methods congruent with the method, demonstrating how I constructed the substantive theory and explaining the social processes supporting it.

The following five chapters present in full the overall findings of this study, examining why and how women construct their decisions to make non-normative choices and the underlying social processes that motivate and drive them. The next chapter begins by explaining the abstracted substantive theory, supported by its theoretical model. The subsequent four chapters present the social processes representing categories arising from the data, supported by conceptual diagrams contributing to the substantive theory's conceptualisation.
Chapter 5  The Substantive Theory

5.1 Introduction

The following five chapters present the overall findings of this study, examining why and how women construct their decisions to make non-normative choices and the underlying social processes that motivate them. The objective of this study was to generate an explanatory substantive theory about how women construct their decision to make a non-normative care choice and, in so doing, explain those underlying processes.

The result of a constructivist grounded theory (cGT) is rarely a formal theory or single core category or concept but rather a narrative presented by the researcher, encompassing categories and concepts, symbolising an abstracted theoretical interpretation of processes situated in the social and temporal context, reflecting the 'viewer as well as the viewed' (Hallberg, 2006, p. 143; Charmaz, 2014a, p. 522). Formal theories aim to be widely generalisable; however, consistent with middle-range theories24 (including substantive theories within cGT), the following substantive theory focuses on a discrete examination of a phenomenon with limited overall generalisability25 (Polit and Beck, 2017) but offering theoretical transferability consistent with the cGT method.

The structure of the next five chapters is guided by Glaser (1978), who proposed:

‘To set out the general nature of the core variable and then funnel it down to a theory on a specific process and problem that is associated with one property’. (Ibid 1978, p. 131)

Consistent with this approach, this chapter begins the presentation of the study findings by introducing the explanatory substantive theory supported by a diagrammatic representation as a theoretical model. The subsequent four chapters will present the processes observed within the data, which were developed into theoretical concepts, offering insight into the experiences of the phenomena in question.

24 See Chapter 4, page 50 footnote
25 Not to be confused with transferability.
For clarity and brevity, I use the term ‘healthcare professional’ about midwives, obstetricians, general practitioners (GP), sonographers and other employees unless the participant or context necessitates role specification. The ‘system’ is adopted here as a descriptor for the broader collection of general elements and processes inherent in health and social care organisations, established around a common purpose: maternity care, including but not limited to the National Health Service (NHS) 26. The term ‘institution’ describes bounded organisations that enact the system as local maternity care providers (Trusts, Health Boards and their employees) and the clinical microsystems through which the participants navigate their pregnancies identified in their accounts (NHSIII, 2005)27.

26 National Health Service (NHS) to refers to the overall publicly funded healthcare organisation responsible for providing amongst other services, maternity care in the four countries of the United Kingdom. Delivery of services and oversight in each country is provided by NHS England, NHS Scotland, NHS Cymru/Wales and Health and Social Care Northern Ireland (HSC NI).

27 See also Chapter.10 p.252, footnote.
5.2 The Substantive Theory

Theory of Reproductive Identity Expression, Reinforcement and Defence

This substantive theory is predicated on the notion that every individual enters their pregnancy and childbearing journey with a unique and subjective reproductive identity. Reproductive identity is dynamically constructed through unique biopsychosocial-cultural influences and reproductive experience, evolving in response to extrinsic and intrinsic macro and micro influences. Expectations for pregnancy and birth linked to reproductive identity are also determined by complex factors, including pregnancy intention, anticipated and unanticipated events during the transitional period pregnancy represents, other reproductive experiences, beliefs, philosophies, and plans for the pregnancy and birth, the extent to which the anticipated change is under the control of the individual or by external sources, processes, and macro structures such as the institution and the acts or omissions of its agents. The degree to which the individual perceives pregnancy and childbirth as a significant life change representing a transition between life stages is also influential. Reproductive identity, therefore, informs a unique individualised normativity, providing a personal lens through which choices are made.

Conception and pregnancy delineate the symbolic liminal threshold of identity transformation and rite of passage through pregnancy, birth, and motherhood. Marked formally by engagement with maternity healthcare services (including non-NHS and independent services), women enter two corresponding and concurrent social processes, one reflecting the journey through and experience of the broader structural systems of contemporary maternity care and the other reflecting the embodied experience of pregnancy and strategies employed for navigating and negotiating those structures and processes. For those whose non-normative choice is to not formally engage with maternity healthcare services, simply becoming known to services while remaining outside of them represents a figurative and paradoxical entry into it, thus exposing some women to systemic structures and processes that have the potential for varying intensities of actions and behaviours intended to influence compliance.

Pregnancy exposes individuals to societal, cultural, and institutional norms and processes which may not align with beliefs, philosophies, and expectations associated with unique psychosocial-cultural and reproductive identities. Such processes and norms present challenges and threats to individual reproductive identity, frequently prompted by institutional systems for risk-based categorisation, classification, and depersonalisation. Such systems can represent a discordance between unique personal beliefs, philosophies, and expectations and the
institutionally perceived risk to the maternal-fetal dyad, regardless of evidence to support the perception. Moreover, at a time unique to the individual and their circumstances, a change in emphasis from woman-centred to fetus-centred care occurs (fetal centring), frequently linked to the timing of routinely offered fetal screening and surveillance technologies. The non-normative choice can be the desired outcome (complex homebirth, planned caesarean birth) or used to achieve a desired outcome (declining elements of care).

There follows a misalignment of opposing expectations between the woman and the system, which outwardly asserts aspirations for choice, personalisation, and woman-centred care while simultaneously imposing standardised approaches to bio-medicalised care which include risk-centred categorisation, classification, and depersonalisation. This is highly characteristic of the area of conflict within which identity threat is experienced. An inference of passivity in the role of the patient, including expected compliance with recommendations and interventions within the institution, reinforces assumptions of authority associated with biomedical knowledge and power. Such expectations reinforce largely unspoken but powerful societal and institutional expectations, implying heightened moral responsibilities on the part of the woman towards her fetus at the expense of embodied knowledge and actions taken to protect and assert reproductive identity. Moreover, erroneous assumptions by healthcare professionals of moral and legal responsibilities towards the fetus and their resultant fear of reprisals in the event of a poor outcome position women at odds with the system and potentially their fetus, restricting choice and representing a threat to reproductive identity.

Despite this apparent diametrically opposed positioning of woman versus fetus-centred care, women rarely make non-normative choices that knowingly risk detrimental outcomes to either party, negating any suggestion that choices are made at the expense of fetal wellbeing. Quite conversely, women are highly motivated to protect the developing fetus but not at the expense of protecting and preserving agency, autonomy, and self-determination where, this was a salient feature of reproductive identity. Women, therefore, sometimes exist in a state of flux and vulnerability, balancing the preservation and expression of reproductive identity with that of the safety of the maternal-fetal dyad.

A response to reproductive identity threat is engagement and enactment of actions and strategies aiming to preserve agency, control and self-determination aligned with personal philosophy, values, and beliefs, drawing upon knowledge gained from external sources (e.g., support groups, publications, journals, and social media), and internal sources (e.g., embodied knowledge, maternal-fetal knowing, previous reproductive experiences). Such
strategies and actions are also influenced by a complex network of barriers (e.g., inflexible guidelines) and facilitators (e.g., facilitative, and supportive healthcare professionals) unique to the specific system setting and those within it. Actions and strategies are evaluated and enacted through making non-normative choices intended to express, reinforce, or defend reproductive identities and, for some, other closely interconnected psychosocial-cultural identities (e.g., professional) in tandem. The choices women make may reflect attempts to resolve feelings towards previous poor reproductive experiences that challenged reproductive identity or attempts to replicate positive reproductive experiences that developed or reinforced their current reproductive identities. In both cases, women anticipate and predict the likelihood and degree to which subsequent non-normative choices might influence future reproductive identity.

Strategies to inform, support and consolidate choices include information-seeking behaviours, including engagement with valued and trusted communities of allies. Communities in this regard might be formal or informal, groups or individuals, within and outwith the system and have their own established set of inter-community norms. Communities provide guidance, legitimation, and suggestions to reinforce and develop group norms while providing passive and active support. This strategy involves women comparing and contrasting information and support offered from within the system against that provided by the communities they belong to to assess legitimacy and credibility. Women also draw upon knowledge and experience from non-reproductive identities and embodied understanding of the current pregnancy. Decisions and choices were frequently modified in light of valued new information, support from communities or through independent research. Rarely were decisions and choices modified in the presence of coercion from healthcare professionals unless avenues for making the choice were exhausted.

Women view their choices as uniquely normative within their sociocultural and reproductive context – unique normativity. The institution and system, however, consider these choices non-normative as they transgress expectations of compliance and imbalance assumptions of power as described previously. Even if women acknowledge choices as non-normative, women rarely position themselves as deviant or transgressive in a negative context but instead, uphold such labels and choices as a positive reinforcement of unique reproductive identity that the choice represents and confirmation of a system unresponsive to authentic choices that do not fit narrow parameters of institutional acceptability. As a result, women are exposed to escalating scrutiny and ensuant
intensification of both formal and informal processes, attitudes, actions, and behaviours intended to influence choices.

Behaviours and actions exhibited by the system include threats, bargaining, ‘shroud waving’, bullying, coercive discussions, punishment, and abandonment. However, these actions are moderated by factors including, but not limited to:

a) The institutional acceptability of the non-normative choice,
b) The institutional memory\textsuperscript{28} of similar choices,
c) The extent to which the choices represent an actual or perceived threat to maternal-fetal physical wellbeing,
d) Medicolegal equilibrium,
e) The existence of facilitative healthcare professionals within the system and the structures and processes in place to support both non-normative choices and healthcare professionals to facilitate them.

Single, discrete, non-normative choices are not usually observed. They are preceded or followed by consecutive non-normative choices increasing in magnitude, depending on the degree of positive support for the initial non-normative choice within the system. Where women experienced facilitative care early in their initial non-normative choice, the less they felt the need to escalate their choices (in number or magnitude) to resolve reproductive identity conflict. The endpoint of non-facilitative care and thus escalating number and magnitude of non-normative choices usually was complete or partial withdrawal from the system, ‘quitting’. Quitting is also seen as a primary strategy in response to historical, embodied, and intergenerational experiences to avoid entry into the system. Strategies employed by women for reproductive identity expression, reinforcement, and defence, supporting this theory, are summarised in the QuEEN model (see Chapter 10, Fig 23).

\textsuperscript{28} Definitions vary of the term ‘institutional memory’, sometimes used synonymously with ‘organisational memory’. Corbett \textit{et al.}, (2018) conceptualise the term drawing upon he work of Linde (2008) and Pollitt (2000, 2008, 2009) as dynamic “‘representations of the past’ that actors draw on to narrate what has been learned when developing and implementing policy...embedded in processes, they become institutionalised” (Corbett \textit{et al.}, 2018, p. 5). In the context of this study, institutional memory uses this definition in relation to similar non-normative choices or outcomes that the institution wishes to avoid having happened previously within the organisation.
Post-pregnancy and birth, reproductive identity is passively and actively reconstructed contingent on temporal factors. Women assume, tacitly or otherwise, a modified, reconstructed reproductive identity, illustrating the cyclical nature of the theoretical model (Error! Reference source not found.). Characteristic of this process is the evaluation of factors, including the degree to which actions and strategies were successful, whether interactions within the system were perceived as negative or positive, and the degree to which achieving or not the non-normative choice influenced the outcome. Significantly, the extent to which a non-normative choice was facilitated, even if the salient or predominant choice was not realised, is an important moderator in how the episode of care was perceived, including being viewed in a negative or positive light, traumatic or empowering. This influences the subsequent reconstruction of reproductive identity and future childbearing intentions. Adjustment to and finally consolidation of a newly constructed reproductive identity over time involves conscious or reluctant engagement with communities within which support was initially sought during the episode of care, becoming part of that community through activism and advocacy while reinforcing community norms as a dominant discourse, thus reinforcing and disseminating learned strategies and sharing experiences to cope with identity challenge and conflict.
Figure 18 Substantive Theory Model
5.3 Conclusion

The preceding chapter has introduced the substantive Theory of Reproductive Identity Expression, Preservation and Defence.

The following four chapters present the four theoretical concepts arising out of the analysis process and representing the social and psychological processes within the context of the studied phenomenon: ‘Constructing Reproductive identity’, ‘Entering the System’, ‘Navigating the System’ and ‘Reconstructing Reproductive Identity’. Diagrams are used across all chapters to assist in explaining complex relationships between the categories therein, demonstrating relationships between concepts, processes, actions, and interactions grounded in the data and within the studied phenomenon (Birks and Mills, 2015; Strauss and Corbin, 2015). Where it has been necessary to provide contextual information, this is referenced in footnotes, a technique advised by Glaser (1978) to avoid detracting from or taking precedence over the substantive theory processes.
Chapter 6 Constructing Reproductive Identity

6.1 Introduction

In this chapter, I introduce the first analytical concept, ‘Constructing Reproductive Identity’. This chapter represents the initial contextual foundation of antecedent conditions that begin to address the aim of the study, examining and explaining why and how women construct their decisions to make non-normative choices. I describe how an individual’s unique and subjective reproductive identity is (re)constructed through sociocultural, historical, and intergenerational influences, understandings, conceptualisations, and beliefs around childbearing.

I explain how reproductive identity and unique normativity offer a lens through which women approach their expectations for childbearing, influencing the extent to which childbirth is viewed as a rite of passage and subsequently informing and guiding decision-making, motivating non-normative choices, and influencing reproductive identity. I present how the pregnancy represents a symbolic crossing of a liminal threshold, representing a phase of separation from previous identity (Van Gennep, 1960; Turner, 1967), into two parallel social and psychological processes explored in the two subsequent chapters and how by doing so and encountering the system, this might represent a threat to reproductive identity established in this chapter.
6.2 Experiencing Normative Expectations of Childbearing

Sociocultural influences refer to characteristic environmental factors influencing the construction of reproductive identity and expectations of conception, pregnancy, and birth, including but not limited to ethnicity, education, gender, sex, economic status, cultural traditions, social values, and class. While family can arguably be included within this definition, intergenerational and family influences formed a discrete analytical category.

Participants described how perceived expectations of their role within families and their wider social circle to conceive and produce children as part of their life course affected their identity and the challenges, they anticipated in rejecting or negotiating this interaction. Angela reflected that while such expectations exist for women, their social roles have changed over time, meaning that pregnancy timing is more varied:

‘The lives of women are becoming so diverse and varied now, it’s not like you will be pregnant with all of your peers at the same time, at the end of school [...] it’s beneficial for society, for us to lead more varied lives outside of childbirth and our reproductive function’ (Angela)

Many openly rejected normative roles and stereotypes of pregnancy, femininity, and womanhood, considering pregnancy and parenthood a low life priority compared to other planned life course activities. Before the pregnancy, some participants described their reproductive identity in the context of placing little value on or desire to become pregnant or by believing through infertility or pregnancy loss that pregnancy and birth were unlikely to be realised, resulting in being unable or unwilling to visualise themselves inhabiting this role. It was notable, however, that some participants experienced external pressure towards married and parental relationships to conceive, reflecting normative expectations of childbearing:

‘We’d been married two years [...] and we were getting a lot of questions, mostly from my husband’s side of the family, lots of people asking when we were going to start trying’ (Angela)

Some participants never intended to conceive and start a family, having reached a mutual understanding with partners that this was not their chosen life course. Darcie illustrates this, having always publicly expressed her wish to remain child-free. Later in her marriage, she started to reconsider, although she could not ‘put my finger on’ why this was the case:
‘... I never wanted kids, [...] never saw myself as a maternal person, I had my dogs, I had my cat, and that was enough for me’ (Darcie)

Conception was negotiated by outwardly displaying a performative ambivalence towards planned conception while behind the scenes doing nothing to prevent it (including ceasing to take contraception), thereby employing a strategy of leaving conception to ‘fate’:

‘We decided that I would come off the pill, and we would see what happened. If it happened, it happened if it didn’t, it didn’t. And we were OK with that’ (Darcie)

Following conception, she engaged a strategy to not share news of the pregnancy for fear of encountering judgement from existing social groups, having previously expressed the wish to remain child-free:

‘I was quite nervous about telling a lot of people, I didn’t announce my pregnancy on social media or anything like that because I didn’t want to have, a few people I had to have the conversation with were like “well you don’t want kids, why are you pregnant?” and I found it quite hard to have those conversations’ (Darcie)

The purpose of strategies concerning reproductive identity may be to ‘save face’ within social groups (with whom participants share similar values, beliefs, and attitudes) and cope with any threats to an individual’s reproductive and other identities. Experience of pregnancy and birth in this context challenges women’s constructed sense of identity, creating dissonance and challenge.

Like Darcie, an essential moderator in displaying conformity to social norms and expectations around pregnancy appeared to be related to the timing of conception in relation to marriage. For instance, Esmie reflected upon internalised normative expectations for pregnancy timing:

‘[with first child] I think it was, you know, married ...next step is having a baby, you know maybe a month or two checking whether I was pregnant and then finally you know pregnant’ (Esmie)

---

29 The concept of face saving is discussed in more detail in Chapter 10.
Sociocultural expectations influenced - but did not necessarily define - what participants considered a good pregnancy.

‘When the mother feels in control, when she feels calm when she feels explained to and understood’
(Darcie)

Many participants expressed overtly the position that pregnancy and birth hold the symbolic significance of varying degrees, reflecting a ‘rite of passage’ (Faye), a ‘normal life event’ (Angela) or ‘everyday event’ (Imogen), implying both an expectation of normativity within a woman’s life course and physiological ability to ‘perform’ conception and childbirth:

‘For me, pregnancy is just a normal life event that lots of women and birthing people [...] very normal physiological event [...] childbirth is bringing a human being into this world’ (Angela)

Notably, the philosophical standpoint of childbirth being a normal, physiological life event is meaningful, particularly concerning participants like Angela, who worked as a midwife. Historically, midwifery as a professional identity aligns itself with the social and salutogenic model of childbearing (see Glossary and Key Definitions) encompassing such philosophical beliefs and, therefore, was noted to be a salient consideration in the construction of reproductive identity in most of these participants.

There was significant variation in participant definition of a good pregnancy and outcome, suggesting an establishment of individualised normativity closely related to their situations, rejecting sociocultural normativity and expectations in favour of intentions more closely aligned with their unique reproductive identity. Mode and location of birth, while presented by some participants as a critical consideration, was not centred on achieving a vaginal birth alone\(^{30}\), as Angela suggests:

---

\(^{30}\) In their analysis, Brown and Mulligan (2023) posit that ethically, caesarean section in the absence of medical indication should go further than being merely supported upon request. The standardised offer of a planned caesarean section as a reasonable medical alternative should feature in all supported decision-making concerning the mode of birth, rather than the apparent default assumption of a preference for vaginal birth.
‘Caesarean should be part of the narratives around labour in a way that they aren't [...] gave birth naturally31 via caesarean, and I think that's really important to say’ (Angela)

Like Darcie’s definition (above), Grace recognises that the choice of mode and place of birth are important considerations insofar as they are linked to feelings of control over experience, suggesting that:

‘Elective caesarean and home birth are the same two sides of the same coin: you're both taking control of your birth experience’ (Grace)

The extent and content of sociocultural childbearing representations exposed to participants compellingly influenced how participants constructed their normative expectations of pregnancy and birth, thus informing their reproductive identity. Sources cited by participants included the presence and absence of representations within family, social circles, cultural and religious communities, and the education system: ‘We don't have very good education about pregnancy in this country [...] women will come across these questions for the first time when they are pregnant because we don't talk about it in school [...] I do think something is lost in women's education and curiosity about pregnancy[...] before it's physically actually happening to them’. (Angela)

A few participants professed no preconceived expectations or knowledge of childbearing:

‘I got pregnant without knowing anything about pregnancy or birth’ (Matilda).

‘I'd never really...learned anything, or seen anything? [...] I can't even recall it at school or anything like that’ (Hazel)

31 The use of the term ‘normal’ and ‘natural’ in relation to mode of birth has become contentious, problematic and continues to be argued within maternity and wider forums. The term is usually understood to mean a low-risk physiological pregnancy and vaginal birth in the absence of intervention, a definition that is mirrored both internationally and nationally (World Health Organization, 1996). While the wider debate around the use of the term in this context is outside the scope of this thesis, it is important that Angela illustrated that many women view a caesarean birth as ‘normal’ within their own context. Work by the Royal College of Midwives (2022c) has sought to address appropriate terminology within maternity care and their recommendations are used throughout this thesis.
Noteworthy were various media sources featuring in accounts of constructing reproductive identity construction. Participants were aware of sociocultural norms and expectations represented in the media shaped their expectations of childbearing.32

‘[I] always found it really interesting to watch on telly [...] one born every minute and I [...] but there is no home birth on that programme, so I wouldn’t have seen that’ (Esmie)

‘a random YouTuber mentioned in one of her videos that because she had had a section with her first child, she now had to fight her doctor for her right for a vaginal birth and I was fascinated by it’ (Faye)Participants expressed how media representations of birth present sanitised renderings of pregnancy and childbirth, perpetuating restrictive, unrealistic normative boundaries. Leah, for example, explains:

‘I’ve seen so many accounts on Instagram where their posts, their pictures, different things have been censored or taken by Instagram because it’s not deemed as appropriate’ (Leah)

Therefore, there exists a dualistic paradox that the messy business of pregnancy and childbirth is expected to remain a largely hidden and private phenomenon while simultaneously rendering women open to socially acceptable public scrutiny; as Bella suggests, ‘being pregnant was such a public thing’ (Bella). Where participants did not see themselves in general representations of pregnancy, or if their choices went against socially normative

32 It has been previously observed that for many women, exposure to representations of childbearing are limited to that presented in the media (Sears and Godderis, 2011). Luce et al., (2016) suggest that television portrayal of childbirth (e.g. Call the Midwife, Life and Birth, This is Going to Hurt), supported by news media is used by women to assimilate childbirth knowledge, despite evidence of it being robustly edited, guided largely by opinion and editorials which, if engaged with uncritically, provides distorted representation of the physiology of childbirth, perpetuate dominant social ideological and hegemonic models of childbearing, present misleading templates of how one should behave in their pregnancy or birth and expectation of conformity to institutional and societal norms. The influence of digital and social media on perceptions of pregnancy and decision making overall falls outside the scope of this study but remains an ongoing field of enquiry (Luce et al., 2016; Tizard and Pezaro, 2019; Wright, Matthai and Meyer, 2019; Smith et al., 2020). As a clinical midwife I have observed this at first hand. The change in how women behaved during labour following the initial 2010 broadcast of One Born Every Minute was notable and remarked upon anecdotally by colleagues across the country.
expectations, this manifested in feelings of being othered. Caleb’s experience as a transgender man illustrates the absence of diversity in broader childbearing representation, as were accounts from participants who lived with illness (e.g. celiac disease, diabetes) and women with a raised body mass index.

This is most significant in the context of reproductive identity, reflecting a misalignment between imposed sociocultural norms and expectations and a perceived or actual threat to identity, laying the foundation for non-normative choices as a response.

### 6.3 Embodied Reproductive Influences

Embodied reproductive influences on reproductive identity are conceptualised as the result of prior experiences of reproductive health, conception, and pregnancy, including but not limited to experiences of contraception, assisted or spontaneous conception, termination, miscarriage, stillbirth, and live birth. All participants had experienced at least one of these elements, which influenced their reproductive identity.

Returning to participant conceptualisations of a good pregnancy and birth, not all participants had preconceived ideas of what this should be; however, for those who did, it was evident that this commonly arose from their own historical childbearing experiences. Rarely did participants’ definitions revolve around physical outcomes or choices, for example, mode or location of birth, but instead remained more abstract, related to experiences, anticipated or actual relationships with healthcare professionals, and whether their choices were validated:

> ‘When the mother feels in control, when she feels calm when she feels explained to and understood. Because they, they spoke to me in such a way that I felt so informed about what was happening, what could happen, what my options were, and they totally understood why I made the choices I made’

(Darcie).

I use the term ‘validated’ here deliberately because, for some participants, previously achieving the choices they had made did not reflect how they subsequently evaluated their birth as a positive or negative experience:

---

33 The process of marking an individual as different from the dominant social group, sometimes through stereotyping. Has the effect of stigmatising, and isolation and is related to power discourse and identity formation (Jensen, 2011; Mills, Durepos and Wiebe, 2023).
'It wasn’t what I had planned, but when I was actually in it when I was actually there, it was a really good birth. And, and I feel very lucky to have had that because some of the stories I’ve heard were horrible.’ (Darcie)

Some participants used accounts of past pregnancies to establish a framework within which they defined a normal pregnancy, as Leah reflects:

‘I had a very, just norm […] well what’s a normal pregnancy? Very uncomplicated. Not a single complication the whole time […] what women are built to do’ (Leah).

Angela described how she did all she could to ‘set myself up for a really good pregnancy’, subsequently offering a personal definition:

‘[…] ease and normality […] unremarkable, in the sense that nothing really went wrong at all’(Angela)

Several participants talked of their experiences of pregnancy loss. Bella experienced a miscarriage during the first COVID-19 lockdown and, seeking support by speaking publicly about her loss, felt that while miscarriage is a common occurrence34, it remains a ‘hidden narrative’ (Bella). She felt strongly that pregnancy loss is a valid part of any reproductive history. As such, this began the basis of her becoming a birth ‘activist’ before conceiving again, and this informed her reproductive identity:

‘I produced this diagram, which was all of the people who in my life who I found out had had miscarriages, and it was like…70 people, 70 miscarriages …and I just was like…if this not part of the story of pregnancy and childbirth, and it happens a quarter of the times…if no one ever tells you that they have them, then you just don’t think that they happen’ (Bella)

34 Pregnancy loss up to 23+6 weeks gestation. Statistics support how common miscarriage is in the UK. In the years 2021-22, 33,352 women (5.8/1000) were admitted for medical attention for miscarriage in England (NHS Digital, 2022). This accounts only for those women requiring treatment with true numbers likely to be significantly higher, the charity Tommy’s (2023) estimating 250,000 miscarriages each year or 1 in every 5 pregnancies overall. 1 in 100 women experience 3 or more consecutive miscarriages.
This also explains how she felt with the anxiety of being pregnant again after the loss presented an ‘illusion of certainty’ (Bella). Nellie explained how, as a midwife, after experiencing a miscarriage, this informed her reproductive identity and non-normative choice:

‘I never really thought that’d be part of my pregnancy journey or, yeah, my identity’ (Nellie)

6.4 Professional Influences

The role that professional status played in constructing participant reproductive identity and vice versa was observed within accounts, appearing to influence the nature, extent, and strategy for making the non-normative choice. Darcie presented her identity as a teacher as among the justifications for her choice of a primigravidae planned caesarean birth:

‘As a person I'm very organised. I'm a teacher I like things done a certain way how they're done, I like to know when things are happening. My diary is meticulous [laughs] and part of having a planned C-section took a lot of the anxiety out of it for me because not knowing when it was gonna happen’ (Darcie)

For those working as midwives and doulas, in particular, their professional identity appeared to contribute to a strong sense of identity overall, informing their reproductive identity and how they approached their pregnancies. Participants recognised and drew upon their midwifery or doula education, primarily (but not consistently) within the biopsychosocial and salutogenic model of childbearing:

‘I think it’s probably tied to my identity as a midwife [...] I think it’s related with my philosophy as a midwife that everything is normal until proven otherwise. Not the other way round.’ (Kali)

Participants who had undergone midwifery training recognised that they could use their knowledge to support making non-normative choices and advocating for themselves where others couldn’t or, indeed, wouldn’t:

‘I think for me it was probably quite paramount that I did have that midwifery training that I felt confident and knowledgeable enough to challenge or dismiss it, you know. With the doctor for example’ (Jade)

Some participants in this cohort acknowledged a privileged ‘insider status’ that allowed them to apply their knowledge to manage their pregnancy journey, predicting and planning for potential confrontation when
negotiating the challenges of making non-normative choices in technocratic and institutional models of childbearing. This sometimes meant choosing their healthcare professionals and location of care:

‘I chose her as my midwife [...] I kind of wanted to surround myself with a team and again I’m talking from a place of huge privilege, I know that people don’t get to pick their teams and even if they did, they might not necessarily know who those people are, it’s because I have kind of this internal knowledge of who they are as practitioners [...]’ (Angela)

Imogen operationalised her insider status to inform her choices. It is notable that her account suggests a rejection of institutional normative behaviours within her previous workplace in favour of supporting choice and that this subsequently featured in her own non-normative choices:

‘[...] (I) worked at an extremely high-risk unit [...] it was very cliquey and there was a lot of bullying [...] there were some things that were not allowed to decline. You were not allowed to decline vitamin K [...] this was just not heard of. You were not allowed to decline if you’re being induced or having an epidural or anything like that [...] That really ground against my own personal values [...] This is wrong, this is not midwifery, this is nursing and so that really informed my own choices about my own birth [...]’ (Imogen)

Nellie considered her insider status and professional knowledge as burdensome, but it informed the construction of her reproductive identity and non-normative choice of a planned caesarean birth. Nellie had already experienced two early miscarriages and was working as a bereavement midwife; she went on to suggest:

‘My view of birth [...] was a bit obscured from a normal pregnant birthing person [...] things that I was exposed to were probably not the norm [...] I did end up requesting to have a C-section for maternal request, mainly due to my anxiety and things just around [...] delivery’ (Nellie).

It is interesting to note Nellie’s use of the label ‘normal birthing person’ in how she described her own experiences, potentially indicating again the hidden nature of discourses outside those discussed above, pregnancy loss forming another intrinsic element of reproductive identity construction, remaining largely taboo and secret.

As previously discussed, participants expressed that childbearing is a largely hidden phenomenon moderated by narrowly constrained representations of childbearing in the absence of broader familial experiences. Participants
whose first exposure to pregnancy and birth was their own professional experience explained that their frame of
reference and thus influence on reproductive identity relied on professional experiences and training, informing
later their non-normative choices:

...I didn’t really know much about midwifery maternity before I did my midwifery training because I had
no family experience. There’s, we’ve not got any young children in the family at all. So, I started my
midwifery training, and it was a massive eye opener really, in so many ways.... I’d never really been
around pregnant women. So yeah, that is kind of what I meant and then yeah. I suppose my midwifery
ethos is very much natural holistic things...(Jade)

The apparent role salience in this group appeared to represent both a central source of conflict and a facilitator for
asserting non-normative choices. For example, Kali reflected on how their professional status was privileged by
other healthcare professionals over her embodied knowledge:

‘...I didn’t really understand...how some certain levels of my life experience as a woman was not
considered highly, but my expertise and experience as a midwife put me in a different empowered
relationship with healthcare. I could have that equal relationship because I was an equal. I wasn’t just
a woman; I was an equal. So, they were looking at the midwife not at the woman […]’ (Kali)

This led to an experience of acute dissonance and identity conflict when the embodied experience of pregnancy
and birth did not transpire in the way participants expected according to their reproductive identity, especially
when they considered their bodies pathologised:

‘I was living it... and I was getting frustrated because I was seeing that in the literature. I was seeing all
of these really poor outcomes and poor experiences, you know, in these kind of appointments and then I
was living it myself and I ended up having such cognitive dissonance afterwards because I was just like,
I’m not sure that I actually believe in my work anymore’ (Angela)

It was clear for birth workers, particularly, that professional identity played a role in reproductive identity
construction and influenced non-normative choices.
6.5 Intergenerational Influences

Intergenerational and family experiences of pregnancy and childbirth were an integral frame of reference for constructing values and beliefs about motherhood, pregnancy, and childbirth. The extent to which participants were exposed to the process of childbearing and outcomes within their immediate and extended family also appeared to influence reproductive identity, shaping personal understandings of intergenerational norms, thus driving non-normative choices in similar but sometimes different circumstances. Without wider societal discourses and representations of childbearing, this can potentially represent a deceptively narrow context within which experiences informing reproductive identity and choices are made. Angela supports this perception by suggesting that having to draw upon immediate familial and intergenerational understandings of childbearing was reflective of ‘women’s lives being really invisible’ within the context of communities and society:

‘…we live like more isolated nuclear lives now. We don't live in a community of women growing up, kind of, with childbirth and pregnancy being normalised and women's lives, and that has its downsides…’

(Angela)

Intergenerational understandings and influences extend to the mode and location of birth, thereby establishing normative expectations for participants and contributing to their expectations of the reproductive journey. A familial history of or preference for a particular mode of birth or pregnancy-related phenomena (i.e., caesarean birth, homebirth, and breastfeeding) provides a normative framework within which participants construct their expectations, values and beliefs around their reproductive identity.

Grace explained that she had been ‘really anti home birth, anti-natural’, having been influenced by (a now discredited) American obstetrician on social media, so she ‘always thought I would have a caesarean section’ and Esmie, before her pregnancy, had a long-established interest in pregnancy and childbirth:

‘Probably the period from age ten onwards [...] women are amazing and look at these babies you know, loved playing babies and mums and doctors and nurses and all that sort of stuff…anything to do with babies’ (Esmie)

She had observed pregnancies in aunts, and friends. When her sister-in-law became pregnant, she sought to develop her understanding of pregnancy by exploring how her body was changing and how she was experiencing
her pregnancy. Esmie identified similarities between her sister-in-law and her own body concerning high BMI and therefore described her sister-in-law as representing:

‘Like the prototype for, you know, the test run for what it would be like for me’ (Esmie)

Graces account illustrates how her interest in reproduction meant she also actively sought information from her mother relating to pregnancy and that this likely influenced her own reproductive identity:

‘Ever since I was a little girl, I was always asking my mum, how was I born? What was it like? I guess it was kind of in as it was sort of in my background as part of my long term, like interest in reproduction basically’ (Grace)

Intergenerational understandings were sought and valued in reproductive identity construction regardless of how removed from or dissimilar family members were to their own reproductive identity:

‘My cousin had had her two babies. So, I’d seen her when she was pregnant. I know that she was really sick, like she was she lost weight in one of her pregnancies. So, I kind of thought that I would end up being like that, but I didn’t really have much sickness ’ (Caleb)

Using family and intergenerational reference points to develop values and beliefs related to one’s own reproductive identity extended beyond incorporating intentions for pregnancy and birth but also to construct a personal normative framework related to their context. Caleb illustrated this as a reason for his expectation to chest feed35:

‘Yeah, well, um, because my mum fed me and my brother and sister, I just kind of, like followed her advice?’ (Caleb)

The absence of exposure to familial reproductive experiences was also considered formative in developing values and beliefs. Hazel became pregnant at the age of seventeen, which was to be the first of thirteen pregnancies. Hazel had helped as a teenager to look after her nephew when his mother had returned to work soon after birth,

35 I use the term chest feeding as Caleb’s preferred term in relation to his journey.
but how much exposure she had had to pregnancy and birth before becoming pregnant was minimal, both within
the family and during education:

‘Not a great deal, to be honest. I had not really looked into it or thought about it or anything. I were just
a silly teenager. Thought, it's not gonna happen to me, kind of thing and. So yeah, wait. I've never. I can't
really recall much at all around pregnancy ... apart from that, I'd never really...learned anything, or seen
anything? I suppose we didn't, really. I can't even recall it at school or anything like that’. (Hazel)

While non-exhaustive, the preceding examples suggest that intergenerational experiences play an essential role in
developing reproductive identity alongside broader personal and professional influences, all within normative
expectations for childbearing.
Constructing Reproductive Identity Concept Diagram
6.6 Conclusion

This chapter has explored the first theoretical concept, ‘Constructing Reproductive Identity’, explaining how reproductive identity is constructed through highly unique and individual contexts, influenced by sociocultural, historical, and intergenerational influences, understandings, conceptualisations, and beliefs around childbearing. I have presented these as contextual foundations and antecedent conditions that begin to address the aim of the study, examining and explaining why and how women construct their decisions to make non-normative choices.

The following chapter introduces the first of two concurrent social processes, ‘Entering the System’.
Chapter 7  Entering the System

7.1 Introduction

In the previous chapter, I examined the antecedent conditions contributing to a uniquely individual-constructed reproductive identity, exploring context and motivations that may influence non-normative choices. This chapter introduces the first of two concurrent social processes, ‘Entering the System’ and ‘Negotiating and Navigating’, the second in the next chapter.

In this chapter, I explore how and why women make non-normative choices, examining the underlying processes concerning entering the maternity care system. I explain how entering the system involves exposure to systemic structures, actions, behaviours, and established norms of contemporary institutionalised maternity care, all of which may threaten individual reproductive identity. In the first part of the chapter, I argue that standardised risk-based approaches and guideline-driven maternity care may have the unintended consequence of representing a threat to reproductive identity through intentional and unintentional actions of the system that depersonalise care outside of risk focussed parameters, centring the fetus, and precipitating systemic actions that inhibit the ability to realise non-normative choices. I then present institutional and systemic processes which imply an expectation of compliance within the system, negating aspirations for choice. Finally, I explore how participants experience escalating actions to encourage compliance with recommended care pathways and institutional, social, and cultural norms. Entering the system can be figurative, as even when choosing not to formally enter the system, simply becoming known to maternity care systems while remaining outside of it, women paradoxically enter in absentia. They are, therefore, subject to the same structures, actions, and behaviours.
7.2 Deconstructing Reproductive Identity

Deconstructing reproductive identity is conceptualised here as a process of depersonalisation that begins with categorising and labelling.

7.2.1 Categorising and Labelling

Participants reported being subject to a biopsychosociocultural risk-based classification system and standardised guidelines, assuming an objective, taxonomical approach to categorising pregnancies and the imposition of a dehumanised institutional identity, failing to account for women’s subjective embodied knowledge. Kali described this process as a ‘conveyor belt thing’.

Categorising took many forms, beginning at the booking appointment36 and consisting of medical, obstetric, and family history, offers of surveillance, examination, investigations, and screening tests, assessing biomedical and psychosocial risk and channelling participants along care pathways37 that best fit their assigned category. Participants expressed that contrary to the intention to facilitate personalised care and choice, guidelines informing these pathways failed to account for personal circumstances and context, subsequently informing non-normative choices. Participants considered standardised pathways depersonalised them and reinforced institutional identities regardless of how they identified or understood the unique normativity of their pregnancies.

Jade described a loss of identity in favour of a clinical descriptor of her reproductive history the moment she entered the system:

‘...the first time I met her [her doctor] she was just very much like, no eye contact, writing things down.

“Oh, you’re a gravida three, para one”. Well, no actually I’m called Jade. Definitely tick box exercises.

.... Just very inhumane, you know’ (Jade)

36 First antenatal appointment, usually with a midwife after self or professional referral. National targets are expected to be completed by 10 weeks gestation (NICE, 2021a).

37 Care pathways are a set of care processes for a defined group of patients over a defined period. Care pathways set out elements of care based on empirical evidence, best practice, and patient preference. Aims to coordinate the roles and activities within the multidisciplinary team and includes arrangements for monitoring and audit (Vanhaeckt, Sermeus and De Witte, 2007; Schrijver’s, van Hoorn and Huiskes, 2012)
For Caleb, this centred around not fitting societal and institutional norms of pregnancy and, therefore, being categorised as different or deviant by being in the system:

‘When I was pregnant. I was really scared. I was like some ‘weird’ thing [...] you always see it sensationalised. ... on the news and stuff, “oh it’s the first man to have a baby”. So, I didn’t post anywhere that I was having a child. I only told the people that were like immediately around me’ (Caleb)

Central to the ongoing process of imposing institutional identity and labelling were repeated biophysical risk assessments at predetermined intervals and subsequent categorising. These then informed clinical recommendations for routine surveillance and interventions based on pathways communicated in the form of national\(^{38}\) and local guidelines for care. Guidelines aim to ensure standardisation despite claiming to facilitate personalisation and choice. Many participants considered guidelines a central source of conflict, with narrow parameters within which women often did not fit. As Angela suggested, the guidelines ‘didn’t fit my body’. Subsequent biomedical evaluation aligned with guidelines led to subsequent categorising and labelling, further imposing a dehumanised, institutional, risk-based identity:

‘You know the labels that we are given for risk factors’ (Esmie)

The positioning of the institutional medical model of childbearing as authoritative in knowledge was an additional and consistent source of tension across many accounts, informing early non-normative choices. Particularly notable were participants’ interpretations of risk as it related to embodied knowledge, and their relationship to the fetus being at odds with institutional assessment and categorising:

‘...there is risk in every choice you make, and there are choices that you’re making, unconsciously, all the time you made a choice to get out of bed in the morning[...] you still did it[...]getting to the toilet[...]getting down the stairs[...]crossing the road[...]there’s certain things that are kind of prioritised as ’risks’ in pregnancy but women are undertaking risks all the time and they’re absolutely fine’ (Angela)

\(^{38}\) NICE (National Institute for Health and Care Excellence) national clinical guidelines stipulate pathways for maternity care in the UK apart from Scotland where SIGN guidelines are used with reference to NICE. Other key guidelines include the Royal College of Obstetricians and Gynaecologists (RCOG) green-top guidelines.
Participants with pre-existing risk factors (including previous caesarean birth, diabetes, advanced maternal age\(^{39}\) and most commonly, a raised BMI) were usually acutely aware of the implications of being categorised according to their ‘risky bodies’ before entering the system:

‘I live in a fat body. I am a fat woman, but it is hard feeling like your body is pathologized all the time’

(Angela)

When Faye requested a homebirth in a subsequent pregnancy, having had a caesarean birth in her previous one, her midwife told her, ‘Well it’s up to the consultant whether you can have a vaginal birth or if you’re gonna have a repeat section, and obviously you’re gonna give birth at the hospital’. Faye rejected this and requested a homebirth:

‘When I first had my (caesarean) section, I wouldn’t even thought that there could be an issue with me having a vaginal birth however many years later. Why would someone say that because you’ve been cut open once, you have to be cut open again? like pregnancies are different, births are different, I was confused but I stored that little bit of information for the future’ (Faye).

Participants made non-normative choices to avoid repeating a previous poor reproductive experience or replicating a positive one. They did so by resisting categorising and subsequent associated pathways. Nellie would have been categorised as low risk according to the biomedical risk assessment and thus encouraged to consider birthing vaginally. She chose, however, to opt for a planned caesarean birth outside of guidelines to avoid the risks of induction, labour, and birth after her first pregnancy ended in an early miscarriage:

‘When we got pregnant the first time, I was so excited for the pregnancy test; whereas this time I felt like I was just treading water the whole pregnancy, I felt like I was drowning, and I just wanted to just get it over and done with. And you have all these people telling you to enjoy it and I just thought I just want my baby here. I can’t enjoy this, this is a really, really anxious time for me’ (Nellie)

\(^{39}\) Varying definitions of advanced maternal age, usually >35 years old in relation to intrapartum care and >40 years old induction of labour (Knight et al., 2017; NICE, 2017) and >45 years cited within MBRACCE reports (Knight et al., 2021)
Nellie felt that her choice to have a planned caesarean birth in the absence of indication, given her profession as a midwife, had the potential for being labelled and stigmatised:

‘At my local hospital, [...] when I’d had the care there, they invalidated a lot of my feelings, and that was one of the obstacles for me not [wanting] delivering normally[...], vaginally, I didn’t trust the care’

(Nellie)

This reinforced her decision to plan her caesarean birth at another hospital, facilitative of her non-normative choice. While she did not conceal her professional identity as a midwife at her birthing hospital, she largely hid her mode of birth intentions within the NHS Trust where she was employed. By avoiding the potential for stigma and judgement arising from her non-normative choice, Nellie preserved her professional identity within wider circles of colleagues while protecting her reproductive identity. This raises an important point around the existence within individuals of dualistic belief systems and, therefore, a potential for dissonance between reproductive identity and other salient identities. By making non-normative choices, both are protected, and subsequent identity conflict is avoided, as discussed further in Chapter 10.

Faye’s choice to initially choose a homebirth after caesarean (HBAC) was motivated by a combination of wishing to avoid categorising, avoid a repeat of a poor experience in her last pregnancy and to negate the labelling of her body as faulty or risky:

‘After my (caesarean) section, for, for a long, long while I felt, like I had failed in a sense. I, I had my healthy baby, I had my healthy myself, but I didn't give birth. So, I felt like, like it's a rite of passage. Yes, I have a child, but I've not given birth and I, I guess I had missed out or like, like I was a less of a woman or something like that. Which it passed, a few years ago I completely happy with it like at the end of the day were both alive and that's all that matters in that situation and I'm not less a woman because, because of how my child was born. But I, I knew that I wanted to experience it. It was important to me’ (Faye)

Making a non-normative choice can lead to perceived or actual labelling by healthcare professionals, verbally or written in clinical notes, including being referred to as ‘challenging’ (Bella) ‘, difficult’(Angela) ’and ‘non-compliant’(Angela). Furthermore, participants described instances of perceived labelling and a suggestion that their choices were unreasonable, ‘radical’ or ‘crazy’:
‘It was kind of like he became really defensive. His face changed completely. Like oh that’s it, another crazy one making crazy choices and demands’ (Kali).

‘I had obviously built myself a reputation because every healthcare professional I bumped into they’re like oh you’re Leah. Word was obviously spreading that there was this kind of radical’ (Leah)

The purposes of institutional labelling as it applies to amplifying actions is explored later in this chapter.

Participants demonstrated a sophisticated understanding of the potential consequences of their choices. They rejected that decisions were made naively or without balancing the likelihood of risk, even if those choices could lead to the death of them or their fetus. This is contrary to any assumptions or judgements made by the system that choices contrary to medical advice might be considered unusual, ill-informed, and irrational, illustrated by Imogen’s stance on choosing to decline fetal monitoring:

‘This is my responsibility, my body, my baby. If my baby dies because of something that I’ve chosen I’m not going to say that’s not going to be difficult to deal with but that’s my decision and that’s my responsibility to reconcile myself with that’ (Imogen)

When Matilda conceived her first pregnancy, she was excited but immediately felt uncomfortable with being part of the maternity system:

‘I knew that my body’s signals were telling me to not access maternity, but also it was very difficult because I had to research on the spot what I did want’ (Matilda)

After her booking appointment, she was advised that her high BMI meant she was not allowed a homebirth. Matilda withdrew from NHS antenatal care, writing to them declaring her intention to decline all antenatal care

---

40Extensive case law exists in English law supporting women who, assuming full mental capacity, make choices that might be judged by healthcare providers as reckless or morally challenging. The Court of Appeal in the case of (St George’s Health Care NHS Trust v SR v Collins and others ex parte S, 1998b) ruled that women are ‘entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant’.
and freebirth (see 8.5.1). Matilda acknowledged that part of her decision-making was an acknowledgement that pregnancy and birth itself aren’t inherently risk-free and that death was a part of birth:

‘Some babies do die. I was OK with that’ (Matilda)

Towards the end of her pregnancy, however, Matilda began to fear how others might react to a poor outcome:

‘I think the fear that I had at the end was if this baby does die, then I’m going to be so blamed for it, and I’m going to be shamed for it, and I’m going to be maybe even in trouble for it. But then I kept coming back to the question what if it’s meant to die…?’ (Matilda)

The open acceptance of responsibility for choices aligned with expressions of wishing to remain at the centre of their care reflected how participants were protective of their reproductive identity, exclusive of their potential to produce a live or undamaged child:

‘I said ‘I know you’re telling me all these risks to the baby but actually it’s not just about the baby, it’s about my experience as well’ […] I remember thinking […] I would feel a lot better if I had all the control because it’s me, my body, my baby. If I had all the control and the choices I could make and there was a bad outcome […] worst-case scenario you know, baby died. In my opinion, if I got to do everything that I wanted to and believed was the right thing to do and that still happened that was meant to be. That’s just the way things were. But and then I can take on that responsibility because those were my choices’ (Leah)

While reflecting on her choices, Grace commented, ‘I put myself above my foetus/baby (boo! hiss!) - I decided that any increase in risk was worth it to me and my baby’. Both Grace and Matilda’s accounts indicate a largely tacit understanding of unspoken, pervasive sociocultural norms and perceived moral responsibilities towards the protection of the fetus. This exposes a subtle but essential acknowledgement of expectations for women to make

\[\text{\footnotesize41}\]

The sociocultural expectation of women to produce live and undamaged children is intrinsically linked to conceptualisations of good motherhood, and in failing to do so represents a lack on normativity, spoiled identity, and stigma (Goffman, 1963). These concepts and their application to reproductive identity threat are discussed later in Chapter 10.
normative choices that avoid risk, ultimately sacrificing their biopsychosocial needs to be selfless nurturers of potential life.

Resisting the ‘good mother’ trope and privileging their own biopsychosocial wellbeing in the context of non-normative choices had a twofold effect. First, the underlying moral disapproval of making non-normative choices risked women being labelled deviant (see Chapter 10). Secondly, judgements were made by healthcare professionals about the participants’ parenting ability, and these judgements formed the basis for justifying coercive actions and threats. How actions manifested included stigmatising, bullying and coercion, punishing acts and abandonment by the system, illustrating again the somewhat contradictory nature of personalisation and choice in a system that cannot truly support it in the presence of prescriptive guidelines. These actions are discussed in more detail later in this chapter and Chapter 10.

7.2.2 Controlling Risk

The medical model of childbirth considers childbirth potentially pathological, with every pregnancy being risky and deemed safe only in retrospect. One commonly held belief amongst participants was that recommendations and interventions solely existed to control biomedical and medicolegal risk. This category, therefore, reflects institutional and systemic positioning of pregnancy and birth as a time of danger, mitigated only by engaging with and birthing within the system. Most participants rejected this default position, believing they were more likely to experience physical or psychological iatrogenic harm within the system. Participants expressed how surveillance and the associated ‘cascade of interventions’ (Angela) were more likely to cause iatrogenic harm than the non-normative choice being made and that by making the choice, they were ensuring safety as they conceptualised it:

‘...get(ting) into labour myself which ...I would prefer because we know that the cascade of intervention increases my risk of needing Syntocinon [and] haemorrhaging [...] and these are like all the worst outcomes that you want to try and avoid with someone who has a BMI like mine’ (Angela)

Similarly, Matilda was clear that she was not opposed to intervention but rather the over medicalisation of her pregnancy:

‘I’m not adverse to medical, it just doesn’t feel like it’s needed unless it’s needed’ (Matilda)
Non-normative choices were made to avoid surveillance and anticipate interventions, including withholding consent to obstetric glucose tolerance tests (Jade), urinalysis (Kali), routine blood tests (Kali), limited or no scans (Kali, Leah, Imogen), or all antenatal care (Matilda). Participants also positioned choices such as this as rejecting interventions that were ‘just in case’ rather than in response to actual physical signs and symptoms. Esmie, who works as a doula, declined prophylactic aspirin during her pregnancy:

‘... I was told that it will prevent the onset of pre-eclampsia. And I just said ‘woah you know like what? that’s a big jump [...] [they said] “oh your BMI” [...] and I said well but my actual blood pressure readings [are fine] and there’s no other symptoms [...] and they were like “it’s fine now but it might not be later so take this now to prevent that” [...] so I pushed [back]’ (Esmie)

Especially noteworthy were experiences related to corporeal differences that triggered categorising and labelling, but which could not be easily concealed, such as body mass index, ethnicity, and age. Caleb’s pregnancy was categorised as low risk from a biological perspective. However, the non-normative nature of transgender pregnancy meant that supporting transgender men through pregnancy drew upon limited empirical evidence. Caleb anticipated the potential for care depersonalisation through the lack of institutional acknowledgement of differences in identity:

‘...one of my biggest fears of like being in labour and being misgendered... He [consultant] didn’t really acknowledge me being Trans [...] he just ignored it, but not in like, ‘oh, it’s kind of normal,’ you know? [...] and he referred to [me in] the way he refers to all of his patients [...] “Oh, my other ladies” and it felt like he was kind of grouping me in with the ladies, even though he probably only is only seeing other ladies, but it felt like, it was just the terminology but that could have just been better’ (Caleb)

It was apparent that BMI was one of the most common examples of categorising and labelling and brought with it an additional dimension of blaming, shaming, and stigmatising:

‘...the consultant said, ’it depends on what you look like because obviously whenever we have a pregnant woman whose BMI is high, we are looking at their body, to make to see which bits work’, it was just awful! I was like, you assess patients’ bodies to see which bits are gonna be difficult for you to deal with? We know that the world is looking at our bodies, but it was bad... ’my body is perfectly fine, I think you’ll find’ (Bella)
Angela wished to use the midwifery-led birth centre while pursuing a physiological birth. Her only risk factor was her weight, and therefore, to be on the ‘low-risk pathway’ meant that she was opting for care outside of local guidelines, which felt like a safer option for her:

‘they’ve got the right midwives in place that kind of really promote that normality and, you know, physiology. That’s not to say that they practice unsafely but just trusting in women's physiology...’

(Angela)

Extensive planning with a consultant midwife meant that a plan was established in advance to support Angela’s choice to give birth in the birth centre; however, Angela subsequently experienced pushback from an obstetrician who wanted to induce her early:

‘She said, ‘Let's talk about induction. So, I think we should book you're in for an induction at 39 weeks because of your BMI’\(^\text{42}\). And I was like, I don't want that. [...] I said I would be happy to have a postdate induction. [...] I will have an induction at 41 plus five. I'm not comfortable going beyond 42 weeks’

(Angela)

Angela also explained how being sent to the ‘Wednesday Club’ illustrated shaming and stigmatising practices, however unintentional these may have been:

‘it’s basically fat club, and you have to go if your BMI is over 40 [...] it was all things like, ‘50% of you will need a caesarean section. So, we would like to do an early epidural, you will be induced to 39 weeks’, you know, there was no language of choice, and there was no sense that there was anything to do with kind of self-determination or feeling positive that there could be a physiological outcome. It was just, these are kind of the things that will happen to you; you will be induced. You will receive a hormone drip; you will have an early epidural, some of you, half of you will end up having a caesarean’ there was no you can do this you need to believe in your body. Let’s stay mobile in your pregnancy. [...] none of that’ (Angela).

---

\(^{42}\) BMI as a sole risk factor is not an indication for induction of labour and has no evidence to support offering as an indication at any gestation (NICE, 2021d)
While the intention of the Wednesday (fat) club and similar weight-related interventions discussed by participants may have been a targeted public health educational intervention designed to share evidence-based information, participants considered them stigmatising and of no value. Even when participants pushed back against the evidence for weight and BMI-based categorising and recommendations, participants overwhelmingly felt that healthcare professionals continued to make assumptions based on outward appearance, refusing to acknowledge the individual context:

‘it's an assumption based on weight [...] because BMI itself is nonsense [...] I'm not struggling with my BMI and in fact losing weight with pregnancy [...] so I think that was a bit of a conundrum for them’

(Bella)

It was clear that where living in a larger body represented a core element of their overall identity, assigning a negative connotation through pathologisation of their bodies represented a challenge to general and reproductive identities, signifying again a label of their bodies being risky, untrustworthy, or broken. Esmie articulated this and argued that despite her considering her weight of minor significance as it related to her pregnancy, the medical pathologisation of her body based on weight alone was stigmatising and used by the system as a rationale for denying her choices:

‘...I'd realised actually what extra risk high BMI was, [it] removes quite a lot of choices for very little, proof, from what I'd seen anyway. And in practise or in amongst friends it's the one that worried me the least.’ (Esmie)

Esmie did not consider her weight a legitimate reason to restrict choices as it applied to her pregnancy and therefore, having a raised BMI was considered a legitimate reason for making a non-normative choice, especially in the absence of physical signs or symptoms of pathology:

‘...there were no signs [...] no indications. All it was, was a textbook saying, 'you know people who weigh this much, and are this short should really have this this and this' so I can see that if I was less educated and less experienced that would have turned out rather differently for me’ (Esmie)
Similarly, Angela suggested, ‘I live in a fat body, I am a fat woman’ as a factual statement of identity. Bella felt that her ‘fatness’, although part of their identity, was not a primary consideration upon which their care should be based. These views again went on to inform the non-normative choices both individuals made.

Bella anticipated categorising, labelling, and judgement, so she withheld consent for being weighed during her obstetric consultations. She also recognised the potential mental health consequences for her in observing her weight on a scale. So, by withholding consent to being weighed, she protected herself from perceived negative consequences, including interventions and surveillance to mitigate or remove the risk that might follow as a result, including restricting choices:

‘it's my choice [...] to not hear it because I don't think it affects my care. So, respect that [...] I just think she [consultant] doesn’t understand the mental health implications of fatness, particularly in the NHS…’

(Bella)

7.2.3 Fetal Centring

Participants consistently presented accounts of fetal centring within the system at the expense of participants' wishes, referred to in various forms and occurring at different times across the pregnancy timeline. Throughout the pregnancy, participants described how the emerging identity and personification of the fetus shifted as a focal point for the system:

‘Yeah, everybody was just obsessed with the baby being alive; it doesn’t matter about anything else as long as the baby’s alive’ (Matilda)

This process resulted in a perceived decrease in focus on participants’ psychological wellbeing, a challenge to participants' identity and an increase in emphasis on fetal safety and outcome. Fetal centring was therefore noted to be a key motivation for making non-normative choices as a form of resistance towards a loss of or challenge to identity:

43 NICE Antenatal guidelines (2021) suggest that weight and height measurement be offered, and BMI calculated for all women at the first face to face appointment and not repeated (although risk assessment in third trimester). If BMI >30kg/m², then offer consultant led care with dietary counselling and a structured weight loss programme offered postnatally.
‘...definitely was baby, baby, baby, baby, and I don’t think you’re going to find anyone who’s gonna tell you any different. That’s the ultimate for them, I think; the baby is the only real thing that matters and not, not the quality of that baby, just the baby and the fact that you know they tick that box; they said all the things that they needed to say to me, and she still declined’ (Esmie)

Fetal centring repeatedly resulted in coercive and restrictive practices intended to dissuade women from making choices that might present a risk to the fetus:

‘They kept saying things to me like “Imogen, it’s your baby’s brain, we’re trying to protect […] we’re thinking about you, we need to agree on a safe birth […] you need to meet us halfway […] come on, think about your baby’ (Imogen)

Kalis’ account of how she felt fetal centring and dehumanisation continued throughout the antenatal period and into her labour:

‘[It’s] definitely fetus centred […] All that mattered was from my neck down […] to get this baby out […] it’s that feeling of being a piece of meat on a table […] there was that point that nobody else was looking at me. All the action, all the lights […] everything is between my legs. Nobody’s bothering to talk to me […] So just really, it’s not centred around me […] It’s centred about getting the baby’ (Kali)

It was unclear exactly when the focus switched from maternal to fetal centring, however many participants believed that it occurred somewhere around the date of legally recognised viability of the fetus44 or when routine care includes surveillance technologies designed to observe fetal growth and structural development. These included routine scans, symphyseal fundal height (SFH) measurements, auscultation of the fetal heart and fetal movement advice45. Rarely did participants report that recommendations for such surveillance accord with their

---

44 Legal age of fetal viability in the United Kingdom is 24 completed weeks gestation.

45 Guidance varies according to when this should be undertaken and recorded. Fetal heart auscultation is not recommended prior to onset of labour as it merely confirms the presence of the fetal heart and has not predictive value in relation to outcome. Despite this it is offered universally as part of antenatal midwifery care. Symphyseal fundal height measurements commence at >24/40 unless contraindicated in which case routine growth scans are offered. (NHS England, 2019b; NICE, 2021a)
understandings through their maternal-fetal relationship\textsuperscript{46}, placing more emphasis on embodied knowledge throughout the pregnancy:

‘I had no concerns about the growth […] it’s the movements that are the most important thing. So, at 37 weeks I measured myself. [...] I monitored movements and I thought I’ve got low risk factors for a small baby. I’m not a smoker. I don’t have preeclampsia. [...] Do I feel that the baby’s growing? Yes, I do. Are the movements fine? Yes, they are, fine, absolutely fine’ (Imogen)

There were similarities in how non-normative choices were used in this context. For example, participant accounts of early pregnancy loss prompted personal postponement of developing a sense of fetal personification until after engaging with surveillance technologies, and then usually outside institutional timetables, including private early scans or asking trusted medical colleagues to perform scans. Similarly, some participants engaged with surveillance technologies later than institutional timetables indicated or declined them altogether, again relying on embodied knowledge and experience instead.

‘I really wanted to feel like I was in partnership with the baby. Every move I made it felt like I was listening to them’ (Matilda)

The preceding discussion has demonstrated how systems designed to standardise risk-based approaches to maternity care enacted through categorising and labelling have the potentially unintended consequence of deconstructing personal reproductive identity. Interventions intended to mitigate or minimise maternal-fetal risk may create a sense of shame and stigma. Additionally, centring the fetus in care planning at the expense of maternal wishes aligned with reproductive identity and embodied knowledge may lead to or reinforce decisions to make non-normative choices as a mechanism to avoid and manage identity conflict.

\textsuperscript{46} Originally conceptualised in 1981 (Cranley, 1981), maternal-fetal relationship (MFR) is used in reference to the ‘development of the woman’s relationship with her unborn child…which manifests in a woman’s thoughts, feelings, attitudes and behaviours towards the baby’ (Darwin and Walsh, 2017)
7.3 Expecting Compliance

Participants believed they were expected to comply with clinical guidelines and recommendations; as Kali suggests, ‘the expectation is that they [interventions and recommendations] will be accepted’. Indeed, the rigid, inflexible application of guidelines was a crucial source of tension for participants who felt that institutional responses lacked understanding, motivation, or capacity for the system to support non-normative choice:

‘I basically refused weighing. So, I went in, and they were like ‘I want to weigh you’ and I [said] ‘no’ and they were like ‘oh, we’ve never had that before’ […] they weren’t unpleasant about it, they were just kind of surprised’ (Grace)

Imogen provided a similar account of healthcare professionals being surprised at her choice, epitomising an expectation of compliance through the inflexibility of guidelines. She had begun her care with an independent midwife but later came into the NHS, choosing to decline a 12-week dating scan and booking bloods as they fell outside what she considered to be of value to her pregnancy:

‘It was just the way she said that to me […] because I knew my dates very well […] “well what did your dating scan say?” I said, “I haven’t had the dating scan”. She said ‘you haven’t had the dating scan? I never see anybody who hasn’t had the dating scan’. (Imogen)

After Grace booked late in her pregnancy and thus did not conform to institutional timetables, she went on to decline booking bloods, explaining that, like Imogen, she saw little value in having them, having evaluated that they had not changed since her last pregnancy. The expectation of compliance in two situations leads to inaccurate

---

47 The term ‘expected compliance’ conceptualised here consistent with Nicholls et al., (2019) definition of contractual compliance, discussed further in Chapter 11.

48 Routinely offered blood tests at the booking appointment are a full blood count, blood group (and save), screening for hepatitis B, human immunodeficiency virus (HIV), syphilis, sickle cell disease (SCD) and thalassaemia. Routine scans are offered for screening and surveillance at: 12 weeks for dating of the pregnancy, to confirm a viable uterine pregnancy, the number of fetuses and a nuchal scan and bloods for Downs syndrome screening. 20 weeks for fetal development and screening for 11 conditions. Other scans offered are non-routine.

49 First antenatal appointment, usually with a midwife after self or professional referral. Expected to be completed by 10 weeks gestation (NICE, 2021a) and is a nationally reported metric.
information subsequently being offered, escalating confusion in healthcare professionals and the emergence of amplifying actions to gain compliance:

‘...[she said] you need to come into hospital for bloods. And I [said], “Oh, do I really need to? I don't think much has changed when my first pregnancy” and they [said] ‘Oh yeah, 100%’ [...]. I had my 20-week scan, and the sonographer goes ‘I'm just booking you in for a 28 weeks scan’ and I was like “why is that?” “Oh yeah, because we need to have two scans from the same sonographer” and I was like “okay, but why? What's the medical need for this?” He's like, “Oh, it's just hospital policy”. And I was like, “Well, I don't want it” and he was like “you have to” and I was like, “well, you go ahead and book it for me and ill ring up and cancel it [...] I'm not coming” and he said, “oh right, I suppose it is your right to decline treatment” Grace)

Additionally, participants recognised that when making non-normative choices, tension arose out of the health care providers' perceived consequences of the risks to the woman and, most commonly, the fetus:

‘...they said, “you know we've had babies die of this and we've had babies die of that and when you walk out of here there's no telling that your baby won't just die on the way home’ (Esmie)

An expectation of compliance appeared to arise partly out of institutional arrangements50 primarily not being in place to support non-normative choices, implied through responses of healthcare professionals not knowing what to do when a non-normative choice was made, mainly when a choice reflected withholding consent to routinely offered examinations, interventions, and surveillance:

‘ [the] obstetricians’ kind of raised their eye when I said I'd been planning a home birth, because they were sort of like ‘why would you? Why wouldn't you just be here?’ (Angela)

50 I use the term ‘institutional arrangements’ as intended by Goffman (1968), micro-level structures through which organisational power is exercised through the institutional fabric woven through the everyday interactions, practices and action of its members (Scott, 2015b).
'the Registrar [said] “but you’re over your due date, we would really like to induce you” I [said] ”No. I’m not being induced” and they were just completely baffled […] they were fine […] but they just were puzzled […] that I didn’t want to be induced’ (Bella)

The following interaction at an antenatal day assessment unit relayed by Esmie, further demonstrated how declining urinalysis was met with confusion and a suggestion that without providing one, she could not access care:

‘…[The] receptionist [took] my notes to book me in and she [said] “can I have your urine sample then?”

“no, I had one done just a couple of days ago”, “but, but ,you need to give your urine, you know you can’t come in without giving us yours”, “I don’t consent to you having my urine, you do not need it right now”’ (Esmie)

Participants acknowledged contemporary issues in the broader maternity care system that they sensed might contribute to these tensions: fear of litigation, regulatory and disciplinary action against the healthcare professional because of poor outcomes, as well as the constraints within which healthcare professionals work, including variation in workplace culture, fragmentation of organisations, human and physical resources, and a lack of empirical evidence to support interventions:

‘… it is more protocol driven […] because of the high litigation risk. I guess […] if something goes wrong, that’s a catastrophic outcome. Like a young woman dying, that's really bad, a baby dying, that's really bad. […] in other fields of medicine, your patients are sick, but in obstetrics, they're not […] they’re very risk averse and I don’t necessarily think that’s a wrong or bad perspective […] a lot of women genuinely want a lot a lot of intervention and if you set out the risks, most women I think most of them would accept the intervention risks’ (Grace)

Participants felt strongly, however, that this should have little to do with their ability to make a non-normative choice, especially within a healthcare framework that outwardly advocates for personalised care. Imogen shared an interaction with a senior midwife who was trying to convince Imogen to change her mind and accept the recommended fetal heart auscultation intervals in labour:
‘...[she] made it very clear that this is about companies and liabilities and insurance and that my birth and my choices are nothing to do with my body or my life or my baby’ (Imogen)

Angela felt that guidelines place too much emphasis on evidence relying on population-based data:

‘You know [...] when those are the things that are not measurable. These are the things that actually you know the richness of kind of people’s lives cannot be sort of pulled out of statistics ‘(Angela)

For those healthcare professionals who do try to support non-normative choices, participants acknowledged the constraints within which they work, the institutional pressure they were under and the possible consequences of genuinely advocating for choice:

‘Basically, the midwives are stuck as well. The ones that go into the profession wanting to make a change very soon discover that there is no change to be made, that it’s a system that’s controlled by those traditions, [...] if [they] try to go against guidelines [they] get bullied out of their profession [...] trying to do what’s right but most of them are just forced to follow the guidelines because they get punished’ (Faye)

Most participants expressed similar sentiments while simultaneously rejecting this as a reason for not having their choices supported.

7.3.1 Enforcing Timetables

Another key process of institutionalising childbearing and expecting compliance was enforcing timetables. Timetables in this context refer to when women are expected to access and conform to the predetermined rules of guideline-based maternity care. Choosing to resist or go outside these timetables characterised some of the non-normative choices made in participants’ accounts, including declining antenatal appointments or routine scans, declining induction of labour and other time-contingent interventions. Timetables reinforced expectations surrounding socially assumed norms concerning pregnancy, including length of gestation51. This is a significant

51 Clinically divided into equal trimesters (280days/3) calculated using a standard 28-day menstrual cycle. Such intervals fail to account individual variation in physiology such as individual menstrual cycle length, reproductive biography and significantly, participants embodied knowledge of their bodies.
consideration given that indications for interventions such as induction of labour are predicated on these normative timetables:

‘Then she said, “so what’s your due date?” I just thought oh my god I don’t have a computer-generated expiry date on my body.’ (Imogen)

It was interesting that induction of labour was, therefore, a commonly declined intervention (Angela, Bella, Faye, Grace, Imogen, Jade), with participants expressing the need to trust and be guided by their own embodied knowledge and processes, resisting institutional and systemic timetables:

‘[in first pregnancy] I was offered induction at term plus ten, and I declined [...] I know all about induction and the risk of intervention etc. so I declined’ (Jade)

Participants such as Leah exemplified how conformity to guidelines-based rules and timetables was evaluated against participants' values and beliefs, reproductive history, and embodied knowledge of their current pregnancy, then rejected or accepted recommendations per how much the participant perceived it as necessary in that pregnancy:

‘If I valued the information that that technology provided, I might decide that small risk is worth it, but I didn’t value the information’ (Imogen)

Imogen’s declining scans and booking bloods and Grace’s booking late in pregnancy illustrate this further. Leah describes her evaluation of personal value in accepting some tests and who conducted abdominal palpation:

‘I still valued the weekly blood tests I got, the urine tests, the scans and well, it was only the community midwives that really had a feel with their hands, to tell me different things. I still valued that kind of care because I did want to know that baby was OK’ (Leah)

Grace conceived during the second wave of the COVID-19 pandemic and was advised that her booking had to be face-to-face (contrary to the NHS Trust published information, which suggested that booking appointments were being conducted over the telephone) before ten weeks gestation. Grace resisted a face-to-face appointment, evaluating the benefits of having her booking appointment against her values and needs and made the choice to
have a private 12-week scan and Non-Invasive Prenatal Testing (NIPT) screening outside the NHS, declining booking at the intervals suggested by NICE:

‘I don’t really see the need to book in now [...] the longer and longer it went on, I was like “this is a joke”, you know, why do I need to book in early at all? [...] there’s no medical need for it [...] especially considering that most hospitals aren’t even giving you the face-to-face appointment now until, like 20 weeks so, you know what, I’m not going to have a face to face until 20 weeks. That’s my decision’. (Grace)

Grace’s account also illustrates how, where timetables and guidelines remain inflexible, women make additional choices to align with their wishes and thus reproductive identity. After further consulting with trusted allies (see Chapter 8) and researching options for a homebirth within the NHS, Grace attempted to arrange a booking:

‘So, I rang up [hospital] and I accepted a booking at 17 weeks and immediately they said to me “we’ve booked you in for a scan tomorrow” I was like, “what? Excuse me what? I’ve had a scan already” and they were like “well it’s not in our system” so I said’ “Well, I’m not having that, so you know, book me in for a 20-week scan please”’ (Grace)

Enforcing timetables also appeared contingent on varying degrees of ritualised practise reflected in guidelines, as Matilda proposes, ‘It’s quite ritualistic to do certain things within maternity’. Where such activities intended solely for protecting fetal wellbeing were declined or resisted, participants viewed these as less acceptable within the institution than those designed to protect their biopsychosocial wellbeing. Imogen wished to decline fetal monitoring in labour altogether. Still, she realised that when discussing this with her healthcare professional, they were ‘a little bit funny’ about it and began a process of negotiation:

‘My feelings were that I was not interested in fetal monitoring. If I personally was worried about the baby, [such as] placental abruptions or a collapse [...] yes, I think it probably will inform my decision-making to check whether that baby is alive or not. [...] But, no, I do not want fetal monitoring that is going to result in trauma and [...] its [not] evidence-based, and it’s not associated with better outcomes. I thought OK so maybe once an hour in the first stage and maybe every 15 minutes in the second stage but I’m not doing every five minutes. (Imogen)
Imogen’s account further demonstrates how participants were prepared to be flexible in their approach to care planning; however, without this being reciprocated by healthcare professionals, they were more likely to make successive non-normative choices and employ strategies and actions to preserve their reproductive identities and realise their choices, illustrated in Chapter 8.

7.4 Amplifying Actions

Participants gave numerous accounts of how the degree to which institutional arrangements were in place to support participants’ choices was directly proportionate to their tendency to amplify actions intended to gain compliance and the severity of those actions. This is conceptualised as amplifying actions, how this manifested dependant on gatekeepers exerting power of varying degrees. Gatekeepers usually represented healthcare professionals but could also be those employed by participants, e.g., doulas, who could control access to services, facilities, the participants themselves or the ability to realise the non-normative choice. They could be facilitative or obstructive and were usually employed in positions of perceived power. Jade illustrated how an interaction with an obstetrician during a discussion of her non-normative choice left her angry:

‘She had an agenda. She wanted my birth her way. Yeah, like she obviously wanted a set thing. And I remember leaving the room and sort of like almost huffing and puffing. I remember thinking like she’s really pissed off that I’ve made this decision’ (Jade)

Leah explained how this power imbalance manifested with clinicians coming together to change her mind over requesting a homebirth with type 1 diabetes:

‘At one point it was a paediatrician, two obstetricians, the head of community midwifery and diabetes consultant all in front of me and they had every scare story under the sun’ (Leah)

Hazel was at term with her 13th pregnancy (P10+2). Her previous labour had resulted in her baby being born before the arrival of a healthcare professional at home (BBA), so she decided to freebirth in the subsequent pregnancy. During labour, she experienced back pain associated with an occiput posterior malposition\(^2\) and instructed her

\(^2\) Commonly referred to as ‘OP’, occipitoposterior position is a common fetal malposition where the fetus lies longitudinally but with the occiput orientated towards the sacrum rather than the preferred orientation towards the symphysis pubis. Affects 2-13% of births and is
partner to call for midwifery support; however, she gave birth to her baby again before their arrival. Once they had arrived, and contrary to Hazels wishes, they persisted in convincing Hazel to accept an intramuscular oxytocic drug to manage her third stage of labour actively:

‘[as] soon as midwives came in, I instantly regretted ringing them [...] she just seemed terrified to be there, asked me constantly to give me the injection and even though I didn't want it, and they read the birth plan, I had it. [Then they] kept saying that now I've had this injection, I've got 20 minutes for the placenta to come out. She's clock watching ... and I told her to get out of the room. I were like “look, just calm yourself down or go out because I don't need this”. Then I'm sat here chilling with a baby and she's like “can you stand up?” I'm like, “No. You can get out. Once I've finished feeding, baby”. And, and it were about 70 minutes, I think it was after she been born... [they] cut cord, passed baby to dad... then I stood up and its come out [placenta] then, so I kind of threw it out into the bucket. [...] but once it got out, she kind of changed to a different person... ’ (Hazel)

This episode is a further example of an expectation of corporeal conformity to institutional timetables (birthing the placenta) and the anxiety this induced in the attending midwives when timetables were unmet.

Vaginal examinations featured frequently in accounts of being coerced into compliance. When Matilda attended the hospital for analgesia, she felt she was being punished for her previous choices and that analgesia was being withheld:

‘She said that I couldn’t have any pain relief unless I had a vaginal examination [...] my options were to go onto a maternity ward without my partner, without pain relief and wait [...] I went to the bathroom and they followed me in, and then without me knowing they’d said to my partner [...] to persuade to get him to persuade me to have a vaginal examination’ (Matilda)

Eventually, she reluctantly agreed to a vaginal examination:

associated with increased rates of instrumental and operative birth (Tempest et al., 2020). Commonly presents with slower labours, back pain and incoordinate uterine activity.
‘...she [midwife] did keep doing the vaginal examinations, because I’d said yes to the first one and then I felt like I’m just going to do it now because I’d already said yes. And to be honest I did keep saying ‘do I have to?’, I don’t really want to. And she was like ‘well it’s really for the best’[...] and all these things. I just went along with it, and it was really horrible’ (Matilda)

As discussed previously, Angela had declined induction of labour. After her interaction with the obstetrician, she subsequently discovered that they had written to her GP:

‘In it she said, ‘client does not accept the risk of having a high BMI’ and I felt so disappointed and frustrated to read that because I just thought, God, this is the power of medicine’ (Angela)

Angela perceived that this action was not only used as a punishment for non-conformity with recommendations but also represented a threat to her professional identity as a midwife:

‘any GP, that I know... they will be able to read that in my notes, and they will think that I am non-compliant, that I'm a difficult person to work with... she's completely tarnished my reputation as a patient[...] I feel that spectre over me every time I speak to a GP, whether they look back and just think, Oh right, yeah, here's someone who thinks she knows more than she actually does[...] who doesn't know what's good for her[...] because you see that all the time happening with women, just feeling like they're being constantly denied choice and being told that they're stupid for wanting something other than what the guidelines recommend.’ (Angela)

Imogen had a history of sexual assault which, although not the primary reason for not wishing vaginal examinations, played an important role in the decision. After being transferred to NHS labour ward for progress not as expected at home and an epidural, she was placed on a CTG showing some concerning fetal heart features. The obstetrician was called:

‘... here was my worst nightmare coming true. A crash instrumental, episiotomy with no pain relief and the doctor came over and she demanded access to my vagina [...] the doctor announced to everybody that I’d had a bowel movement on the bed ... and then she said “fully dilated “ and she said to the midwife, “get her legs up and do coached pushing” ’ (Imogen)
This account of Imogen’s care represented what she considered to be dehumanising, impersonal and shameful. Despite this, Imogen resisted and attempted to advocate for herself by employing negotiation strategies, however, this resulted in the obstetrician becoming aggressive:

‘I said I am not doing that. There was absolutely no way they were going to get me to do that horrendous thing. So, I refused to comply with coached pushing and the doctor said, “we need to deliver this baby, you’re in serious danger” [...] the doctor threw her hands up in the air and she said “well, what do you want me to do if you’re not going to do what I tell you?” I started crying and I said to the midwife, please do not let them do an instrumental delivery on me without pain relief’ (Imogen)

Abandonment in various forms was noted within participant accounts, ranging from not being listened to, previously agreed arrangements rescinded, being denied analgesia when in pain or not being believed:

‘I started to push, the first thing they said was “your contractions are five minutes apart you can’t be pushing”. I said, “well my body’s pushing, you think I want to give birth in an ambulance?”’ (Faye)

‘Went into the hospital and straight away oh we’re going to hook up to the CTG. I said I don’t want CTG. We need to do a vaginal exam. Don’t want a vaginal exam. And everything was a battle and they just never, they never listened to me’ (Leah)

Even when birth plans were carefully written in advance to support care outside of guidance, these were not always followed. Esmie requested midwives use earphones on the dopplers when auscultating[53] so that she did not have to hear the fetal heart, therefore remaining undisturbed. This was initially agreed:

‘The midwives that came on the night didn’t have headphones; they didn’t come with them’ (Esmie)

Faye hypothesised that abandonment was consistent with healthcare providers distancing themselves from choices to protect themselves from repercussions:

‘it’s like if I can fit into mould and they have their, their own guidelines I think it’s all to do with the risk aversion and they just wiped their hands and stay as far away as possible so we, if anything goes wrong,

[53] Listening to the fetal heart with a pinards stethoscope or handheld doppler device.
which they are almost always expect to go wrong then at least it’s not their fault and there not tied to it in anyway’ (Faye)

A sense of abandonment was reported by many participants. Imogen withdrew from the NHS and booked with an independent midwife who she felt would better support her non-normative choices:

‘I would have gone without food to pay for care outside the NHS […] I’m absolutely not interested in giving birth in the NHS. It’s just abuse. It can’t be called anything else’ (Imogen)

At 25 weeks gestation, however, her independent midwife could not follow through with Imogen’s care due to ill health. Imogen’s care was transferred to a private midwifery company:

‘I said ‘I do just want to tell you straight up that actually I will be making a lot of alternative choices […] and I’m going to need you to refer me to a midwife who is happy with that’. She came back and said “we need to have a conversation about this” […] and she’d clearly gone away and had a chat with her manager [who Imogen thought] was telling her what to say. She said unless you consent to fetal monitoring in line with NICE guidance, so we’re talking 15 minutes and five minutes with a handheld Doppler, then we will withdraw care […] So by this point I was 37 weeks […] I’ve got no idea when I’m going to go into labour. I thought I’m completely alone’ (Imogen)

Abandonment was reported to be considered by participants as a punishment for making non-normative choices, creating a cause for caution in participants’ decisions to access the system or not when they needed help:

‘…at 40 weeks when I had my first [episode of reduced fetal movement] I thought “oh my god what can I do?” I just thought there is nothing that I can do. The same with the growth, so here I am at 40 weeks feeling like a pariah, feeling like no-one will support me or even talk to me or come close to me’ (Jade)

Examples of threats include emotive and manipulative statements, suggesting that participants might be putting the safety of their fetus at risk by making non-normative choices and as a means of coercing women to comply with recommendations and diminishing choice. Coercion also manifested in suggestions that care was contingent on accepting interventions. As previously noted, Imogen had returned to NHS care after describing how she had been ‘abandoned’ by independent and other midwives employed outside of the NHS. A meeting with the
consultant midwife at 39 weeks gestation did not reassure her that she would be cared for and her non-normative choices respected:

‘“if I go into labour tonight is somebody going to come out to me?” The consultant midwife said no, not until […] we […] do all your bloods, […] test your urine and […] write up this birth plan for you. I didn’t want my urine tested because I’m asymptomatic and I thought the last thing I need to be is diagnosed with is GBS54 and them telling me I’ve got to be put on antibiotics, or that they’re telling me I’m anaemic and I can’t have a home birth. Anyway, they made it very clear that if I didn’t consent to that they would deny me a home birth’ (Imogen)

Badgering came in the form of persistently repeating risks and consequences of non-normative choice or non-compliance with rules and timetables, verbally and in writing. Badgering could occur either at one contact or throughout the pregnancy; Esmie explained how she considered the intention to be to wear her down, exploiting the unique vulnerability that pregnancy brings:

‘They’ve got a lot of time to do it in and like you’re well aware it’s as each day goes on as each week in pregnancy goes on, you get a little bit weaker mentally, […] it’s a weak time in someone’s life’ (Esmie)

Further, Esmie suggested how ‘… the dead baby card was waved around’ as a means of coercion and badgering. Overt threats sometimes accompanied such behaviours, but rarely were such discussions fully documented in clinical notes:

‘They said “you know we’ve had babies die of this and we’ve had babies die of that, and when you walk out of here there’s no telling that your baby won’t just die on the way home” […] they were actually overtly saying those words over and over again. But […] you read the notes, and they won’t be in […] there’s only ever small paragraphs written on that, you’re well aware that things were discussed that weren’t actually written in notes and no one’s ever going to write ‘I discussed dead babies with Esmie’” (Esmie)

54 Group B Streptococcus (GBS), bacteria that colonise intestines, rectum, and vagina in up to 40% of women. Not routinely screened for, but if found, treatment includes intrapartum antibiotics to prevent early onset infection in the neonate which can be fatal (Hughes et al., 2017)
Coercion of varying intensity and success was also noted in accounts given by Bella, Hazel, Imogen, Matilda and Leah. A frequent means of coercion after making a non-normative choice was referral to social services:

‘I then had horrible postnatal depression. I declined medication for postnatal depression. And they referred me to social services, not because of that but because of the whole thing.’ (Imogen)

Matilda self-discharged after her caesarean birth. She and her husband were clear they did not want midwives visiting in the postnatal period as she found the previous experience profoundly traumatising:

‘they said they wanted to check the baby, and he said well they’ve checked the baby, we’ve got the information and everything’s fine[…] All the doctors in the hospital said they weren’t worried about me discharging myself[…] my [husband] said no three times, and then they called him and said if you don’t accept it then we’re going to call social services, which was probably the worst thing that had ever happened to me in life[…] with everything in the hospital, and then all of a sudden […] because of course I don’t want social services to come round to my house when I’m feeling like that[…] I didn’t have to say yes, but I said yes because […] the whole fear of having her taken off me ’ (Matilda)

Despite agreeing to allow the check and being provided with reassurances, however, the midwife did, in fact, refer her to social services:

‘I felt betrayed because she said that she was honouring everything beforehand, and then she was the one that said that she would call social services’ (Matilda)

Imogen’s account of her birth experiences in the institution starkly illustrates the escalation of behaviours, shift in power dynamics and exploitation of vulnerabilities (see 8.5.5) that can be seen to represent obstetric violence (see 10.4) as the extreme culmination of amplifying actions. After a protracted search for support outside of the NHS and resisting interventions such as vaginal examinations to protect her both physically and psychologically55, she accepted care within the NHS but at home. After her labour failed to progress according to guideline-based

55 Imogen disclosed a history of sexual assault which contributed to her declining vaginal examinations and a preference for not having an instrumental birth.
timetables, Imogen was offered a transfer to the labour ward at her local hospital. Imogen agreed and requested an epidural when she arrived:

‘I went through the doors saying right, let’s get the epidural started. Because it’s going to take 45 minutes to contact the anaesthetist and get the trolley in [...] They were like no it’s too late for that. And they put a CTG on me and she [fetus] had reduced variability’ (Imogen)

Imogen resisted and refused to be coached in her pushing, stating that it ‘was the only time I managed to stand up for myself’.

Participant accounts here illustrate the ingrained nature of systemic actions and behaviours enacted by healthcare professionals that, intentionally or otherwise, not only undermine the non-normative choices that have been made but also give rise to layers of behaviours exhibited by healthcare professionals that had the potential to escalate throughout a pregnancy.
Figure 20 Entering the System Concept Diagram
7.5 Conclusion

In this chapter, I have introduced and explored the first of two concurrent social processes centred around explaining experiences of making non-normative choices within the system. The process illustrated in this chapter has considered the normative parameters within which participants were expected to make choices, which include institutional timetables and rules with an expectation of compliance with care recommendations. A key driver in constraining such choices includes standardised, risk avoidance-based practices and guideline-driven maternity care, which, contrary to ambitions for choice and personalisation, serve to depersonalise, categorise, and label women, mostly perceived by them negatively. Fetal wellbeing was centralised throughout participants’ childbearing journeys, often at the expense of women’s choices and frequently featuring in coercive and bullying conversations with healthcare professionals. Failure to comply with recommendations and institutional norms amplified systemic actions and behaviours intended to inhibit the ability to realise non-normative choices. Throughout this chapter, I have presented elements of my argument that the processes described above represent varying degrees of threat and challenge to a participant’s reproductive identity, precipitating further or initial choices to address and defend against the challenge and protection of individualised autonomy and agency, core to reproductive identity.

While this chapter has introduced some of the motivations for making non-normative choices, the following chapter will explore in detail the processes, actions, and strategies women enact to enable them to make non-normative choices, exert agency, control and self-determination and thus align with preservation of reproductive identity.
Chapter 8    Navigating the System

8.1 Introduction

In the previous chapter, I presented the first of two parallel social processes that establish the systemic constraints within which women make non-normative choices, the expectation of compliance with normative recommendations for care and how these might represent a threat to reproductive identity and the amplifying actions enacted by the system as a result. I have presented examples of motivations for non-normative choices and introduced how they might be employed to respond to reproductive identity threats.

This chapter, ‘Navigating the System’, explores the parallel process to the previous chapter, ‘Entering the System’. In this chapter, I present the processes, actions and strategies enacted by women to realise their choices to protect their reproductive identity and defend against identity threats. I begin by demonstrating that while some women resist entering the system at all (quitting), in most cases, choices are made incrementally rather than an immediate rejection of the system or recommendations. I demonstrate that non-normative choices are informed by a process of seeking and gathering knowledge (evaluation), engaging with supportive communities (engaging), and ‘doing nothing’, an abstract conceptualisation of actions and strategies employed to perform a role of seeming compliance and agreeableness, while employing strategies behind the scenes to realise choice on their terms. I argue that communities are sought to align with participants’ reproductive identity and are used as sources of information, valued by participants over institutional knowledge, unless trusted healthcare professionals represent trusted communities. Finally, I explore how negotiation and compromise are important strategies for achieving non-normative choices with the potential of failure to reach a compromise, resulting in giving up and compliance.
8.2 Evaluating Information and Knowledge

Seeking and gathering knowledge was the foundation of strategies to inform and support non-normative choices. This was an ongoing process, with participants utilising this knowledge to constantly adjust their knowledge base and choices, navigate the system, negotiate with healthcare professionals, or enact strategies to achieve their choice. There was both implicit and explicit rejection (see information seeking below) of the institution as a source of trusted knowledge. The view that information provided by the healthcare system was untrustworthy was evident across accounts, with participants preferring to locate ‘neutral’ sources that ‘don’t fall into one camp or the other’ (Grace).

8.2.1 Information seeking

When engaging with the system, many participants understood that they distrusted information provided by the institution, being especially suspicious of how risk data were presented. Participants felt information was used to coerce them away from their choices, either overinflating or obscuring absolute risks with statistics or cherry-picking and omitting to communicate the risk of intervention altogether:

‘Anything that any health officials tell you [...] they might be just telling you one thing ... but then what they don't tell you is that basically the only increased risk might not be .1%, not even 1% which is tiny. So, if you look into it ...it's nothing and it's not really a risk at all’ (Hazel)

Nor could women trust the intentions of the healthcare professionals offering the intervention or how accurate the information provided by surveillance technologies was. Grace declined both routine and ad-hoc scans:

‘[they were] all unnecessary I felt, scans, they do those, all sorts of scans, try to, to tell you babies got seven heads or whatever.... yeah...and a tail’ (Grace)

56 The use of relative risk as a means of communicating increase in likelihood is problematic from a legal standpoint the Montgomery ruling (2014) explicitly stating that “The assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude”, but also from the perspective of risk presentation in absolute terms (Ferguson, Shapiro and McDonald, 2023)
Leah even suggested that ‘the obstetrician went out of her way to kind of sabotage those scans’ to encourage compliance with recommendations:

‘I’m very curious. I always watch the scans. I watched exactly what they did. I wanted to know what all the numbers meant...I watched those scans that suddenly, the chart had gone up and I wasn’t happy with how they did those scans. You know, only, where they dragged the little cursor to I just, I knew it wasn’t right. And I also knew my body’ (Leah)

Hazel was in her thirteenth pregnancy. She had a previous caesarean birth and nine vaginal births. She wished to give birth at home and was experiencing resistance from the local maternity team, having been through several discussions with various professionals. They were concerned about the likelihood of uterine rupture and post-partum haemorrhage as Hazel was categorised and therefore labelled grand-multiparous. When negotiating over her choice, she challenged the evidence upon which the recommendation to give birth in a hospital instead of at home was based and how that applied to her circumstances:

‘...I asked her [Head of Midwifery] if she could provide me anything...rather than you saying, “you’re at higher risk of this”, show me something to tell me that I am. Why should I listen just to you if you can’t actually show me anything, how can I make an informed choice...If you're not giving me anything to be informed about? Because it's just your word.’ (Hazel).

This example was consistent with accounts rejecting healthcare professionals as a source of authoritative knowledge favouring a participant’s research and embodied knowledge, validated, and legitimised within their trusted communities (see 8.3). Healthcare professionals’ knowledge and expertise tended to be viewed as

---

57 Likelihood of rupture for one previous caesarean section is 0.5% (compared to 0.02% in an unscarred uterus). Chance of successful vaginal birth after caesarean if vaginal birth before or since caesarean, approx. 90% compared to 72-75% if no previous caesarean birth. Comparable to likelihood of vaginal birth as nulliparous (RCOG, 2015a). Grand-multiparity not an independent predictive factor for rupture.

58 Grand multiparity definition varies: ≥ 4 births after the age of fetal viability (Alsammani et al., 2019; NICE, 2017). Associated with increased risk of post-partum hemorrhage, particularly when accompanied by increased maternal age and other comorbidities.
defensive in nature, overestimating risks, or criticised for not being applicable to the participant's individual circumstances. There was explicit acknowledgement that much empirical research that informs guidelines and clinical recommendations are rooted either in population-based data or consensus within the obstetric and medical community\textsuperscript{59}, further reinforcing distrust in clinical knowledge, professional advice, and suggestions for care.

Participants actively engaged in autonomously seeking sources that legitimised and supported their non-normative choice. This included extensive searching for research literature pertinent to their situation in anticipation of having to justify and fight for their choice:

‘I’ve researched this, I’m well informed and this is the right decision for me, and I’ll be in contact with you [healthcare professionals] if I do need anything’ (Matilda)

Leah, a person with type 1 diabetes, considered herself an expert in her condition, exerting agency and control over managing her diabetes, forming an important part of her non-reproductive identity. She knew before pregnancy that her diabetes would determine her care pathway; therefore, she undertook to optimise her health before conception. Additionally, Leah hoped for multidisciplinary care between obstetricians and midwives (see Needing Community), expected to be part of the supported decision-making process:

‘because of my type 1 diabetes [...] automatically, I was put in a high risk category [...] I went into the pregnancy [...] assumed I was going to have a hospital birth [...] just someone who kind of conformed [...] I went into the diabetes consultant and even before she even opened my notes, even before she knew anything about me but my name, she said ‘right, well you’ll be induced before 39 weeks’. I think that’s something that’s going to stick with me forever. Just, I was seven weeks along and that was the first thing that was ever said to me. And that was a huge wakeup call that something wasn’t right’ (Leah)

To counter the apparent challenge to identity resulting from the pregnancy, Leah engaged in seeking information as a critical strategy in pushing back:

\textsuperscript{59} Prusova et al., (2014) examined the 52 Royal College of Obstetricians and Gynaecologists Green Top Guidelines published at the time and found that of the 1652 recommendations, 9-12% represented best quality evidence with 40% based on ‘Recommended best practice based on the clinical experience of the guideline development group’ alone (Ibid, p.708).
‘I quit work [...] I was happy to spend all of my time reading, researching pregnancy, birth, parenthood, the healthiest thing to do, the most up to date research. You know, anything that would educate me and help me make better choices and have the best experience that I could’ (Leah)

Subsequently, later in pregnancy, when Leah was faced with an obstetrician relaying ‘scary stories at me [...] about big babies, about shoulder dystocia, neonatal hypoglycaemia, all the usual kind of, stereotypes with diabetes pregnancy and babies’, she felt she was able to push back and challenge:

‘Everything they were telling me I knew; I know all the risks [...] I know why those things happen and that because my diabetes is so well controlled, the risk of neonatal hypoglycaemia is miniscule’ (Leah)

Publicly available material was also not always considered reliable information for women. Information tended to be generic, intended as a tool to facilitate personalised conversations; however, when used in isolation without nuanced consideration of individual circumstances or context, participants felt they were not represented in the information provided:

‘a lot of people in these books, they talk about being pregnant [...] about giving birth and [...] how excited they are but not everyone’s excited, and not everyone wants to have children, not everyone plans to have children, sometimes these pregnancies are accidents, sometimes, you know people are, people can’t always relate to what’s in a book because, as far as I’m concerned these people in this book they’ve planned their pregnancy then set then you know they’ve got married, they’ve had decided turn baby they got pregnant, this this, this, this and that’s not what my life was like. I’d never set out those life goals and I felt very dissociated from kind of books and stuff like that’ (Darcie)

Darcie’s quote illustrates the broader normative social expectations around ideals of pregnancy, birth, motherhood, and womanhood, all of which may be at odds with participants’ reproductive identities and represent identity threats.

Another information-seeking strategy noted was ‘sounding out’ of the healthcare professionals’ stance and testing plans to note reactions. Leah described this as their ‘line in the sand’, eventually informing non-normative choices and future negotiation strategies and planning. This was evident in Imogen’s interaction with her midwife:
'I did say to her if I go into labour at 36+6 I don't want to go into hospital and she said [...] [they] aren't allowed to come out under 36 [weeks] [...] So I thought fair enough, we've had the conversation where you've drawn the line in the sand. [...] So, what that means to me is if this baby’s breech, I have to have a free birth or [...] choose a planned hospital birth and if I go into labour pre-term, again, the same thing. Fine [...] I don't agree with it [...], but fair enough, that’s the line in the sand.' (Imogen)

Having discontinued care with a group of privately run midwives, she began seeking potential independent midwives to support her choices. Eventually, she began to plan a freebirth:

‘I said [to the independent midwives], “if I have a free birth would you come out to me afterwards? Just let me know the point at which you’re happy for me to contact you, I’m assuming it will be placenta out, no active breathing and what I really want you to do is exclude the third-degree tear”. This midwife said, ‘yeah of course we will, I’ll do that’ and then was asking me about what happened [...] after probably about five or six back and forth emails, she stopped responding. And I had asked her if she would be prepared to provide postnatal care for me, and she didn’t get back to me, and my feelings now are that she communicated with me because she wanted the gossip!’ (Imogen)

Similarly, Esmie tentatively explored the community midwife’s skill and, thus, institutional approach to supporting a potential breech birth at home after a private scan had shown a breech presentation at 26 weeks gestation:

‘To find out their stance on you know, home birth [...] she was disgusted, she was just like “that wouldn't be happening, that wouldn't be happening”, it was “you're, you're too high risk to have a home birth anyway so it doesn't matter whether the baby is breech or not, you're not having that”’ (Esmie).

---

60 3-4% of fetal presentation at term are in the breech position (Impey et al., 2017)
8.2.2 Weighing Evidence

Weighing evidence was a strategy used to reframe and challenge recommendations and guidelines. Central to this was the process of evaluating evidence as it applied to participants’ circumstances, which they felt were not occurring within the institution. Participants displayed various levels of evidence literacy:

‘I don’t see, the point after looking at the literature. It’s not necessary for me, the individual. Same with GAP/GROW\(^\text{61}\), [it] should not be in ANY hospital. The fact that it is in any hospital is an outrage […] there’s very little evidence, a lot of things that happen […] just because we’ve always done it which is not a good enough reason for me to do and also with GAP/GROW, that’s Perinatal Institute and they make money off that’ (Grace)

Participants demonstrated complex understanding, assimilation and evaluation of statistics applied to their risk profile, challenging how this was presented in a perceived biased manner to gain compliance. Imogen returned to NHS care, having exhausted other options (as above). She requested a homebirth:

‘They recommended I didn’t have a home birth […] she said it’s your first baby […] she starts talking about the birthplace study\(^\text{62}\). First of all, that isn’t what the birthplace study says. But she was saying we don’t support you having a home birth because it’s your first baby, we want you to come into the delivery suite […] I said that the [birthplace] study was 10 years old and all the evidence since then […] look at

\(^{61}\) GAP/GROW = Growth Assessment Protocol, a proprietary package of software, training, guidelines and care pathways published by the Perinatal Institute, adopted by many NHS Trusts within the England to assist in fulfilling the requirements of risk assessment, surveillance and management of fetal growth restriction as part of Saving Babies Lives care bundle. (NHS England, 2019b). High quality evidence suggests that there is no observable effect that GAP protocols improve antenatal detection of small for gestational age fetuses compared to standard care (Vieira et al., 2022)

\(^{62}\) First UK study to examine perinatal outcomes according to place of birth including birth at home. Showed a slight increase in risk for the babies of nulliparous women born at home compared to birth in hospital (9.3 v 5.3/1000) with no significant difference for multiparous women (Birthplace in England Collaborative Group, 2011).
the Hutton analysis. She didn’t obviously know what I was talking about. And she said we don’t count that evidence; we don’t count that research; the NHS uses the birthplace study.’ (Imogen)

Weighing up evidence included evaluating recommendations as they pertained to individual circumstances in a way that participants felt healthcare professionals could not, or would not do, preferring to over-medicalise to remove risk but not acknowledging iatrogenic risk. Again, BMI features consistently across accounts in this regard. Bella challenged evidence with an anaesthetist related to the risk of birthing in a body with a raised BMI:

‘they don’t tell you what the appointment was for, so I got there and I said, “what's this about?” and they said, “well your BMI” and I said “let's just start by saying BMI is bullshit, so tell me what exactly the problem is - is it high blood pressure? is it high cholesterol? [...] tell me what it is that's the worry because BMI as a number that is not based on my body at all, it's nonsense’’ (Bella)

Participants with previous or current professional expertise in childbirth, such as midwives or doulas (Angela, Esmie, Imogen, Jade, Kali, Nellie), drew from their knowledge of childbearing physiology to inform their choices, reject or challenge recommended care. Angela, for example, rejected the assertion that a raised BMI meant that she would not labour effectively due to potential uterine visceral fatty deposits:

‘So much fat that it disrupts the uterotonic [...] receptors in your uterus? , I don't know if that is actually based in medicine or not, I'd literally never heard of that, that you have so much fat, it disrupts the normal physiological process of labour’ (Angela)

This example was consistent with accounts rejecting healthcare professionals as a source of authoritative knowledge favouring a participant’s research and embodied knowledge, validated, and legitimised within their trusted communities. Healthcare professionals’ knowledge and expertise tended to be viewed as defensive, overestimating risks, or criticised for not applying to the individual.

As previously discussed, healthcare professionals were not usually a primary, trusted source of information, nor did most participants consider them authoritative or privilege them above their research and embodied knowledge.

---

63 Systematic review and meta-analysis of 14 studies which included 500,000 planned home-births showed overall no difference in risk of neonatal or perinatal mortality compared to birth in a hospital (Hutton et al., 2019).
Key trusted sources to gather and evaluate evidence were usually internet and social media-based, notably prominent social media influencers, some of whom were prominent obstetricians, midwives, researchers, and doulas, but many of whom were not, including celebrities, lay commentators and service users:

‘I joined a few Facebook groups, one was for VBAC [...] I started keeping an eye on the conversations and a lot of the time women asked the same questions over and over and then other women replied to them with research article links and stuff like that [...] I just started reading the research and there are like a lot of women who are researchers who are on Instagram and on Facebook, and they share research or like make it understandable for simple women’ (Faye)

‘I read this guy’s thing [...] I follow a lot of Obstetricians on Twitter like [name] [...] like you know, you read [independent midwife], you know exactly what she was gonna say before you go to the website’ (Grace)

The value participants placed on the information gathered in this manner depended on aligning with their own reproductive identity, beliefs, needs and desired principal birth outcome (e.g., a positive birth experience etc.).

Most participants explicitly referred to institutional guidelines as problematic in their blanket application when there was little regard to individual biopsychosocial considerations. In particular, perceiving the evidence base as weak, population-focused, contrary to personalised care and of no personal value:

‘I was like yeah; I know the ARRIVE trial [...] it’s not generalisable to a UK population. You know this is a study that is based on whether [...] they can make their service more efficient for them, not for the woman who they’re caring for’ (Angela)

8.2.3 Privileging Embodied Knowledge

Participants felt attuned to their bodies and fetuses in a way that healthcare professionals were not, using this to demonstrate a nuanced, personalised understanding of risk and safety per their circumstances. Participants drew heavily upon embodied knowledge in their pregnancies to guide their non-normative choices. Privileging embodied knowledge was also used to reject institutional identity as it pertained to categorised and labelled risky body narratives perpetuated by the institution (see Entering the System). These included requesting additional
care, pushing back against institutional recommendations, or resisting entering the system. Jade declined an obstetric glucose tolerance test offered because she had a first-line relative with diabetes:

‘I [was] well at the time […] was just around 30 years old. Really fit. I was doing three gym classes a night. My diet was really good. So, me weighing up whether I really needed that GTT I felt like I didn’t […] there was just no need’ (Jade)

Imogen declined induction of labour, evaluating how she felt at the time and her expectations for when labour would begin:

‘I was completely comfortable. I was absolutely fine. This baby will come when this baby is ready’ (Imogen)

Nellie’s sense of maternal-fetal relationship informed her future request to plan a caesarean birth outside of guidelines:

‘I felt like I had these really strong connections with her [the fetus] […] I had quite a few strong gut feelings when I was pregnant […] I knew I think from six or seven weeks […] I had a really strong feeling I was having a girl, picked her name at 13 weeks, I hadn’t even had my 20-week scan, that was really strong for me […] once that got confirmed that I was having a girl I trusted my gut even more then’ (Nellie)

Embodied understandings of the pregnancy helped participants to distance themselves from accusations of being reckless with their own or fetal safety. Embodied knowledge was drawn upon to escalate concerns and to resist escalation:

‘[I had] a very strong idea where I would want escalation and none of those things came up’ (Grace)

---

64 Obstetric glucose tolerance test offered to women who are assessed at risk of gestational diabetes by virtue of an ethnicity with high prevalence of diabetes, first degree relative with diabetes, gestational diabetes in previous pregnancy, baby born weighing ≤4.5kg (macrosomia) or a BMI ≤30kg/m² (NICE, 2015)
Hazel knew her fetus was in the occiput posterior malposition and therefore used this to guide her decision to escalate and call the local hospital:

‘She were back-to-back. And now we’re in this massive pain and I’ve never felt this pain like it. And so that’s why I told him to ring somebody.’ (Hazel)

Jade provided an example of how she used a combination of embodied knowledge and evidence to weigh up the decision to ask for help when she experienced reduced movements, refuting again any notion that women would put themselves or their fetuses at risk when enacting their choices:

‘I listened to my body, and I thought at this point if these reduced movements would have been earlier in my pregnancy I probably wouldn’t have bothered as much. But because of the prolonged pregnancy [...] that coupled with [...] it wasn’t like a little episode. It was like quite a significant [reduction in] movements. So, I thought it’s a sensible time now. I probably need to go in’ (Jade)

Participants used embodied knowledge alongside that previously discussed as having been obtained through participants' professional status as midwives and doulas, further supporting the association between professional and reproductive identity informing non-normative choice:

‘I don't think I can ever really sort of divide the midwife away from my personal beliefs [...] I know I have an enormous amount of privilege because of my [...] my educational background [...] I’m aware that I have opted for certain things that I wouldn't necessarily get otherwise. [...] being a midwife means that I was privy to having a scan with [chosen senior obstetrician] [...] I was already on folic acid five milligrams prior to becoming pregnant because I know that reduces the risk of [Neural tube defects] [...] I already knew that I wanted to have continuity of care [...] I booked with the home birth team, and I self-referred to the hospitals and my GP[...], I booked with my friend I texted her and said, you know,
will you be my midwife, and she said yes of course. So, I thought I was setting myself up for a really good pregnancy’ (Angela)

Angela’s account illustrates how participants used their professional knowledge to predict and plan early in their pregnancies and sometimes pre-conception to lay the foundations for achieving their non-normative choices and, in many cases, inform the decisions to make the choices. Predicting and planning, however, were not however exclusive to these participants.

8.2.4 Predicting and Planning (Acts of Preparedness and Strategising)

All participants exhibited processes and strategies consistent with predicting potential outcomes and elements of their pregnancy that might need a strategy to manage. For some, this meant predicting how the system might receive their choices (see battling with the system) and for many, this also meant predicting and planning for scenarios they might encounter because of their choices, i.e., consequences of declining care, making outside of guidelines choices concerning place or mode of birth. Hazel also engaged in activities that allowed for predicting and planning for emergencies in the event of an issue occurring during her planned freebirth, therefore retaining some control over foreseeable eventualities:

‘I debated all the way through. I’d joined [a doula] freebirth course, gone through that and I’ve done my planning and I were like right? We’ll just play it by ear…’ (Hazel)

Exhibiting a preference for operative or assisted birth in the event of their primary non-normative choices not being realised was a notable strategy, what some described as having a ‘plan B’ (Bella):

‘I’d said to myself that if anything happened, if I had to go into hospital, I’d prefer to have a C section over anything else, because that allowed me to stay in control […] I do not want forceps, I want to have a quick escalation to caesarean if it’s going down that road you know, I’m very, very clear that I didn’t want rotational or mid cavity forceps ’ (Grace)

---

65 Angela’s account is consistent with studies exploring the influence of midwives ‘insider knowledge’ in decision making to achieve agency in mode and place of birth, who provides care, the impact of care and transition to motherhood (Coulton Stoliar, Dahlen and Sheehan, 2022a, 2022b)
This example of the need to remain flexible and fluid in decision-making reinforces the need for participants to be able to change their minds and is reflected in the extent of planning and predicting their choices; this was also noted in accounts of compromising (see later in the chapter). Alongside accounts of planning for foreseeable eventualities, participants indicated the likelihood of psychological harm, weighing up the benefits and risks of not accepting recommended care against their own social, cultural, and psychological circumstances and how this might impact reproductive identity. In her account of navigating elements of a scan, Kali accepted the offer to check the size of a fibroid that she was aware existed however, she also predicted that the sonographer would likely undertake a fetal growth assessment simultaneously, which hadn’t been requested:

‘At that scan I told the sonographer I only wanted to check for the fibroid […] we are doing this just for the fibroid, just to make sure that it’s moved, or it hasn’t gone bigger or it’s not blocking the cervix or anything like that...’ (Kali)

Kali wanted to avoid this to prevent firstly worrying about fetal growth and, secondly, because she did not see the value to her of this element of screening in the absence of physiological indicators of pathology.

8.3 Needing Community

Seeking and engaging with communities was characteristic of the strategic process of navigating within the system. Allies and advocates within communities aligned with participants' reproductive identities were vital for supporting, counselling, and engaging in problem-solving actions. Such communities were varied and could be friends, social media, family and notably, some trusted healthcare professionals who were facilitative – openly or otherwise – of non-normative choices.

8.3.1 Seeking Community, Allies and Advocates

In the absence of an existing community membership, many participants actively pursued membership of communities during pregnancy in response to the amplifying actions and behaviours exhibited within the system to develop coping strategies and locate allies who share similar reproductive identities. Some participants, however, came to their pregnancy already being part of such communities, having become part of them following previous experiences or as part of predicting and planning. Bella illustrates this in her reflection on others sharing their experiences:
‘[…] people being really positive about the care they received and really defiant is also very inspiring for me’ (Bella)

Social media provided participants an important community space to explore and support non-normative choices. Some participants valued the possibility of anonymity and invisibility, helping them discuss their choices frankly and without judgment. While it could be argued that communities are used for developing connections and sharing knowledge at their core, this does not imply that anonymity counters this purpose. The reason for anonymity being valued may be three-fold.

Firstly, participants recognised the potential social and cultural implications of making choices that may be seen as other or deviant, acknowledged by their self-labelling and especially when their choice positions them at the centre of the care rather than the fetus. Secondly, by their very nature, public discussions of non-normative choices mean that participants might be identifiable, their choices being unique in many cases. Healthcare professionals also occupy such spaces for various reasons, including themselves moderating groups or seeking community outside of their professional circles, where their choices might be seen as contrary to their professional identity. Anonymity reduces the likelihood of participants’ identification by healthcare professionals - women moderating the information they choose to share within the discussion - and therefore reduces the risk of repercussions such as referral to social services. Finally, strategies employed to ‘play the game’ or ‘do nothing’ (see later in the chapter) do not risk being exposed and, therefore, are more likely to be successful if seen through to fruition. I propose, therefore, that maintaining anonymity in this way reflects a means of control retention and a powerful strategy for reinforcing and protecting reproductive identity.

Several participants illustrated how their communities were important in interrogating evidence concerning their situation and fundamentally expressed how they trusted these sources above institutional recommendations:

‘[they] convinced me. It's not evidence based […] I think the Facebook group was emotional support […] then I actually took [to] Twitter, where I felt like […] I've seen the other side, a lot of the other obstetricians who are much more, not intervention-y. So, I felt like I kind of had this layer of expertise on Twitter and I was able to interact with as well. So that's a great thing about Twitter. You can speak directly to these people’ (Grace)
Some of the participants in this study had been pregnant during the COVID-19 pandemic. For some, this was a crucial driver in seeking communities and advocates outside of the institution and, thus, motivations for non-normative choices:

‘Because of COVID I wasn’t even offered any antenatal classes or anything. So, I did everything myself. I ended up following so many amazing people on Instagram’ (Leah)

Leah subsequently discovered that the pandemic would be instrumental in permanently changing local maternity services. She felt that before the pandemic, her choices would likely have been resisted; however, reconfiguration of maternity services to accommodate pandemic arrangements positively influenced the extent to which the system realised Leah's non-normative choice:

‘They decided to put a home birth team together [...] [new senior midwife] came in at the most perfect time and she was [...] fully supportive. She said “We’re going to do everything we can to get you into spontaneous labour” [...] I don’t know who was watching down on us or who put us together, but it couldn’t have been any more perfect. I knew that the whole thing was going to change and that I was going to have my home birth’ (Leah)

Leah’s account illustrates how some supportive communities were found within the system, with key healthcare professionals acting as powerful advocates. This, however, was not the norm. Most participants identified healthcare professionals, including obstetricians and senior midwives (heads of midwifery, labour ward coordinators, safeguarding midwives, etc.) as powerful gatekeepers to experience and choice facilitation.

Participants were regularly referred to consultant midwives as powerful gatekeepers who assisted in care planning when making outside-of-guideline choices. Kali anticipated this and, knowing her local consultant midwife, actively planned to see them, reasoning that, in her opinion, the consultant midwife’s role was as much

66 A senior midwife appointed within a Trust/Health board to provide expert advanced midwifery leadership and consultancy with an emphasis on strategic service development, education, training and development, research, and evaluation. It is common practise to refer women with non-normative choices to Consultant Midwives alongside the obstetric team as part of ‘outside guideline’ pathways for care planning and counselling.
about empowering midwives to support her choices as it was care planning itself, thereby improving her chances of other midwives being comfortable in facilitating her choices:

‘I saw the consultant midwife. I really liked that appointment, I decided to see the consultant midwife during pregnancy just so my colleagues were supported with my outside of guideline choices’ (Kali)

Imogen’s experience as a consultant midwife, however, was very different. Amongst other choices in her pregnancy, Imogen declined fetal monitoring at home, having thoroughly researched the evidence base for contemporary recommendations and made an informed decision. She reflected on a document sent to her after meeting with a consultant midwife:

‘I just remember thinking, this didn’t happen. You’re not listening. I’m trying to talk about evidence. And all the consultant midwife said to me was that I was high risk […] that I was ineligible for a home birth’ (Imogen)

Continuity of care and carer was also noted across accounts, fulfilling participants’ expectations of a supportive community. Caleb was happy to be case loaded by a continuity team of midwives. Continuity was important because Caleb did not have to repeatedly respond to questions about his trans-pregnancy, which allayed anxieties around being misgendered. Being looked after by the continuity team became a mechanism for acknowledgement and protection of Caleb’s identity in the presence of a non-normative pregnancy:

‘I think I was okay with it […], it felt good in a way because I knew that I’d know the midwife that was going to be there […] because I was a bit worried about going to Sure Start centres and going to my midwife appointments because I thought that people would see me and ask questions’ (Caleb)

Caleb explicitly recognised that while the difference in his pregnancy needed to be acknowledged- and he felt it was important that it was- he was clear he should not be seen as a curiosity, as his example of two encounters with doctors illustrates:

‘She wasn’t really very educated [about Trans pregnancy] […] she didn’t want to do anything wrong; she was excited and asked me questions […] another time with a doctor, we were talking about […]my testosterone levels[…]he didn’t really acknowledge me being Trans[…] he just ignored it’(Caleb)
Seeking allies within a community of midwifery care alongside or instead of obstetric-led care was a strategy employed by participants wishing to pursue physiological birth:

‘All my care was obstetric care which I wasn’t happy with […] just seeing doctors who are very tunnel visioned about birth […] only seeing the problem or complex or difficult cases, they don’t see a lot of physiological births […] what women are built to do. And yes of course there’s so many reasons why we need intervention, […] medication […] but it’s being forced on people […] where it’s not needed’ (Leah)

Participants spoke of being ‘lucky’ or fateful in finding supportive healthcare providers who acted as advocates because they assumed that healthcare professionals would resist their non-normative choices. When Grace declined the GAP/GROW protocol, she, supported by her continuity midwife, predicted, and planned accordingly:

‘they’ve offered you an appointment with the consultant and they want you to come in and speak to the head of their gap/grow team. I'm assuming you don't want that. ‘I [said] “That is correct” […] I was fortunate that […]I had a very, very, very supportive midwife and she basically[…]protected me from a lot of the coercion that I would have got’ (Grace)

Participants sought membership within communities and with individuals that aligned with their own reproductive identity. Jades’ community was found through a Facebook group to support women seeking advice for pregnancy past 42 weeks gestation. Jade had peer support with a woman who she met as a midwife but then reconnected with when pregnant herself:

‘She declined, she went I think 43 plus weeks with quite a few, a couple of hers [pregnancies]. But she’s very vocal on, like local groups […]. So, she was very much ‘you know your own body. You know that you’ll be getting these sort of inner voices. You are absolutely fine. Believe in yourself’. Yeah, she was like a really good support’ (Jade)

This was significant for Jade in reconciling and making sense of her choices.

---

67 See p192, footnote.
8.3.2 Sharing Community Values and Philosophies

Shared philosophy and understandings that aligned with participants’ reproductive identities were important in seeking valued and trusted communities and valued by participants. Trusted allies and advocates within the system were sought through ‘sounding out’ critical non-normative choices. Faye clearly expressed to her midwife that she wished to decline routine vaginal examinations:

‘My midwife actually chuckled and said “we don't do that anyway because it doesn't tell us anything about so the actual it's just a snapshot of a moment and it doesn't help us is this where the woman is in labour there are a million other ways to assess that” and I said well, good to hear’ (Faye)

This alignment of shared philosophies and mutual trust of embodied knowledge fostered strong bonds in relationships with trusted healthcare professionals that were facilitative of non-normative choices:

‘[My Midwife] has a very similar ethos to me [...] there was a point [...] I could feel [fetus] going through, that U bend you know, the pelvis [...] I remember looking over at [her] and it was like we had some sort of weird bond [...] and I didn’t need to say anything. I made eye contact with her; she made eye contact back and it was if I was saying to her like baby’s coming [...] she winked at one point as if to say like ‘I know’ ‘(Jade)

The notion of shared philosophy was commonly linked by participants to continuity of care, either through previous pregnancies or with a trusted healthcare professional with whom they were familiar. Participants who knew their carer felt they were able to safely make non-normative choices in the knowledge that they would be supported, rather than having to make efforts to conceal their intentions:

‘[The midwife] knew me. She knew that I would decline. She’s really good and she said, ‘I still have to tell you about it but if you decline that’s fine and I’ll support you’ and she did’ (Jade)

Characteristic of this alignment with communities was the act of positive self-labelling in ways that reinforced their individual and reproductive identities. That of the community as outsiders, discovering and conforming to the community’s norms to which they belonged. This appeared to be a common strategy for rejecting institutional identity while maintaining a sense of agency, autonomy, and self-determination:
'I quite enjoy being difficult [...]. I suppose I expected they were going to give me a hard time [...] it was quite tough to decline some of the stuff, but I'm just quite a bolshie personality. So, I was always like, I'm gonna do this and nothing is gonna stop me’ (Grace)

‘they don’t deal with people like me [...] I bit my tongue because I had to bite my tongue a lot. I wanted to be. I didn’t want to be a real troublemaker [...] I had obviously built myself a reputation because every healthcare professional I bumped into they’re like “oh you’re Leah”. Word was obviously spreading that there was this kind of radical’ (Leah)

These labels were rarely how participants presented themselves to the system, participants suggesting that presentation would vary depending on who they were speaking to, the purpose of the encounter, perceived intentions, and motives of the healthcare professional. This is characteristic of the strategies drawn upon to through the process performed for the system.

8.3.3 Hidden Communities

Communities such as facilitative healthcare professionals remained hidden until participants actively sought them out or came across them by chance. The degree to which communities were hidden appeared commensurate with the degree of normativity the pregnancy or choice in pregnancy represented or how transgressive the choices being supported were in the context of social, cultural, and institutional acceptability. As a pregnant transman, Caleb found that he was unaware of similar birthing parents, other than those identified in the media, alongside the problematic and sensationalised nature of how this was reported68:

---

68 This is consistent with data from the ITEMS survey (LGBT Foundation, 2022), which reported that transgender/non-binary birth parents received a lack of perinatal information, were twice as likely to feel they did not receive feeding support and three times more likely to say they did not receive midwifery or health visit help when requested. Transgender/non-binary parents were more likely to conceal their identities as a strategy- ‘passing’ (Breakwell, 1986; Goffman, 1967) to avoid judgement and transphobia, and that choosing to freebirth stemmed from a motivation to avoid perceived discriminatory care systems. Where respondents were black or brown, 46% of the respondent sample chose to birth without accessing any perinatal care (compared to 30% of transgender/non-binary respondents overall). These data are cautiously interpreted however as the report has been criticised for a lack of methodological and interpretative rigour (Webb et al., 2023)
‘I didn’t realise that there was like as big of a Trans community that had babies [...] [a researcher] held a conference thing. And so, when I went to that I got in touch with them, there was loads with a Trans parent’ (Caleb)

Hidden communities were evident for those who made a non-normative choice that they felt would be perceived negatively by virtue of their professional identity. As a midwife, Nellie wished to have a planned caesarean birth but postponed the decision initially because:

‘I felt quite ashamed of that for quite some time, and that was probably a big obstacle for me making that decision. I didn’t want to be labelled with whole too posh to push element of it and I thought as a midwife I’ve never experienced contractions, I haven’t been in labour, If I go for an elective caesarean, is that going to impact me and how people judge me in the future?’ (Nellie)

Communities can also be hidden in plain sight. For example, Graces mother-in-law had been an obstetrician and was ‘furious’ when she decided she was having a homebirth. Grace’s hidden community turned out to be her mother, who she assumed would be ‘anti-homebirth’:

‘I was quite surprised [...] I’d actually forgotten that when I was growing up, she had these books from Sheila Kitzinger everywhere [...] I’ve always thought I would have a caesarean section and my mum was always very disappointed by that. Back in the 80s. She’s always been very much like a natural birth side’ (Grace)

---

69 The apparent contradiction of a midwife as a pregnant woman wishing to choose a caesarean birth is potentially illustrative of internalised ‘role conflict’ (Goffman, 1972) which may account for Nellie initially concealing her wishes. This is of course contingent on normative expectations of the professional philosophical positioning of those practising midwifery and these being the same as those held personally by the individual. Nellie’s account in fact exposes how a midwife’s professional experiences may influence her practice and vice versa. While outside the scope of this thesis, a body of evidence exploring this phenomenon is growing (Coulton Stoliar, Dahlen and Sheehan, 2022a, 2022b; Milne, 2022a)

70 Sheila Kitzinger (1929-2015) was a social anthropologist, leading childbirth activist and childbirth and pregnancy expert. A leading voice in the need to resist medicalisation of low-risk pregnancy and birth and support women’s choice to birth at home. She believed in the transformative and political nature of pregnancy and birth, resisting power in the hegemonic medical model of childbirth and its ability to control women’s bodies.
A small number of participants demonstrated how hidden communities represented their colleagues working within the system, either as professionals who shared a similar philosophy or who they knew would support their choices:

‘I chose my obstetrician [laughs] which was a big thing, and so I think that kind of did affect my pregnancy, it did really affect, my choices, I wanted to make sure that I was going to be with an obstetrician that respected me’ (Angela)

As discussed above, Nellie did not initially realise that her supportive community would be her peers until a midwifery manager recognised how her mental health was being affected by her reproductive history and role and suggested a caesarean birth:

‘My manager suggested having a C-section. She said to me, when we were talking about birth planning [...] ‘you do realise that this is an option for you? you don’t have to give it [vaginal birth] a go [...]’. you don’t have to ask permission either?’. And I said to her ‘I feel like a bit of a fraud though, if I have a C-section, I’m worried about what people will think’ and she’s like ‘you’ve been through a lot, you’ve had two pregnancy losses really close together[...] you’re pregnant after a loss[...] she listed everything[...] hearing it from somebody else’s viewpoint I [thought] I do have a bit of a valid reason here’ (Nellie)

As previously suggested, hidden communities were also noted to be facilitative midwives and obstetricians who work to facilitate choice, sometimes risking reproach from colleagues and employers, accusations of unsafe practice and recrimination from the wider obstetric and midwifery community should something go wrong71.

‘The second midwife [...] she listened to me. [...] she listened to me, I felt very good connection with her right way, that’s why I asked us to swap to her, she was like night and day difference’. (Faye)

71 Contemporary research focussing on healthcare professionals’ experiences of supporting suggests that this perception is well founded. Feeley, Downe and Thomson, (2021) suggest midwives and other health professionals when supporting physiological birth outside of guidelines can be constrained by organisational culture, particularly when the culture did not ‘value or support midwives or women’s autonomy’ (ibid, p:448)
Kali felt this in the approach to facilitating her choices between midwifery and obstetric colleagues once her labour progress stalled, linked directly to her ability to feel in control:

‘It was completely different things when it was only the midwives involved. I was in control. Everything that they offered […] they just say, this is what we offer you, this is what we recommend. But I was the one making the choices. And things changed completely once the doctor got involved […] there was no like immediate danger for my life or the baby’s, it was a matter of ‘this is not progressing’ […] It’s not like a life-threatening emergency, so it could have been some time but the control I had over the process changed completely once the doctors got involved’ (Kali)

8.4 Engaged in a Battle

8.4.1 Battling with the System

During this process, women anticipated the likely success of their non-normative choices with varying degrees of opposition and potential conflict with healthcare professionals challenging them. Participants frequently used language that reflected this as a ‘battle’ or a ‘fight’, suggesting again the notion that choices might feature in defence of their reproductive identity:

‘It feels almost like a battle and like it’s almost this idea of women always need to justify our choices all the time no matter what you do.’ (Kali)

In anticipating these battles and resistance, participants planned accordingly by reframing and challenging recommendations, predicting, and planning or ‘doing nothing’ (see Doing Nothing). For Leah, this meant deliberately seeking out the care of community midwives who she believed would align with her values in pursuing a homebirth in the presence of diabetes. This was not, however proven possible, and this decision became challenging:

‘I [felt] like midwives who move into the community maybe […] a bit more open minded. That was my thought that they would be a bit more kind of supportive. I was wrong. And then from that point onwards it was a battle’ (Leah)
For others, they needed to select the battles they wished to fight in favour of predicting and strategising future means of navigating and negotiating within the system:

‘You need to also choose your battles’ (Kali)

It was curious that these ‘battles’ appeared to feature mainly in women’s accounts in pursuing a physiological birth or where participants wanted less care than is recommended rather than more (i.e., requesting intervention), particularly where fetal wellbeing might be compromised. Faye illustrates this in her pursuit of a vaginal birth after caesarean:

‘The amount of women on [social media] VBAC groups who are there after their one or two sections, to, just as me, arm themselves with knowledge, because they know they have a right for a vaginal birth, but they have to fight for it. How is that, why do I have to fight for something that is completely normal?’ (Faye)

The reason for this is not immediately apparent. However, I theorise that healthcare providers’ anxieties surrounding regulatory and medico-legal consequences of fetal demise or birth injuries and a contemporary social shift towards medicalisation and institutionalised care, thereby controlling the childbearing process, motivate actions to encourage compliance. This is discussed further in section 10.3.

It is interesting to note the analogy of being ‘armed’, consistent with the language of the battle, further reinforcing the use of information as a powerful tool in negotiating choices and any arising conflict. Moreover, the analogy of fighting was also observed in accounts of trying to obtain suitable pain relief post-caesarean birth:

‘there was[…]a constant kind of battle between me and the people that were meant to be looking after me[…]they didn't give me any tramadol[…]I managed to get it from the GP but […] by the time it arrived I didn’t need it[…] pain relief stuff was a battle[…]I just had major surgery, why are you fighting me on this?’(Bella)

8.4.2 Pushing Back

A key element within this concept was initiating actions designed to push back against, often repeated, attempts to gain compliance, influence choices, or sway decision-making. Before the pushback occurred, especially for
participants who had not decided to make a non-normative choice before pregnancy, there were suggestions that a tipping point occurred, an event which acted as a ‘lightbulb moment’ (Grace) and representing the point at which a decision was made to make a non-normative choice. Such a moment is characterised by recognising a threat to reproductive or other identity, agency, and control. Leah, who has type 1 diabetes, knew she would be categorised as high risk in her pregnancy, despite describing herself as ‘on the grand scheme of things, very healthy’ and therefore had taken steps to optimize her physiology and health before conceiving:

‘My diabetes was in the best condition it’s ever been during pregnancy, I decided to quit work. I decided to focus on my diabetes 100% because I knew how important it was to be as healthy as I could be for pregnancy and birth’ (Leah)

Despite this, an encounter at her first appointment with her medical and obstetric team represented firstly the imposition of the institutional identity but also a realisation that despite planning and preparing, Leah’s embodied understandings and her being an expert in her condition would be rejected in favour of guideline and fetal centred care:

‘My first appointment included a scan at that was at seven weeks gestation and I went into the diabetes consultant and even before, even before she even opened my notes, even before she knew anything about me but my name and she said right, well you’ll be induced before 39 weeks. And I think that’s something that’s going to stick with me forever. Just, I was seven weeks along and that was the first thing that was ever said to me. And that was a huge wakeup call that something wasn’t right’ (Leah)

Esmie anticipated resistance to her choices, which was confirmed when receiving a letter from the obstetric team stating, ‘we are the ones overseeing your pregnancy’, attending her obstetric appointment:

‘So that was the first appointment it just kind of it just made me realise that you know every appointment is going to probably be like that’ (Esmie)

Once a decision was made to make a non-normative choice, participants enacted them through a variety of overt and implicit actions and strategies. These might include withdrawing altogether or pushing back against institutional resistance and behaviours of healthcare professionals, enabling participants to stand their ground.
Esmie recalled that when faced with being informed that she would not be allowed a breech homebirth in the event of that being a possible scenario, she challenged the clinician:

‘I just said “you know you shouldn’t be talking to me like that I think what you MEAN to say is that YOU [Esmie emphasis] personally are not comfortable to attend […] you personally don’t feel confident in that situation and perhaps you’ve overlooked my question which was do you know anyone in your Trust? anyone on your, your community team?[…] and you know she was like “no. no one’s going to sign you off for a home birth”’ (Esmie)

Bella also explained how, after seeking information and weighing evidence, she finally ‘took things into her own hands’ by applying the knowledge she had gained to her circumstances (she was aiming for a VBAC) but had predicted and planned for the possibility that she might be offered an induction of labour because a scan at 39 weeks revealed ‘excess water’ and increased fetal growth velocity. Bella had already decided that induction of labour was not an option for her, even in the current circumstances:

‘We were all really clear about the no induction mandate […] they were really worried that […] he was going to be really big[…] they were like “we’re going to book you in for induction” and I was like “I don’t think you are” I would say that that’s not going to happen then they’re really surprised’ (Bella)

There ensued intense negotiation between healthcare professionals and Bella to plan for birth, often with conflicting information and plans provided between professionals. The consultant eventually offered to book a planned caesarean birth without induction of labour being a viable option for Bella; however, Bella still wished to prepare for a vaginal birth. Eventually, Bella had a facilitative discussion and reached a compromise with a consultant obstetrician:

‘I am sick of being pregnant, but induction is […] is more likely to lead to outcomes that I don’t want, a planned caesarean at this point is better than induction AND an emergency, hands down[…] [the Consultant said] you shouldn’t change your plans at all… you should be aiming for VBAC if that’s what you want, and then you’ve got the planned caesarean scheduled for the date’ (Bella)

Various accounts demonstrated that participants were open to negotiation and compromise, treated respectfully, allowed to remain in control, and supported in their decision-making with alternatives that acknowledged
participants’ autonomy and embodied knowledge. Jade had attended the hospital 16 days past her due date, having had an episode of reduced fetal movement. She was offered an induction of labour using an intravenous oxytocin infusion but declined, preferring to opt for an artificial rupture of membranes instead because she believed it ’mimics the most natural thing’. Jade continued:

’She [obstetrician] said ‘we need to break your waters because I we need to know what colour they are’. So, I told her at that point I can tell you what colour they are already because I was postdates. They’re going to be meconium. I know this. Anyway, went to the labour ward although I was told that I could stay on the birth centre. Went to the labour ward. Waters broken.’ (Jade)

It is interesting to note the element of prediction and planning in Jades’ account, stating that there was likely to be meconium liquor following the artificial rupture of membranes, a key consideration in her subsequent negotiation for birth in water. By acknowledging that she was likely to have meconium liquor and stating her belief that this was likely due to being ‘postdates’, Jade established her own ‘line in the sand’ by ‘sounding out’ professionals. She also predicted that water birth in the presence of meconium was likely outside of Trust guidelines. To counter this and reassure clinicians, Jade accepted a CTG to confirm fetal well-being:

‘The doctor then said that she wanted me to stay on the monitor because she wanted to monitor baby for a long amount of time. I stayed on for 20 minutes, I looked at the trace myself and said right I’m happy with that. I’m getting off. So, I took it off against advice again. I took the monitor off. I can only describe; it was like some sort of superwoman moment where I jumped into the pool and 26 minutes later baby was born.’ (Jade)

Jades clearly illustrates the nature and variety of overt acts employed to push back and exert autonomy in the presence of recommendations and institutional resistance to her choices. In this case, her actions resulted in her choices being realised. It was not, however, just with professionals that participants ‘sounded out’ intentions:

‘I kind of like joked about it with friends like well maybe I’ll freebirth, that kind of thing ’ (Kali)

72 Typically, induction of labour is offered sometime after 41 weeks of pregnancy for postdates or earlier with any concerns over fetal wellbeing, such as in this case of reduced fetal movement (NICE, 2021d).
Kali’s account here illustrates how ‘sounding out’ amongst peers helped evaluate their social reaction and the extent of support towards her intentions while simultaneously establishing her line in the sand and boundaries within which she was prepared to birth.

8.5 Doing Nothing

The category ‘doing nothing’ is a somewhat paradoxical term in the context of the study, as doing nothing implies a passive submission of the participant to an agentic process. In ‘doing nothing’, participants are in fact actively engaged in doing something; actions and interactions are designed to realise their choices on a spectrum from resistance to compliance. Additionally, the category describes the sometimes clandestine but often overt activities between facilitative healthcare professionals and participants to achieve choices, representing a role modelling of choice provision within the system.

8.5.1 Quitting the System

Woven throughout the accounts were examples of withdrawal or quitting the system, either in part or whole, during the antenatal, intrapartum, and postpartum period. For many, this strategy represents an avoidance of engaging with the healthcare professionals’ participants anticipated might exhibit actions intended to persuade or coerce compliance. Hazel having experienced difficult episodes of care in her previous ten pregnancies, noted when deciding to decline obstetric appointments:

‘If I don’t see him, they can’t force me into doing anything that I don’t want to do, and I don’t have to have arguments over what I want to do as opposed to them saying you can’t do this ’cause of that’ (Hazel)

 Quitting the system was observed across accounts in various guises, with examples already presented throughout these findings chapters. Quitting was employed across the whole childbearing continuum but most significantly at the beginning or before entry to the system (see Error! Reference source not found.4 for examples) or as a final strategy, having exhausted all other avenues. The ultimate expression of quitting the system was the decision to freebirth, which usually (within this context) resulted from repeated exposure to coercion, bullying or abandonment rather than as a cognitive decision resulting from an inherent trust in the physiology of birth. Participants explicitly stated that quitting- in particular freebirth- was a past or future consideration because of their experience of making non-normative choices (Hazel, Kali, Imogen, Matilda, and Leah)
8.5.2 Playing the Game

A key strategy in ‘doing nothing’ was accounts of having to perform for or play along with the system and adjusting or adapting self-presentation to achieve choice. This often involved employing elements of knowledge drawn from the community or embodied knowledge to subvert the system or personalise risk-based approach to care by predicting behaviours and actions of the system-based primarily on guidelines- and then moderating or withholding information provided to influence recommendations:

‘The scan was all fine. Funnily enough, because I’d fiddled my LMP date to make it compatible with my ovulation date and the NHS calculate gestation, it came out bang on what I had calculated’. (Imogen)

Participants might feign forgetfulness to ‘play silly’ or ‘trick’ the system (Kali), ‘playing the game’ (Grace, Kali), or ‘pretend’ that they would accept care when they had no intention of doing so (Imogen). To avoid unwanted appointments and accompanying screening and interventions that she did not value, Kali employed a similar tactic to Imogen, providing a clear rationale:

‘I had the booking appointment and then I did not see my midwife again until 28 weeks[...] when I arrived and she [said] ‘Oh you didn’t come for 16 weeks and again for 24 weeks’, [...] I always feel like there’s no point really me going to those appointments[...] not going to do anything important[...] I want to start monitoring the growth of the baby but before that I’m not going to find anything. The midwife is not going to explain to me anything I don’t know already[...]. I played that whole like “oops I forgot”’

‘(Kali)

Grace’s account was fascinating because she sought to avoid what she described as ‘appalling care’ in her previous labour by making a non-normative choice, including requesting a homebirth outside of hospital guidance. Yet, because past care was deficient, she could moderate the information she offered to achieve her choice. Grace predicted that if she disclosed a post-partum haemorrhage (PPH) in her last labour and birth, she would be restricted in what she was offered, including her desired place of birth. Grace’s strategy, therefore, was to not actively seek confirmation of the PPH in her previous episode of care nor mention it explicitly:

‘They never said to me “you’ve had a PPH” [...] which was very useful for me because it allowed me to truthfully say at my booking an appointment with the home birth midwives. I've never had a post-partum
haemorrhage’ [...] even though I knew that I had? [...] If they asked me directly, I’d say that it was never mentioned because that’s the truth.’ (Grace)

Similarly, Jade predicted referral for an obstetric glucose tolerance test (OGTT), so she planned for this by deliberately withholding information about her family history:

‘My dad is type 2 diabetic. [...] I know about guidelines; I know about all the research behind it. I decided that it was almost too much of a fight to disclose and be truthful [...]. So, I just didn’t tell them, when that came up in my booking [...] I lied ultimately. But was well informed in that choice and I knew the risks and the benefits, I’m not daft [...]. I was never then offered a [O]GTT’ (Jade)

Planning to withhold information was also a strategy that Nellie planned for when anticipating who might be caring for her:

‘I was really worried that I would have a healthcare professional that wasn’t really aligned with my views and then I had to withhold certain information of what I was thinking and feeling at the time’

(Nellie)

Kali withheld intentions from others, stating that ‘Even when I considered free birth, I never discussed it with anyone’, exercising caution by anticipating others’ reactions or responses.

Another strategy for playing the game was offering insincere sincere apologies, used by Bella when challenging an anaesthetist, who explained that she did this to curry favour and influence how they were perceived:

‘I actually came out of that meeting, I said “I’m sorry I’m really direct”. I wasn’t sorry. I really wasn’t sorry; I was really direct [laughs]’ (Bella)

8.5.3 Negotiating

For some participants, negotiation and compromise strategies were an effective means of achieving non-normative choices. Bella initially wished to have a VBAC to avoid, amongst other issues, poor post-caesarean pain management. A meeting with the anaesthetist reassured her that should a caesarean be required, adequate analgesia would be provided; indeed, if she wished to continue with a VBAC, an early epidural would be recommended. Bella had decided that she wanted to continue pursuing a VBAC and would like to use the birth pool for analgesia.
Still, she felt that she had to choose homebirth to achieve this as she experienced resistance to using the birth pool in the hospital. Bella believed that having a water birth facilitated in a hospital would be safer than having a home birth:

‘This is a compromise, that I don't particularly want a home birth, I want to have a water birth. I don't like the idea of big volumes of water in my house and so for me this seems like a perfect compromise’ (Bella)

Similarly, due to primary tokophobia, Darcie had planned a caesarean birth with her first baby. On her last day of work, she had a spontaneous rupture of membranes (SROM) and started labouring. When she arrived at the hospital, she was given the option to continue with a planned caesarean or continue with labour:

‘I'd like to have a go at doing it naturally but if my anxiety peaks, if anything happens, I want to be taken to have the C-section’. She [obstetrician] said that's fine, we can do that […] see how we go and if it all gets too much then we can just switch to the C-section plan […] it's gonna be the same amount of time for either, by the time we've got you prepped for surgery you could have pushed him out’ (Darcie)

The ability to be flexible, change her mind and have choices respected appeared to be a critical factor in encouraging feelings of control and retaining power within the decision-making process. These features were powerfully characteristic of many positive accounts of compromise and negotiation.

### 8.5.4 Achieving the Choice

For most participants, achieving their non-normative choices was an empowering experience, reinforcing their choices as the correct course of action for their uniquely normative context. Jade achieved her water birth despite being outside of guidelines and declining elements of care. She believed that right up until the last minute, there were attempts to coerce her into compliance because the midwife was concerned about the chance of shoulder dystocia. The midwife discouraged her from getting into the pool because she wanted to monitor the fetal heart rate:

---

73 Defined as pathological fear of pregnancy and birth (Hofberg and Brockington, 2002), first described by Knauer (1897).
“‘I want to monitor you because[…] I think that you’re at risk of having shoulder dystocia because you’ve gone so past your due date your baby’s probably big[…]’. At this point [I was] quite near to the end of the birth and I remember coming off after the contraction had eased and I said that’s not evidence based at all […] most shoulder dystocia’s happen and they’re absolutely random […] not linked to postdates[…]’. I remember having this conversation and I shouldn’t have had it. She [baby] was ten pound six, and I had a nice normal straightforward birth in the pool with an intact perinium. Which I doubt I’d had if I would have stayed on the bed monitored. So, I feel like I was very empowered, but I declined a lot of things but with good reason’ (Jade).

Choices did not have to be realised to feel empowered, but rather, how choices were responded to and whether the system attempted to facilitate and support them was important. Esmie explicitly identified this in her account of sharing her intention to consume part of her placenta (placentophagy) in the event of a PPH:

‘Nobody ever said “ergh, why you doing that?” […] I know from when I worked at (another NHS Trust) if anyone had asked for something so weird, that it would be all about “Where’s the evidence for this? Have you seen the evidence for this? Can I see the evidence for this?”. I thought that worst case scenario, they were going to tell me how to chop it up myself and eat it, but they were so committed to doing it that even when I didn’t have a bleeding problem, they were still there with the piece of placenta…’ (Esmie)

8.5.5 Complying (Giving Up)

Not all choices were realised or respected, and for some participants, once the point was reached where they felt they couldn’t continue with self-advocacy or that resisting coercion was too difficult, participants felt their only recourse was to give up and comply. While this was not a common occurrence, it was significant that compliance was only seen as a last option and only then reflective of an extended period of institutional actions and corresponding participant strategies to resist. It was noteworthy that such accounts usually centred around episodes of care in labour and birth rather than antenatally:

‘They still had the CTG hooked up. They weren’t happy with baby. They wanted to put the scalp electrode on her. At this point I was just, I didn’t have the battle in me to battle, to say no to anything. So, it ended up she got the scalp electrodes’ (Leah)
I propose that the reason for this is threefold. Firstly, the immediacy of decisions made in the comparably short period that labour and birth occupy compared to the antenatal and postnatal period demands a sense of urgency. Secondly, this is arguably when most institutional anxiety exists around the medicolegal consequences of feto-maternal mortality and morbidity. Faye’s account illustrates this, being encouraged into hospital from home while attempting a home birth after caesarean, for what she considered to be unnecessary and inauthentic reasons:

‘Due to the pandemic rules my husband wasn’t allowed in with me, so I was there all alone, in pain, tired, easily swayed. Which had been my main reason for wanting a home birth in the first place -- to have my husband there to advocate for me. Baby was born 24 minutes after I got to the hospital, with no additional interventions’ (Faye)

Unless cared for within a continuity model of care inclusive of obstetric colleagues, carefully developed care plans to support non-normative choices were likely to be overridden or ignored by healthcare professionals not involved in the planning, preferring to fall back on guideline-centred care. Particularly noteworthy, therefore, was that such encounters usually occurred within the labour ward environment of the hospital. Where it happened at home, this was often the result of the presence of healthcare professionals either unknown to the participant or unfamiliar with supporting birth at home for women with complex needs (see. Hazels account in 7.4, Amplifying Actions).

Thirdly, the potential for a shift in power dynamics within the institutional birthing space occurs, regardless of notions of shared or supported decision-making or the degree to which care had been facilitated or planned before admission (also see above re: continuity of care and planning). Labour and birth render women vulnerable to incremental actions to coerce and persuade compliance. Such interactions were noted across accounts with various degrees of intensity and success, significantly where participants reported being physically and emotionally tired. Strategies and actions employed by participants, especially those in the ‘doing nothing’

---

74 In the years 2021-22, there were 1243 obstetrics related claims representing 12% of all clinical negligence claims by volume in the NHS, 38% of total clinical negligence payments (£2.4bn), 62% of claims by value (£6bn), 60% of the total clinical negligence cost of harm (£13.6bn) and in the top 3 specialties by number of claims. A significant percentage of these costs relate to cerebral palsy and brain damage claims related to intrapartum care (NHS Resolution, 2022, pp. 30–31).

75 The term supported decision making is used here in preference to ‘shared decision making’ which is referenced in national guidance. Shared decision making is a misnomer, as legally, decision making lies with the woman alone (NHS England, 2021e)
category, are less likely to be enacted successfully unless supported by advocates or in the presence of prior planning. Accordingly, participants reported ‘giving up’ and complying with care recommendations. Again, this illustrates the importance of time and space in decision-making and advanced complex care planning and the importance of continuity of care and carer in following through plans of care.
Figure 21 Navigating the System Concept Diagram
8.6 Conclusion

In this chapter, I have explored the second of two parallel social processes centred around making non-normative choices within the system. This chapter has presented the processes, actions and strategies women enacted to realise their non-normative choices, protect their reproductive identity, and defend against identity threats. While motivations for and the nature of the non-normative choices were varied, some commonalities existed, including how the choices were realised and strategies and actions for doing so. The chapter has demonstrated how participants sought trusted advocates and allies within communities - sometimes hidden - due to the nature of the choices being made. Participants engaged communities to make sense of options, legitimise existing or suggest future incremental choices and inform strategies that could be enacted within the system. A key strategy when executing choices was ‘doing nothing’, an abstract conceptualisation of actions employed to perform a role of compliance and agreeableness while using actions behind the scenes to realise intention on participants’ terms, exerting agency, control, and self-determination, and thus aligning with an expression, reinforcement, and defence of reproductive identity.

The following chapter sets out the final stage of the theoretical model presented in the substantive theory, explaining the final process of reconstruction, reinforcement, and consolidation of participants’ reconstructed reproductive identity due to their experiences post-pregnancy and birth.
Chapter 9  Reconstructing Reproductive Identity

9.1 Introduction

In the previous chapter, I explored the processes, actions and strategies enacted by women to realise their non-normative choices to protect their reproductive identity and defend against identity threats. In this final findings chapter, I explain the processes that occur post-pregnancy and birth and explore how participants reconstruct, reinforce, and consolidate their new reproductive and other identities as a result of their experiences and how their non-normative choice was supported or otherwise.

I first explore how participants expressed how they adjust to their new reproductive identity by reflecting upon and evaluating what they would or would not change about their non-normative choices and their experience of navigating the two concurrent processes both in terms of how successful they had been in achieving them and the extent of the support they did or did not receive to make them. I argue that this evaluation and reflection inform future childbearing intention and choices to protect their newly reconstructed identity by enacting similar or more extensive non-normative choices. Furthermore, I demonstrate how becoming part of a community, either in the context of the previous two processes or during the process of identity reconstruction (within the system and within the community of which they were now a part), motivated participants to become activists and advocates for those with similarly shared experiences and reproductive identities. Finally, I present how some participants' professional identities as birth workers were influenced by their non-normative choices and vice versa, arguing that these individuals are unique in the connection between professional and reproductive identity. This chapter represents the exit from the liminal phases of pregnancy, within which many non-normative choices are made, to a stage of reconstruction of identity, reflecting a process of incorporation (Van Gennep, 1960; Turner, 1967).
9.2 Adjusting to New Identity

Regardless of the nature of participants’ experience within the system and having choices realised or not, a period of adjustment to new reproductive identity occurred, willingly or not. Imogen explained how in the process:

‘I think I’ve learnt a lot about myself’ (Imogen)

Significantly, this includes a self-reflective dialogue and evaluation of negative and positive experiences during the pregnancy, birth, and postnatal period and of the non-normative choice/s. Of note was the evaluation of how non-normative choices may or may not have been facilitated, respected, or realised and how this did or did not contribute to maternity outcomes. This period also encompasses adjustment to changes to non-reproductive identity, embodying and coping with the physical and psychological transition to parenthood and changes to, amongst others, relationships, career, and social networks.

During this time, which is of undetermined length and highly individual, the degree of ongoing support was fundamental in both reconciling any feelings or emotions resultant of the non-normative choice (being met or otherwise) as well as physical and emotional challenges that might have arisen because of pregnancy and birth. For Leah, that meant returning to the hospital with her husband to review her birth notes, make sense of her experience and fill in perceived gaps in understanding. Leah noted that this raised more questions than it answered:

‘I have found some things in my notes that either I didn’t consent to […] or that I didn’t even know happened. I just want answers […] for example […] I wanted the placenta to come naturally and apparently, I was given the injection […] actually, they pulled it out […] that was against everything that I wanted. I was given antibiotics. I don’t remember consenting to […] It’s not written anywhere, I’ve no memory of it. So, I’m bringing everything to a close as well […] it’s taken me five months to kind of build up the courage to do that. It still is fresh.’ (Leah)

9.2.1 Blaming Myself

Many participants whose non-normative choices were not respected expressed disappointment in themselves for not having advocated strongly enough, regardless of this being outside of their control or the intensity of amplifying behaviours experienced (see Chapter 7). Furthermore, contributing to feelings of shame and trauma
were explicit expressions of self-blame for not having realised choices, such as Kali’s difficulty postnatally, reconciling how she felt about accepting antibiotics against her wishes after having had her membranes ruptured for more than 48 hours and experiencing a single episode of pyrexia:

‘at that point I couldn’t fight anymore [...] I think I just remember saying like “do I have to?” and the midwife saying ‘I would recommend it’ [...] and I did not discuss more. It’s one of those things that has haunted me postnatally but one of those things, like I should have choice because it was a single temperature. And it meant two days in the hospital with antibiotics that maybe we could have avoided if maybe we reassessed the baby for signs of infection. So, there was not really a discussion’ (Kali)

Such expressions of self-blame were particularly notable (but not exclusively) in those who worked as midwives and doulas. Internalised self-blame in these individuals appears to represent an additional layer of identity conflict, especially where their professional identity aligns closely with their own reproductive identity or their coming to the profession resulted from poor experience. Being unable to advocate for themselves in a system that actively aims to deconstruct their reproductive identity is again indicative of feelings of identity conflict concerning professional identity.

Imogen, whose experience as a midwife informed her decision to withdraw from the system (see also 8.5.1 Quitting the System). To avoid harm reflected on having to fight to have her choices respected and still internalised blame despite clearly recognising how the system worked against her:

‘When they denied me a home birth, you know, I really blamed myself because I knew that that’s what they would do to me. I had worked in that system, I’d trained in that system, and when it came down to it all I could do was refuse coached pushing and insist on pain relief’ (Imogen)

Conversely, those who did achieve their choices felt that this reinforced their decision to label themselves in a manner that outwardly appears negative but that participants used in a positive, self-affirming way, as Grace illustrated in her stating, ‘I quite enjoy being difficult’. This was characteristic of the nature of their non-normative choice/s, their experience, the degree to which they felt they were perceived by themselves, those within the system (difficult, bolshy, challenging) and those within the communities they engaged with (advocate, exemplar). Again, these self-labels were rarely negative but instead affirmed the ‘rightness’ of their choices. Participants used mechanisms and strategies to reconstruct their new reproductive identity based on these perceptions in both cases:
'It’s affirmed my values. And I feel really, really proud of the decisions I was able to make. I’m so proud I
stood up to that horrible obstetrician, even though she had all the power and was going to do to me
whatever she was going to do’ (Imogen)

9.2.2 Coping with trauma

The extent of support offered and obtained after a participant’s experience was inconsistent and yet instrumental
in shaping how somebody experienced trauma:

‘I’ve said to family members about […] suffering from a bit of birth trauma and they said, “oh you’ll
soon forget about it and you’ll have more babies” I think there’s, a huge difference in attitude and
understanding between the generations’ (Leah)

For participants who did not have their choices respected or fulfilled, they identified this as a direct cause of
personal trauma, which they associated with losing control, autonomy and avoiding a repeat of previous
experiences of making non-normative choices:

‘Patient pain is an important of this process that has an impact on trauma and care in ways that are not
being fully explored. This was my experience and was a significant part of the challenges in my recovery’
(Bella)

Matilda was, for example, coerced into accepting vaginal examinations and then referred to social services, which
had a profound effect postnatally:

‘it had a big impact on sexual stuff […] the trauma that I experienced was from doing things, I the vaginal
examinations basically because I didn’t want to do it […]As soon as I got home, I had severe trauma,
flashbacks. […] and then they started calling my partner and hounding him to let them come round to
the house’ (Matilda)

For Imogen, her trauma arose out of a combination of not having her choices facilitated (despite having fought
throughout her pregnancy), losing control over her preference for avoiding a particular mode of birth and feelings
of shame:
‘I’m ashamed of having a forceps delivery […] I am really traumatised by what happened [...] that word pariah really sticks in my mind […] the trauma of being forced down this narrower and narrower path, and ultimately, I was denied pain relief until I consented to instrumental delivery […] every single decision that I have made in pregnancy, from preconception right up until that day, was to avoid […] a crash forceps delivery. And when it came down to it the only thing that I could insist on was pain relief’ (Imogen)

Bella suggested that issues with bonding with her baby might be related to her birth:

‘I just didn’t feel a connection to him I think partly because of the way he came out’ (Bella)

Imogen felt that if the care was different as it might be in the future and that by actively pursuing another pregnancy and birth, this could be restorative:

‘I feel that I need another birth in order to heal […] I feel that it has validated everything that I held to be true about maternity care. And it was such an opportunity, wasn’t it? to take a really traumatised woman who had been traumatised by her childhood, traumatised by abused women in the NHS, and somebody could have restored my faith in the maternity care system, but they just pushed me further and further away’ (Imogen)

Similarly, Leah acknowledged:

‘I feel like I’ve been completely let down and I have absolutely no faith in the system at all anymore. If I could you know, never use it again I’d be very happy to do that’ (Leah)

9.2.3 Planning the Future

Participants engaged in varying methods of reclaiming control and reconstructing identity at various periods postnatally. This represented a threshold across which participants passed while reconstructing their reproductive identity. Such activities included seeking physical and psychological support outside of the maternity system, as Imogen explains, focusing on well-being, including seeking and maintaining membership in supportive communities of other women, contributed to healing her traumatic experience:

‘I felt considering what they did to me […] it was the most physically traumatic birth you could have. I recovered very quickly. I focus on healthy nutrition and breastfeeding and getting out and making contact
with mother and baby groups and that kind of thing. So, I feel recovered and well supported by my family and now I’ve made a really good friendship group as well. I’m in a very, very different situation this time’

(Imogen)

A critical element of reconstructing reproductive identity for some participants was the effect of their experience on future childbearing intentions. The extent to which choices were achieved, facilitated, or represented a negative or positive experience could ultimately influence whether they wish to conceive again or not and the timing of conception:

‘We always had planned to have two kids, and that experience has completely put me off. Right now, there’s just no hope that I would ever want any future children because of that. And that makes, that’s the saddest part. That, because it is life changing. It is life-changing these experiences, good or bad’

(Leah)

Planning for the future also included deciding whether to pursue non-normative choices in future pregnancies, again moderated by the factors described above. Having experienced barriers to realising non-normative choices, this helped to inform how somebody might approach strategies differently to achieve their non-normative choices and desired experiences in a future pregnancy:

‘I’d never have a birth in the NHS. I am firmly planning a free birth […] I’ve learned my lesson and I should have had a free birth [previously]. It will be the biggest regret of my life not having a free birth because as much as I might have recovered, my baby has, in my opinion, been damaged. We are lucky I didn’t have a third-degree tear. We are lucky she didn’t have a cracked skull. We’re lucky she doesn’t have allergies because they gave her antibiotics. And I am very grateful for that luck because we have got out relatively unscathed’ (Imogen)

The reflective self-dialogue supported a rationalisation and affirmation of intention for future similar or modified choices, evaluating both the value and benefits of making similar choices in future pregnancies:

‘Would I change anything that I did? I would want to have the same midwife. It’s a really important factor with me. Again, I would choose to give birth as home like I intended with [baby]…I think I would have done everything similar because I felt really strong-willed’. (Jade)
This becomes significant when considering how becoming part of a community and sharing experiences can influence others making similar choices but also becomes a critical element of reconstructing the participant’s own reproductive identity.

Even when participants did not perceive their experiences as traumatic, they felt that having to fight for their choices was unjust. Matilda shared how, as a result of her experiences, she observed the issues with the system and that other women, perhaps not realising that they have a right to autonomy in decision-making, are being taken advantage of by the system:

‘I feel OK about. I’ve made a connection with my daughter, and I’m just loving motherhood and I find it easy. I’ve not found it really challenging. I just absolutely love everything about it and about my life. But I feel angry that this is the situation, and that people are experiencing things without even knowing it’ (Matilda)

As a midwife, Angela expressed similar sentiments when reflecting on her experience. She also reflects on the experience of others, recognising that as part of the system (professionally), she can observe the dysfunction from the inside:

‘We’re looking at women so traumatised by birth they will not have another baby’ (Angela)

This is an important and potentially impactful recognition from the perspective of professional identity and personal experiences' influences on professional attitudes and approaches to women making similar decisions. It also reinforces the interconnectedness and influences of antecedent identities and conditions on reproductive identity and vice versa, especially concerning those working as midwives, doulas and obstetricians.

The COVID-19 pandemic amplified the restriction of normative and non-normative choices, notably concerning partner support, access to waterbirth and homebirth76. While this undoubtedly influenced decision-making, participants described how their experiences during this time would also influence future decision-making

76 Evidence exploring the effects of the COVID-19 pandemic has exposed varying degrees of restrictions on choice which in some Trusts and Health Boards were still in place at the time of writing (Coxon et al., 2020; Romanis and Nelson, 2020).
regardless of the presence of a pandemic because the changes highlighted in some cases that there were choices to be made and that complying with the norm did not necessarily equate to safer or more respectful care:

‘I would actually only go to a few essential appointments, and I would probably consider freebirthing'. As scary as that sounds. Two years ago [...] I didn't even know that that is something that can happen [...] now I know better. I know my body. I know that I can do it so I probably just wouldn't, wouldn't let myself be scared into some midnight trips to the maternity unit for some random scans again’ (Faye)

Choosing to freebirth to avoid perceived unsafe or traumatic maternity care, to avoid discrimination, to retain control over the birth experience or because homebirth services are unavailable or denied as a choice features consistently in freebirth evidence literature, with the COVID-19 pandemic amplifying decisions (Feeley and Thomson, 2016a, 2016b; Greenfield, Jomeen and Glover, 2019; Nelson and Romanis, 2020; Greenfield, Payne-Gifford and McKenzie, 2021a).
9.3 Becoming Part of the Community

Some participants reconstructed their identity by remaining or becoming part of the communities they sought before or during pregnancy, valuing preferred peer interaction with those sharing similar reproductive identities rather than pursuing resolution through interaction with the system. Many engaged in activism that sought to improve the experiences and understandings of others accessing the service and to affect change within the system. Types of communities’ participants became a part of included charities, social media and support networks and for birth workers, role modelling advocacy for women making similar choices featuring heavily across accounts. Darcie suggested that peer-to-peer communities were important in this respect and that others should actively seek others with similar circumstances:

‘Speak to people[…]find people, there's so many groups out there that are supportive birthing and parenting groups, find someone that's had it, find someone that you can speak to […]going to places like that I'm finding people that have experienced it is really important, because I think you can research all the facts, but it’s not the same’ (Darcie)

Communities did not need to be formal but could represent groups of individuals with similar experiences, goals or expressions of reproductive identity. Overall, membership of communities was characteristic of an additional means of reflection and evaluation, as well as contributing to consolidation and legitimisation of their newly reconstructed reproductive identity:

‘I decided this after the birth […] since then I’ve met quite a lot of women are very similar-minded who I know would support me in that way. So, I feel like it’s already taking shape if there was another [pregnancy]’ (Matilda)

Bella recognised how the activist element of reproductive identity reconstruction for her had started before the pregnancy she described in this study. Bella had experienced a miscarriage and became frustrated with how experiences of miscarriage remain taboo; she believed it should be part of a public narrative of pregnancy and birth:

‘I became an activist really, I became someone that if an experience happened to me, I wanted to talk about it’ (Bella)
Bella continued her activism after pregnancy and incorporated her experiences into supporting others by confronting harmful narratives around an ideal mode or place of birth:

‘I think caesarean should be part of the narratives around labour in a way that they aren't. I was at a [signing] course and the instructor [...] showed us the sign for giving birth and I was like ‘that wouldn't be the sign for me because its showing a baby coming out of your vaginal passage[...]’ I said what this this would be my sign?’ and like did the chopping...[he asked] ‘did you give birth naturally?’ yes it was a caesarean I didn't die on the table, only I didn't die in the woods? like my baby came out naturally[...] via caesarean.’ (Bella)

Matilda also used discussions postnatally within postnatal groups to challenge misinformation that she felt was widespread, initiating challenges to educate and inform:

‘I noticed nearly every single person when they talk about pregnancy and birth it’s around these matters, around these ways of talking. And recently, there was a situation where I did speak up, but I feel like sometimes I don’t want to stir people’s trauma. You have to be very careful with what you say because some people aren’t ready, or I don’t feel like it’s good to confront things with people when they say things like that.’ (Matilda)

Matilda’s acknowledgement of others’ trauma appeared to moderate the extent of the information offered and subsequent challenges to misinformation but, importantly, also represents the peer sanctioning of conduct within the membership of the communities. As membership in these communities is voluntary, so is the amount of support offered. However, it is clear that becoming part of a community is valued, and the peer-to-peer interaction that sustains the culture and shared goals of the community, however challenging these might be. This recognition and moderation of actions speaks to a degree of self-regulation within the boundaries of the community.

Leah stated that because of her experience, ‘I’ve joined the local Maternity Voices’ (Maternity Voices Partnership78), observed to be a common means of becoming an activist, engaging formally with institutional

78 Maternity and Neonatal Voices Partnerships (MNVP), formally Maternity Voices Partnerships (MVPs). Established as NHS working groups, they comprise members of women, providers, and commissioners supporting co-production and service development.

232
discourses, and planning activities, further demonstrating the importance and value of membership of formal groups who wish to provide feedback and improve services.

Several participants became advocates for others to support similar non-normative choices within their communities. Matilda spoke of how she became aware she wasn’t alone in her experiences:

‘I’ve been going to a Sure Start group and there is such a feeling to me of grief, of experiences that people have. There’s a very hush-hush tone to it. They’ll talk about going past 42 weeks but “I was made to have this”, or “I was made to have that”, “I was told to do this”, “I was told to do that”’ (Matilda)

9.3.1 Sharing Experiences (Advocating)

A key strategy for performing advocacy was the practice of sharing experiences. For some participants, this meant becoming or continuing as birth workers, such as doulas or moving into formal and professional advocacy roles, including midwifery. Sharing experiences came in many guises, mainly within their communities, including social media. Where the opportunity to share experiences directly back to the system arose, i.e., making a formal complaint, some participants willingly did so, acknowledging its importance in seeking closure and improving experiences for others:

‘I actually made a formal complaint about the healthcare professional[...] in the letter that I received about it they said that [...] they said that they had had issues with her in the past, so yeah ’ (Bella)

Jade reflected on how she felt she could have shared her experience with the system because she knew that how she was treated was wrong:

‘I mean, when I look back, should I have written in and not complained but offered it as feedback? I think I went to the Maternity Voice Partnership, the local ones, and I did feed it back that way. I didn’t put any sort of formal complaint in. Possibly, I should have because it was really wrong of that obstetrician and to really misinform me. You know, we should be providing evidence-based care and research ’ (Jade)

Postnatal peer-to-peer support groups featured as a common place where information was shared and compared. Matilda saw this as an essential space for disinformation to be challenged through experience sharing, and in doing so, act as an advocate:
‘There was recently a situation where one of the [...] Sure Start workers was [...] being judgemental and then I said that I went to 44 weeks. And she was like “oh” and before that, she said “I don’t think that women should go past 42 weeks because that’s really dangerous”’ (Matilda)

Likewise, Nellie used her experience in a peer-led social space to discuss how there might be other choices to consider during pregnancy:

‘a lot of my mum group who haven’t got any kind of medical experience, quite a few of them had really traumatic deliveries[...] it’s put them off having second babies and things, and I’ve said them that you can just request a caesarean, I did it’ (Nellie)

Faye shared her experience of supporting a friend who had four previous caesarean births but who was considering a vaginal birth:

‘she didn’t know that she could [have a vaginal birth] [...] she was told that the next one is going to be a section as well, she had four births, and one of her babies were stillborn, but she had four sections. She wanted a home birth, and she said she wasn’t allowed. Then, when I said that, ‘Well, I’m having a home birth,’ she said, “But you had a section” I said, “Yes,” she said “are they letting you?” I said, “Well, I’m the one who’s doing the letting; they can’t NOT let me unless there is a medical reason for me to give birth at the hospital; I don’t intend to”’ (Faye)

Membership in communities was not always easy (see Hidden Communities). Caleb was initially unable to find communities outside of the system when he required support that would be respectful of his gender identity, affecting access to support:

‘sBecause I’m a Transparent [...] there wasn’t any, you know, prenatal, prenatal, prenatal groups where most people would go to them and like learn all of the things like tips and stuff. I didn’t go to any of those because I was scared about, like, whether I’d be welcome or whether they be inclusive and stuff like that. So, I didn’t get as much support as I would have liked’ (Caleb)

Caleb did locate a Facebook community which, after his pregnancy and birth, he used to share his experiences, also becoming an advocate for others:
‘They were the Trans birthing parents and loads of like researchers. It was like really nice to see so many supportive people. And that's how I like got like, into the community.’ (Caleb)

Most participants demonstrated their advocacy by offering insightful reflections on how they would advise others to seek advice and share experiences if asked:

‘Women don't know that they have a choice. That's what's wrong with the system [...] we trust them with our health [...], but then the maternity system takes complete advantage of that [...] They have a right to decline any and all scans, tests [...] you don't even have to let them know that you're pregnant’ (Faye)

‘Anything that any health officials tell you, take it away and look into it because they might be just telling you one thing when actually [...] look into it. Don't let anybody put you off or tell you to do one thing because you don't have to; there's always options and choices’ (Hazel)

### 9.4 Professional Advocacy and Identity

For somebody already involved in birth work, their reproductive identity and experience of making non-normative choices informed their ongoing professional philosophies or indeed adjusted how they might approach women making similar choices:

‘I think my own maternity journey, researching all my own alternative choices, means that I’m now more prepared to support women [...] women don’t have to justify their choices. If someone comes to me and say I don’t want that, fine [...] it’s that experience of I didn’t have to fight for my choices. I was my own midwife.’ (Kali)

Kali’s and others' accounts reinforce a connection between professional and personal reproductive identity to remain advocates and, in other accounts, enhance their sense of advocacy within their professional roles. By operationalising their experience as outsiders, they could support women in their insider (healthcare professional) role to make non-normative choices by navigating the system and educating other healthcare professionals.
through role modelling\textsuperscript{79}. Esmie explained this as feeling like ‘a mystery shopper sometimes at these appointments.’

Notably, advocating and supporting others’ non-normative choices was not restricted to only similar choices to their own, but rather by engaging principles of choice, autonomy, and self-determination regardless of the non-normative choice itself. Nellie’s account illustrates this by counselling a colleague who wished to freebirth:

‘One of my midwifery friends at the minute she’s [...] declined all her scans; she wants to free birth. She doesn’t trust the NHS at the minute. She had quite a traumatic first time around. And I was just like, “Well yes, if that’s what you want to do then, and that’s going to ultimately make you feel better, then go for it” [...] just making sure she’s supported. But she’s had a different experience; she’s been told off lots of times by different healthcare professionals and things, whereas I feel quite protective over her. Now, even though I’ve chosen the completely opposite experience’ (Nellie)

Angela also remained in a midwifery role after pregnancy and birth and was able to reflect on her personal and professional experiences of maternity care:

‘I know that you’re protecting women, I know that you’re respecting that, you know, pregnancy is a life event [...] I wish we had more time with women to discuss everything because I think that [it] comes down to [...] not feeling like we have enough time to discuss[...] and reassure women about [...] their choices....it's difficult because I think we conflate this idea of having choices in pregnancy with feeling like you have control. Ultimately, you may not have any control about what happens in your labour and birth[...] there's certain things that are kind of prioritised as ‘risks’ in pregnancy but women are undertaking risks, all the time and they're absolutely fine’ (Angela)

\textsuperscript{79} It is noteworthy that by advocating for non-normative choice within the system, this can expose healthcare professional, and in particular midwives to accusations of radicality and deviancy, encouraging women to make non-normative choices and being unsafe (Feeley, 2019; Madeley, Williams and McNiven, 2019; Larner and Hooks, 2020; Price, 2020; Feeley, Downe and Thomson, 2021; Morris, 2023).
The influence of personal experience on professional identity and vice versa appears significant, especially in the context of those who engage in birth work as a response to reproductive identity reconstruction after making non-normative choices$^{80}$ and whose professional identity is reinforced or reconstructed through their experiences.

$^{80}$Contemporary research has explored the extent to which previous childbirth experiences (particularly in the pursuit or trauma resolution) motivate entry into the midwifery profession, philosophy of care and choices offered to women by midwives and student midwives (Church, 2009; Milne, 2022a, 2022b).
Figure 22 Reconstructing Reproductive Identity Concept Diagram
9.5 Conclusion

In this chapter, I have explored the final post-pregnancy and birth process of reconstructing reproductive identity. It explains how participants reconstruct, reinforce, and consolidate their new reproductive and other identities, regardless of whether their non-normative choice was supported. Participants expressed a strong sense of what they would or would not change about their non-normative choices, which informed the future for similar or more extensive non-normative choices. While this chapter represents an exit from liminal phases of pregnancy within which non-normative choices are made, the reconstructed reproductive identity continues as a recurrent and repeated influence in future reproductive experiences, including but not limited to future pregnancies and birth, pregnancy loss and termination, childbearing intentions, contraception, assisted reproductive technologies episodes, sexual health encounters, menstruation, and menopause.

In the next chapter, I present a discussion of the findings and substantive theory of reproductive identity expression, reinforcement and defence, demonstrating how by exploring these in the context of extant theory and literature, the findings of the study ‘refines, extends, challenges or supersedes extant concepts’ (Charmaz, 2014a, p. 310)
Chapter 10    Discussion

10.1 Introduction

In this chapter, I present a synthesised discussion of the essential findings and, consistent with the constructivist grounded theory approach, situate these within a broader theoretical and conceptual landscape. I demonstrate where the substantive theory ‘refines, extends, challenges or supersedes extant concepts’ (Charmaz, 2014a, p. 310). I begin by outlining and examining reproductive identity as a broad conceptual framework to position the substantive theory, explaining how the findings expand the existing concept and definitions. I then compare and contrast a variety of extant theoretical and classical literature, explicitly concerning how the institution and its activities represent threats to reproductive and other identities. I then explain the strategies for reproductive identity expression, reinforcement, and defence resulting from perceived or actual threats to reproductive identity.
10.2 Reproductive Identity

A consensus definition and conceptualisation of reproductive identity in its own right remained largely elusive until Athan (2020) offered a deliberately broad and inclusive definition, elevating its importance alongside other psychosocial and cultural conceptualisations of identity (e.g. sexual, cultural, gender, ethnicity, class, disability):

“Reproductive identity is how you self-identify (author emphasis) when it comes to your reproductive experiences. The term is intentionally broad, inclusive, and exists on a spectrum...It conveys both conventional categories of parenthood & non parenthood, as well how people make sense of their feelings within the sphere of reproduction more generally” (Sexuality, Women and Gender Project, 2020)

Contemporary definitions until this point were vague and almost always conflated with psychosocial discourses of motherhood (McMahon, 1995; Bailey, 2001; Adams et al., 2021), perpetuating essentialist and pronatalist views of heteronormative women’s identity (Woodward, 1997; Ervin and Stryker, 2001; McLeod and Ponesse, 2008). Athan (2023) suggests that the conspicuous absence of formal definitions supports a position of broader sociological biases and sociocultural norms, failing to account for the variance and diversity of reproductive experiences outside those of a socially normative life course. A lack of formal definition also reinforces reductive eurocentric, heteronormative and male-exclusionary conceptualisations (Athan, 2023), rendering existing understandings of reproductive identity too narrow and difficult to operationalise. The term ‘reproductive identity’ is frequently used in the literature but is commonly conflated with reproductive biography or used as a proxy or a loose umbrella term to describe relationships between self-perception and childbearing experiences, and then only alongside expressions of other identities such as, for example, ethnicity, profession, sexual orientation, disability, or gender. While these elements contribute essential aspects of reproductive identity (re)construction, these remain only constituent elements and do not provide the whole picture, as this study has shown.

My study’s findings support Athans (2020) proposition that any definition of reproductive identity should be considered a standalone expression of identity, expanding the definition by simultaneously considering the intersection, impact and influence of salient and central others (Lawler, 2008). Moreover, my findings extend Athans conceptualisations and foreground reproductive identity by encompassing tacit understandings and influences of intergenerational experiences and recognising the intersectionality of other central and salient
identities. The findings of my study have shown that reproductive identity is a unique, dynamic personal construction, derivative of and in constant fluid interplay with biopsychosocial-cultural influences and other identities. Reproductive identity, therefore, is a part of an individual’s overall identity. A centred, subjective reproductive identity influences expectations for childbearing, moderated by personal understandings of the process, the biopsychosocial implications and attitudes towards the pregnancy, and an implicit evaluation of the magnitude of subsequent identity transformation.

Moreover, the social processes explained within my study, involving the interaction with maternity care systems, expose and render an individual’s reproductive identity vulnerable to threats. By acknowledging this, it is clear how participants in this study defended, expressed, and reinforced their reproductive identities through non-normative choices, seeking support from communities to legitimise and strengthen their reproductive identities’ (re)construction. Consequently, reproductive identity is critical in shaping decision-making about non-normative choice, representing and informing strategies for expressing or reinforcing reproductive identity. These findings have demonstrated the interplay and intersection between reproductive identity and other central and salient identities, informing the non-normative choice alongside strategies for defence against perceived or actual identity threats (discussed later in this chapter).

This study has identified how intergenerational experiences and understandings of childbearing influence and impact the construction of reproductive identity, expanding definitions and conceptualisation offered by Athan (2020). These intergenerational understandings influenced beliefs about the optimum conditions and likelihood of modes for birth, i.e., vaginal or caesarean birth, and whether pregnancy and birth represented a significant life change and rite of passage\(^1\) (Van Gennep, 1960; Allen and van de Vliert, 1984; Janusz and Walkiewicz, 2018; Van Gennep, 1960; Allen and van de Vliert, 1984; Janusz and Walkiewicz, 2018; Janusz and Walkiewicz, 2018; Van Gennep, 1960; Allen and van de Vliert, 1984; Janusz and Walkiewicz, 2018; Rites of passage such as puberty, funerals, weddings, baptisms etc historically have been described and centered within studies. The rite of passage of childbearing represents, ranging from preconception, across the childbearing continuum, encapsulating wider reproductive experiences across a life span has only recently been the focus of definition and a growing evidence base. Initially conceptualised by Raphael (1975) and later developed by Athan (Athan and Reel, 2015), the term ‘matresence’ refers to the biopsychosocial, political and spiritual transition towards motherhood, and fundamentally in relation to this thesis, reflects a period of unique individualism and the social and neurophysical responses to experiences. While this thesis focusses on these issues specifically in relation to reproductive

\(^1\) Rites of passage such as puberty, funerals, weddings, baptisms etc historically have been described and centered within studies. The rite of passage of childbearing represents, ranging from preconception, across the childbearing continuum, encapsulating wider reproductive experiences across a life span has only recently been the focus of definition and a growing evidence base. Initially conceptualised by Raphael (1975) and later developed by Athan (Athan and Reel, 2015), the term ‘matresence’ refers to the biopsychosocial, political and spiritual transition towards motherhood, and fundamentally in relation to this thesis, reflects a period of unique individualism and the social and neurophysical responses to experiences. While this thesis focusses on these issues specifically in relation to reproductive
Reed, 2021). Familial and intergenerational understandings and knowledge were a significant, often tacit influence on non-normative choices, primarily where choices reflected a withdrawal from (quitting) and avoidance of the system based on community and intergenerational assumptions, including institutional racism, discrimination and prejudice, illustrating the intersection of these salient identities and reproductive identity (Birthrights, 2022). Overall, this element of the findings explains how some women, without personal embodied biophysical experience of childbearing, draw upon these broader influences to make non-normative choices to express, reinforce or protect their reproductive identity.

The findings of my study have confirmed the reciprocal influence of reproductive identity on professional and other identities, supporting those of Church (2009) concerning how midwives construct their reproductive identity. The findings of other studies exploring how the childbearing experiences of midwives might influence identity transformation and threat, matresence as a concept has important parallels, especially in relation to decision-making that warrants further future exploration in future research. This recommendation is discussed further in Chapter 11.
personal and professional decision-making are confirmed and extended by my study, shedding new light on how these two identities may be at odds with one another, thereby representing identity conflict as a result of conflicting identity salience. This is important because it explains how many of the non-normative choices made by those expressing or reinforcing firmly held professional identities complement and align with their own reproductive identity, but also how strategies for these choices are operationalised as a defence against identity threat where those identities exist in opposition (Stryker and Serpe, 1994).

This study has shown how conception, pregnancy and entry into the childbirth continuum reflect the separation from previous stable salient and central identities into a liminal, crisis phase. Reminiscent of Van Gennep’s (1960) work conceptualising rites of passage, pregnancy has long been considered an example of such. Separation from previous identities into an uncertain liminal phase is distinguished by a loss of social identity, position or personal continuity and transformation into other identities, imposed or otherwise (Draper, 2003; Janusz and Walkiewicz, 2018). The liminality of pregnancy, therefore, represents a symbolic suspension, loss or threat to previous and reproductive identities. Turner (1996) suggests that liminality in the context of a rite of passage is characterised by ‘symbols of anonymity, lack of ownership, and nakedness’ (Janusz and Walkiewicz, 2018, p. 154). My study has shown that these processes represent a challenge to reproductive identity, with choices made to maintain control over both the uncertainty of the experience of liminality and to express or reinforce reproductive identity when entering and navigating the system. The reconstruction of reproductive identity described by participants exiting the system parallels those described by Van Gennep (1960) as the final incorporation phase of a rite of passage (Janusz and Walkiewicz, 2018). More generally and crucially, it represents a newly constructed social identity, as I propose in this thesis, a reconstructed reproductive identity. The entire process described here supports my assertion of the cyclical and ongoing nature of the substantive theory and the significance of the substantive theory in application across a broader scope of reproductive encounters.

Other literature addresses issues of non-reproductive identity concerning fertility control (Marston, Renedo and Nyaaba, 2018), motherhood (Katz Rothman, 1990; McMahon, 1995), infertility and involuntary childlessness (Letherby, 2002), childbearing desire and intentionality (Miller, Jones and Pasta, 2016), conception and childbirth in the context of biographical disruption (Pollard and Saleem, 2020), reproduction and ill health and desire, intentionality and reproductive orientation related to same-sex relationships (Riskind and Patterson, 2010; Pralat, 2021) and the reciprocal effect of one’s professional identity on the development of reproductive identities.
(Church, 2009, 2014, 2019). Reproductive identity remains within this body of literature as an adjunct to, influence on or component of other central and salient identities, excluding broader impacts observed in my study.

Several recent studies are beginning to make connections between intergenerational factors and their influences on biopsychological consequences and outcomes. These include maternal perinatal trauma, stress and mental health disorders and long-term biological effects on the infant (Bowers and Yehuda, 2016; Cook, Ayers and Horsch, 2018; Horsch and Stuijfzand, 2019), short and long-term pregnancy outcomes (Glover et al., 2018; Peters et al., 2018; Dahlen et al., 2021), behavioural, socio-emotional and mental health disorders (Garthus-Niegel et al., 2018; Van den Bergh et al., 2020). However, the effects of intergenerational understandings on maternal choice and decision-making remain largely unexplored. Contemporary maternity reports have exposed how racialised, marginalised, and minority communities experience poorer obstetric outcomes (Commission on Race and Ethnic Disparities, 2021; MBRRACE-UK, 2022). While possible socioeconomic factors, including deprivation and poverty, have been identified as contributory factors, other reports have highlighted deep-rooted historical, cultural and institutional racism, prejudice, biases and a euro-centric approach to maternity care implicit in contributing to these outcomes, including non-engagement with services (Taylor, 2020; Birthrights, 2022; Peter and Wheeler, 2022). Part of this is the assumed pathologisation of black bodies, noted to be a vital issue within the report undertaken by Birthrights (2022).

I propose that reproductive identity should be considered a standalone and unique one, noting its influence within reproductive healthcare and, in the context of my study, its influences on making non-normative choices. My results shed new light on the need to consider reproductive identity as a standalone salient identity alongside and concerning different central, intersecting, and affected identities and how this influences the construction of unique individualised normativity and the nature and extent of non-normative choices in childbearing.
10.3 Medicalisation and the Institution as a Source of Identity Threat

The findings of my study suggest a fundamental misalignment between expressions of reproductive identity considered normative within women’s reproductive identity, temporal and spatial context, and the authoritative and influential processes within contemporary maternity care, reflective of sociocultural norms and expectations. This dissonance has exposed a contradiction between aspirations for personalised care and the reality of achieving choices that reflect personalisation within the system's constraints. This confirms that women feel othered when they do not conform to institutional arrangements. The findings show that for many, this misalignment represents an actual or perceived threat to reproductive identity and, in some cases, other central and salient identities. A perceived or real threat precedes non-normative choices, subsequently made to express, or reinforce existing reproductive identity or defend from a threat against it. The magnitude of reproductive identity threat is characteristic of singular, ongoing, consecutive, non-normative choices that influence when and how they are enacted (see 10.4).

Various conditions might trigger a perceived or actual threat to reproductive identity. Firstly, there is the potential for contradiction between reproductive identity and other central and salient identities, for example, in transgender pregnancies or making choices that contradict existing identities and associated normative expectations, e.g., midwives requesting a caesarean birth or women having previously chosen to remain childfree. Secondly, the perceived or actual stigma associated with transgressing socio-cultural normative expectations such as biopsychosocial and corporeal presentation, choices that deviate from institutional rules, timetables, expectations of compliance or deviations from social expectations and judgements towards constituents of ‘good’ mother or womanhood. Thirdly, the deconstruction and depersonalisation of reproductive and other identities through the

---

82 Conceptualised as the institution or ‘system’.
83 Acknowledging that the term ‘institution’ could be used synonymously, a pragmatic decision has been made to deliberately separate the thesis conceptualisation of the ‘institution’ as described above, from the ‘institution of motherhood’ described by feminist writer Adrienne Rich in her controversial work ‘Of Woman Born: Motherhood as Experience and Institution’ (Rich, 1977). Rich describes this institution as the structures of universal demand and expectation placed on women to be nurturing and selfless in adaptation and experience of motherhood, while simultaneously failing to place any value on the inherent emotional, social, and physical demands. Moreover, Rich explored how feelings of apathy and ambivalence towards the process are often hidden and taboo. Notwithstanding, there are parallels with themes that reflect Rich’s
imposition of a homogenous risk-centric institutional identity through categorising and labelling. Labelling practices included gestational potentiality, evolving or existing medical and obstetric conditions and applying high-low risk binaries. Resistance towards these practices included outward expressions or reinforcement of reproductive identity in the form of non-normative choices outwith socially normative practices. Distinct sources of identity threat within the system are rooted in engrained compliance expectations (explained later in the chapter). These include implied and explicit expressions of heightened moral responsibilities towards the fetus by the woman and the institution, routinised and standardised timetabling of care, and biomedical risk-based categorisation and classification. The rigid application of institutional guidelines, to the exclusion of sociocultural and embodied knowledge, was a significant source of tension for participants.

An important finding in my study was the magnitude of the anticipated threat to reproductive identity evolving alongside a perceived change in emphasis from woman-centred to fetus-centred care, frequently occurring at or around the time of fetal viability or routinely offered screening and surveillance. This change in focus appeared to increase in importance to the institution as the pregnancy progressed, alongside interventions for fetal wellbeing, manifesting as actions on the part of the institution to persuade compliance with recommendations. Making repeated and consecutive non-normative choices counter these threats throughout the childbearing continuum. This is a significant finding concerning proposals for resolving conflict related to this process (see recommendations for clinical practice). A further significant result of this study was the apparent value and importance women placed on supportive and facilitative practices within the system, critical moderators in challenges to identity threats.

Stigma refers to something unusual or indicative of the individual's moral status. According to Goffman (1983, 2006), normality is a sociocultural construct that contributes to social order through expressions of social intercourse within a given setting, perpetuated, and reinforced by social and institutional rituals and expectations of behaviours and conformity. Stigma arises from the perceptions of individuals transgressing these attributes, characteristics, or behaviours in the eyes of those offering judgment. Labelling practices reinforce stigma (Becker,
1963; Link and Phelan, 2001; Scott, 2015c) and experiences of shame, discrimination, and stereotyping. Studies have noted that people are perceived to have more than one characteristic or attribute that might be stigmatised; this intersectionality can present particular challenges concerning the magnitude of stigma experienced (Jackson-Best and Edwards, 2018). Historically, women’s bodies and biological functions have been stigmatised as problematic, dangerous, unpleasant (gus, 2011) and risky in the context of childbearing (Chadwick and Foster, 2014).

Extensively described within the literature, common stigmatised identities, embodied attributes, and intersectional issues in maternity care include:

- **Ethnicity** (Jackson-Best and Edwards, 2018; Birbeck et al., 2019; Birthrights, 2022; Peter and Wheeler, 2022)
- **Perinatal and existing mental health issues** (Smith et al., 2019)
- **Disability** (Malouf, Henderson and Redshaw, 2017; Hall et al., 2018)
- **Obesity** (Earle, 2003; McNaughton, 2011; Puhl, Peterson and Luedicke, 2013, 2013; Sutin and Terracciano, 2013; Puhl and Suh, 2015; Greenfield and Marshall, 2022; Ryan et al., 2023)
- **Age** (Friese, Becker and Nachtigall, 2008; Ellis-Sloan, 2014; Jones et al., 2019; Scala and Orsini, 2022)
- **Sexuality and Gender Identity** (Greenfield, Payne-Gifford and McKenzie, 2021a; LGBT Foundation, 2022).

Personal historical experiences of pregnancy, including stillbirth and undesired modes of birth, are also noted in the literature and acknowledged globally to contribute to stigmatising practices (Murphy, 2012; Pollock et al., 2020, 2021; Simelela, 2020).

Crucial to understanding some strategies enacted by participants (see 10.4), stigma can arise from attributes and characteristics within a generational context, defined as ‘tribal stigma’ (Goffman, 1963, p. 4). Attributes might be hereditary, genetic, or familial predisposed diseases and complications in pregnancy, e.g., diabetes, hypertensive disorders, preterm-birth and congenital disorders (Barbitoff et al., 2020) included those offered as part of the NHS Antenatal and Newborn (ANNB)Screening Programme (NHSE and OHID, 2022)
Turner (1992) proposes that the body, particularly women’s, is the focus of and subject to shifting temporal, cultural, social, and moral practices which aim to regulate their function. Childbearing, by its nature, is unpredictable and over the last century, women’s bodies have come to be considered a source of unacceptable risk, requiring management and control, subject to medical power (Oakley, 1986; DeVries, 1992; Cahill, 2001; Newnham, 2014). The pregnant body remains observed as inherently faulty, defective and ‘imperfect’ in need of ‘constant manipulation by men’ analogous to machines requiring women to follow socio-culturally acceptable and institutional timetables and norms (Roth, 1963; Martin, 1997; Davis-Floyd, 2001).

The shift towards risk-averse guideline-based care - despite their known limitations (Gabbay and May, 2004; Kotaska, 2011; Jones, 2014; Frohlich and Schram, 2015) - serves to homogenise and categorise women into examples of ‘cases’ (Foucault, 1977) situated within a risk labelled subgroup to be ‘described, judged, measured and compared with others’ (ibid 1977, p. 191). Furthermore, Goffman (1961) argues that categorisation and routinisation are less about necessity and more about role stripping - intentionally stripping individuals of their social roles thereby depersonalising them - in this case as a means of encouraging submission with pathways, guidelines, and hospital routines (e.g. ward rounds), and allowing the ‘self to be shaped and coded into an object that can be fed into the administrative machinery of the establishment…worked on smoothly by routine operation’ (ibid 1961, p. 16). The literature critiquing guideline based-care has consistently argued that stringent non-critical application directly affects woman-centred care (Kotaska, 2011; Frohlich and Schram, 2015; Greenhalgh, 2018), and yet examples of blanket application were noted consistently within my study, contributing to conflict and deconstruction of reproductive identities, alongside the imposition of potentially stigmatising institutional identities. Notwithstanding a small body of literature outside of the United Kingdom (Stoll et al., 2021, 2021) (see also literature review), women’s voices remained largely absent aside from explorations of discrete elements of care or choices.

A contemporary international body of evidence has provided some insights into clinicians’ experiences and approaches to supporting women who make non-normative choices (Cobell, 2015; Madeley, 2018; Larner and Hooks, 2020; Price, 2020; Westbury and Enion, 2021; Morris, 2023) and while these experiences fall outside the scope of this thesis, it is significant to note that risk discourse and judgements surrounding the lack of tolerance in clinicians towards women’s non-normative choices feature heavily as a tension between women and their caregivers within these studies. Jenkinson’s (2017) study of refusal of maternity care in Australia identified
healthcare professionals’ boundaries within which they judged the ‘reasonableness’ and acceptability of women’s non-normative choices. Clinicians evaluated their conceptual ‘line in the sand’ (ibid 2017, p. 4), which in other studies has been shown to vary among clinicians (Thomson, 2013; Jenkinson et al., 2016; Feeley, Thomson and Downe, 2020). Transgressing this line would trigger an escalation of behaviours intended to gain compliance with recommended care. Interestingly and somewhat contradictory, this conceptual boundary existed alongside acknowledging a woman’s rights to exercise autonomy and agency. Strategies used by clinicians to gain compliance involved risk-focused discourse, including manipulation, badgering, judgement, and fetal demise, again centring the fetus above acknowledged women’s rights. A comparison of Jenkinson’s (2017) work with my current study shows significant similarities in the escalation and nature of behaviours exhibited by the system to gain compliance. What is particularly compelling is the use of the term ‘line in the sand’, which was expressly used by a participant in this study.

It is interesting to note that participants in my study who asked for more than recommended care, for example, planned caesarean birth, while experiencing some resistance, did not appear to encounter the degree of actions exhibited by the system experienced by those asking for less, despite the biomedical risks of operative birth (Murphy, Strachan and Bhal, 2020). Moreover, participants in my study who viewed vaginal birth as physiologically or psychologically risky considered caesarean birth normative within their context. Rather than judging this as a reflection of a technocratic approach to childbirth, making non-normative choices, such as planned caesarean birth outside of recommendations, reinforced their reproductive identity by privileging their embodied and tacit knowledge and experience, further supporting conceptions of unique normativity. This shares similarities with other studies (Fenwick et al., 2010; Hollander et al., 2018), where requests for more care than is recommended were less likely to be declined or viewed as non-normative by providers (Jenkinson, 2017) and supporting Hollander et al (2018) assertion that more intervention has ‘become so common, they are not registered as being against guideline’ (Ibid 2018, p. 510).

Conversely, studies have identified that supportive and facilitative practices do indeed exist within the system for non-normative birth choices, reliant on relational, trusting and supportive care, centred around the reinforcement and protection of maternal autonomy through inter and outwith institutional negotiation (Feeley, 2019; Feeley, Thomson and Downe, 2019). My findings are consistent with others that women making non-normative choices perceive value in relational care, primarily when continuity of caregiver is achieved (Earle, 2000; Forster et al., 2010).
2016; Sandall, Mackintosh, et al., 2016; Sandall, Soltani, et al., 2016; Perriman and Davis, 2018). However, it is important to acknowledge that simply achieving continuity of care or carer is insufficient. Where trusting relationships cannot be built, women are withdrawing (quitting) the system in part or whole (McKenzie, Robert and Montgomery, 2020; Greenfield, Payne-Gifford and McKenzie, 2021a; Feeley, 2023). Participants evaluated the extent to which their identities aligned with their healthcare providers' philosophy of care and how caregivers (individual and institutional) legitimised and validated elements of participants' reproductive identity and subsequent non-normative choices. In my study, participants had an expectation of reproductive identity alignment, expressed through shared values, philosophies, and attitudes, demonstrated through continuity, care planning, support, and advocacy. The relationship-building process was a significant moderator in how participants experienced identity threats and their subsequent strategies employed to manage the threat. Discrepancies laid the ground for conflict, loss of trust and potential quitting of the system. These findings extend existing understandings by confirming that relational continuity of care goes beyond simple facilitation of choice. Secondly, ample opportunities occur during the childbearing continuum whereby women might be more inclined to engage with a relationship-based, trusted system rather than quitting altogether.

The findings of my study have demonstrated that the institutional arrangements for standardisation of care, and in particular expected conformity with guidelines, actively challenge women’s tacit understanding of their own reproductive identity by deconstructing it in favour of an imposed institutional, risk-based, anonymous, categorised identity. Moreover, the findings have shown that non-normative choices can result in imposed unwanted labels, either by the nature of women's choices or by being labelled as deviant and judged by others to be transgressing normative expectations. This can modify how that person views their reproductive identity and stigmatising them (Becker, 1963; Bernburg, Krohn and Rivera, 2006), thus representing future identity challenges.

My study has demonstrated practises and characteristics within the system sharing similarities with Goffman's (1961) descriptions of the operation of a total institution, notably the bureaucratic management of large groups of people through rules, realisations and tight schedules. Moreover, there are similarities in expectations of conformity and permissiveness, expressions of power, and reduction of the individual to a ‘role’ - particularly that of being possessed of sickness - through admission procedures and entry into the system. Particularly compelling are the practices described by Goffman of losing one’s identity and the imposition of an institutional one, reduced to a number or file (Goffman, 1961), consistently seen as a powerful source of conflict resulting in non-normative
choices throughout this study. It is interesting to note that the total institution is the antithesis of the remaining individual (Jones and Fowles, 2008), and this is important, as within my study, issues arose out of discrepancies between the imposed institutional identity and individualised understandings of participants reproductive identity, particularly observable in assigned identities, labelling and stigma arising out of perceived physiological attributes, character traits, diagnosis, gestation, gravida or parity status, or risk status. For women who could not conceal particular characteristics, for example, BMI, ethnicity, age or gender expression, the findings have confirmed other large-scale studies that suggest women feel stigmatised by risk messaging and that this challenges their autonomy (Blaylock et al., 2022). Being labelled as ‘high risk’ can have a harmful psychological effect (Stahl and Hundley, 2003), with the perceived loss of control amongst other ill effects resultant of the label (Symon et al., 2015).

Participants with raised BMI in my study frequently cited weight and fatness as a source of tension and a stigmatised identity consistent with existing literature. Crucially, many of the participants in my research living with fatness, who were black or brown, or over 40, expressed that stigma and judgement already existed by just existing in society, particularly within women’s healthcare. Therefore, they anticipated a threat to identity before pregnancy, subsequently influencing early and ongoing choices, such as withholding consent to weighing, BMI calculation and care planning for analgesia. Participants identified that because they could not hide their physical presentation, there were layers of stigmatisation created by the intersection of age, BMI and ethnicity. These non-normative choices they then made defended against the identity threat created by those categories. The findings build upon those of previously discussed studies (Friese, Becker and Nachtigall, 2008; Ellis-Sloan, 2014; Jackson-Best and Edwards, 2018; Birbeck et al., 2019; Birthrights, 2022; Peter and Wheeler, 2022; Scala and Orsini, 2022, Earle, 2003; McNaughton, 2011; Puhl, Peterson and Luedicke, 2013, 2013; Sutin and Terracciano, 2013; Puhl and Suh, 2015; Greenfield and Marshall, 2022; Ryan et al., 2023). Where this study differs was in how identity challenge was anticipated but not then subsequently experienced by the transgender participant (Caleb) because the system took measures to support the non-normativity of his pregnancy, and the anticipated threat related to the system did not occur (Greenfield, Payne-Gifford and McKenzie, 2021a; LGBT Foundation, 2022). This does, however, reaffirm other findings in my study supporting how facilitative and supportive care can moderate how identity threats might be experienced. However, Caleb enacted the same expression, reinforcement, and defence strategies as others despite the absence of threat (See Error! Reference source not found.4).
With increasing contemporary emphasis placed on the personalisation of maternity care and reinforcement of the choice agenda (Jolly, 2021; NHS England, 2021b, 2021c), viewing the institution through this lens and taking account of my findings exposes fundamental barriers and key discrepancies to enacting national strategies and aspirations. Facilitative encounters clearly illustrate how some institutions aim and succeed in providing personalised care. My study has shown that conversely, where there is a lack of capacity, precedent or expertise within the system to support choices outside of guideline or expected compliance (Nicholls et al., 2021), and heightened institutional anxiety about litigation, regulatory action and sanction (Watkins et al., 2022), women may be exposed to disrespectful and potentially harmful consequences of measures intended to gain compliance.

Reconsidering the thesis definition of a non-normative choice presented in Chapter 2, non-normative choices that reflect requests for less care than recommended (notwithstanding issues around reproductive identity expression, reinforcement, and defence) should be considered simply a withholding of consent for recommended care or interventions. Framing them this way refocuses how clinical management of non-normative choices should be approached- from an ethical and legal perspective- rather than problematising them. I recognise, however, that this framing may not be without difficulty. Contemporary studies have identified how institutional consent processes and can be potentially counterproductive to preserving autonomy in decision-making. For example, Dixon-Wood et al (2006) study investigating why women who consent to surgery contrary to their wishes reported that women exposed to institutional structures and social expectations for behaviour were more likely to ‘obey professionals' requests’ (Ibid, 2006. p.2742), thereby reducing their agency and choice.

Moreover, Dixon-wood et al (2006) assert that due to these structures, the consent process cannot always be relied upon to safeguard autonomy, a view supported by some sociologists who argue that contemporary consent models do not represent the realities of the process due to the influences of autocratic and hegemonic medical practices and social norms, all of which serve to influence an individual's ability to exercise choice and work in direct opposition (Corrigan, 2003). My findings are in agreement with these views, reaffirming that non-normative choices represent a critical test (Jenkinson, 2017; Anon, 2022) towards genuine, personalised care and choice and acknowledging the powerful influence the institution wields over providing systems and processes that support choices that fall outside of institutional and social norms. Furthermore, my findings accord with studies exploring the phenomena of expected compliance and the subsequent dissonance experienced within the institution when
women do not comply, explaining some of the reactions and responses towards participants making non-normative choices.

Nicholls et al. (2021) study of pregnant women (16) and healthcare professionals (15) views of the consent process found that while theoretically provided, women's experience was contingent on 'contractual compliance' (ibid 2021, p. 134). Furthermore, expressing choice was highlighted as a means of constructing a sense of control over a variety of aspects of the childbearing process, concordant with many other studies (Cook and Loomis, 2012; Regan, McElroy and Moore, 2013; Coxon et al., 2017; Leahy-Warren et al., 2021), and indeed reflective of the findings of this thesis. Significantly, Nicholls et al. (2021) asserted concerning the relationship between the clinician and the pregnant woman:

'Reframing patient ‘consent’ as a ‘choice’ process seems a simple way to at least signal an intentional partnership’ (ibid 2021, p. 136)

Considering how participants in my study valued relational, respectful, and facilitative care, I argue that combined with the preceding arguments, the opposite of this statement is also true, and that patient ‘choice’, especially in reference to declining care and recommendations, should be reframed as ‘withholding consent’. The reason for this is twofold. Firstly, the legal, ethical, and regulatory framework within which healthcare professionals work in the United Kingdom is explicit in its requirement for consent to be obtained before proceeding with care or pathway. This is reinforced by the increasing manifestation of women-centered language, foregrounding explicitly autonomy and consent within NICE and other national guidelines (Mobbs, Williams and Weeks, 2018). Secondly, informed consent (and the ability to withhold consent) is a significant feature in national drivers for personalised care planning in maternity care. By framing the enactment of non-normative choices in this way it removes negative connotations of deviance and the expectation of compliance whilst simultaneously providing positive reinforcement for healthcare professionals to allow support of these choices as a key element of personalised care and maternity transformation across the childbearing continuum (NMC, 2018; NHS, 2019; GMC, 2020, 2024).\footnote{Both the Nursing and Midwifery Council and General Medical Council make explicit provisions for registrants to support and respect the choices of patients who withhold consent, decline care or reject advice (NMC, 2018, p. 7; GMC, 2024, p. 11). Moreover, legal precedent (see Ch. 2) affords a level of protection for registrants provided any harm that occurs because of a non-normative choice is not due in part or whole to neglect by the institution or healthcare professional.}
This study goes beyond previous studies by exploring non-normative choices across the childbearing continuum within the United Kingdom. The studies synthesised discussed in Chapter 3 studied women's perspectives and decision-making related to discrete phenomena such as:

- Declining induction of labour (Roberts and Walsh, 2019)
- Freebirth (Feeley and Thomson, 2016a, 2016b; Plested and Kirkham, 2016; Davison, 2021; Greenfield, Payne-Gifford and McKenzie, 2021a),
- Planned Caesarean Birth (Tully and Ball, 2013),
- Water VBAC (McKenna and Symon, 2014),
- Complex homebirth (Lee, Ayers and Holden, 2016b, 2016c; Lee, Holden and Ayers, 2016),
- Screening (de Zulueta and Boulton, 2007).

The findings of my study have exposed some similarities; however, I have expanded the scope by exploring a broader spectrum of choices along the childbearing continuum (see Fig 7). My results reaffirm many of the conclusions of studies that identify risk discourse, consent, control, agency and autonomy as critical moderators and motivations for making alternative or non-normative choices while further extending knowledge by indicating how non-normative choices might also be made as a strategy for expression, reinforcing or defending against identity threat.
10.4 Strategies For Identity Expression, Reinforcement and Defence

The interface between the woman and the System leads to an arena of conflict where actions are taken to simultaneously encourage compliance with recommendations (the system) and preserve, reinforce, or express reproductive identity (the woman). If non-normative choices are respected and facilitated early, women are less inclined to take action to resolve an anticipated or experienced identity threat. Conversely, when actions conflict with women's choices, the number and magnitude of actions and inactions in response increase in frequency and magnitude. Neither causation nor association can be inferred within a grounded theory or qualitative study. However, it is compelling that participants value facilitative encounters, recognising that respectful and relational acknowledgement of their identity expression was less likely to result in a pushback against the system. Where choices were supported, participants remained open to flexibility and negotiation in finding a mutually agreeable middle ground.

An important consideration is that non-normative choices in response to historical experience and associated identity threats represent a slim opportunity for engaging with women to build trusting relationships. Again, this reinforces the iterative and cyclical nature of the substantive theory concerning singular reproductive events while simultaneously highlighting how previous challenges may represent contemporary threats to reproductive identity. Participants in this study demonstrated this, seeking to express and reinforce their reproductive identity through reproducing positive prior experiences or, conversely, women who sought to reconcile negative feelings towards previous negative reproductive experiences. Significantly, experiences influencing contemporary choices need not always be within the context of childbearing. Withholding consent to specific interventions- notably routine screening and surveillance, induction of labour and operative birth - appeared to generate the most tension between participants and the institution, while full or partial non-engagement (quitting) -either before entry to the system or at any point in the continuum- featured consistently as a powerful strategy for responding to identity threat. Moreover, participants who quit the system before entry as a response to anticipated identity threat resulting from historical experiences (rather than those quitting mid-way through pregnancy or in response to escalating behaviours) were less inclined to find a middle group or engage with the system overall, seeking to avoid a repeat of those experiences. I discuss this further later in the chapter.
My results demonstrate that women use their non-normative choices to express, reinforce or defend their reproductive identity, not in a fixed state but fluidly, undertaken within a personal value-driven context. An important finding is that women evaluate individual choices against their perception of risk and context – unique normativity- consistent with other studies (Heaman and Gupton, 2009). Non-normative choices remain consistently flexible, often starting with more minor, apparently less remarkable choices to establish the ability of the system to support them (sounding out), engaging with strategies for seeking and operationalising information and knowledge to inform their choices. Women constantly re-evaluate their decisions in the context of new information (which includes the behaviours and actions of the system), seeking support networks within trusted communities of allies either formally or informally. Communities are influential sources of legitimisation and guidance to reinforce women’s choices, significantly existing within intercommunity norms.

This finding is crucial because supportive communities can be located within the system, e.g., facilitative healthcare professionals. When trusted allies are not identified within the system, women are less inclined to engage with the institution altogether, distrusting the intention and personal value of routine information and interventions being offered, commonly rejecting the system as credible. Moreover, where coercive or obstetrically violent85 behaviours are encountered- even when presented with accurate risk information - women are disinclined to either believe or act on that information, preferring to afford value towards information or advice given by their other, trusted communities. The extent to which the system supports non-normative choices is therefore an critical mediator in how women evaluate their immediate passage through the system, which informs their future reproductive identity (re)construction and non-normative choices.

---

85 The World Health Organisation defines obstetric violence (OV) as:

‘physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures..., lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications...’ (World Health Organisation, 2014, p. 1)

McKenzie (2022) argues that obstetric violence can be overt, undertaken deliberately as a range of physical abuses (Dubravka, et al, 2019), or more typically implicit. acts of OV undertaken unintentionally by healthcare providers, the acts being reflective of structural routine and normalised institutional expectations and practices (Sadler et al., 2016)
My findings suggest that contrary to institutional assumptions that women making non-normative choices knowingly endanger fetal wellbeing, participants were protective of their fetuses. Nevertheless, it was also clear that participants strongly valued agency and autonomy and wished to retain a sense of identity concordant with their understanding of their reproductive and other identities. This state of flux assisted in informing their non-normative choices while remaining flexible, balancing their expression, reinforcement, or defence of identity with the well-being of the maternal-fetal dyad.

A significant finding of my study is the enactment of common strategies employed to express, reinforce, and defend against perceived or actual identity threats (Fig. 24). I have previously discussed withdrawing from, or ‘quitting’ the system, evaluating information, and engaging with communities. ‘Doing Nothing’ was another powerful strategy involving various activities, discourses, and modes of performance, which outwardly gave the impression of conformity and intention but inwardly reflected methods of resistance to the expectations of the system and society.

![Figure 24 QuEEN Model of Common Strategies for Reproductive Identity Expression, Reinforcement and Defence.](image-url)
Identity conflict is defined as ‘conflict between the values, beliefs, norms and demands, inherent in individual and group identities’ (Ashforth and Mael, 1989, p. 29), ‘a sense of discrepancy between the beliefs, norms and expectations held by an individual’ (Horton, Bayerl and Jacobs, 2014, p. 1) and by Breakwell as:

‘The processes of identity, assimilation\textsuperscript{66}-accommodation and evaluation are, for some reasons, unable to comply with the principles of community, distinctiveness and self-esteem, which guide their operation’.

(Ibid 1986, p. 47)

Further, Breakwell’s model of identity, threat and coping (1986, p. 46) theorises that a threat or challenge to identity must be ‘derived from its implications for identity’ and that this type of experience can be perceived as an identity threat. Studies have identified that an identity challenge or threat, although likely to occur in any setting and circumstance, is most foreseeable during central life transitions, health and reproductive experiences being particularly fertile grounds (Allen and van de Vliert, 1984; Charmaz, 1991; Letherby, 2002; Murphy, 2012; Jarvie, 2016; Mumford, Wilkinson and Carroll, 2023)

Bodies of work have explored theoretical responses and strategies for managing identity conflict (Breakwell, 1986, 2021; Petriglieri, 2011); however, as (Carminati and YingFei, 2022) suggest, existing research on identity conflict has to date primarily focussed on identities as ‘monolithic entities’ (Ibid, p.2), rather than the conflict that arises out of the triggering of simultaneous but incongruent identities. (Brown, 2017). Identity coping strategies are thoughts or actions one employs to remove or modify that threat, whether the actions or thoughts are tacit or explicit (Breakwell, 1986). Within Breakwell’s model, there are numerous specific examples of coping strategies which might be employed individually or simultaneously, such as self-protection (deflection, acceptance and evaluation), intrapersonal (isolation, negativism, passing and compliance) and intergroup relationship change (multiple group membership, group support, group action) (Breakwell, 1986).

\textsuperscript{66} Assimilation and accommodation in relation to interrelated processes inherent in social identity theory describing the processes of identity change through absorbing new information into the construction of one’s identity, firstly maintaining a degree of self-consistency (assimilation), while making necessary changes (accommodation). Evaluation refers to what is assimilated, and what is accommodated (Breakwell, 1986).
Breakwell’s description of intrapersonal coping strategies are also reminiscent of Goffman’s four methods of ‘secondary adjustments’ (Goffman, 1961, pp. 61–64), which, he theorised, inmates enact in response to institutional threatened and imposed identities. They include fighting back against the system, paying ‘lip service’ (Jones and Fowles, 2008, p. 105), accepting the institutions' identity or view of themselves and significantly, in the context of both Breakwell and my study, withdrawing, or quitting, confirming the importance of this as a strategy for expressing, reinforcing, or defending against identity threat.

These coping strategies and secondary adjustments, aligned with my conceptualisation of ‘doing nothing’ are an important finding in relation to how doing so is operationalised by women as a non-normative choices, being an active rather than passive strategy for expressing, reinforcing, or defending against identity threat. Scott (2018), in response to Brekus’s (1998, p. 34) call for a ‘sociology of the unmarked’, argued that the sociological nothing-compared to the sociological something- is neglected in the literature yet holds symbolic interactionist power. Doing nothing therefore, represents a type of social action (Weber, 1948). Moreover, the act of performatively ‘doing nothing’ should be understood as it occupies a social space as non-participation, non-presence, and non-identity. Performativity in this context reflects Goffman’s (1959) concepts of self-presentation and impression management, with activities and displays during a defined period depending on the audience; indeed, identity is expressed pragmatically through observable action (Scott, 2015a). According to Turner (1969), performativity regulates emotions to ‘survive the transformation of the self’ (Janusz and Walkiewicz, 2018, p. 155). Much of Goffman’s work surrounding dramaturgical analysis echoes an individuals’ many strategies to manage their impressions (Goffman, 1959, 1970, 1971, 1972; Goffman, Drew and Wootton, 1988). Performativity was seen, for example, in accounts such as Esmie and Bella, where they outwardly expressed intentions to comply with recommendations with little to no intention of doing so (performative compliance) or when managing how others might perceive them, such as having children when previously expressing the desire to remain childfree (Darcie).

The connection and purpose between performativity and face-saving are discussed later in this chapter. There is congruence between the theoretical perspectives identified above and the strategies described within the substantive theory and social processes participants employed for reproductive identity expression, reinforcement, and defence. This study, therefore, extends and refines our understanding of how women use non-normative choices to cope with identity threats, consistent with existing theoretical perspectives concerning the management of threats.
Quitting, withdrawing or self-isolation from the system was noted as a critical intrapersonal strategy for women who both anticipated identity threat and had experienced it previously. My study has found that quitting occurred across the continuum but most notably at the beginning or before entry to the system, observed in accounts of, for example, freebirthing and late bookings, and, or during the pregnancy continuum, as a final strategy, having exhausted all other avenues, for example deliberately not attending appointments. As previously noted, withdrawal from or non-entry into the system in any sense remains paradoxical because simply becoming known to the institution while remaining outside of it represents symbolic entry into it, thus exposing participants to the systemic structures, processes, and scrutiny they wished to avoid in the first place. By quitting and remaining isolated, participants were able to prevent escalation of institutional actions such as categorising, labelling, coercion and associated stigma while being able to ‘perform’ plausible deniability, thereby playing the game (Goffman, 1959; Strauss, 1977; Scott, 2010; Benschop et al., 2017). Quitting was a powerful strategy for identity expression, reinforcement and defence within this study, representing a symbolic ‘non-presence’ (Scott, 2018, p. 11).

Breakwell (1986) proposes that withdrawal is a strategy of inaction rather than action, removing the person from a threat by avoiding scrutiny and the anticipated consequences of being present. Conversely, Scott (2018) argues that withdrawal does not mean inaction but rather that absences induce women to follow alternative courses of action, observed clearly in this study by participants symbolically ‘doing nothing’. Sub-strategies include engagement with communities and becoming activists, thus contributing to (re)constructing their identity. Returning to Scott’s exploration of the sociological nothing (2018), the broad definitions of sociological acts of commission and omission are further refined and extended to explain and understand how women use non-normative choices to perform the action of ‘doing nothing to express, reinforce or defend against identity threat:

- **Acts of Commission**: Choosing to avoid or do something- active avoidance-Examples: Choosing not to enter the system, withholding consent to interventions, openly rejecting identities, i.e., gender risk binaries, and rejecting normative expectations such as compliance with rules and timetables.

- **Acts of Omission**: Passive rejection or disinclination to act: Scott (2018) asserts that acting in this space does not necessarily hold a strong reluctance towards one option or another; instead, they are drawn to one because it has more meaning—Examples: Late booking in for antenatal care, not calling labour ward when in labour.
From a symbolic interactionist perspective, non-identity, non-participation, and non-presence are powerful symbolic objects (Blumer, 1969) with social causes and consequences. There is a meaningfulness assigned by the individuals doing this and is therefore illustrative of a form of social action (Weber 1949/1904: Scott, 2018).

Many participants used the metaphor of being ‘in a battle’ to describe their engagement experience. Sontag (1991) suggests that the use of metaphor towards illnesses stigmatises and shames patients; however, in my study, participants consistently refer to their struggle, not about illness, but about preserving their ability to enact non-normative choices. In this context, specific language is more likely used to evaluate and draw personal meaning from the process, simultaneously withstanding shame and stigma, which might pose an identity threat. Critics of Sontag's work (Clow, 2001) would support this, suggesting that metaphor is employed to develop symbolic meaning.

Consistent with Breakwell’s (1986) description of negativism as a response to identity threat and Goffman’s (1961) definition of ‘pushing back’, many examples of engagement and negotiation as a strategy were observed within the study. Withholding information, or what Roger (1983 p.167) describes as ‘selective exposure’, is a practice closely linked to the symbolic interactionist argument that regardless of the morality of a practice (right or wrong), it serves a social function: to frame something in a ’socially useful way’ (Scott, 2015b, p. 222) (Scott, 2015).p222. Instances included withholding information, particularly for participants wishing to avoid stigma, categorising and labelling associated with familial and intergenerational reproductive experience- genetic or medical history- and participants who predicted disclosure might result in unwanted intervention, social disapproval (within communities as well as in the institution) or restricted choices.

Some participants could, however, conceal their corporeal presentation, which might otherwise have resulted in risk-based categorisation. These were considered in this study to be ‘face-saving’ acts of face work and ‘passing’; strategies intended as to negate stigma and discredited identity by appearing closely aligned with normative expectations (Sedgwick, 2008). Face as a concept was offered by Goffman (1959, 1967) as an explanation for the image one presents and acts in society to claim a favourable social position. Facework and face-saving therefore are the interactions and strategies an individual enacts to maintain or elevate the presentation of self (facework) and the performance of actions and strategies to avoid losing social status or being perceived unfavourably (face-saving). These strategies applied to reproductive identity expression, reinforcement and defence were noted
particularly (although not exclusively) when other salient and central identities did not align with reproductive identity and outward expressions needed to be carefully managed to avoid perceived negative associations and repercussions, e.g., midwives choosing caesarean section and concealing previous reproductive intentions. Conversely, ‘passing’ as a strategy was enacted through participants performatively appearing to agree or align with professionals' recommendations while intending to do the opposite or hide outward appearance by using other ‘deceptive’ methods where quitting may not be an option (Breakwell, 1986).

Strategies of insincere apologies to appease the recipient are also described by Goffman (1967p.47-96) as a ‘gesture of deference’, apparently designed to reduce the likelihood of both a challenge and the perceived impact of a challenge. Participants' accounts demonstrated insincere apologies, confronting a clinician’s status by challenging their authoritative knowledge and recommendations. Moreover, Goffman's strategy of ‘cooling the mark out’ (1952, p.451) and what Scott (2015, p.203) describes as an ‘identity performance of obedience and conformity’ for performative regulation were noted within accounts. I use the term ‘performing’ deliberately, drawing from both Goffman’s work around performativity (Goffman, 1963), the Total Institution (Goffman, 1961, 2017) and performative regulation in the reinventive institution (Scott, 2010, 2015b).

Compliance- performative or otherwise- played an intriguing role in identity threat resolution and was observed across many participants' accounts. Commonly enacted where participants experienced repeated and escalating coercive practices (e.g., abandonment and badgering) the intention of compliance varied depending on when and how the participants enacted it as a strategy. Breakwell (1986, p. 121) asserts that compliance tends to be an active strategy where others have failed or when compared to the experiences of others, the individual complies to avoid conflict. Moreover, Goffman (1967) describes compliance as a strategy for coping with identity threats by accepting behavioural expectations and 'playing the role'. Deceptive or performative compliance was observed as a strategy antenatally, closely linked to ‘playing the game’, intended to conceal a participant's true intentions and then usually preceding an act of quitting. However, in this study, compliance during intrapartum care frequently reflected a loss of agency and autonomy in making non-normative and other choices, with participants having exhausted other strategies. Compliance in this regard often occurred where escalating institutional actions made resistance impossible or when quitting was not a viable option.
This response is reminiscent of the phenomena of learned and personal helplessness (Seligman, 1975; Peterson, Maier and Seligman, 1995)- whereby an individual comes to believe, following repeated negative experiences or events, that they lack control, thereby becoming passively resigned to the inevitability of a situation, becoming compliant- and that of the fawn response to trauma (Aigner, 2022; Clayton, 2023). The fawn response – behaviours such as submissiveness, appeasement, or people-pleasing to avoid perceived danger or distress and foster a sense of safety- alongside other psychological survival responses (fight, flight and freeze) are recognised as a physical or psychological safety mechanism in response to threat (Walker, 2003; Poulter, 2023; Warren, 2023). Significantly, fawning is closely associated with the trauma arising out of relational abuse, such as that perpetrated in childhood or by caregivers, with contemporary research drawing connections with the fawn response as a response to shame and loss of self (Aigner, 2022; Clayton, 2023), and it is been theorised that the presence of high levels of oxytocin (such as during labour and birth) render individuals particularly susceptible to triggering a fawn response, critical in the understanding of this as a mechanism in response to identity threat and coercive practises (Poulter, 2023). This is significant in the context of relational care or lack thereof within the institution and the potential experiential repercussions that inform future reproductive identity and non-normative choice-making.

Helplessness and the fawn response offer compelling insights into how compliance occurred as a final response to reproductive identity threat in this study, women having either exhausted all other strategies or being exposed to escalating actions to gain compliance. Notwithstanding performative compliance as a means of ‘doing nothing’, compliance was observed to be a psychologically protective mechanism in response to continued and repeated threats to identity and in response to a profound loss of control and agency. This is important in two significant ways. Firstly, experiences of helplessness are linked to poor mental health and depressive conditions (Abramson, Seligman and Teasdale, 1978; Peterson, Maier and Seligman, 1995) and the fawn response to complex post-traumatic stress disorders (Walker, 2003, 2018; PTSD UK, 2023). Secondly, unwanted relinquishment of control and agency in childbearing has been understood for decades to negatively impact future mental health, childbearing intention and experience choices and significantly contribute to trauma (Viisainen, 2001; Snowden et al., 2011; Cook and Loomis, 2012; Newnham, 2014; Reed, Sharman and Inglis, 2017; Tracey and Page, 2019, 2019; Leahy-Warren et al., 2021). This has fundamental implications, not only for the woman’s immediate and
long-term psychological well-being but also, considering the broader findings of this study, for future reproductive identity-related decision-making in future pregnancies.

A significant finding of this study with implications for clinical practice is that the degree to which the non-normative choice was achieved did not necessarily represent an identity threat; instead, the crucial element in threat moderation was that choices are being facilitated and respected. Where a non-normative choice is used as a coping strategy to defend against an existing threat to reproductive identity, it is the degree to which the choice is respected and facilitated and the process itself that is important, not necessarily the outcome nor the nature of choice itself (considering the identity-related reasons for choosing in the first place). Furthermore, these factors also appeared to moderate the extent to which participants expressed whether they found their experience traumatic; these findings do not rule out the influence of other complex biopsychosocial factors. This is consistent with Breakwell’s (1986, p. 79) proposition that a threatened identity coping strategy is not concerned with the outcome of the strategy—even if it fails—and Banduras’ (1982) suggestion that perceived success is more important than actual success regarding self-efficacy, also supported by contemporary literature (Schwartz et al., 2015; Tilden et al., 2016; Soh et al., 2020). This finding is therefore significant.

The role group membership, trusted allies, and communities play in forming coping strategies for identity threats (Breakwell, 1986, 2021; Tajfel and Turner, 2004) and reproductive identity (re)construction is essential. Not only did communities act as a powerful source of alternative information provision and evaluation, but they also served as spaces for choice legitimisation, primarily where choices were not supported or legitimised within the NHS or other institutions. Engagement with these groups for choice legitimisation and identity threat defence is a course of action consistent with Mullaney’s (2001, p. 19) assertion that a ‘display of resistance’ must be observed by the group to be successful. Constructed of peer communities and often without a single authoritative figure, Bauman (2012) this study suggests that groups are powerful social legitimisers whom women consider authoritative due to recognising themselves in peer-shared narratives. Unexpectedly, within these spaces (virtual or otherwise), non-normative choices became normative, removing any semblance of non-normativity ascribed within the institute, further supporting the conceptualisation of an individual and collective unique normativity. Mutual surveillance within these groups was characteristic of what Scott (2010) suggests as a means of identity protection or reinvention through ‘anticipating positive effects of liberation, empowerment and self-actualisation’
Ibid, p219) and that mutual surveillance in this context relates to an element of performativity defined as “taking place between individuals of the same stratum… members monitor each other’s conduct and shape their progress towards a common goal” (ibid, p.50). This culture of mutual surveillance is contingent on activities and actions within community membership representing active and/or passive engagement between members, legitimising choices while simultaneously establishing unique community norms. Furthermore, sharing experiences, information, and solutions to common challenges encountered when making non-normative choices, alongside being able to question and interrogate approaches, provides a framework of positive mutual surveillance, reinforcing community norms. Some participants reflexively self-labelled as ‘difficult’ or ‘bolshy’ but took pride in doing so within the contexts of their communities, concordant with expressions of legitimisation in ‘not doing’, aligning with community norms and mutual surveillance within and between the participant and communities (Scott 2018). This reinforced their position within the community membership norms and helped reconstruct reproductive identity post-birth.

Many participants did not feel the need to seek direct support from their community; however, by being able to access other community members’ accounts and experiences (e.g. social media groups), it is possible to evaluate the value of information and potential meaning within women’s context, develop frameworks around which her choices and strategies for achieving them are modified and legitimised, providing a safety net and reinforcing reproductive identity associated with membership of the community. Not only were these factors significant in identity expression, reinforcement and as a response to identity threat, but they also played a significant role in reproductive identity reconstruction, evident in those participants who subsequently became activists within those groups after their experiences.
10.5 Conclusion

In this chapter, I have explored and discussed the complexity of the basic social processes and substantive theory utilising reproductive identity as a broad conceptual framework, extending its definition to include wider biopsychosociocultural influences to reposition it as a central and salient identity. I have explained how reproductive identity construction, expression and reinforcement are dynamic, subject to contextual, temporal, and social influence and, above all, highly individual, situating the findings within the broader literature. I have explored how the institution deconstructs reproductive identity and, using risk-based categorisation and labelling practices, imposes impersonal institutional identities while simultaneously expecting compliance with rigid institutional norms. I have demonstrated that in the presence of institutional behaviours intended to influence compliance, women employ several strategies to express, reinforce or defend against the perceived or actual reproductive identity threat. I have shown that these strategies described in the social processes are reminiscent of and extend existing identity threat strategies, represented as the QuEEN model, quit, evaluation, engagement, and nothing.

The following chapter will conclude the thesis by presenting the study's unique contributions, examining its strengths and limitations, and providing a personal reflection on the study.
Chapter 11 Conclusion and Recommendations

11.1 Introduction

In the previous chapter, I provided a discussion of the key findings of this study, exploring and discussing the complexity of the basic social processes and the substantive theory of reproductive identity expression, reinforcement and defence situated within and extending the theoretical literature. This chapter concludes my thesis by summarising the study and how it has addressed the research aims and objectives. I provide an evaluation of the strengths and limitations of the study, then offer a brief discussion of my thesis's unique contributions to methodological, theoretical, and empirical knowledge, summarising the clinical and political implications and prospective application of the substantive theory and accompanying QuEEN model as they relate to future clinical practice and maternity care, broader healthcare policy and recommendations for future research. Finally, I provide reflection on the study alongside concluding thoughts.
11.2 Summary of this Study

This thesis posed the question:

‘What Are the Experiences of Women and Other Birthing People Who Make Non-Normative Choices Along the Childbearing Continuum in the United Kingdom?

The following summarises the study’s significant findings, answering the research question. I have summarised them according to the research aims and objectives:

**Aim One: To examine and explain why and how women and other birthing people construct their decisions to make non-normative choices and the underlying social processes that motivate and drive the decisions.**

Reproductive identity is central to understanding why and how women and birthing people construct their decisions to make non-normative choices through expressing, reinforcing or, where necessary, defending against institutional and systemic identity threats. My study has expanded Athans’ (2020) conceptualisation of reproductive identity, offering new insights into a broader scope of experiences, tacit and embodied knowledge and intergenerational understandings drawn upon, interpreted, and assigned meaning that continuously influence uniquely individual reproductive identity construction. Moreover, I argued that reproductive identity is fluid and standalone rather than an adjunct to intersecting salient and central identities. I have shown that intersecting central and salient identities contribute to reproductive identity construction and act as a source of tension when a misalignment or dissonance exists between them. My findings demonstrate how a single pregnancy and childbearing episode and the experiences of entering and navigating the system contribute to a reconstruction of reproductive identity, influencing future non-normative choices and illustrating the cyclical nature of the substantive theory. Further, my study has shown how this process and reconstructed reproductive identity contribute to reconstructing other salient and central identities, e.g., professional.

My findings and substantive theory have shown that examining non-normative choices through the reproductive identity lens offers new insight into an individual's unique normativity, explaining how women make choices to express and reinforce their reproductive or defend against threat to reproductive identity. This study has raised important questions about the conceptualisation and application of reproductive identity as a standalone central
and salient identity in conception and childbearing, informing women's approach to decision-making and representing a significant element of what personalised care means to women.

**Aim Two: Examine women’s experiences in relation to navigating the maternity care system.**

The empirical findings in this study provide a new understanding of how, by entering the system, women are exposed to various actions and practises that categorise and label them according to the biophysical risk and pregnancy status, representing a profound depersonalisation and, thus, identity threat. Reproductive identity threats within the institution included, among other practises, centring fetal wellbeing above personal autonomy, failure to personalise recommendations and care through the blanket application of guidelines and thus rules and timetables uncritically. Moreover, by making non-normative choices, women are exposed to labelling as deviant, feeling othered, and stigmatising practices, representing a threat to identity. Institutional rejection of embodied and tacit knowledge presents further identity threats with a reciprocal rejection of the institution and healthcare professionals as trusted sources of knowledge.

Women respond to actual or anticipated reproductive identity threats by enacting common critical actions, modelled in this thesis as the QuEEN (Quit, Evaluate, Engage, Nothing) strategies for expressing, reinforcing, or defending against identity threats. These strategies are not sequential, and the perceived success -or otherwise - of each singular strategy can precipitate further, more extreme choices moderated by the extent to which the system, institution and healthcare professional are empowered to support and facilitate the initial choice. This finding is significant as it confirms that while achieving a non-normative choice is important- acknowledging that for the women their choices are normative in their own context- being supported by facilitative and respectful healthcare professionals is the critical mediator in whether further, more extreme non-normative choices are made or quitting the system occurs. My study has shown that quitting as a first or last resort and actions conceptualised as ‘doing nothing’ were significant actions women enact to achieve their non-normative choices, expressing and reinforcing their reproductive identity and defending against threats.
**Study Objective:** To generate an explanatory substantive theory about how and why women make non-normative choices and, in so doing, explain the underlying social processes.

This thesis has presented an abstracted and conceptualised constructivist substantive theory, grounded in the data representative of the social processes - Theory of Reproductive Identity Expression, Reinforcement and Defence. The substantive theory expands and builds upon existing theoretical and conceptual perspectives, which, to date, have focussed outside the context of maternity care. The substantive theory centres on an expanded and developed conceptualisation of reproductive identity as a standalone identity, thereby offering an original contribution by explaining how and why non-normative choices are made in the context of reproductive identity expression, reinforcement, and response to identity threat.

11.3 Study Strengths and Limitations

11.3.1 Strengths

There are several strengths to this study.

This study has rigorously adhered to the principles of constructivist grounded theory methodology developed by Charmaz (2014) and integrated Noblit and Hares (1988) method for meta-ethnography as methodologically concordant processes. The methodology's inductive nature and iterative constant data comparison, supported by cGT memoing and subsequent theoretical sampling, ensured methodological rigour and the findings were firmly grounded within the data, reinforcing trustworthiness. The use of meta-ethnography enhances the credibility and resonance of the final substantive theory, simultaneously offering a unique methodological contribution. The process of synthesised member checking also supported this process while confirming resonance within and across participants. The results of the meta-ethnography, alongside reflexive techniques, are a strength of this study, enriching and informing the empirical data generation and analysis and enhancing theoretical sensitivity (see 4.13.5).

Initial purposive and later theoretical sampling allowed for diversity in geographical locations across the UK. Participants offered diversity in experiences of making non-normative choices, including the nature and degree of success in achieving them. This again added to a broader understanding of the phenomenon while allowing for a formal definition of non-normativity across maternity care (see below).
The purpose of any qualitative research method is not to achieve generalisability but rather the degree to which the research findings are transferable to other settings. Green and Thorogood (2018a) suggest that this can be achieved by considering the ‘kind of relationship’ (Ibid. 2018. p.308) the findings represent in other populations and settings. It is here that I can once again draw upon Goffman’s (1963) work, whereby he rejects population-based or empirical generalisability in favour of the theoretical usefulness of the abstracted concepts and theory introduced in this study: conceptual generalisability (Green and Thorogood (Green and Thorogood, 2018a, p. 309). The analysis and interpretation of the findings in this study are drawn from data obtained from fourteen participants, which was a small sample size but is entirely consistent with constructivist grounded theory methodology and, therefore, not considered a limitation. This a key strength of this study, which aimed to and succeeded in offering both the substantive (middle range) theory concerning reproductive identity expression, reinforcement, and defence and the conceptual (QuEEN) model of strategies enacted to do so. Therefore, these theoretical and conceptual findings are transferable in the context of the phenomena studied and may offer future opportunities for understanding broader phenomena outside of the immediate context of maternity care.

Notwithstanding the potential limitations of empirical transferability, this study has included an extensive range of non-normative choices within its scope, not limited by mode or place of birth. Indeed, formally defining and conceptualising what is meant by a ‘non-normative choice;’ allowed for further refinement and contributed to the novel findings represented in the development of the substantive theory and associated QuEEN model. This has provided unique and original insights into the granular phenomena of non-normative choice-making within the social processes and the more abstract, theoretical concepts of the substantive theory.

11.3.2 Limitations

While I have fulfilled the intended aims and objectives of the study, all research studies have limitations:

No participants from Wales were recruited either purposively or theoretically. While this might be considered a limitation, theoretical sampling does not aim to be representative, consistent with constructivist grounded theory. Moreover, as the aims and objectives of my study focussed on the social processes involved in the phenomena rather than geographical influences, I do not consider this a significant limitation.

Chapter 4 addresses the methodological limitations. In summary, methodological limitations relate to the potential for subjective interpretations of data. However, these were addressed through the rigorous application of the
constructivist grounded theory method, memoing and reflexive techniques, and the use of social media-based recruitment.

11.4 Original Contributions and Implications of this Study

The following points summarise and evaluate the overall significant contributions of the thesis and their implications:

11.4.1 Methodological and Theoretical Contributions

My study adopted a constructivist grounded theory approach, methodologically appropriate in research that explores processes where little is known, including the exploration of processes where little is known about the phenomena of interest, allowing theoretical generation with the explanatory power of meaning and action and providing a method for critical enquiry (Birks and Mills, 2015; Charmaz, 2017). As a midwife researcher, this method accounted for my insider status, becoming part of the researcher-researched dyad of knowledge construction (Charmaz, 2017; Bukamal, 2022). The use of meta-ethnography (Noblit and Hare, 1988) initially allowed me to conceptualise and formally define what a non-normative choice in maternity care means, representing an original contribution. Further, meta-ethnography as a methodologically similar process to synthesise existing knowledge concerning the phenomena served not only to establish the empirical and theoretical gap this study now fills but also the abstraction and theorisation required for the development of a line of argument synthesis, latterly informing the empirical work and becoming part of the data itself, reflected in the discussion. Meta-ethnography enhances the credibility and resonance of the final substantive theory, simultaneously offering a unique methodological contribution. Combining meta-ethnography and constructivist grounded theory as congruent methodologies (the link between them discussed in 4.9.1), therefore, represents a significant original methodological contribution.

This study contributes to and expands recent conceptualisations and formal definitions of reproductive identity (Athan, 2020), enhancing our understanding of the influence of reproductive identity on choice-making in maternity care. Considering reproductive identity as a standalone identity alongside, and not adjunct to, other central and salient identities acknowledge the intersection and influence of other identities and how these can represent a threat in themselves or as critical elements of non-normative choice-making to express or reinforce
identity or, when experiencing identity threat, defend against it. This contributes to existing theoretical and empirical knowledge regarding responses to identity threat overall and specifically a new contribution with its application in maternity care, building upon the work of Goffman (1961), Breakwell (1986) and Scott (2015a). The expanded definition of reproductive identity, substantive theory of reproductive identity expression, reinforcement and identity threat and QuEEN model of strategies addresses the gap in empirical and theoretical knowledge this study aimed to fill offering the potential for broader application across clinical and academic disciplines.

Moreover, women do not view their non-normative choices as such but as normative in the context of their own reproductive identities. This study reinforces our understanding of the fundamental importance of personalised care as a central tenet in maternity care and, thus, centralisation of this within the maternity transformation programme (NHS, 2019; NHS England, 2021c), especially when women make choices that are counter to expectation. The study's findings also reinforce the necessity to consider broader intersectional and biopsychosocial-cultural influences on reproductive identity rather than focusing on a narrow biomedical and medicolegal risk-clouded lens.

The principal theoretical contribution of this study is the development of the theory of reproductive identity expression, reinforcement, and defence. My theory provides an abstract theoretical explanation of the social processes inherent in the experience of making non-normative choices in contemporary maternity care. Chapter two discussed the contemporary historical, social, and political climate in which women make non-normative choices within their childbearing journeys, the historical influences on the choice agenda and the evolution of how medicalisation, institutionalisation, and risk discourses have shaped the contemporary provision of maternity care. This study and the resultant substantive theory contribute a new understanding towards how these influences have contributed to deeply embedded systemic and institutional arrangements that oppose aspirations for choice and personalised care through fear of medicolegal and regulatory action despite a robust legal and ethical framework existing to protect women’s bodily autonomy. My study has exposed some critical systemic and institutional mechanisms by which this occurs, including the imposition of narrow risk-focused criteria for categorising according to risk and mitigating these risks through strictly applied guideline-driven care. My study has shown how this process works against aspirations for personalisation because of the expectation of compliance with recommendations and the actions likely to be taken when compliance isn’t realised. Labelling practises that frame
non-normative choices themselves as ‘outside of guideline’ or ‘declining care’ also reaffirm this expectation of compliance, compounded by a lack of acknowledgement and arrangements in place for what to do when recommendations are declined, or requests are made that do not feature in the guidelines. My study has shown that non-normative choices as a response to identity threat are rarely singular and discrete but rather a series of consecutive choices intended to express and reinforce reproductive identity or defend against an identity threat.

11.4.2 Clinical Implications

The clinical implications of the substantive theory knowledge and political considerations are significant within the clinical institution and wider political landscape. Recognising potential sources of reproductive identity threat within the institution is vital in developing appropriate institutional arrangements for supporting and facilitating non-normative choice within legal, ethical, and regulatory frameworks. Conversely, if the initial choice is restricted or denied, then it is likely that concurrent, more extreme choices will be made. The insights gained from this study, the substantive theory and the QuEEN model may assist in understanding the rationale for non-normative choices, pre-empting actions and strategies women and other-birthing people may enact, thereby providing respectful and relational support and care. Moreover, the theory and model might have more comprehensive applications outside maternity care in understanding how and why patients might decline care, interventions, and support. This addresses the gap in empirical and theoretical knowledge.

At a local clinical level, understanding the nature of information sources valued by women and the role of the institution and gatekeepers in providing support can influence strategies for choice. It can inform and guide the commissioning of structured support networks and teams. Supportive communities were noted as moderating factors in women's journeys, including seeking and engaging with trusted communities - within or outside the institution- to assist in information and knowledge seeking and legitimisation. Where the trusted community is within the institution and where initial choices are respected and facilitated, it is foreseeable that women will be disinclined to disengage- in part or whole - from the system. Of note was the importance of role models, including the consultant midwife role, with close partnership with obstetric colleagues, who are open to psychologically safe discussions and care planning. The relevance of this to other studies highlights the importance of relational and, where possible, continuity of care, with robustly supported institutional arrangements to support choices outside of expected compliance with guidelines, as women in this study explicitly expressed their valuation of facilitative care and ideally a continuous provision of care or carer, contributing to existing knowledge. This offers
a new understanding in two respects. Firstly, there is a need for healthcare professionals who share similar philosophies to provide skilful continuity of care, be skilled, and have expertise in the choice being made; otherwise, this can represent an identity threat. Secondly, engaging with such healthcare professionals renders the non-normative choice often less important than the journey experience itself. The endpoint of non-facilitating was quitting or compliance, so the result of compassionate, relational care was a disinclination to further or more extreme non-normative choices. This has significant clinical implications related to future complete withdrawal before entry into the system in future childbearing episodes resulting in a reconstructed reproductive identity, personal experiences of trauma, and, crucially, the outward influence of sharing experiences intergenerationally and within broader communities, laying the ground for others' non-normative choices. By applying knowledge of the QuEEN Model of Common Strategies for Reproductive Identity Expression, Reinforcement and Defence, healthcare professionals can anticipate quitting or provide safe relational care in the engagement, negotiation and nothing stages to prevent quitting -either in this pregnancy or the next.

11.4.3 Political Implications

As highlighted in Chapter 1, I profess no preference nor engrained ideology other than fundamentally held beliefs that women have the right to bodily autonomy, free to make personalised choices and decisions related to their pregnancy and birth in a respectful and relational space, free from obstetric violence, and with their chosen support network. It is important to note, therefore, that this study intentionally focused on all choices made by women across the whole childbirth continuum, regardless of mode or place of birth, choice of analgesia, anaesthesia or indeed none at all. Other studies have not focussed on this broad spectrum, making this study distinctive.

This study has raised important questions about the conflict and power imbalances between individual institutions when women present with unexpected or challenging choices about their care, as well as the complicated relationships between broader agendas for safe and personalised care and their application, within the institutional environment. At the time of writing this thesis, the United Kingdom is amid many inquiries and investigations into poor maternity care (Kirkup, 2015, 2022; Ockenden, 2021), and at the core of all these reports are similar themes: women not being listened to or believed, unsafe care, and lack of consent. All participants in this study had their own credible personal reasons for making their choices, many not understood by their care providers, precipitating those behaviours discussed through the thesis, discordant with national policy and ethical practice and rooted in similar themes to national reports – not being listened to, lack of consent, and unsafe care. The NHS
Constitution for England (DHSC, 2023) explicitly outlines commitments and values which all public servants working within the NHS must demonstrate, including informed choice and maintaining patients at the centre of their care journey. This involves acknowledging women's rights to autonomy over their bodies throughout the childbearing continuum, which includes withholding consent to offered recommendations. This is further supported by statute, legal precedent, regulatory guidance, and the fundamental ethical principles of healthcare practice. Despite this, the discord and fundamental misalignment between the choice agenda, women's understandings of what safety means for them related to their context and how choices come to be realised in systems that are regulated by the misapplication of guideline-centric and fetus-centric care is vast.

At a local level, under-resourcing, staffing constraints, reduced capacity, and acuity challenges blend with a lack of education and understanding of the legal, ethical, and regulatory implications of women making fully informed decisions about their care, resulting in the individual and institutional behaviours experienced by participants in this study. This is somewhat exacerbated by the constraints and pressures exerted upon clinicians and institutions to operate within and demonstrate compliance with national guidelines and reporting metrics, which are not designed to support non-normative choices. Further, this study has shown how expectations of compliance contradict aspirations for choice and the lived reality of making choices in a contemporary NHS setting. I have discussed in Chapter 10 the evidence that many individual obstetric and midwifery clinicians strive to maintain; the balance between choice, personalised care and working within a risk-averse system steeped in blame culture, significant fear of reprisals and repercussions of not following guidance, especially if an outcome is poor, which can have a substantial toll on professional wellbeing and morale. It follows, therefore, that this study has considerable clinical and political implications in how we understand the granular activities and strategies undertaken by women to realise their choices in the face of the complex influences described above. This implies a fundamental shift being required in how maternity care is conducted to support personalised care in the context of contemporary maternity agendas, adequate resourcing, and training to support ALL elements of choice, and a review of the nature of what personalised care means in the context of this study’s new understanding and conceptualisation of reproductive identity.

The following section considers the original contributions, including clinical and political implications, to make recommendations for future research, policy, and practice.
11.5 Recommendations for Future Research, Policy, and Practice

In the next section, I offer the following recommendations for policy and practice, drawing upon the findings of this study and its original contributions. The purpose of this is to provide suggestions on how the results of my research can be implemented and considered to improve the experience and outcome of women making non-normative choices:

Research:

- Further research applying the expanded conceptualisation of reproductive identity in broader settings would provide an insight into the influences on and of this as a standalone identity concept. Potential applied research areas might include gynaecological and other reproductive arenas, including abortion, conception, IVF, and pregnancy loss. Furthermore, consideration of its intersectional applicability offers exciting potential for further avenues of research.

- My study has shown that rather than being a hidden and predominantly minority phenomenon, non-normative choices are being made across the UK. Responses to the initial call for participants indicate an appetite for women to share their experiences of making non-normative choices within the National Health Service. Therefore, an extensive nationwide mixed-methods survey could be conducted to explore this, including the type of choice, the extent to which women felt supported, and their perceived barriers and facilitators.

- Establishing a national dataset to evaluate the prevalence, incidence, and outcome of common non-normative choices across the United Kingdom including free birth, complex homebirth, and declining recommended care. Notwithstanding those pockets of research being undertaken at the regional level focussing on discrete choices and phenomena, it would be appropriate to add this to reporting metrics at a national level and then share across healthcare systems to assist workforce planning, identify trends and plan for future specific research. This might be facilitated through the existing UKMidSS system.\(^{87}\)

---

87 UK Midwifery Study System (UKMidSS). Establishing as part of the National Perinatal Epidemiology Unit to facilitate national studies and surveys of practice, exploring uncommon conditions and events.
or by establishing a standalone research/data collection programme within the NHS. The collection of this data will inform future research direction and guide the development of specific targeted policies and guidelines to allow an understanding of how services can be adapted to support women in these choices.

- A mixed methods investigation into existing arrangements across the National Health Service (trusts and health boards) in the United Kingdom to identify areas of good practice in facilitating and supporting non-normative choices. This should include survey and interview/focus group data with key stakeholders, including senior management teams (board and legal teams), midwives, obstetricians, neonatologists, and service users (especially those from vulnerable and under-represented groups).

Policy

- The establishment of a professional network for interested parties to attend and share learning across disciplines related to facilitating non-normative choices. This might be a joint venture led by the Royal Colleges or by NHS England, Scotland and Wales, contributing to a formal knowledge network within which policy, guidelines and good clinical practice can be shared, discussion of cases for learning be undertaken and trends identified that informs future national and local research proprieties.

- Adopting a standardised statement within all national maternity policies and guidance (e.g., NICE and RCOG Green top Guidelines) mirrors those within regulatory codes of conduct that where an offer or recommendation for care is made, women have the legal right to decline and withhold consent. This statement should require that organisations have formal arrangements to accept this decision and that the expectation of compliance respectfully and professionally with guidelines should not be the norm.

Practice

Given the importance of institutional interpretation of national guidance and the implementation and application of this at a local level, I offer the following recommendations for NHS organisations and Higher Education Institutions:

- Identify champions within the midwifery, obstetric, neonatal, and senior teams at a local level to operate as key contacts, leads, and liaisons for staff members to consult with when supporting women to make
non-normative choices. Moreover, these lead individuals can contribute to the programme of guideline review (see below).

- Each NHS Trust or Healthboard should employ at least one senior midwife in a Consultant midwife role with a clearly defined remit for the recommendation above.

- Maintaining an open, blame-free learning culture with mechanisms for multidisciplinary sharing of experiences and reflection, co-produced service development and innovation.

- Within each maternity service, integrate a learning programme into mandatory training that reinforces the legal, ethical, and regulatory protection of clinicians when supporting non-normative choices, women's rights to make the choices, and the vital contribution of authentic, informed consent practices towards safe and respectful care.

- Establish clear local pathways for multidisciplinary team discussion and resolution of complex care planning for women making non-normative choices, including senior-level management and NHS Trust legal teams. Establish a shared understanding and approach towards incidences of non-normative choices.

- Collect audit data at a local level that collates the nature and outcomes of non-normative choices that are outside of guideline care to evaluate and plan for local trends outside of guideline requests.

- Each organisation should conduct a full review of institutional policy and guidelines, emphasising women’s rights to withhold consent to care (decline) and employee signposting and support where this happens. This should include a liaison with the legal teams of the Trust or Health Board to ensure that the approach to care is moderated by evidence-based and accurate legal information.

- Consider a standardised change in framing non-normative choices (outside of guidelines care/declining care) to negate the ill effects of othering through language and reflect this in naming referral pathways and clinics, especially those conducted by consultant midwives. Suggestions include:
  - Personalised Care Pathway/Clinic
  - Enhanced Personalised Pathway/Clinic
- Supported Decision-Making Pathway/Clinic
- Pregnancy Options Pathway/Clinic

Any renaming should include engagement with external service user representatives to identify which are more acceptable to those accessing the service. Furthermore, replacing ‘declining care’ with ‘withholding consent’ as standard practice (nationally and locally) provides a legally and technically accurate focus and removes the negative connotations and implications of documenting declining.

- Creating a standard personalised care plan template that supports non-normative care planning recognises that it may be declined where a standardised offer of choice is made.

- Ensure that personalised care discussions with women include exploration of intergenerational influences, including pregnancy experiences, mode of birth and breastfeeding, and how this might influence the choices being made.

- Staff support for those who feel challenged when supporting non-normative choices, including debriefing sessions for them and resolution sessions for women who experience difficulties in making non-normative choices.

- Regular workshops for all levels of staff to discuss anxieties, develop a culture of openness and identify gaps in knowledge to build into the education cycles of the trust for supporting women who make non-normative choices.

- For teams providing continuity of care in specific circumstances that might be viewed as non-normative, facilitating and exploring personal biases, care philosophies, and approaches to care can move towards an alignment with the women they support. This also includes identifying skills and knowledge gaps to plan for educational and practice development.

- Establish local groups for engagement with women as a feedback mechanism for those who cannot attend meetings to discuss experiences and develop opportunities for improvement.

- Within midwifery education, ensure that the principles of personalised care planning and non-normative choices are explored from a legal, ethical, and practical perspective to provide a firm basis from which
newly qualified midwives have the confidence to support both the women in their care and also educate their more experienced colleagues.

- Within midwifery education, embed discussions of intergenerational and immediate biopsychosocial-cultural factors in planned activities related to personalised care planning, birth trauma, and decision-making influences.

11.6 Reflections on the Study

In Chapter 4, I noted that reflection is somewhat second nature as a healthcare professional, a mandated element of safe clinical and other practices (NMC, 2018). Reflexivity is a distinct process alongside the research continuum, requiring an honest examination and acknowledgement of one's positioning, beliefs, judgements, and decisions within the research journey. By acknowledging this at every stage, researchers can evaluate the impact of decisions along the research process, contributing to transparency and rigour. In the spirit of structured reflection consistent with clinical practice and reflexivity in research, I offer the following final reflection on the study's inception, guided by the principles of Johns' (1995) model of reflection.

In Chapter 1, I described my professional and personal motivations for undertaking this study, positing that my interest in non-normative choices was rooted in my childbirth experiences and midwifery practice. The meta-ethnographic review of the literature confirmed my hunch that in exploring non-normative choices, existing research centred on the authoritative knowledge of clinicians, with only discrete phenomena being studied from the woman's position. I had to focus on the whys and the women themselves – to make a difference, it needed to come from them. I found it hard at first to articulate why I tacitly knew this to be accurate, and it is only now, having completed this work, that I understand. It is also clear that the seeds of this thesis had been sown far earlier than I knew, even before my own childbirth experiences, and as expressed previously, undertaking this study has forced me to confront and reconcile elements of my reproductive journey that I already knew reinforced my clinical and academic positioning as a midwife and researcher. To commit to paper some of my feelings around not just my childbirth journey but those within my broader reproductive identity (as I have conceptualised within this thesis) would be challenging, involving strong emotions, and therefore, not appropriate for this reflection. Notwithstanding, I have no doubt that this process will continue far into the future, even past the completion of this study.
Using grounded theory (GT) as a methodology was a daunting prospect initially, having only been exposed to what I now understand to be limited and somewhat reductive ideas of GT during my MSc. This study was not originally envisaged as using GT; however, the more I engaged with the broader constructivist grounded theory literature, the more it resonated with me regarding the intended outcome and my role as an insider researcher. Moreover, it resonated completely with my view of how unique and contextual knowledge is constructed. I was to become part of the data generation, not just an objective observer and interpreter. This proved a significant decision for me and one that I am glad I took, as it rendered my professional and personal experiences valid and provided the conduit I needed to move beyond description and interpretation and offer explanatory power.

I entered the research process a meticulous planner for every foreseeable event (which, incidentally, I contend contributes to good midwifery practice, predicting everything and having a strategy); however, early in the study, I found I had to embrace the complex and chaotic nature of constructivist grounded theory research. I did not know where the data would take me, which was exhilarating and terrifying no matter how often I was told to trust the process. I was wracked with self-doubt and imposter syndrome, which occasionally resulted in stasis, not being able to reconcile the meticulous, all-eventuality-predicting midwife in me with the emerging constructivist grounded theory researcher. Many reflexive discussions during this time included discussion about what came to be jokingly referred to as my ‘existential crisis’; I realised that I needed to relinquish control to be thoroughly insightful and introspective to achieve reflexivity in my work and remain grounded in the data. I found writing hard, and I had to work constantly at articulating succinctly what was happening in my head and the complex tangle of processes in the data. A comment made during my first year relating to a lack of academic background in social sciences and, therefore, social theory being a potential barrier to timely completion was a significant personal turning point in my PhD journey. This made me even more determined to immerse myself in sociological and psychological literature and reflexive mechanisms to take a metaphorical comb to the tangle of ideas, opening doors to understanding and organising data and making sense of participants’ stories.

An important subject to address is why there are so many midwives in the study sample. This vexed me throughout and formed the basis of many reflexive discussions with supervisors, journal entries and memos. During recruitment and subsequent sampling, it was evident that several prospective participants shared my profession, and I reflected extensively on this subject with my supervision team. Once identified, I tried to address this by explicitly avoiding sampling midwives during theoretical sampling. Nevertheless, I discovered that one participant
subsequently selected for their experience had received midwifery training before her current role, which she had not disclosed until partway through the interview. It was as if I could not avoid midwives in the sample. Upon reflection, the number of midwives was important and, subsequently, one of the theoretical hooks upon which abstraction and theorisation hung. I maintain that the final number remains non-problematic but rather indicative of the nature of the substantive theory, illustrating how not only does professional identity influence reproductive identity but vice versa. It remains interesting, therefore, that there were some midwives in the sample, but no more so than similar numbers of teachers, homemakers, and managers. Ultimately, it did not matter what the participants' profession was; instead, it had a reciprocal influence on their reproductive identity. What midwifery training did provide for these women was an insight into how their professional knowledge helped them navigate the system for themselves and others - they knew it, they lived it, and so did I. Their insider knowledge afforded them a privilege others may not have, so they role-modelled the essence of advocacy for themselves personally and professionally. This reflection brings me full circle into my entry into the profession and subsequent reproductive choices; for all intents and purposes, the midwives in this research are me, and I them. I now reflect on how this reciprocal influence has fundamentally reinforced my professional identity (and thereby positionality) as a midwife, researcher, and mother, shaping how I approach advocacy and protecting a woman’s right to bodily autonomy and choice.

That is not to say that hearing about my profession and the wider maternity healthcare community has been an overwhelmingly positive experience during this process. Data generation involved over a year of being the custodian of women’s and other birthing people's childbearing stories, which was a huge privilege, but at times evoked emotions of sadness, joy, and, commonly, anger. I was angry at the familiar stories of incivility, rudeness, coercion, assault, and obstetric violence. I’m ashamed that I had worked within a system that traumatised and damaged those who entered with vulnerabilities. When participants dared to say, ‘enough is enough’ and steadfastly advocated for themselves in their decision-making, they met with behaviours I had seen myself and - I am ashamed to admit - as a junior midwife, just accepted. After one particular interview, I had to not conduct another interview for two weeks because I was profoundly upset by an account of coercion and obstetric violence that made me rage. Here, I leaned heavily into my reflexive mechanisms – journalling, memoing and lengthy discussions with supervisors to maintain rigour in the research process and hold me steady in my position. The realisation that, conducting this study, I was not only giving voice to women and other birthing people who might otherwise have gone unheard, lost in the hushed whispers of ‘that woman declining care’ or ‘the non-compliant
woman choosing not to be induced’ or the ‘non-attender who needs referring to social services’ (my emphasis) but also giving myself a voice, towards my future clinical and academic positioning and philosophy.

11.6.1 Concluding Thoughts

I have learned so much about myself professionally and personally alongside the experiences of my study’s participants, which will make me a better researcher, academic and midwife. It is often viewed as a cliché, the researcher who professes a profound shift in their outlook and perspectives due to undertaking a PhD; however, I now understand what that means. My research journey has validated the work I have undertaken in all tenets of my professional life (and some journeys I have taken personally). Still, it has also reinforced the need to pursue research to enhance the care of women and other birthing people within the contemporary maternity system. I now have the tools to contribute to broader knowledge and safer, more respectful clinical and academic practice in the future. To this end, I am committed to my future academic and clinical career in advocacy for choices made willingly and freely in the name of reproductive identity and healthcare and to ensure that women and other birthing people can make those choices, however, challenging their care providers or wider society views them.
References


Anon (2022) ‘Personal Correspondence. Review Comments’.


Booth, A. (2001) ‘Cochrane or cock-eyed? How should we conduct systematic reviews of qualitative research?’, in Qualitative Evidence-based Practice Conference, Taking a Critical Stance, Coventry University.


Downe, S. *et al.* (2009) ‘Template for meta synthesis’. sdowne@uclan.ac.uk.


Hauck, Y. et al. (2020) ‘Women’s reasons and perceptions around planning a homebirth with a registered midwife in Western Australia’, Women and Birth, 33(1), pp. e39–e47. Available at: https://doi.org/10.1016/j.wombi.2018.11.017.


Hoddinott, P. et al. (2018) ‘How to incorporate patient and public perspectives into the design and conduct of research [version 1; peer review: 3 approved, 2 approved with reservations]’, F1000 research, 7, pp. 752–752. Available at: https://doi.org/10.12688/f1000research.15162.1.


Hutton, E. *et al.* (2019) ‘Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses’, *The Lancet*, 14, pp. 59–70.


Knight, H.E. et al. (2017) ‘Perinatal mortality associated with induction of labour versus expectant management in nulliparous women aged 35 years or over: An English national cohort study’, PLOS Medicine, 14(11), p. e1002425. Available at: https://doi.org/10.1371/journal.pmed.1002425.


Maternity Services Select Committee (1992) Health Committee Second Report. HMSO.


MBRRACE-UK (2022) MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk.

McCartney, M. (2014) ‘Margaret McCartney: Have we given guidelines too much power?’, BMJ, 349(oct06 1), pp. g6027–g6027. Available at: https://doi.org/10.1136/bmj.g6027.

McDermid, F. et al. (2014) ‘Conducting qualitative research in the context of pre-existing peer and collegial relationships’, Nurse researcher, 21(5), pp. 28–33. Available at: https://doi.org/10.7748nr.21.5.28.e1232.


Milne, S. (2022a) ‘Does a student midwife’s personal experience of childbirth affect their philosophy of care and the choices they offer to women?’, MIDIRS Midwifery Digest, 32(3), pp. 320–324.


Morelli, A. et al. (2023) ‘Outcomes for women admitted for labour care to alongside midwifery units in the UK following a postpartum haemorrhage in a previous pregnancy: A national population-based cohort and nested case-control study using the UK Midwifery Study System (UKMidSS)’, Women and Birth, 36(3), pp. e361–e368. Available at: https://doi.org/10.1016/j.wombi.2022.11.002.


Olsen, O. and Clausen, J. (2023) ‘Planned hospital birth compared with planned home birth for pregnant women at low risk of complications’, *Cochrane Database of Systematic Reviews* [Preprint], (3). Available at: https://doi.org/10.1002/14651858.CD000352.pub3.


Open University HREC (2020) ‘Ethics Principles for Research with Human Participants’. Open University HREC.


Peel, J. and Standing Maternity and Midwifery Committee (1971) *Domiciliary midwifery and maternity bed needs: report of the Sub-Committee of the Standing Maternity and Midwifery Advisory Committee*. 1st edn. London: HMSO.


PTSD UK (2023) ‘Trauma: Its more than just “fight or flight”’, Trauma: Its more than just ’fight or flight’. Available at: https://www.ptsduk.org/its-so-much-more-than-just-fight-or-flight/ (Accessed: 10 October 2023).


RCM (2022a) ‘Care outside guidance. Caring for those women seeking choices that fall outside guidance’. Royal College of Midwives. Available at: https://www.rcm.org.uk/media/5941/care_outside_guidance.pdf.


Rowe, R. et al. (2018) ‘Outcomes for women with BMI>35kg/m2 admitted for labour care to alongside midwifery units in the UK: A national prospective cohort study using the UK Midwifery Study System (UKMidSS)’, *PLOS ONE*, 13(12), p. e0208041. Available at: https://doi.org/10.1371/journal.pone.0208041.


Sanderson v Guys and St Thomas’ NHS Foundation Trust (2020).


*St George’s Health Care NHS Trust v SR v Collins and others ex parte S* (1998).


Steel, N. *et al.* (2014) ‘A review of clinical practice guidelines found that they were often based on evidence of uncertain relevance to primary care patients’, *Journal of Clinical Epidemiology*, 67(11), pp. 1251–1257. Available at: https://doi.org/10.1016/j.jclinepi.2014.05.020.


## Appendix 1 – Relevant Publications and Works Arising out of Thesis.

### Conference and Poster Presentations

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>The Open University</td>
<td>Exploring Non-Normative Choice in Childbearing</td>
<td>WELS PGR Conference</td>
</tr>
<tr>
<td>20/6/21</td>
<td>University of Birmingham</td>
<td>Supporting Challenging Choices: Facilitating Home Birth for Women and Birthing People Outside of Guideline</td>
<td>The home birth symposium organised by Midwifery Society open to the wider academic and clinical community.</td>
</tr>
<tr>
<td>2021</td>
<td>The Open University</td>
<td>Exploring Non-Normative Choice in Childbearing</td>
<td>Annual poster competition</td>
</tr>
<tr>
<td>2021</td>
<td>University of Cardiff</td>
<td>Supporting Challenging Choices: Facilitating Home Birth for Women and Birthing People Outside of Guideline</td>
<td>Session for third year midwifery students</td>
</tr>
<tr>
<td>27/1/22</td>
<td>Maternity and Midwifery Forum/MatFlix</td>
<td>Personalised care in the presence of challenging choices: Findings from a Meta-Ethnographic Review of the Literature</td>
<td>Presenting findings of Meta-Ethnography</td>
</tr>
<tr>
<td>16/2/22</td>
<td>Anglia Ruskin University</td>
<td>Complex birth and caring for women that fall outside the guidelines</td>
<td>MSc Students - invited to discuss legal, ethical and midwifery aspects and present PhD work so far</td>
</tr>
<tr>
<td>Date</td>
<td>Location/Event</td>
<td>Title</td>
<td>Details</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23 and 24th</td>
<td>Royal College of Midwives Education and Research Conference 2022</td>
<td>Challenging Choices in Pregnancy and</td>
<td>Poster Presentation</td>
</tr>
<tr>
<td>March 2022</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8th June 2022</td>
<td>Maternity and Midwifery Forum (live and online)</td>
<td>“They are that Unicorn”</td>
<td>Asserting atypical choices in a complex maternity system. A national online and face-to-face conference discussing the implications of Ockenden on personalised care. presented the preliminary findings of the study concerning the personalisation of care.</td>
</tr>
<tr>
<td>15th June 2022</td>
<td>University of Northampton</td>
<td>“They are that Unicorn”</td>
<td>Asserting atypical choices in a complex maternity system. Presented preliminary findings of the study concerning personalising care.</td>
</tr>
<tr>
<td>9/3/23</td>
<td>Open University, International Women’s Week events</td>
<td>Exploring non-normative choice in childbearing</td>
<td>Presentation of work to support equity during International Women’s Day</td>
</tr>
<tr>
<td>05/07/2023</td>
<td>East Suffolk and North Essex NHS Foundation Trust (ESNEFT)</td>
<td>Experiences of Women and Birthing People Who Make Non-Normative Choices in Childbearing</td>
<td>Presentation of brief study findings about personalisation of care and choice</td>
</tr>
<tr>
<td>Date</td>
<td>Clinical Ethics Advisory Group, University of Oxford, and University Hospitals Oxford. John Radcliffe Hospital</td>
<td>Clinical ethics: choice and autonomy in obstetrics: Outside of Guideline Care – Insights from Women</td>
<td>Sharing findings of research about clinical practice</td>
</tr>
</tbody>
</table>
Peer Reviewed and Other Publications

Madeley, A (2022). No is a complete sentence, *British Journal of Midwifery*, 30 (2) pp. 66-68


Appendix 2 - Meta Ethnography: Example Iteration of Search Strategy
<table>
<thead>
<tr>
<th>Date</th>
<th>Search</th>
<th>Search terms/ Booleans/ Wild cards</th>
<th>Limiters applied(e.g., date range, subject, language, country)</th>
<th>Hits</th>
<th>Included?</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/20</td>
<td>S1</td>
<td>( wom#n or female ) AND pregnan* OR expectant OR gravid</td>
<td>Published Date: 19900101-20201231; Geographic Subset: Australia &amp; New Zealand, Europe, UK &amp; Ireland; Pregnancy; Age Groups: Adult: 19-44 years, Middle Aged: 45-64 years, Aged: 65+ years, All Adult; Language: English</td>
<td>36,146</td>
<td>Refined</td>
</tr>
<tr>
<td></td>
<td>S2</td>
<td>experience OR perception OR attitudes OR view OR perspective</td>
<td>Published Date: 19900101-20201231; English Language; Geographic Subset: Australia &amp; New Zealand, Europe, UK &amp; Ireland; Pregnancy; Age Groups: Adult: 19-44 years, Middle Aged: 45-64 years, Aged: 65+ years, All Adult; Language: English</td>
<td>116,248</td>
<td>Refined</td>
</tr>
<tr>
<td></td>
<td>S3</td>
<td>(experience OR perception OR attitudes OR view OR perspective) AND (S1 AND S2)</td>
<td>Published Date: 19900101-20201231; English Language; Geographic Subset: Australia &amp; New Zealand, Europe, UK &amp; Ireland; Pregnancy; Age Groups: Adult: 19-44 years, Middle Aged: 45-64 years, Aged: 65+ years; Language: English</td>
<td>5,780</td>
<td>Refined</td>
</tr>
<tr>
<td>02/12/20</td>
<td>S4</td>
<td>( S1 AND S2 ) AND ( high risk pregnancy or complicated pregnancy ) OR risk pregnancy AND ( homebirth or home birth or home delivery or home childbirth )</td>
<td>Published Date: 19900101-20201231; English Language; Geographic Subset: Australia &amp; New Zealand, Europe, UK &amp; Ireland; Pregnancy; Age Groups: Adult: 19-44 years, Middle Aged: 45-64 years, All Adult; Language: English</td>
<td>171</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>S5</td>
<td>( S1 AND S2 ) AND ( refusal of treatment or refusal of care or refusing treatment ) OR ( declining care or against medical advice or outside the guidelines )</td>
<td>Published Date: 19900101-20201231; English Language; Geographic Subset: Australia &amp; New Zealand, Europe, UK &amp; Ireland; Pregnancy; Age Groups: Adult: 19-44 years, Middle Aged: 45-64 years, Aged: 65+ years, All Adult; Language: English</td>
<td>155</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Query</td>
<td>Published Date: 19900101-20201231; Geographic Subset: Australia &amp; New Zealand, Europe, UK &amp; Ireland; Pregnancy; Age Groups: Adult: 19-44 years, Middle Aged: 45-64 years, All Adult; Language: English</td>
<td>Results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S7</td>
<td>(S1 AND (declining care or against medical advice or outside the guidelines) AND (homebirth or home birth or home delivery or home childbirth or birth at home)) AND (S13) AND (experiences or perceptions or attitudes or views)</td>
<td>2 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8</td>
<td>(S1 AND S2) AND free birth* OR unassisted birth</td>
<td>29 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9</td>
<td>(S1 AND S2) AND (cesarean section or caesarean section or c-section or cesarean delivery) AND (homebirth or home birth or home delivery or home childbirth or birth at home)</td>
<td>9 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S10</td>
<td>(S1 AND S2) AND (elective cesarean section or planned cesarean) OR elective cesarian OR against medical advice</td>
<td>17 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S11</td>
<td>(pregnant women or pregnancy or expectant mothers) AND (waterbirth or water birth or birthing pool or under water birth) AND (experiences or perceptions or attitudes or views)</td>
<td>6 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>389 12</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3 – Meta Ethnography: Characteristics of Included Studies
<table>
<thead>
<tr>
<th>Author and country</th>
<th>Aims and objectives</th>
<th>Sample, Data Collection, Analysis Method</th>
</tr>
</thead>
</table>
| **1** Bakkeren et al (2020)  
*Netherlands* | Views and opinions of pregnant women who have made the decisions about whether to accept prenatal screening tests. | 19, Semi-structured (SS) interviews, Thematic analysis |
| **2** Crombag et al (2016)  
*Netherlands* | Determine if screening policy and healthcare system influences individual decision-making and uptake | n = 46 (n = 22*), Focus group Framework analysis |
| **3** de Zulueta and Boulton (2007),  
*United Kingdom* | Decision-making processes and informed consent around routine antenatal HIV testing | N=32 (n=6*) SS interviews, matrix based thematic analysis. |
| **4** Eide, Morken and Bærøe,  
(2019),  
*Norway* | Exploration of maternal request for planned caesarean section in the absence of obstetric indication | n = 17, SS interviews, Thematic cross case analysis |
| **5** Feeley and Thomson, (2016)*a  
*United Kingdom (UK)* | Identify and explore influences on women’s decision to freebirth. | n = 10, Narrative accounts, SS interviews, Interpretative phenomenological analysis (IPA) |
| **6** Feeley and Thomson, (2016)*b,  
*UK* | Explore conflicts and tensions in freebirth through the views, experiences, and motivations of women who to choose freebirth | n = 10, Written narrative accounts, SS interviews, IPA |
| **7** Fenwick et al., (2010)  
*Australia* | Describe women’s request for caesarean section in the absence of a known medical indication. | n = 14, Interviews and questionnaire, thematic Analysis |
| **8** Gottfreðsdóttir, Björnsdóttir and Sandall, (2009),  
*Iceland* | Decision-making to undergo nuchal translucency screening among both couples who accept and couples who decline screening | n = 10, SS interviews, thematic framework analysis |
<table>
<thead>
<tr>
<th></th>
<th>Author(s) and Year</th>
<th>Location</th>
<th>Study Title</th>
<th>Sample Size</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Henriksen et al., (2020)</td>
<td>Norway</td>
<td>Describing motivations and preparations for freebirth</td>
<td>n = 12</td>
<td>SS interviews, Thematic Analysis</td>
</tr>
<tr>
<td>10</td>
<td>Hollander et al., (2017), Netherlands</td>
<td>Netherlands</td>
<td>Motivations for high-risk homebirth and unassisted childbirth.</td>
<td>n = 28</td>
<td>SS interviews/field notes, Constructivist Grounded Theory</td>
</tr>
<tr>
<td>11</td>
<td>Holten, Hollander and de Miranda, (2018), Netherlands</td>
<td>Netherlands</td>
<td>Explore how the choice to birth outside of the system was negotiated in clinical encounters.</td>
<td>n =10</td>
<td>SS interviews, Descartes phenomenology</td>
</tr>
<tr>
<td>12</td>
<td>Jackson, Dahlen and Schmied, (2012), Australia</td>
<td>Australia</td>
<td>Explore the perceptions of risk held by women who choose to have a freebirth or a 'high-risk' homebirth.</td>
<td>n= 20</td>
<td>SS interviews, Qualitative interpretative</td>
</tr>
<tr>
<td>13</td>
<td>Jackson, Schmied and Dahlen, (2020), Australia</td>
<td>Australia</td>
<td>Motivations for birthing outside of the system (high risk homebirth and freebirth)</td>
<td>n= 20</td>
<td>SS Interviews, Grounded Theory</td>
</tr>
<tr>
<td>14</td>
<td>Jenkinson et al., (2016), Australia</td>
<td>Australia</td>
<td>Perspectives of women, midwives and obstetricians after introduction of a formal process to document refusal of recommended care.</td>
<td>n= 9</td>
<td>SS interviews, Qualitative interpretative thematic analysis</td>
</tr>
<tr>
<td>15</td>
<td>Jenkinson, Kruske and Kildea, (2017), Australia</td>
<td>Australia</td>
<td>Explore experiences of refusal of recommended maternity care.</td>
<td>n= 9</td>
<td>SS interviews, Feminist thematic analysis</td>
</tr>
<tr>
<td>16</td>
<td>Keedle et al., (2015), Australia</td>
<td>Australia</td>
<td>Reasons for and experiences of choosing a Home Birth after Caesarean (HBAC)</td>
<td>n=12</td>
<td>SS interviews, Interpretative/ Feminist framework</td>
</tr>
<tr>
<td>17</td>
<td>Lee, Ayers and Holden (2016)a, UK</td>
<td>UK</td>
<td>Explore women’s decision-making during high-risk pregnancies, half planning high risk homebirth</td>
<td>n=26*</td>
<td>SS interviews, Thematic Analysis</td>
</tr>
<tr>
<td>18</td>
<td>Lee, Ayers and Holden (2016)b, UK</td>
<td>UK</td>
<td>Explore women's perceptions of interactions with obstetricians and midwives during high-risk pregnancies. Examine differences and similarities between women planning to give birth at home or in hospital.</td>
<td>n= 26*</td>
<td>SS interviews, Thematic Analysis</td>
</tr>
<tr>
<td></td>
<td>Author(s) and Year</td>
<td>Research Question</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Analysis</td>
</tr>
<tr>
<td>---</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>19</td>
<td>Lee, Ayers and Holden (2016)*, UK</td>
<td>Examine perception of risk among women with high-risk pregnancies who were either planning to give birth in hospital, or at home despite medical advice to the contrary. Consider differences and similarities between groups to examine how risk perception relates to the choice of place of birth.</td>
<td>n= 26*, SS interviews, Thematic Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Lee, Holden and Ayers (2016)</td>
<td>Explored women’s use of lay information during high-risk pregnancies to examine differences and similarities in the use of information in relation to planned place of birth.</td>
<td>n= 26*, SS interviews</td>
<td>Thematic Analysis</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Liamputtong et al., (2003), Australia</td>
<td>Reasons for declining prenatal screening and diagnosis</td>
<td>n=46*, questionnaire, thematic analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Lindgren, Nässén and Lundgren, (2017), Sweden</td>
<td>Experiences of unassisted planned homebirth in Sweden</td>
<td>n=8, SS interviews</td>
<td>Phenomenology</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>McDonald and Kirkman, (2011), Australia</td>
<td>Accounts from HIV-positive women of their use and non-use of treatments for the prevention of mother to child transmission</td>
<td>n = 16 SS interviews</td>
<td>Thematic framework analysis</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>McKenna and Symon, (2014), UK</td>
<td>Explore the reasons for requesting a water vaginal birth after caesarean and experiences</td>
<td>n = 8 SS interview, IPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>O’Boyle, (2016) Ireland</td>
<td>Explore the choice to birth unassisted</td>
<td>n=4, Survey/ Interview, Thematic analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Plested and Kirkham, (2016) , UK</td>
<td>Examine the lived-experience of women who birth without a midwife or other health-care professional including risk discourse</td>
<td>n=10, SS Interviews, Hermeneutic phenomenology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Rigg et al., (2017), Australia</td>
<td>Explore reasons why women choose to give birth at home with an unregulated birth worker (UBW)</td>
<td>n=9, SS interviews Thematic Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Rigg et al., (2020), Australia</td>
<td>Explore the experiences and reasoning choosing unregulated birth workers for a homebirth.</td>
<td>n=82, survey, content analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Roberts and Walsh, (2018), UK</td>
<td>Explore women’s understanding, experience, and balance of risks of prolonged pregnancy and induction.</td>
<td>n = 21, SS interviews and focus groups, thematic analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Sahlin et al., (2013), Sweden</td>
<td>Primigravida experiences of caesarean section in absence of medical indication.</td>
<td>n=12, SS interviews, thematic analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Tully and Ball, (2013), UK</td>
<td>Examine experiences of operative birth in a UK hospital, explores how women understand and rationalize their birth experiences.</td>
<td>n = 115*, SS interviews, thematic analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Wätterbjörk et al., (2015), Sweden</td>
<td>Reasons for declining extended information visit on prenatal screening among pregnant women and their partners</td>
<td>n=8, SS Interviews, interpretative thematic analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Weaver et al (2007), UK and ‘Eire</td>
<td>Examine whether, and in what context, maternal requests for caesarean section are made</td>
<td>n = 64 (diary), 44 (interview), thematic Analysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 – Meta Ethnography: Table of Constructs
### Refutational Translation

<table>
<thead>
<tr>
<th>Second order constructs (key codes, themes metaphors)</th>
<th>Third order constructs</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth philosophy influences decision making (7, 17, 27, 30, 31, 32)</td>
<td>Philosophy, values, and beliefs</td>
<td>Influence and motivation</td>
</tr>
<tr>
<td>Previous experience shapes decision (4, 7, 8, 10, 13, 14, 15, 16, 27, 30, 33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust your instincts and the embodied process (6, 9, 10, 11, 16, 17, 19, 20, 26, 27, 28, 29, 30, 33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A healthy baby is not enough (4, 6, 31, 12, 15, 16, 17, 18, 24, 27, 28, 32,)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence of social norms and associated stigma (1, 3, 16, 18, 21, 25, 30, 32, 33)</td>
<td>Socio-cultural influences</td>
<td></td>
</tr>
<tr>
<td>Playing God (1, 3, 21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society has a hidden agenda (32)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social disapproval inhibits disclosure of intentions (25, 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distrust of risk discourse (2, 7, 10, 11, 13, 14, 18, 19, 21, 26, 29)</td>
<td>Risk interpretation and safety</td>
<td></td>
</tr>
<tr>
<td>Individuals’ perception and interpretation of risk (2, 4, 6, 7, 8, 9, 10, 11, 12, 15, 16, 17, 18, 20, 25, 33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety is situated in autonomy and trust in the (birth) process (3, 10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Knowing would not change the outcome’ ambivalence re the intervention (1, 2)</td>
<td>Ambivalence</td>
<td></td>
</tr>
<tr>
<td>Handing over control (7, 21)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The pursuit of the perfect, healthy baby is what counts (7, 30, 32, 33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice based on distrust of bodies ability (4, 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of fear (4, 7, 16, 26, 27, 33)</td>
<td>Fear and (re)traumatising experience</td>
<td></td>
</tr>
<tr>
<td>Experience of trauma (13, 14, 16, 24)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shame (6, 21, 24, 28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iatrogenic physiological and psychological harm (12, 16, 24,)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not being heard or listened to (11, 14, 17, 16, 18)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of or restricted choice, control and autonomy (4, 9, 11, 16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCP attitudes and fear (6, 10, 11, 14, 15, 16, 18, 26, 27, 29, 33)</td>
<td>An inflexible, fearful, risk-averse system</td>
<td></td>
</tr>
<tr>
<td>Distrust of the system (24, 26, 27, 29, 32)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routinisation of the intervention (1, 9, 12, 22, 27)</td>
<td>Policy, procedure, and guidelines</td>
<td></td>
</tr>
<tr>
<td>Over medicalisation (1, 6, 9, 11, 12, 16, 18, 26, 27, 28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No one said I could just do nothing (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wasn’t asking for much (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of coercion (5, 10, 11, 14, 15, 16, 18, 26, 27, 28, 29)</td>
<td>Institutional manifestation of fear</td>
<td></td>
</tr>
<tr>
<td>The bad mother stigma (5, 26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shroud waving (16, 26)</td>
<td>Dehumanisation and infantilisation (16, 18, 26, 27,)</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Experience of obstetric violence (9, 10, 11, 13, 15, 16, 24, 27, 29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defining moments (11, 14, 27, 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking individual responsibility (12, 16, 17)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asserting choice and autonomy (10, 11, 14, 16, 17, 18, 27, 30)</td>
<td>Defining moments</td>
<td></td>
</tr>
<tr>
<td>Taking back control (7, 9, 10, 11, 13, 14, 16, 17, 22, 24, 27, 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information is needed for informed choice (1, 4, 6, 8, 11, 12, 13, 15, 16, 20, 27)</td>
<td>Seeking and evaluating knowledge</td>
<td></td>
</tr>
<tr>
<td>Tactical planning (5, 28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighing the evidence (3, 9, 11, 19, 16)</td>
<td>Knowledge as empowerment</td>
<td></td>
</tr>
<tr>
<td>Decision-making as empowerment (3, 6, 22, 33)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My choice, my rights (2, 3, 9, 30)</td>
<td>Operationalising knowledge</td>
<td></td>
</tr>
</tbody>
</table>

**Refutational Translation**

<table>
<thead>
<tr>
<th>Second-order constructs (key codes, themes, metaphors)</th>
<th>Third order constructs</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sub themes</td>
<td></td>
</tr>
</tbody>
</table>

338
<table>
<thead>
<tr>
<th>Managing opposition (13)</th>
<th>The Middle Ground</th>
<th>The middle ground</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping the door open (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting the best of both worlds (27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No guarantees (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust in HCPs (7, 11, 27)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving and enhancing the birth experience (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finding the middle ground (6, 13, 14, 27, 14, 7, 11, 27)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5 – Recruitment Process Chart
Appendix 6 – Recruitment Advert
Participants Needed for Research

Are you a Woman or Birthing Person who during your pregnancy and birth...

...Requested care or place of birth that isn’t routinely offered, recommended, or medically indicated?
- e.g., Caesarean Section outside medical or obstetric reason, non-low risk home birth or waterbirth (list not exhaustive)

...Declined or refused care or intervention that IS recommended, offered routinely?
- e.g., induction of labour, vaginal examinations, antenatal care, fetal monitoring, screening, clinical examination (list not exhaustive)

Would you like to share your experiences of making these choices as part of a research study?

To take part you must be:
- Over 18 years old
- English speaking
- Received care in England, Wales, Scotland, or Northern Ireland
- Not currently under the care of maternity services in the UK.
- Made these choices within the last 5 years

What is involved?
A confidential interview with a researcher over the telephone or using video conferencing software (e.g., MS Teams, Zoom) about your experiences of making these choices.

For more information or to register your interest, please contact the researcher confidentially anna.madeley@open.ac.uk.

NB: Study recruitment information is NOT to be shared through the NHS, NHS communications or by NHS staff in their capacity as NHS employees.

This research project has been reviewed by, and received a favourable opinion, from The Open University Human Research Ethics Committee on 10/08/21 – HREC reference number: 4062

PhD Supervisors: Dr Sarah Earle (Lead Supervisor), Dr Lindsay O’Dell, Dr Sally Boyle
Appendix 7 – Participant Information Sheet
Research Study Participant Information Sheet

An Exploration of Women and Birthing Peoples Alternative Pregnancy and Childbirth Choices: Non-Normative Choices Along the Childbirth Continuum.

Contact details
My name is Anna-Marie Madeley (Anna) and I am a PhD research student at the Open University in the School of Health, Wellbeing and Social Care, Faculty of Wellbeing, Education and Language Studies.

If you have any questions about the research, do not hesitate to contact me by email at anna.madeley@open.ac.uk.

My PhD supervisors for the study are Dr. Sarah Earle (Lead Supervisor), Dr. Lindsay O’Dell and Dr. Sally Boyle. If you would like to speak to an alternative, independent person about this research, please contact Dr Sarah Earle on email at Sarah.Earle@open.ac.uk.

Overview
You are being invited to take part in a research study which will form my PhD thesis.

The purpose of the research is to improve understanding of and explain why and how women and birthing people make their decisions to make non-normative or alternative choices as well as the underlying social processes that accompany them. I want to gain an insight into these experiences along the whole pregnancy and childbirth journey. To do this I will ask women and birthing people about their experiences of making their choices along that journey.

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 as much time as you need to read the following information carefully.

What you have been asked to do
You have been asked to participate because you responded to a request to volunteer in this study.

I am interested in what sort of choices women and birthing people make and why they make them throughout their childbearing journey. This will help us to learn more about the alternative (non-normative) choices that women and birthing people make around before and during pregnancy and childbirth.

Examples of a non-normative choice in pregnancy and childbirth might be:

- Requested care or place of birth that isn't routinely offered, recommended, or medically indicated? e.g., Caesarean Section with no medical or obstetric reason, non-low risk home birth or waterbirth, freebirth (list not exhaustive)

- Declined or refused care or intervention that IS recommended, offered routinely e.g., declining pre-pregnancy care or preparation for pregnancy, screening, induction of labour, vaginal examination, antenatal care, fetal monitoring, screening, clinical examination (list not exhaustive)
This research project has been reviewed by, and received a favourable opinion, from The Open University Human Research Ethics Committee on 10/08/21 – HREC reference number: 4082.

Do I have to take part?

No, participation is entirely voluntary, and it is up to you to decide whether to take part.

If you agree to take part in this study, you will be asked to return the reply slip via email/ via the link attached to the email. This will ask you to provide some details about you, your background and choice/s you made in pregnancy and childbirth, the experience of which we are interested in studying.

One of the objectives of the research is to explore the part, if any, diversity plays in the making of these decisions which is why you have been asked for some information relating to your age, occupation, relationship status, gender identity, ethnicity, and sexual orientation.

I will then carefully review the information you send.

If your information indicates that you fulfill the inclusion criteria, I will contact you to ask you to participate in the study.

Sometimes, the information about you or the choice/s you made might indicate that you do not fulfill the inclusion criteria for the study. If this is the case, I will send you an email and let you know that we cannot consider your part for the study with brief details of why.

What will I be asked to do if I am suitable and agree to take part?

I will contact you to arrange an interview at a time and date convenient to you. You will be given a copy of this information sheet to keep and be asked to sign a consent form. This will either be a paper or digital copy.

The interview, which is like a conversation, will take place either by telephone or video conference (skype/MS Teams/Zoom). The length of interviews varies but usually will usually last no more than 1 hour. I will ask you to talk about yourself and your experiences in your own words. If you want to stop the interview at any time, you can do so without any reason. You can also request that the recording that has been made up until that point be deleted if you so wish.

With your consent, I will record the session and use selected, anonymised quotes to illustrate elements of the study. These quotes in the final thesis and publications will be linked only to a pseudonym and will in no way be identifiable as yours. During the interview I will also be taking some notes (field notes) which might include body language, hesitations, tones of voice, gestures etc that might guide further questions or probes and/or my own reflections on the interviews.

Your responses will not be discussed with other interviewees in the study and your identity will not be discussed with any of my PhD supervisors (see above).

How will my interview be used?

Once your interview is finished, the interview will be transcribed and analysed by me alone. Access to your interview data will be restricted to me and the PhD supervision team.

I will assign the recording and transcript a unique number and an alphabetically ordered pseudonym (you may choose your own and will be given the opportunity to do so after the interview). This is to ensure that after deidentification and anonymisation, you cannot be personally identified or linked to the interview. The pseudonym is only for the purpose of illustrating quotes and paraphrasing in the published thesis/work.

The point at which your data is deidentified and a link to you removed will depend on if you wish to take part in a process called “member checking”. You do not have to do this.

☐ If you do want to do this, you will be sent the preliminary analysis of your data sometime after the interview and asked to provide feedback guided by some short questions on a form or electronic link. You will not be sent your individual transcript. Once you have returned your response any link between your data and you, confidentially held by me for
this purpose alone (see data storage and protection) will be removed, removing any link to you.

☐ If you do not want to do this, your data will be anonymised at the point of transcription and will revert to your pseudonym, removing any link to you.

You will also be given the opportunity to receive a summary of the completed research. If you would like to receive this summary, your contact details will be held securely for this purpose alone by me, not linked to your data, and securely destroyed after the summary has been sent.

Can I decide to withdraw after the interview?

You have the right to withdraw from the study at any time before, during and immediately after the interview and you do not have to give a reason and you will suffer no adverse consequences. You also have the right to ask for your data to be removed/destroyed after participation in the study up until the point of withdrawal or removal would not be possible.

For this study, withdrawal and data removal is possible up until the point all data are deidentified (anonymised) and a pseudonym has been assigned. You will be advised of a specific date for this in an email sent to you after the interview.

You can withdraw or ask for your data to be removed/destroyed by contacting me on anna.madeley@open.ac.uk.

How will the research be used?

If you agree to participate in this study the research, the data you provide will be analysed and primarily published as a PhD thesis. Once successfully submitted, the PhD thesis will be deposited online open access in the Open University Open Research Online (ORO).

The research may be published in academic and practice focused journals, book or book chapters, and conference presentations/webinars. However, you will not be identifiable in any publication of the research.

Data Protection

The Open University is the Data Controller for the personal data that you provide. The lawful reason for processing your data will be that conducting academic research is part of The Open University’s public task. (The consent we request from you relates to ethical considerations).

Data Storage and Retention

All anonymised data (including audio recordings, transcripts, personal and demographic information, and member checking) and completed consent forms will be digitised, encrypted and stored on secure servers/research data repositories at The Open University, physically located in the UK. Any physical copies of anonymised data not digitised (although not anticipated) will be stored securely in a locked cabinet on The Open University premises. Digitised copies of consent forms will be kept separately from digitised research data. Only Open University Systems and Devices will be used to process personal data.

All personally identifiable information held for the purposes of correspondence will be securely destroyed once no longer needed:

• If you choose not to take part in member checking, this will be after anonymisation and deidentification of your research transcript. I will confirm this date in an email.
• If you choose to take part in member checking, this will be after you have sent back your responses and I will confirm this date in an email.
If you choose to receive a copy of the research summary at the completion of the research, your contact details will be held separately for these purposes alone and will be securely destroyed once this has been sent to you. This will be by 30th September 2023.

Storage will be for the duration of the study and is necessary for the period required by journals in which the research is published, but not longer than for a period of up to 10 years in accordance with Open University research data management policy, retention schedule and General Data Protection Regulation GDPR, after which time all remaining data will be securely destroyed.

The Open University complies with GDPR and Freedom of Information Acts. We do not share any identifiable information you have given to us.

You have several rights as a data subject:
- To request a copy of the personal data we have about you
- To rectify any personal data which is inaccurate or incomplete
- To restrict the processing of your data
- To receive a copy of your data in an easily transferrable format (if relevant)
- To erase your data
- To object to us processing your data

To find out more about how we use your personal data, please see our privacy notice at www.open.ac.uk/privacy If you are concerned about the way we have processed your personal information, you can contact the Information Commissioner’s Office (ICO). Please visit the ICO’s website for further details.

What are the possible advantages and benefits of taking part?

Taking part in this study will contribute to a better understanding of how and why women and birthing people make alternative choices around pregnancy and childbirth. It addresses a gap in current knowledge which will help to support women and birthing people making similar choices in the future.

We regret that we are unable to offer any recompense for your time.

What are the possible disadvantages and risks of taking part?

You will be asked to give up approximately an hour of your own time to complete the interview.

Given the nature of the interview, it is unlikely you will come to any harm. We recognise that discussion around these choices and decisions are particularly unique and there is potential for identification. All measures will be taken to ensure that data remains non-identifiable. Full attention will be given to anonymity and confidentiality.

We hope that participation in this study is a positive experience, however we also acknowledge the impact of telling your story and exploring details of your pregnancy and childbirth experience and choices can be difficult. If you feel that you are upset or have difficult feelings after our interview, we can provide you with information and resources that may help. We have listed some sources of information and support at the end of this information sheet for reference if needed now or in the future.

How do I agree to take part?

If you have decided that you wish to take part, please complete the reply slip you received with this participant information sheet, either by email or by post (address on reply slip) or by clicking on this link https://forms.office.com/r/L4ZsgfA8hp and completing the details.

I will then contact you afterwards to discuss participation.

Thank you for taking the time to read this information sheet
Sources of information and support:

- Action on Postpartum psychosis (APP) app@app-network.org
- AIMS – Association for Improvements in Maternity Services AIMS.org.uk enquiries@aims.org.uk Tel: 0300 3650063
- APNI - Association for Post-Natal Illness and Post Natal Depression www.apni.org Tel 0207 386 0888 (10-2pm Mon-Fri)
- Birth Trauma Association - www.birthtraumaassociation.org.uk Tel: 01264 860380
- Birthrights - Birthrights.org.uk info@birthrights.org.uk tel:0300 400 3400
- Mind - www.mind.org.uk tel: 0300 123 3393
- Miscarriage Association - www.miscarriageassociation.org.uk Tel: 01924 200799
- National Childbirth Trust - www.nct.org.uk Tel: 0300 330 0700
- PANDAS info@pandasfoundation.org.uk Tel: 0843 2288 401 (9am-8pm 24 hrs a day)
- Petals Petalscharity.org/counsellingcontact counselling@petalscharity.org Tel: 0300 688 0068
- Tommy's – tommys.org.uk Tel: 0800 014 7800
- Stillbirth and neonatal death charity (SANDS) www.sands.org.uk Tel: 0808 164 3332
- Samaritans jo@samatitans.org Tel: 116 123 (free to call and will not appear on your phone bill)
Appendix 8 – Consent Form
Consent form

An Exploration of Women and Birthing Peoples Alternative Pregnancy and Childbirth Choices: Non Normative Choices Along the Childbirth Continuum

Principal Investigator (PI): Anna-Marie Madeley, PhD Student, Faculty of Wellbeing, Education and Language Studies, School of Health, Wellbeing and Social Care.

Please highlight your choice by clicking inside the appropriate box

1. Taking part in the study

<table>
<thead>
<tr>
<th>I have read and understood the information sheet for the following study: An exploration of women and birthing people’s alternative pregnancy and childbirth choices: non normative choices along the childbirth continuum or it has been read to me. I have been able to ask questions about my participation and my questions have been answered to my satisfaction.</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions I am not comfortable with, stop the interview at any time, ask for any data collected up until that point to be deleted and that I can withdraw from the study by contacting Anna-Marie Madeley <a href="mailto:anna.madeley@open.ac.uk">anna.madeley@open.ac.uk</a> up until data has been de-identified, anonymised after member checking without having to give a reason.</td>
<td>YES ☐ NO ☐</td>
</tr>
<tr>
<td>I understand that taking part in the study involves an interview which will take place either on the telephone or video conference (skype/MS Teams/ Zoom) for approximately 1 hour.</td>
<td>YES ☐ NO ☐</td>
</tr>
<tr>
<td>I agree to the interview being audio recorded</td>
<td>YES ☐ NO ☐</td>
</tr>
<tr>
<td>I agree to the interview being video recorded</td>
<td>YES ☐ NO ☐</td>
</tr>
<tr>
<td>I understand that I will be offered the opportunity and can be involved in checking the analysis of my data but that I don’t have to.</td>
<td>YES ☐ NO ☐</td>
</tr>
<tr>
<td>I understand that I can take part in an interview only.</td>
<td>YES ☐ NO ☐</td>
</tr>
</tbody>
</table>

2. Use of the information in the study

| I understand that information I provide will be used for publication in a PhD thesis, academic journals, and conferences. Information about the study and its findings may be shared on social media, but only in a fully anonymised, de-identified form. | YES ☐ NO ☐ |

AMM120721 v2.

This research project has been reviewed by, and received a favourable opinion from, The Open University Human Research Ethics Committee on 10/8/21 – HREC reference number: 4602.
I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared with anyone and only the researcher will have access to this.

I understand that my data will be stored in password-protected and access-controlled documents on secure University servers and equipment. Any paper documents will be digitised and then the paper documents securely destroyed. Data will be stored for the duration of the study and if necessary for the period required by journals in which research is published, but for no longer than 10 years, after which it will be securely destroyed in accordance with OU research data management policy.

I agree to being quoted anonymously by use of a pseudonym

3. Future use and reuse of the information by others

I give permission for the de-identified, anonymised transcripts and checking of the analysis of my data where applicable, (also see participant information sheet for more information) that I provide to be deposited in a specialist data centre after it has been anonymised, so it can be used for future research and learning. Depoited data will be de-identified by allocation of a unique ID number and pseudonym at the point of transcription. Access to the data will be restricted to the researcher and PhD supervisors alone. Paper consent forms will be digitised and stored securely; their paper counterpart then securely destroyed

4. Signatures

<table>
<thead>
<tr>
<th>Name of participant [to CAPITALS]</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Electronic signatures may be accepted)</td>
<td></td>
</tr>
</tbody>
</table>

Please indicate if you wish to take part in further data collection via member checking (see patient information sheet)

YES □ NO □

Please indicate if you wish to be sent a summary of the research after completion [if yes, please provide an email address below]:

YES □ NO □

Email address: ________________________________

AMM120721 v2

This research project has been reviewed by, and received a favourable opinion from, The Open University Human Research Ethics Committee on 10/8/21 – HREC reference number: 4802.
Appendix 9 – Initial Interview Guide
The questions included in this interview schedule addresses the research questions and aims of the research question. One of the aims of this schedule is to ensure questions are appropriate and anticipate and prepare for the likelihood of experiencing distress or an emotional response (Dempsey et al., 2016) by also outlining actions to be taken in the event that participant distress is evident (see distress procedure) (Eimir et al., 2011; Dempsey et al., 2016).

<table>
<thead>
<tr>
<th>Focus area/ domain of enquiry related to aims of research (Karp, 2009; Charmaz, 2014)</th>
<th>Questions</th>
<th>Examples of Probes</th>
</tr>
</thead>
</table>
| **Preamble/Introduction** | - Thank for participation, reintroduce self (see HREC form, recruitment procedures)
- Ensure that environment is private (participant and interviewer)
- Reiterate that I will be taking notes throughout and that the interview is being recorded.
- Confirm consent has been sought and signed
- Explain/ reiterate the purpose of the research
- Reiterate that they can stop the interview at any time or take a break | - Can I just go over a couple of things you said?
- When you said [what participant said], can you clarify what you meant?
- I was interested by [what they said]. Tell me more about that.
- How did that make you feel? |
| **Opening Questions** | - Tell me about yourself/ family
- How would you describe yourself as a person?
- Can you tell me what pregnancy and childbirth mean to you?
- How do you view pregnancy and birth? | |
| **Exploring the non-normative choice** | - When you responded to the advert, you gave some information about acknowledge the choice they disclosed in the initial response I’d like to ask you to start by telling me about that.
- What were your experiences/ knowledge/ understandings of pregnancy and childbirth before your own experience? What stands out?
- Could you describe your experience during [episode of care/birth/making choice]
- Can you tell me about your thoughts and feelings during the time? | |

(Karp, 2009; Charmaz, 2014; Dempsey et al., 2016; Green and Thorogood, 2019)
| Have your thoughts or feelings changed in any way? |
| Can you tell me about your support networks? |
| - Can you describe the relationship you had with your care givers/obstetric/midwifery, doula team? |
| - As you look back on [episode of care/birth/making choice] are there any events/interactions/times that stand out in your mind? |
| - Can you tell me whether, looking back, you might change your view/decision/choice? |
| Tell me about factors that influenced your decision? |
| - Who if anyone influenced your decisions/ choices? |
| - How did they influence you? |
| Can you tell me about any interactions with [midwives, obstetricians, medical, social services] that stand out to you? |
| - How did these interactions influence your decision? |
| - How did you respond? |
| - Has any organisation been helpful/ not helpful? |
| - Do any individuals stand out in your mind? |
| - What was the most helpful/ person during your experience? |
| - Who or what made the choice harder/ difficult? |
| When you were deciding what to do/ how to do it/ make your choice, tell me about how you sought information/advice |
| - Were there any choices made that were because of another or were unexpected? |
| Tell me how this has affected you (positively or negatively) |

| Can you give me a little bit more about... [what participant said] |
| You said [what participant said], how did that make you feel? |
| You mentioned [what participant said], describe an example of how that works. |
| You talked about [what participant said], what usually happens then? |
| Tell me what you have noticed about [what participant said] |
| What stands out to you/ was most memorable with respect to [what participant said]. |
| That's interesting, can you tell me more about that? |
| Would you try to define/explain that more for me so I have it in your words? |
| Can I just check that my understanding of what you said is correct from your point of view [ask] |
### Interview Guide/Schedule Tool

<table>
<thead>
<tr>
<th>Question</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>After having this experience, what advice would you give to anyone who might be in a similar situation?</td>
<td></td>
</tr>
<tr>
<td>What do you think are the most important ways you dealt with the experience?</td>
<td></td>
</tr>
</tbody>
</table>

One of the aims of the research is to explore the role diversity might have on making choices/having experiences such as yours:
- Can you tell me how you think this might have affected your experience?
- Can you tell me of any instances that stand out for you?

**Preamble to known sensitive questions/situations/outcomes of experience negative (Karp, 2009; Charmaz, 2014b)**

- Could I ask you [then question – gives opportunity to decline]
- I don’t know if this is an appropriate/question you’d like to answer, but...
- If your feel this question is too personal/difficult you don’t have to answer.
- I’d like to ask you about [sensitive subject], is that ok?

**Closing questions**

- Is there anything that you might not have thought about that have only just occurred to you during this interview?
- Is there anything else you think I should know/need to understand more?
- Is there anything you would like to add?
- Is there anything you would like to ask me?

**Procedure in the event of distress (see also HREC form section)**

Sensitively acknowledge and validate their feelings, suggesting “I can see that you are upset…” then:
- Ask the participant if they would like to suspend/terminate the interview/continue at another time
- Ask participant if they want to take a break/turn off the recording medium
- If continues to remain distressed, offer to remain on call with participant until calm and composed, offer referral to someone who can provide support (see post interview leaflet for details)

With consent, after an episode of distress, I will:
- Offer to provide details of appropriate support networks
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Obtain permission to contact them by phone later in the day/ the following day to ensure that they no longer remain distressed.</td>
</tr>
<tr>
<td></td>
<td>Contact supervision team to discuss and explore any further action required on an individual basis without disclosing personal details.</td>
</tr>
</tbody>
</table>
Appendix 10 – Transcript Extract Sample

So I got pregnant without knowing anything about pregnancy or birth. I just did what I knew that most people would do, just record it at the doctors. I was excited about the fact that I was pregnant obviously, but I guess the sharing of that as well. But then as soon as I did that and took the actual book in I felt that it was completely an unaligned choice. My whole body just did not want to be in the system of the maternity system I guess. I felt very panicked because I had to do a lot of research to work out what was going on, and also I know myself very well. So I knew that my body’s signals were telling me to not access maternity, but also it was very difficult because I had to research on the spot what I did want.

And also going against the status quo when I didn’t necessarily have the support to do that at the time, but I knew that I had to. So I went for my first book in appointment, and then after consideration I know that I just didn’t want to be part of it at all. I guess it was quite stressful until the point I decided that. And I communicated that with the midwifery team that I’d booked in with already, because it was felt it was really important for me that I was honest about everything and that I communicated everything to midwifery so that I didn’t feel an added pressure of going behind someone’s back or just trying to do something to get away with it.

I think in my letter I said I want to have a birth without medical professionals. I’ve researched this, I’m well informed and this is the direct decision for me, and I’ll be contact with you if I do need anything. And then they responded and said that they would respect my decision. They respected all of my decisions, and I think that was it. I declined any more testing or didn’t have a scan or anything. I
Appendix 11 – Example of Theoretical Concept Evolution through Coding
<table>
<thead>
<tr>
<th>Focussed Codes</th>
<th>Subcategories</th>
<th>Theoretical Categories</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutionalising Pregnancy and Birth</td>
<td>Categorising and Labelling</td>
<td>Deconstructing Reproductive Identity</td>
<td>Entering the System</td>
</tr>
<tr>
<td>Imposing Identity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk and surveillance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bombarded and overwhelmed with information</td>
<td>Controlling Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying reasons for risk-based practices</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| ‘It’s hard to feel your body is pathologised all the time.’
| Judging based on risk                              |                                |                                        |                                |
| Lacking evidence for a pathway                    |                                |                                        |                                |
| Pathway dictated by what could happen              |                                |                                        |                                |
| Fatness as a problem                              |                                |                                        |                                |

**In-vivo codes**
<table>
<thead>
<tr>
<th>Imposed identity of defective body</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhabiting a body being judged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacking acknowledgement of being an individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scrutinising the body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognising changing body during pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal identity and personhood</td>
<td>Fetal Centering</td>
<td></td>
</tr>
<tr>
<td>‘A healthy baby is not all that matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetus centred care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shroud Waving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rules and Timetables</td>
<td>Enforcing Timetables</td>
<td>Expecting Compliance</td>
</tr>
<tr>
<td>Enforcing guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An Illusion of Choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceiving choice as inequitable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Choice is magical thinking'</td>
<td>Recognising the root of healthcare professional anxiety</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Recognising the need for control through choice</td>
<td>Reflecting on consequences of choice</td>
<td></td>
</tr>
<tr>
<td>Undermining Choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Whose choice is it anyway?’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognising gatekeepers with power</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflicting professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifying key player</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacking Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We’re in charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assaulted</td>
<td>Punishment</td>
<td></td>
</tr>
<tr>
<td>Accusatory behaviours</td>
<td>Amplifying Actions</td>
<td></td>
</tr>
<tr>
<td>Dehumanising interactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disrespectful attitude towards choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacking compassion due to workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate discussions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punishing non-compliance and deviancy in decision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acknowledging constraints of the system</td>
<td>Abandonment</td>
<td></td>
</tr>
<tr>
<td>Advocating for herself because no one else will</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expecting to know to ask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling abandoned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fighting at a time when she was most vulnerable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not being believed, listened to or taken seriously</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manifesting anxiety in behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going it alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not supporting choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being othered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microaggressions after resistance</td>
<td>Bullying and Coercion</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>Restating risks to gain compliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing badgering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing coercive behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate discussions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labelling and stigmatising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damaging Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling like an outsider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treated as an inconvenience</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Figure 26 Evolution of Concepts And Theoretical Categories From Focussed Coding*
Figure 27 Early Diagram Exploring Basic Inter-Theoretical Categories and Subcategory Connections
Figure 28 Diagram Used to Explicate Semantic Relationships Between Subcategories and Theoretical Categories
Appendix 12 – Synthesised Member Checking Documents
Category One  

“Developing Reproductive Identity”

This category explains Reproductive Identity (RI). RI is flexible and recognises reproductive history. We propose RI and non-normative choices are fundamentally linked, influenced by 3 subcategories:

Non-Reproductive self-identity (NRSI) describes how participants view themselves independent of their reproductive history within their own cultural and societal context. NRSI is influenced by work and career, social roles, beliefs about themselves, how they identify in relation to gender, sexuality, economic status, education, self-esteem, and confidence. NRSI plays a role in RI development and choice making notably where participants were involved in birth work.

Values and beliefs around childbearing describes influences and experiences including their culture (social and gender norms, religion, customs), education and exposure to childbearing across social and other media. Participants spoke of both fear and confidence in conception and childbearing, perceived expectations to conceive and produce children, choose a particular mode of delivery or the understanding of the fetus influenced choices. Some participants had a firm idea of what a ‘good pregnancy and birth’ might mean to them including the social acceptability of declining or requesting interventions such as screening, monitoring and surveillance, place, and mode of birth and who might be involved in their care. Some participants did not know the time of conception however as the pregnancy went on, experiences they had informed this knowledge.

Embodied knowledge of childbearing describes influences related to 2 themes. Family related knowledge and personal experiences of contraception, conception, pregnancy loss and termination, pregnancy, birth, and parenting. Participants described how their bodies had been considered defective, scrutinised, and judged at significant points in their reproductive history which informed future non-normative choices.

Category Two  

“Negotiating and Navigating”

This category explains the individual actions participants took to make non-normative choices and strategies for achieving them. Motivations for the non-normative choice were varied and made throughout the whole pregnancy journey. When declining elements of recommended care, choices were never a rejection of all recommended care.

Seeking and gathering knowledge was a foundation to strategies intended to support choice. Key sources included research, social and other media, friends, communities and their own relationship and understandings of their bodies, used to develop a nuanced, individualised understanding and evaluation of risk and safety. Participants felt attuned to their bodies in a way that their healthcare providers were not and expressed frustration at how the fetus became the focus of care to the exclusion of their own needs. Healthcare professionals (HCPs) were not trusted sources of information and so advice and recommendations were rejected.

Seeking and engaging communities (including friends, social media, trusted care providers, family) was instrumental in forming choices. Communities were an important source of support, counselling and problem solving, and often hidden. Some participants felt the anonymity of social media helped them discuss their choice frankly, without judgement, suggesting strategies for achieving non-normative choices. Communities had their own norms and were able to act as gatekeepers and facilitators to exclude the system and act as a place of psychological safety.

Once made, the choice involved Rejecting an Institutional Identity. Participants did this by reframing and challenging views of their bodies as risky, resisting coercion, negotiating, and taking responsibility. The perceived intentions and motives of the HCP were frequently regarded with distrust. This is the space in which the non-normative choice was made.

Two key strategies were Doing Nothing (consciously and unconsciously disengaging with the system, choosing not to do something, choosing to do nothing) and Performing and Planning (developing plans and preparing for various situations, predicting responses from, and negotiating with HCPs, accepting some interventions and advice to reject others).
Category Three: “Entering the System”

This category explains the institutional processes, structures and behaviours which support or undermine participants non-normative choices as participants experienced them.

Institutionalising childbirth explains norms that exist within the national and local maternity systems, dependant largely on culture of the institutions, philosophy, and leadership. Usually reflected experienced as inflexible rules and timetables, designed to categorise and control women and birthing people. Participants felt that it didn’t fit their body excluding their own subjective embodied knowledge. Narrowly focussed risk assessment and surveillance favoured ‘fetus centred care and failed to account for personal context, circumstances and choice, decentralising and de-personalising the participants reproductive identity.

Characteristic of experiences of making non-normative choices, were judgements made such as labelling and stigma. Such judgements happen when assumptions were made about the participants body (BMI, gender identity, fetal growth/size of bump, caesarean scars), and/or the choice itself (being a ‘good mother/parent’, questioning mental capacity). Participants were subsequently channelled down predetermined, restrictive care pathways with an emphasis on protecting participants physical health alone (more commonly fetal wellbeing) whilst not accounting for individualised psychological or emotional needs. The non-normative choice was often therefore made address these issues.

There was an emphasis on HCPs expecting compliance. Participants were met with surprise, resistance and varying degrees of behaviours intended to change their minds (labelling and stigmatisation, bullying and coercion, abandonment, and punishment). Gatekeepers (obstetricians, consultant midwives, named and independent midwives, sonographers) exercised varying degrees of power that could positively support choices but more commonly negatively resisted the participants non-normative choice. Participants were clear that they felt they didn’t really have choices in childbearing.

Category Four “Reconstructing Reproductive Identity”

This category explains how participants reconstruct, reinforce, and consolidate their new identity because of their experiences and non-normative choices.

A period of adjustment to new reproductive identity occurred. Significantly this included reflection and evaluation of their choice(s) and how these may or may not have been facilitated, respected, or contributed to maternity outcome. During this time, support was fundamental in dealing with any feelings about the non-normative choice as well as physical and emotional challenges that might have arisen because of pregnancy and birth.

Participants developed a strong sense of what they would or wouldn’t change about their non-normative choices and this predicted future choices. Characteristic of this was how successful they had been in achieving their choices and the support they did or did not receive to make them. For some participants who did not have their choices respected or fulfilled, they identified this as a cause of personal trauma which they associated with losing control and autonomy or not having their deeply held beliefs respected (many choices being made to protect these factors). This was a reason for negatively affected physical and psychological health and wellbeing including but not limited to breast/chest feeding, bonding with the newborn, post birth recovery and fundamentally, mental health. Many participants who did not have their non-normative choices respected expressed disappointment in themselves for not having advocated strongly enough for themselves. Conversely those who did achieve their choices felt that this affirmed their decision. Strategies to reconstruct their new reproductive identity included supporting other to make similar non-normative choices within their communities. They did this by Sharing Experiences and Becoming Advocates, moving into formal and professional advocacy roles and Becoming Activist within organisations such as charities, social media, and support networks.