Choosing the Birth Centre: Exploring women's experiences of place of birth decision-making

by

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Abstract

The Birth Centre is a midwife-led, out-of-hospital facility for normal births that opened in the fall of 2011 in Winnipeg, Manitoba. Exploring women's experiences of choosing the Birth Centre was the primary objective for this thesis, seeking to understand how women make the uncommon choice to plan for an out-of-hospital birth and the meaning that women ascribe to this decision-making process. Through a feminist perspective and using interpretative phenomenological analysis (IPA), each participant's idiographic description of the decision-making experience was analysed. A sample of seventeen women fit the socio-demographic characteristics of the actual users of the Birth Centre. These women participated in in-depth interviews. Six themes emerged through the qualitative analysis: 1) Exercising personal agency; 2) Making the decision in the context of relationships; 3) An expression of one's ideology; 4) Really thinking it through; 5) Fitting into the eligibility criteria; and 6) The psychology of the space. The findings suggest that a woman's sense of safety is related to these themes. The women had a normal birth influence in their lives from personal relationships, past experiences, or personal values and beliefs. The study is significant because it is the first research exploring women's experiences of birthplace decision-making at a birth centre in Canada. It contributes to a small but growing field of out-of-hospital decision-making literature. The study has implications for midwifery practice and health-care policy making in terms of reviewing the midwifery informed choice policy, developing client education on birth settings, validating the birth centre concept, and upholding the women-centred, midwifery model of care. The study highlighted the importance of access to midwifery services in order to increase awareness and access to the Birth Centre.

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CHAPTER ONE

Introduction

In Manitoba, a woman can choose where she will give birth. When midwifery became a regulated health service in the year 2000 funded by the provincial government, the option for women to choose out-of-hospital birth settings attended by registered midwives became a reality. Informed decision-making is a regulated and "fundamental standard of practice for midwives in Manitoba" (College of Midwives of Manitoba, 1998) where women are recognized as the primary decision-makers in a process facilitated by the midwife who ensures the woman's right to choose care options that relate to her pregnancy and childbirth planning. The impact of choice has been found to have a more positive influence on women's memories of their childbirth experience than the details of the experience itself (Cook & Loomis, 2012). The midwifery practice of informed choice situates decision-making within a context of a trusting relationship between women and midwives, acknowledging the role of the woman's family (as she defines it), through a collaborative and interactive process that culminates in a woman's choice (College of Midwives of Manitoba, 1998).

In the fall of 2011, the opening of the Birth Centre in Winnipeg presented an additional out-of-hospital place of birth option for women in the city. "Out-of-hospital" is defined by the College of Midwives of Manitoba (CMM) as locations where other specialized medical care (obstetrical, paediatric, and surgical and/or anaesthetic services) is not provided on site (CMM, 2011). Out-of-hospital locations can be homes, birth centres, nursing stations, and some remote or rural hospitals. The Birth Centre meets the out-of-hospital birth criterion as it is a freestanding centre, not attached to a hospital. Eligibility criteria for an out-of-hospital birth are framed through many standards and guidelines of the midwifery regulatory body that define the parameters of normal pregnancy and labour, specify conditions for consultation, and guide the scope of midwifery practice.

In Winnipeg, the option for women to choose to plan a birth in a given setting – at the Birth Centre, in private homes, or at the hospital – is directly related to the availability of midwifery care and the guidelines that define eligibility and inclusion criteria for planning to give birth at the Birth Centre. These aspects are consistent with Kirkham's definition of a birth centre as "an institution that offers care to women with a straightforward pregnancy and where midwives take primary professional responsibility for care" (2003, p. 5). Choosing and planning the location for birth is an evolving and complex process of decision-making throughout pregnancy.

Despite midwives' enthusiasm for out-of-hospital births and growing research into the safety of out-of-hospital births, the majority of women continue to choose hospital birth over the out-of-hospital options (Kightly, 2007). Uncertainty and fear about birth are prominent social messages communicated through media, familial and friendship relations, and health care practitioners (Scamell & Alaszewski, 2012). There are many influences and factors that not only contribute to women's thought processes and experiences but also impact birthplace decision-making with the result that the majority of women in high-resource countries choose hospital birth (Coxon, Sandall, & Fulop, 2013). Out-of-hospital birth is an uncommon choice in Canada where less than two percent of births occur in out-of-hospital settings (Murray-Davis, McNiven, McDonald, Malott, Lehe, & Hutton, 2012). From 2011-2013, about 2% of all births in Winnipeg were out-of-hospital (WRHA, 2013). Regardless of the growing evidence that midwifery-attended out-of-hospital births have good outcomes and that studies report women's positive experiences and high satisfaction (both discussed in chapter 2), the number of out-of-hospital births represents a small fraction of the general population's birthplace decisions and experiences (Coxon et al., 2013). Women who choose out-of-hospital births are making a choice that is not considered a mainstream decision and it does not represent the majority of women's experiences, yet at the same time health research and public health resources are supporting both normal birth and birth centres. For these

reasons this study asks two key questions: How do women decide to plan their birth at a birth centre? And, what does the birth centre decision-making experience mean to women?

An Overview of the Thesis

This first chapter introduces the study and describes the Birth Centre in Winnipeg. Chapter two provides background with a literature review of current research on out-of-hospital birth, birth centre case studies, birthplace decision-making research, and theories of decision-making models. The third chapter presents the feminist perspective and the interpretive phenomenological analysis (IPA) methodology used to guide the study design, analysis, and interpretation. The methodology chapter goes on to describe the details of how this study was carried out, including the aggregated data of the sample along with descriptive data from the Birth Centre, and then provides details of the steps used in the data analysis. The feminist perspective and idiographic goals of IPA acknowledge that the women who participated in the study are the centre of the research process. In keeping with the feminist perspective and idiographic methodology, the fourth chapter (Findings), introduces each of the women along with a significant aspect of their individual context or experience. Chapter four goes on to describe the six superordinate themes that represent women's experience choosing the Birth Centre through verbatim quotations and interpretations of the meaning of the experiences. A discussion of the key findings and implications for practice and research from the women's experiences concludes the thesis in the fifth chapter.

A Description of the Birth Centre in Winnipeg

To give contextual perspective to women's birthplace decision-making in Winnipeg, a brief history and description of Winnipeg's Birth Centre is warranted. From the 1990's to 2005, there was a progression of low-risk hospital obstetrical unit closures in Winnipeg. During that time, in the year 2000 midwifery became a funded and regulated health profession in Manitoba. The idea and subsequent community action calling for a stand-alone birth centre in Winnipeg came, in part, as response to these closures along with a number of different organizations within a context

where midwifery services had been successfully established and integrated into the Winnipeg Regional Health Authority (WRHA) and its hospitals (Kaufert & Robinson, 2004). Legislating, regulating, and integrating midwifery into the health services of Manitoba in June of 2000 was certainly a key factor that allowed the idea of a birth centre to take a step into the realm of possibility.

In 2007, Boscoe, Danner, and Robinson submitted a comprehensive joint proposal for a midwife-led free-standing birth centre in south Winnipeg on behalf of the Women's Health Clinic and the WRHA. In early 2010 Theresa Oswald, the Minister of Health, announced that the government would establish a birth centre in Winnipeg. This birth centre funding was significant because it presented an option intended to support normal birth. Also noteworthy of this commitment to build a birth centre was that all of the political parties in Manitoba supported this funding. Committing to a birth centre can be seen as a political and ideological statement recognizing that normal birth is important to women, families, and public health.

The Birth Centre (the formal name) was opened in the fall of 2011. It is operated by the Women's Health Clinic and offers many community programs and services including prenatal and postnatal education classes, support groups, and counselling services in addition to midwifery services and birthing rooms. The space is characterized by natural light, warm colours, and curving lines. There are meeting rooms, a kitchen, play area for children with staff to provide child-care while parents are in visits, midwifery visit rooms (for prenatal and postnatal visits), and office space. An online photo tour of the facility is available (womenshealthclinic.org/what-we-do/birthing-mothering/the-birth-centre/). The birthing area has four large birth rooms, a garden room, family room with a kitchen, and an outdoor garden. Each birth room has a large birthing tub, a private bathroom with a shower, space to move, various features to support active birth, a double bed, and equipment that may be needed for use by the midwife. Windows are located high on the

wall for natural lighting and privacy. The Birth Centre is located on a prominent corner in the neighbourhood of Old St. Vital with close proximity to main routes to the Saint Boniface Hospital.

Midwifery services are operated through the Winnipeg Regional Health Authority (WRHA). Midwives provide primary care for women from conception to six weeks postpartum. Organized into groups, midwives work out of various community health clinics in the city. There are four primary sites for midwifery practice groups in different areas of the city: Access Rivereast, Mount Carmel Clinic, Access Downtown, and the Birth Centre. To access midwifery care, women may self-refer by calling a central intake telephone line or they may be referred by family physicians, social workers, or public health nurses. Midwives follow a model of continuity of care, meaning that a group of up to four midwives may share primary care for each woman. This small group of midwives share a call schedule to ensure that a midwife is available at all times for a woman's needs. Trusting relationships where the woman is the primary decision-maker and feels known by her care providers are central tenets of midwifery. Midwives provide care for up to forty women per year per midwife. During the timeframe of the present study, there were about twenty-five midwives working in Winnipeg. Midwives provide prenatal care in their clinic spaces, and they attend labour and births in women's homes, in hospitals, and at the Birth Centre. During pregnancy, women along with their midwife and significant family members discuss birth plans, birthplace choices, and make decisions for planning their births. A "place of birth consent form" is reviewed and signed.

When women start labour they communicate with the midwife to determine the next steps for a labour assessment. When labour is established, the midwife either goes to the woman's home with her equipment to set up for the birth, or meets the woman at the hospital or Birth Centre. At the Birth Centre, midwives provide support and on-going labour assessment, conduct the birth of the baby, and facilitate newborn transition with immediate postpartum care. At least two midwives attend every birth at the Birth Centre. In addition, the Women's Health Clinic employs a new cadre

of support staff called the "birth centre assistant" (BCA) who assist with setting-up for the birth, support family members and midwives, clean the space in the immediate postpartum period, and provide supportive care to the mother as she welcomes her baby, breastfeeds, and bonds. Repair of lacerations is performed by the midwives if needed. Women can shower, eat, and rest. Women and their families may go home once the woman and her newborn are stable which is usually between four and six hours postpartum. A midwife will then visit the woman and her newborn at home the next day and is available on-call at all times, providing primary care until six weeks at home or clinic visits. It is anticipated that up to five hundred women will welcome their babies each year at the Birth Centre. The Winnipeg Birth Centre is not only a place to give birth but it is a physical and active expression of an underlying philosophy that values women and healthy families within a social model of care.

CHAPTER TWO

Literature Review

At some point in a woman's life or pregnancy, she may consider the choice to plan the birth of her child to take place in a given setting. The Wittmann-Price (2004) concept analysis of decision-making and emancipation in women's health speaks to the need for women to have the experience of choice and freedom in order to have truly humanistic care. Within Wittmann-Price's concept analysis, the elements of emancipated decision-making include a flexible environment, considering social norms, self-reflection, feeling empowered, and one's personal knowledge. Choice is an essential goal of feminist and critical social theory that acknowledges that women have been and continue to be oppressed by institutional guidelines designed to foster compliance (Fahrenfort, 1987). Likewise, when a woman has more freedom in her choices she experiences greater sense of control over her own life, with the accompaniment of agency and opportunity. It has been acknowledged that place of birth is a complex phenomenon that incorporates many influences including risk perception, social context, past experience, and worldview (MacKenzie & Van Teijlingen, 2010; Wagner, 1994) aligning the place of birth decision-making experience with the concept of emancipated decision-making. In core documents defining the basic principles of midwifery informed choice model, a woman is encouraged to make decisions about the care that she receives and at the same time the model promotes a shared and relational decision-making process between the woman, her family, and her midwife (CMM, 1998). The requirements outlining the informed choice process includes a discussion of the issue addressing the range of evidence and variations in practice. The principles of the midwifery informed choice model provides a framework for this literature review, it is essentially a feminist document that places that woman as the primary decision-maker and requires the midwife, in a non-authoritarian manner, to share what is "known and what is unknown" about the topic. This literature review takes a similar approach to the study themes of birth centres and decision-making; addressing what

is known and what is unknown about birth centres in terms of women's satisfaction with out-of-hospital births, the research discussing out-of-hospital birth outcomes and evaluations, and the studies and theories of birthplace decision-making. Birthplace decision-making is multifaceted that is unique to each person's worldview, past experiences, and present relationships.

Satisfaction with Out-of-hospital Births

High satisfaction rates and positive experiences of women using birth centres have been reported in the United Kingdom, New Zealand, and Australia (Barlow, Hunter, Conroy, & Lennan, 2004; Deery, Jones, & Phillips, 2007; Newburn, 2012; Skinner & Lennox, 2006; Rogers, Harman, & Selo-Ojeme, 2011; Smythe, Payne, Wilson, & Wynyard, 2009). Women who make out-of-hospital birth choices experience autonomy which is recognized as a foundational aspect that contributes to a positive experience and has been emphasized as characteristic of out-of-hospital births (Murray-Davis et al., 2012; Walsh, 2007a). Research on birth centres consistently concludes by recommending midwife-led birth centres for maternity care in terms of both safety and women's experiences.

An ethnographic research study of a birth centre in the United Kingdom found that women chose a birth centre because of a perception of biopsychosocial safety (Newburn, 2010). Biopsychosocial safety is a concept that involves a nurturing environment , holistic care, perceived as a safe place with personal, respectful relationships (Buultjens, Murphy, Robinson, & Milgrom, 2013; Davis-Floyd, 2001). Birth centres are recognized as places of obstetrical safety (Rogers, Pickersgill, Palmer, & Broadbent, 2010; Walsh & Downe, 2004) and biopsychosocial safety within the social model of maternity care (Walsh & Newburn, 2002). In another qualitative study of birth centres in the U.K., Deery, Jones, and Philips (2007) found that women were satisfied with their experience, that they would use the birth centre again, and that they valued the continuity and trusting relationships. These are elements of the social model of maternity care that has been used as a subtext describing the essence of birth centres (Kirkham, 2003).

In Canada, there has been no published research on women's experience of birth centres. There are fewer than twenty birth centres in Canada, primarily in Quebec and in northern territories (Heberte, personal communication, 1 May 2013). There is one privately run birth centre in Alberta, and more recently two publicly funded birth centres opened in the fall 2013 in Ontario. Reports of women's experience of midwifery care in Canada has been published in notable studies from the British Columbia Homebirth Project and the Canadian Maternity Experiences Survey (Janssen, Carty, & Reime, 2006; Janssen, Henderson, & Vedam, 2009; O'Brien, Chalmers, Fell, Heaman, Darling, & Herbert, 2011). In both of these studies, women confirmed that they felt very positive about their experiences with midwifery care.

Perinatal Outcomes of Out-of-hospital Births

There is an active discussion about safety and the risks and benefits of place of birth both in the literature and in the informal discourse in the field, particularly in regards to the health outcomes of women and newborns at homebirth. The strength of the quantitative evidence of health outcomes for women and newborns seems to be the prominent focus of the debate (Gyte, Dodwell, Newburn, Sandall, Macfarlane, & Bewley, 2009). Most of these studies conclude that for low-risk women, place of birth should be an option when the provision of care is integrated and supported in a health care system with emergency transport and access to consultation and transfer of care to obstetrical services (Birthplace, 2011; de Jonge, vander Goes et al., 2009; Homer, Davis, Petocz, Barclay, Matha, & Chapman, 2000; Hutton, Reitsma, & Kaufman, 2009; Janssen, Saxell, Page, Klein, Liston, & Lee, 2009). In a meta-analysis, Wax, Pinette, and Cartin (2010) disputed the safety of homebirth reporting a statistically significant increase in neonatal mortality in homebirths. This particular study has had significant critique (Vedam, Schummers, Stoll, & Fulton, 2012).

Primary maternity care providers – midwives and physicians – have differing perspectives and understandings of the research and the associated interpretation of safety. In a Canadian

survey of maternity care providers, it was found that 99% of midwives believe homebirth to be safe and 89% of physicians believe homebirth to be unsafe (Klein et al., 2011). In another survey evaluating Canadian maternity care providers' perceptions of homebirth, less than 4% of midwives believe that women who choose homebirth are risk-takers (Vedam et al., 2012). Obviously, the concepts of safety and risk are understood in vastly different ways depending on the perspective of the individual.

Out-of-hospital birth outcomes in Canada have been investigated in two large studies. A retrospective study of midwifery outcomes in Ontario found that midwifery care with midwives integrated into the health care system led to favourable obstetrical outcomes (Hutton et al., 2009). In British Columbia, a study that compared interventions and obstetrical outcomes between planned homebirths attended by midwives and hospital births attended by midwives or physicians found reduced rates of obstetric intervention and other adverse perinatal outcomes in planned homebirths with registered midwives (Janssen et al., 2009). Both studies concluded that out-of-hospital birth is safe and therefore should be a viable option for low-risk women.

In 2009, a Cochrane Review was done comparing home-like settings to conventional settings for birth (Hodnett, Downe, Edwards, & Walsh, 2009). Home-like settings in this review included both free-standing birth centres and in-hospital birth centres. The primary objective was to compare birth outcomes. Although this review found lower rates of interventions and epidurals in home-like environments, the authors reported that it was difficult to evaluate perinatal outcomes because the data for women who had planned to give birth in a home-like environment but were transferred to a high-risk or conventional setting were not always clearly differentiated within a given data set. The review found lower rates of interventions and epidurals in home-like environments and small increases in spontaneous normal birth rates. The review also found that there were possible increased risks of perinatal mortality. In spite of the somewhat confusing data, there was greater maternal satisfaction evident in home-like environments.

"The Birthplace in England" was a large prospective cohort study that was carried out by the Birthplace in England Collaborative Group (Birthplace, 2011). The Birthplace study compared women who had planned to birth in hospital obstetrical units with women who were attended by midwives in out-of-hospital settings; both free-standing birth centres and home births. There were many significant findings in this study. The Birthplace Study evaluated the odds ratios of "primary outcomes" for home and birth centre births compared to hospital obstetrical unit births. All data included was for women starting labour without complicating conditions. The study used the term "primary outcomes", defined as perinatal mortality, intrapartum related neonatal morbidities (stillbirth after start of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and brachial plexus injury or fractured clavicle). Babies of healthy women having their first birth and planning home birth may be at higher risk of a primary outcome with significant odds ratio (adjusted odds ratio, 1.75, 95% CI, 1.07 to 2.86). However, the risk of primary outcomes for babies born to nulliparous women (women who are giving birth for the first time) at freestanding birth centres did not have a significant odds ratio for primary outcomes (adjusted odds ratio, 0.91, 95% CI, 0.52 to 1.60). The conclusion of the Birthplace in England Study was to support a policy offering all low-risk healthy women the choice to give birth in out-of-hospital settings.

For over twenty-five years, studies of birth centre outcomes in the United States have concluded that birth centres are safe alternatives to hospitals, birth centres have lower interventions, and perinatal health outcomes for women and newborns are comparable to those in low-risk hospital units (Rooks, Weatherby, Ernst, Stapleton, Rosen, & Rosenfield, 1989; Stapleton, Osborne, & Illuzzi, 2013). Birth centres in the United States are suggested as an alternative to the growing medicalization of childbirth and in particular, the rising rates of caesarean section (Stapleton et al., 2013).

Transfer to Hospital from Out-of-hospital Settings

All of the studies discussed above acknowledge the importance of midwifery care being integrated into the health care services. In order to achieve comparable outcomes for low risk women in out-of-hospital settings, transfer to hospital must be available for non-urgent and emergency transport. Rowe and colleagues (2012) conducted further analysis of the Birthplace Study results focusing specifically on transfer rates. The transfer rates from planned place of birth to hospital obstetrical units are higher for women having their first babies. The Birthplace study reports transfer rates from freestanding birth centres to be 36.3% for nulliparous women, with the most common reason being slow labour (failure to progress). The transfer rate for multiparous women (a woman who has given birth at least once previously) is lower at 9.4% from birth centre to hospital (Rowe, Fitzpatrick, Hollowell, & Kurinczuk, 2012).

Women having their first baby in addition to being of advanced maternal age (greater than 35 years old) had an increased risk of transfer. Starting labour after 40 weeks of gestation and the presence of complicating conditions at the start of care in labour is associated with a higher rate of transfers. The most common reason for transfer to hospital was for prolonged labour with the second reason being meconium staining. Less than 2% of transfers were considered acute emergencies. The overall transfer rate for all women in this study was 21.9%, similar to reports from other studies (Rowe et al., 2012).

Transfers to hospital do come with an emotional cost for women as birth plans are changed with the associated loss of control and limited choice. The transfer rates must be addressed in all informed choice discussions on place of birth. Planned place of birth does not equate to actual place of birth and cannot be overlooked as transfer does have a significant impact on a woman's experience and does influence her place of birth decision (McCourt, Rance, Rayment, & Sandall, 2011).

Case Studies and Evaluations

Three books focusing on research and evaluation of three different birth centres have been published in the United Kingdom. The first one, *Evaluation of the Edgware Birth Centre* (Saunders, Boulton, Chapple, Ratcliffe, & Levitan, 2000), describes a midwife-managed out-of-hospital unit in the outskirts of London, England where women have the choice of hospital, home, or birth centre. This evaluation used a mixed-methods approach with interviews and questionnaires of women and birth centre staff, questionnaires sent to practitioners and managers in the receiving unit (when transfer of care), and data analysis of the perinatal outcomes. The Edgware evaluation has been used as a beacon for birth centre development and expansion. There are many aspects of the Edgware evaluation that relate to the question of choice. First, the questionnaires addressed women's prenatal reasons for their choice and relative comparisons between the birth centre and home or hospitals. In the comparison questions related to the birth centre or hospital birth, women reported being attracted to the birth centre because of the home-like and relaxed atmosphere along with freedom to do what felt right while in labour (p. 60). In comparison questions related to the birth centre or home birth, the birth centre had "great attraction" because there were more facilities than at home and the midwives were always present at the birth centre, so that women didn't have to wait for the midwife to come to them (p. 63). Furthermore, in the postnatal interviews, women strongly agreed that the birth centre provided a safe alternative to home and to hospital birth (p. 67). One of the key findings was that although the birth centre was popular, it was only accessible to 27% of the women in the health trust area due to stringent eligibility criteria (p.12). Women who did book at the birth centre had lower intervention rates than the comparable women who booked at hospitals (p. 12).

Denis Walsh, a midwife and researcher, did a comprehensive ethnography of a small U.K. birth centre and published his findings in a book called *Improving Maternity services: Small is beautiful- Lessons from a birth centre* (2007). Walsh acknowledged that the findings of this project

were not easily generalizable because the study was specific to only one birth centre. He did, however, suggest that his study has theoretical relevance by illustrating that birth centres can provide positive responses to rising caesarean section rates, women's right to choose, need for cost-efficiency, and maternity care provider shortages (p. 123). Walsh proposed that birth centres be considered viable options to "mainstream" hospital care.

Tensions and Barriers in Improving Maternity Care: The story of a birth centre (Deery, Hughes, & Kirkham, 2010) tells the story of a birth centre that closed after only five years in operation. This study used a grounded theory approach to identify why this birth centre closed as well as to learn about the circumstances that can lead to the failure or success of birth centres. Issues that should be addressed with birth centre staff, according to the authors, include conflict resolution, openness to change, an increase in reflective practice, and the support of personal autonomy for women and midwives. One of the primary tensions identified in this study was "between the desire to craft systems that seek safety through uniform management of patients and the desire of clinicians to craft relationships with individuals in their care" (p. 113). The study also concluded that birth centres must offer choices for women and midwives "in both rhetoric and reality" (Deery et al., 2010).

Birth Centre Comparisons

Decision-making, by its nature, includes a comparison of the various options available. Birth centres may be compared to homebirths and to hospital births. Birth centres and homebirths have similarities in that both are classified as out-of-hospital locations (CMM, 2011), both are within the midwifery scope of practice, and both provide similar options for care. Midwives facilitate active, natural birth with few interventions for women with normal physiological pregnancies, labours and births (Kirkham, 2003) in all birth locations. The Birth Centre in Winnipeg and other birth centres are described as being home-like environments (Boscoe et al., 2007; Kirkham, 2003; Laws, Lim, & Sullivan, 2009; Walsh, 2006a; Walsh, 2006b). The equipment,

medications, and capacity for interventions are very similar between home and birth centres with the same list of essential equipment on the College of Midwives' Standard for Out-of-hospital births. Characteristics from the social model of maternity care are integral in both homebirths and birth centres including being woman-centred, valuing relationships, watching labour unfold, and understanding childbirth as a normal life event (Walsh & Newborn, 2002). Beyond these similarities, there are also key differences between birth centres and homebirth which have not been thoroughly evaluated in the literature but are included in the informal discourse about birth centres. Differences between homebirth and birth centre include team accountability (with more people around), specific procedures and rehearsed protocols, greater familiarity of the environment for the midwife, and predictability of the facility including easier access for emergency transport. Other key differences between a birth centre and homebirths include perceptions of risk, cleanliness, and social influence (Newburn, 2010).

In a report on place of birth in Australia, the government declined to fund homebirths but funding for birth centres was allocated because birth centres were understood as being half-way between home and hospital (Dahlen, Jackson, Schmied, Tracy, & Priddis, 2011). Birth centres have been seen as a middle ground between home and hospital place of birth in other studies as well (Griew, 2003; Newburn, 2010). This follows the midwifery pilot project in Quebec between 1996-2000, when midwifery was introduced but was only funded and accessible in birth centres, not in home or hospital. In many ways, this deliberate choice to have midwifery care only in birth centres and excluding midwifery care from hospitals isolated midwifery and created a system that was not integrated and thereby unsafe (Blais & Joubert, 2000; Collin, Blais, White, Demers, & Desbien, 2000; Klein, 2000). From another perspective the Quebec model was considered insulation, ensuring that midwifery care remained steadfast in the social model of care (Heberte, 2011). It took over ten years of midwifery services in Quebec before homebirth and midwife-assisted hospital birth became an option for women. According to Klein (2000), the Quebec midwifery pilot suffered due

to lack of integration of midwifery services into the hospital and medical system. Since the time of the pilot project midwives in Quebec have been granted hospital privileges, offer homebirths, and have experienced greater integration into the health care system (Heberte, 2011).

A comparison between hospitals and birth centres also includes some similarities and key differences. The aim of all births, in hospital, homes, and birth centres, is for safe and healthy women and newborns. An integral part of this aim is that women would have a positive birthing experience. Many labour and delivery units include being "woman-centred" and ensuring "a caring environment" in their definitions, concepts that are fully integrated and expressed in all aspects of the Birth Centre. The two hospitals offering labour and birth services in Winnipeg do not use "woman-centred" in their definitions but rather use the concept of "family-centred" (wrha.mb.ca).

The Birth Centre in Winnipeg is midwife-led with a central goal of high normal birth rates and to ensure low rates of labour and birth interventions and reduce the medicalization of childbirth (Boscoe et al., 2007; Women's Health Clinic, 2010). Facilities led by midwives are known to be firmly grounded in the social model of care which does not view birth as a medical event, a fundamental and philosophical difference between birth centres and medical facilities (Kirkham, 2003; Turkell, 1995; Walsh, 2007b; Walsh & Gamble, 2005).

In the United Kingdom, where there has been considerable debate about the medicalization of midwifery, the use of birth centres has been growing (Walsh & Devane, 2012). Kirkham (2003) boldly states that birth centres facilitate "real midwifery" that is woman-centred with a watchful, waiting philosophy. In a meta-analysis of birth centres in the U.K. in 2004, Walsh and Downe found lower overall interventions and lower operative birth rates in the birth centres than in hospital births. Deery, Jones, and Phillips (2007) evaluated women's experiences at a U.K. birth centre and concluded that at birth centres "women are in the driving seat" (p. 23). Birth centres such as these in the United Kingdom provided a model and example for the Birth Centre in Winnipeg (Boscoe et al., 2007).

Birth centres in southern Canada were first established in the 1990's in Quebec where they have continued to grow and expand (Heberte, 2011). Manitoba is the first province outside of Quebec to establish a publicly funded birth centre. The Quebec birth centre experience and perinatal outcomes have not been widely published since the initial pilot project with only a few papers describing the project in 2000 (Collin, Blais, White, Demers, & Desbiens, 2000; Klein, 2000; Reinharz, Blais, Fraser, & Contandriopoulos, 2000). These papers focused on concerns about integration into the health care system.

Birth Centres in northern Canada were established earlier and have been influential in the presence of birth centres in southern Canada. The first birth centre in northern Quebec, the region of Nunivik, was opened in 1986 and has been an icon in the movement of returning birth closer to home for northern communities. The outcomes for babies and mothers in these remote northern, midwife-led birth centres, without access to surgical capacity, were compared to Canadian data of similar data from other remote communities. These northern birth centres were found to have lower rates of fetal and neonatal mortality (VanWagner, Epoo, Nastapoka, & Harney, 2007).

Birthplace Decision-Making

In 2011, Rogers, Harman, and Selo-Ojeme reported that research on women's experiences of decision-making regarding place of birth has been limited. However, since this time there have been more research publications on birthplace decision-making, primarily focusing on homebirth choices. Murray-Davis and colleagues (2012) conducted a grounded theory study asking why women in Ontario and British Columbia choose homebirth and found that women choose homebirth first through internal motivation, then by learning and unlearning what is known about birth, and finally by taking ownership for the decision. The results from the Murray-Davis study suggest that women go through a progression of *wanting* homebirth for a variety of reasons, then *becoming informed* about the evidence, and finally *choosing* homebirth with confidence. They identify internal processes and external influences to the homebirth decision-making process.

In a comprehensive qualitative study of women's experiences planning homebirth in Scotland, Nadine Edwards interviewed thirty women four times, twice prenatally and twice postpartum. A multitude of themes and experiences were identified including safety, relationships between women and midwives, and the ethical implications from obstetrical practice asking who is in charge of the birth. Edwards' findings were reflected in her title, *Birthing Autonomy* (2005) meaning that women who had homebirths had control and self-determination in their birthplace decisions and experiences.

In Finland, women who choose homebirth identify that their main reason for the decision was based on previous experiences, belief in birth as natural, increased autonomy, intuition, mistrusting medicine, and the option of having their other children present at the birth (Jhouki, 2012). Boucher, Bennett, McFarlin, and Freeze (2009) performed a survey questioning why women in the United States stay home to give birth. The themes identified by 160 women who answered an online survey were safety, avoiding interventions, previous negative experiences with hospitals, more control, comfort and familiarity, as well as trusting in the birth process. The women felt that medical interventions are related to reduced safety and that women's bodies are capable of giving birth naturally.

An integrative review on women's perceptions of their right to choose the place of childbirth examined twenty-one articles between 1999 and 2009 from seven different countries (Hadjigeorgiou, Kouta, Papastavrou, Papadopoulos, & Mårtensson, 2012), which reviewed variety of qualitative, mixed, and quantitative research. Four themes are identified in the review: women who chose OOH births want to avoid medicalized childbirth; decision-making is influenced by the midwives and the depth of discussion; perception of safety influences a woman's choice (where a woman feels safe is where she perceives herself to be safe); and autonomy and informed choice are interconnected.

Recently, Lothian (2013) conducted a qualitative study with a series of interviews in the prenatal and postnatal period asking women, "How did you come to decide to have a homebirth?" Her results were consistent with those of the above mentioned studies. Women's assessment of safety grounded their homebirth decision. Lothian's research confirmed Murray-Davis and colleague's findings that women experienced a preparatory time of "wanting" homebirth followed by a multi-step rational decision-making process where women conclude that homebirth was the safest place for their own births.

There are many similarities and some differences in emphasis of the findings from the above studies. Strikingly similar themes weave through all of the homebirth decision-making studies discussed above. Some of the different central themes from these studies are reflected in the article or book titles such as "Being Safe" and *Birthing Autonomy*. Themes of control, relationships, natural birth, information seeking, avoiding intervention, and familiarity were consistently represented. These themes are reinforced by the integrative review by Hadjigeorgiou et al. which was not limited to homebirth studies but was predominantly characterized by studies which incorporated homebirth options.

Sociocultural theories of risk framed an analysis of women's birthplace decision-making experiences for both hospital obstetrical units and out-of-hospital births (Coxon et al., 2013). Cultural and historical associations of safety and birth are the basis of women's decisions within the current discourse about societal concerns of risk and blame. Despite strong evidence to support normal birth in non-medical environments, women continue to choose hospital, and a cultural shift would be required to change this reality (Coxon et al., 2013).

Newburn (2012) acknowledges the risk-focused approach to childbirth decision-making by practitioners and women, highlighting that evidence should not hinder informed choice by being coercive; a common tendency in a risk-adverse, biomedical culture. There is conflict in the discussion and discourse of normal birth between a prospective and retrospective consideration of

when and how birth can be considered normal and this risk categorization is one of the factors that challenges both women's decisions and practitioners' presentation of choices (Scamell & Alaszewiskib, 2012; Walsh, 2010). It is questioned whether women truly have choice in maternity care, when evidence-based practice and protocols create strict parameters for clinical practice which may or may not be presented nor understood with a perspective of autonomy (Edwards, 2008; Lothian, 2012).

Midwifery Decision-Making Models

The midwifery model of informed choice, although highly esteemed within the feminist framework of midwifery care, is both complex and controversial. Paterson (2010) asserts that midwifery has lost its feminist approach by employing a medical model of care through an emphasis on risk assessment. On the other hand, McKenzie (2009) promotes the midwifery informed choice as an "egalitarian, relational, empowering, woman- centered" (p. 165) principle that fits firmly in the feminist rhetoric. The midwifery model of informed choice has been promoted as a progressive model of reclaiming the rights of citizens to make choices, implement free-will, and participate in their own health care (McKenzie, 2009; Shenaz, Louise, Tizro, & Shickle, 2012). This literature review began with a discussion of emancipated decision-making; a concept that includes a flexible environment, considering social norms, self-reflection, feeling empowered, and applying personal knowledge. Choice and free-will are not experiences that occur in isolation but rather in they exist in the context of one's relationships and social influences.

Spoel (2006) provides a thorough critique of the midwifery informed choice model, recognizing ethical implications that reveal it to be contentious within the midwifery model of care where informed choice is intended to be non-authoritarian based on relational principles of mutual trust and respect. However, the informed choice model may also be understood as a consumerist model where women are assumed to be dominant and independent persons. Spoel explains this contention as follows:

> A consumeristic ethic mystifies the social determinants of choice by focusing on the ideal of individual freedom of choice; it privileges the unidirectional transmission of (ostensibly) value-neutral biomedical information above other ways of knowing and communicating; and it promotes disengagement between the health professional and the recipient of care. (p. 197)

Spoel (2006) and Lupton (1997) recognize that a consumerist, autonomous concept of the woman as the primary decision-maker has a fundamental problem by assuming what kind of person this is supposed to be and does not take into account or allow for differences of gender, sexual identity, age, ethnicity, social class, and life experience. Through the feminist perspective, there is a belief that all women, regardless of their demographics, should have freedom of choice and the opportunity to grow in their personal agency, confidence, and strength. However, the process of hearing and then applying evidence informed research based on biomedical models of safety may not be the most applicable process for each individual woman (Spoel, 2006). Other authors also recognize that the idea of individual choice is a societal value that it is not essentially feminist in that only the individual who already has power really has a choice (Lippman, 1999; Sherwin, 1998).

The midwifery informed choice model and related policies used by Canadian regulatory bodies (CMM, 1998; CMO, 2013) are in some ways similar to other definitions that apply to the interaction between practitioner and person in medical decision-making. This paper uses the full phrase "midwifery informed choice model" when speaking about Canadian midwifery regulatory bodies' definitions of informed choice to differentiate a similar but distinct concept called the "informed model" used in other jurisdictions and fields of practice (Charles, Gafni, & Whelan, 1997; Cox, 2014; Fowler, Wescott, Stilwell, & Reifler, 2013). The midwifery informed choice model and the informed model will be compared below.

Charles, Gafni, and Whelan (1997) first defined and compared the paternalistic, the informed model, and the shared model of medical decision-making. The paternalistic model is

based on the premise that the care practitioner is the knower and decision-maker. In theory there are not direct comparisons between paternalistic decision-making and the midwifery informed choice model. The informed and shared models begin with the care provider presenting and delivering information to the person faced with a decision. The informed model suggests that a person will go on to consider the information and make an autonomous, independent decision for their own health. The shared model is described as beginning in a similar way as the informed model with information delivery and translation from the practitioner to the person (Charles et al., 1997; Cox, 2014). However, the next steps of the shared model deviate from the informed model. In the shared model, there is a dialogue between the practitioner and the person, where the person expresses her understanding, her preferences, her values and her needs. The practitioner and the person continue with a mutual and interactive exploration of the factors involved in the decision-making process exchanging ideas, and discussing the person's own context—a person or woman centred perspective (Murray, Charles, & Gafni, 2006). The process of deliberation in the shared model is different from the informed model in that the informed model does not suggest ongoing interaction but leaves the information with the person to deliberate independently as the primary decision-maker. The final decision in the shared model is described as a "consensus [with] both parties having an equal investment in the decision" (Cox, 2014, p. 240). There are three aspects of the decision-making process in the shared and informed models from the person's perspective: information gathering, deliberation, and final decision.

In the informed model, care providers translate evidence-based information, answer questions, and then place the responsibility in the person's realm to decide alone. In contrast, the shared decision-making model involves a greater mutual process between care provider and person. Again, the provider presents the evidence and information, but here the person expresses their values, context, knowledge, and preferences. The provider listens, inquires more, individualizing the approach to encompass the needs of the person and together they engage and

interact to come to consensus (Fowler et al., 2013). This differentiation between shared decision-making and the informed model complicates an understanding of the midwifery informed choice decision-making models because it combines the elements of the informed model with the shared model.

The shared decision-making model incorporates what is important to each individual person seeking care or treatment in the decision-making process, thus ensuring a person-centred approach (Barry & Edgman-Levitan, 2012; King, Eckman, & Moulton, 2011; van der Weijden, Pieterse, Koelewijn-van Loon, Légaré, Boivin, Burgers Stigglebout, Faber, & Elwyn. , 2013). Person-centred care and incorporation of one's personal values are essential tenets of the shared model. The person seeking healthcare identifies and communicates their own values and preferences to the practitioner, who continues to facilitate a cooperative process of coming to a decision that works for the person in her context. Newer models of "shared decision-making" recognize that women making birth choices do request input from their social and familial relationships in this decision (Cox, 2014).

Table 1: Comparison of decision-making models

	Informed model (Charles et al., 1997)	Shared model (Cox, 2014)	Midwifery model of informed choice (CMM, 1998; CMO, 2013)
Information transfer	Provider to citizen	Provider to citizen	Provider to citizen
Deliberation	Independent	Two-way; provider has a dialogue to understand citizen's values, preferences, life circumstances; interactive exchange	Two-way; provider has a dialogue to understand citizen's values, preferences, life circumstances; interactive exchange
Decision	Citizen is autonomous decision-maker	Citizen and practitioner come to a consensus	Citizen is primary decision-maker

The midwifery informed choice model implies that the decision-making experience is "an empowering, relationship-building process that allows midwives to implement key aspects of their women-centred philosophy of heath care" (Spoel, 2006, p. 201). The midwifery informed choice model is a combination of the two models discussed above; a comparison can be seen in the table 1.

All three of these models have a woman/person-centred aim, putting the woman in the middle of the decision-making process with an emphasis on autonomy and independence. The recently revised policy on midwifery informed choice from the College of Midwives of Ontario (CMO, 2013) specifically incorporates the language of both shared and informed decision-making models. The Colleges of Midwives of Ontario and Manitoba Informed Choice policy both recognize the woman as the primary decision-maker, while the College of Midwives of Ontario has recently added that the midwifery informed choice model is one of "fostering a relationship of trust and respect; considering the experience, feelings, beliefs, values, and preferences of the client" (CMO, 2013). Whereas the College of Midwives of Manitoba (1998) does not direct the midwife to incorporate the experiences, feelings, beliefs, values, and preferences of the woman, it does recognize that the woman makes a decision in the context of her family: "the interactive process of informed choice involves the promotion of shared responsibility between the midwife and the woman and her family" (CMM, 1998).

In Noseworthy's dissertation on relational decision-making in midwifery (2013), she compares the three decision-making models of paternalism, informed, and shared. She concludes that none of these three models fully explain the complexity between midwives and women in that they are "premised on an erroneous concept of the decision-maker as someone who acts independently, without others' influence, has the skills to make choices, is free to make any choice, and will have that choice respected" (Noseworthy, 2013, p. 48). Spoel (2006) also contends that the midwifery model of informed choice does not align directly with any three of these models (paternalism, shared, and informed), but aims for a woman-centred approach that incorporates

women's lives in relationship and community. Thackuk (2007) suggests that through the midwifery model of informed choice women may be able to experience an escape from oppressive life relationships where the midwifery model facilitates safety and freedom for a woman to experience "relational autonomy" in the midwifery relationship and the woman is truly free to make her own choices. Noseworthy (2013) critiques the three decision-making models and the midwifery informed choice model in her rationale for a relational model of decision-making. She contends that the midwifery informed choice model is not actualized in the reality and the "complexity of the decision-making between women and midwives" (p. 48).

Noseworthy (2013) proposes a relational model that recognizes and validates the role of many people and relationships involved in the woman's decision-making process. She asserts that decision-making cannot and should not be isolated to the woman alone, nor even solely between the woman and the midwife. Noseworthy endorses a relational model of decision-making as an interactive process between the woman, the midwife, and the woman's social community. "A relational decision-making model extends decision-making beyond the individualized midwife-woman relationship to a consideration of previously unacknowledged familial, cultural, and socio-political contexts within which decisions about care are made" (Noseworthy, Phibbs, & Benn, 2013). Spoel (2006), Thackuk (2007), and Noseworthy (2013) all reference Sherwin's (1998) concept of relational autonomy in their discussions which position women in the context of social and political relations. Sherwin's relational autonomy states that a woman's opportunity for self-determination is shaped through complex social influences not the least of which are power imbalances that come from oppression and marginalization of women based on race, culture, economics, and gender.

In Manitoba, midwives are directed to facilitate an informed choice decision regarding place of birth, in early pregnancy and again in the third trimester, when women are asked to sign a form signifying their choice for birthplace planning (CMM, 2011). Birth planning is an essential part of

the midwifery informed choice process where a woman and her midwife discuss the benefits, risks, and alternatives. Birth planning and decision-making are influenced by a woman's values and beliefs about birth, risk perception, and the input from her midwife (Lindgren, Radestad, Christensson, & Hildingsson, 2008; Noseworthy, Phibbs, & Benn, 2012). Discussions of birth choices and possible outcomes may lead women to feeling well-prepared and less likely to have traumatic experiences if interventions or unexpected outcomes are encountered (Barnes & Dossey, 1999). Midwives initiate discussions with women about place of birth early in pregnancy (CMM, 2011) presenting options and engaging together in the decision-making process throughout their pregnancy. The factors that influence decision-making and the ultimate choice are complex. Additional complexities of the midwifery informed choice model include issues related to power, autonomy, medical-legal concerns, social influences, risk assessment, and more (Crossley, 2007; Marshall & Kapp, 2007; O'Cathan, Walters, Nicholl, Thomas, & Kirkham, 2002; Spoel, 2006; Thackuk, 2007). The phenomenon of informed choice decision-making is layered and complicated by many influences, factors, and contextual experiences. Despite adversity, the midwifery model of informed choice decision-making is still upheld as a gold standard for midwifery care (CMM, 1998; CMO, 2013; Spoel, James, & Hobberlin, 2013). The midwifery informed choice model is a process as well as an outcome. In many ways the midwifery informed choice model suggests a shared decision-making process culminating in a woman's informed decision (Spoel, 2006).

Personal Decision-making Theory

This last section in the literature review on the psychology of decision-making theories is important because it provides background on how the mind works in decision-making. Decision-making is complex. Daniel Kaheneman, a preeminent scholar in the field of decision-making, describes decision-making as "the problem of choice" in his preface to Kahneman and Tversky's expansive collection of essays, *Choices, Values and Frames* (2000). Modern research describing this complexity recognizes that individuals don't make decisions in isolation. Decisions may be fast and

instinctual or slow, deliberate, linear, and rational (Evans, 2008; Jarvilehto, 2000; Kahneman, 2011; Li, 2008; Rilling & Sanfey, 2011). Decisions are not made in a void of other mental processes or other influences. Epstein (2013) presents research on shared mind and whole mind decision-making. Epstein begins his discussion by describing classical decision-making characterized by rational, linear, logical decision processes that exclude intuition and feelings. Epstein presents whole-mind decision-making as incorporating values and preferences and also recognizes the "shared mind" in which people make decisions in relationship with others. Li (2008) states that classic rational, isolated decision-making theory is an inaccurate description of how people actually make decisions

Evans (2008) reviews the concepts in dual and multiple processing cognition theories from research in a range of different fields. Evans summarizes a dual thinking process, system one and system two, that is common in current theories. System one is recognized as fast, automatic, implicit, and unconscious associative responses. System two is characterized by a slower, more deliberate, conscious, analytical thinking process. Although many authors have suggested that these two systems are distinct and competing mental processes, Evans' review proposes that there are multiple systems at work creating an inter-play and enmeshment between the systems. A simple distinction of two processes does not adequately explain the process of reasoning, judgment, and social cognition. Kahneman (2011) provides evidence that system one and system two do not act separately and Kahneman and Tversky (1982) also identify that people make decisions by exploring alternatives, imagining possibilities, and consequences.

Groopman and Hartzband (2012) describe case studies of individuals faced with medical treatment decisions. They identify characteristics of people that may support practitioners to understand classifications of ways that people consider medical decisions based on individual preferences and beliefs. These characteristics include minimalist or maximalist approaches, seeking simplicity in treatment or wanting to try every possible treatment available. Some

individuals have a belief in treatment plans and others tend to doubt proposed plans. Natural healing might be highly valued by some while others will seek latest high-technologies. Groopman and Hartzband suggest that individuals faced with health decisions should consider self-assessing their own values and beliefs during the process in order to make decisions that reflect their own preferences. In this way, a person will feel more comfortable with their decision and experience less regret regardless of the outcome.

Literature Review Summary and Rationale for the Thesis

While facilitating informed choice discussions with women, midwives acknowledge the risks and benefits of a birth centre delivery. The primary risk of planning to give birth at birth centres and other out-of-hospital settings is the possibility of transfer to hospital, particularly with first births where the transfer rate from out-of-hospital to hospital ranges as high as 35-45% for nulliparous women based on the U.K. Birthplace Study (2011). In summarizing the research, it can be said that birth centres appear to have good perinatal outcomes, implement informed and shared decision-making in the provision of care, and enact woman-centred care. The literature that is currently reporting on birth centre outcomes, experiences and descriptions, calls for greater implementation of the birth centre model to meet the needs of women and maternity care services (Birthplace, 2011; Dixon et al., 2012; Stapleton, Osborne, & Illuzzi, 2013; Walsh & Devane, 2012) even though at this time, out-of-hospital birth remains an unconventional choice in high resource countries. There is a small but growing body of knowledge on out-of-hospital decision-making that addresses women's experiences of choosing homebirth, the progression of making this choice, and the factors that women consider in the process.

Midwifery care is a relatively new regulated health profession in Canada, less than twenty years old and only fourteen years in Manitoba. It has been identified that in order to understand the factors and experience of women and place of birth decisions, there is a need for "local research in order to encapsulate women's needs locally" (Hadjigeorgiou et al., p. 389). This research is

focused on the Birth Centre in Winnipeg responding to local needs and context, but there is also a broader applicability of the findings from this research across jurisdictions with similar models of midwifery care.

The Birth Centre in Winnipeg demonstrates an intentional investment in the promotion of normal, physiological birth in a midwife-led service and facility. Promoting physiological birth in a society where medicalized birth is the experience of the majority requires health care practitioners and policy makers to increase their understanding of birthplace decision-making. It is important to delve deeper into women's experience of choosing to plan to give birth at the Birth Centre. The study asked two key questions: How do women make the decision to plan to give birth at the Birth Centre? And, what does the birth centre decision-making experience mean to women?

CHAPTER THREE

Methodology

The methodology for the study aimed to place each woman who participated as the expert of her own experience. The methodology of interpretive phenomenological analysis (IPA) has a strong idiographic focus, where the unique experience of each person in the study is preserved (Smith, Flowers, & Larkin, 2009). The methodology of IPA parallels the feminist perspective that is the basis for designing and understanding this research. The feminist perspective outlined below also validates the individual woman and her life experience within a complex world of influences. This chapter begins with a description of the IPA methodology and goes on to outline the feminist perspective that frames the application of the methodology into the study design and decisions therein. The second main section of this chapter describes how the study was carried out: the actual processes, participants, contextual data, the interviews and data collection, and the methods used to analyse each woman's lived experience in a way that interprets the data from the particular into a shared experience.

IPA and the Feminist Perspective Guiding this Study

Interpretive Phenomenological Analysis (IPA) developed by Jonathon Smith in the mid-1990s (Smith, 1994; Smith, 1996) has been used increasingly in health research and expanded on in textbooks and in research by Smith and others. Smith, Flowers, and Larkin (2009) have described the theory, methodology, and research in very accessible terms and format, making it useful as the primary source for practical suggestions in implementing the research design of the present study. The impetus for applying the IPA method to the topic of birthplace decision-making was based on its application in a variety of other decision-making research studies including decision-making of birth choice following caesarean section (Goodall, McVittie, & Magill, 2009), decision-making of planned lesbian parenting (Touroni & Coyle, 2002), and decision-making processes in candidates for genetic testing for Huntington's Disease (Smith, Michie, Stephenson, & Quarrell, 2002). These

studies illustrated that it would be appropriate to use IPA to explore women's decision-making experience of choosing the Birth Centre. IPA is based on an existentialist approach, meaning that each person is seen as a free and responsible agent; hence, IPA has been used to explore significant life-transforming events or decisions (Smith, 2004). The experience of childbearing is certainly one such life-transforming event (Larkin, Begley, & Devane, 2009; Oakley, 1993; Simkin, 1991; Simkin, 1992; Vania, Klein, Hivon, & Mason, 2010).

Interpretive phenomenological analysis is a way of coming to know something – an epistemology – through a set of guidelines of research methods that looks at a collection of individual experiences (empirical knowledge) (Smith, 2004). Phenomenology is a qualitative method of inquiry seeking to find deep understanding and meaning in a specific human experience or event. The phenomenological approach, rooted in philosophical epistemologies that involve concepts such as intentionality, the essence of experience, and life worlds (Welch, 2011), focuses on the meaning of experience and on uncovering the essence or the "lifeworld" of individuals. Lifeworld is described by Murray as "a bodily life in which bodies coexist through empathy, in meaningful community with others, and in intimate proximity with the world" (2012, p. 290); implying an interconnectedness of personal experience, relationship with others, and with the surrounding environment. IPA is an idiographic process that takes each person as a case on its own where the goal is not to create a general theory (as in grounded theory which is more nomothetic) but to seek to understand and interpret each individual's unique life experience bringing the discrete understandings into a shared meaning.

In health sciences, phenomenology has been increasingly used over the past quarter century to give practitioners a deeper understanding of people's experiences (McWilliam, 2010). Husserl, the originator of the initial concept of phenomenology, was concerned that the meaning of life and its experiences would be lost through the societal shift towards a belief that only objective, quantitative research could validate knowledge. He was also concerned that fact-minded sciences

form people who focus on facts and lose sight of the individual and human experience (Bondas, 2011).

Phenomenology can take different approaches. One approach is to focus on the pre-reflective state of an event, where the researcher and participant attempt to isolate the phenomenon and segregate one's past experience and context by focusing solely on the specific phenomenon—a practice called bracketing. Another phenomenological approach is interpretive or hermeneutic. Interpretive phenomenology recognizes and invites interpretation of the phenomenon by the participant and the researcher throughout the study. IPA is a hermeneutic, interpretive method by which interpretation comes from contextual insight, personal background, and experiences that both the participant and the researcher bring into their understanding of the phenomenon. In telling a story or sharing a memory, "the experience begins its interpretive journey" (Smythe, 2011, p. 36). The interpretive aspect of this study makes space in the interview process for the participants to interpret their own meanings and apply a reflective process to their stories by asking what the experience of decision-making meant to them, in this way making room for various levels of interpretation (Smith, 1996). IPA can be described as detective work looking for themes and using a double hermeneutic where the researcher attempts to make sense of what the participant is trying to understand from the experience. Smith (1996) said "the meanings individuals ascribe to events should be of central concern to the social scientist but also that those meanings are only obtained through interpretation" (p. 263). IPA is useful in uncovering complex processes to find the insider's perspective of the experience relying on the assumption that participants reflect and seek meaning from their own experiences (Brocki & Weardan, 2006; Smith & Osborn, 2008).

A feminist perspective provides a theoretical framework in the present study. Yuill (2012) said that "midwives are in an ideal position to use feminism as a theoretical perspective to perform research that is truly women-centred" (p. 36). The feminist perspective aims to ensure that

women's voices are heard with the goal of improving care. A common aspect of the feminist perspective is the understanding of the relationship between gender and oppression. A feminist perspective acknowledges the strong relationship between the concepts of emancipated decision-making, informed choice, and women-centred care, recognizing that oppressive systems limit women's choice and life experiences. The way in which childbirth is approached represents how the position of women in society is valued (Oakley, 1993). Feminism is both about recognizing inequality and oppression and about seeking ways to rectify and transform the present state towards equality, individual agency, and freedom.

Dorothy Smith (1987) suggested the everyday world to be problematic in that there are ruling relations that have and continue to silence women and their lived experiences. She defines the "everyday world" to be the "various and differentiated matrices of experience—the place from within which the consciousness of the knower begins" (p. 88). Smith goes on to propose a feminist research strategy that intentionally does not begin with an existing theory or discourse but seeks to understand the experience first from the lives of the women themselves. Within this feminist sociology, there is a pragmatic attempt to focus on the everyday as problematic and how it is expressed in actual activities of actual people. The inquiry is considered a cooperative effort in coming to a new understanding of the standpoint of women, their lived world, and the meaning that it holds: "it is the individual's working knowledge of her everyday world that provides the beginning of the inquiry" (p.154).

One of the first steps in making a decision is awareness of options, a key aspect of emancipation and free choice (Wittmann-Price, 2004). In other words, a lack of awareness is a form of oppression, a concept notably discussed in Freire's *Pedagogy of the Oppressed* (1970). In the Manitoba midwifery context, equity and access are tenets of the midwifery model where a Policy on Equity and Access (CMM, 1998) directs midwifery practices to work towards an equitable and accessible service. Included in the Principles of Service for the Birth Centre is a statement that

identifies the need to take a focused approach to ensure that women from diverse backgrounds, cultures and life experiences are welcomed and receive service at the Centre (Women's Health Clinic, 2010). These principles identify the need to reduce barriers—a key rationale for using a feminist perspective to frame the methodology for the present study.

The relationship between informed choice and autonomy is essential to this study's methodology and will ensure a woman-centred approach (Bates, 2006). Woman-centred care, according to Walsh (2006a) is focused on the whole person, integrating biopsychosocial aspects such as respect, relationship, context, environment, celebration of difference, intuition, and self-actualization, thus aligning woman-centred care with an emphasis on the elements of the social model of care. "At the centre of feminist thought is the recognition of women's experiences, beliefs, views, ways of being, and ways of knowing as legitimate and authoritative sources of knowledge" (Welch, 2011, p. 125). From a feminist perspective, women's experiences and their own understanding of their experiences, carry authentic and valid knowledge that should be studied, documented, and shared.

Ackerly and True (2010) recommend using a "feminist research ethic" for every stage of the research process, suggesting four primary principles of a feminist research ethic: attentiveness to power, attentiveness to boundaries, attentiveness to relationships, and situatedness of the researcher. The first three principles of paying attention to power, boundaries, and relationships find expression in the final principle of being conscious of the situatedness. Situatedness means that the researcher acknowledges her own perspective, background, and potential bias in order to work towards minimizing the impact of power imbalances and boundaries that exist between researcher and participant. This feminist research ethic aligns with Flyvbjerg's (2001) writings on *Making Social Science Matter* where he recommends that the researcher continually ask: "what am I doing?", "is it desirable?", and "what should be done?" Additionally, by acknowledging power dynamics the question of "who gains and who loses?" is also be addressed. It is through applying

the feminist research ethic along with a continuous awareness of power, relationships, and boundaries that the voices and experiences of women truly emerge as authoritative sources of knowledge.

In speaking of phenomenology, Giorgi (2005) suggests that the purpose of deeper understanding of an experience is that it has the potential for global transformation and McWilliam (2010) interprets this as phenomenology for improving the world. This study defines feminism first as an acknowledgement and attentiveness to the fact that women have experienced oppression and secondly, as a call to action to purposefully change oppressive systems. By removing oppressive structures and designs in order to ensure freedom and activation of individual capacity and agency, feminism moves beyond theory becoming a reality. Feminism and feminist ethics were used in the development of the research design to ensure that oppressive structures are avoided in the research design and methodology. Feminism as a guiding theoretical perspective ensures that there is space for inclusion, for voice, active involvement, and generating new knowledge and understanding. Maintaining this feminist perspective gives insight and direction to every stage of the study design and methodology including recruitment of participants, the researcher's journal, the collection of data, the analysis and interpretation of this data, and the application of the findings to practice and policy.

The IPA methodological approach reinforces the feminist perspective in that the individual lifeworld is the primary focus. "The source of phenomenological knowledge is the experiencing person and an epistemology of their specific lifeworld. Recognizing this means that phenomenological designs may open up new perspectives and develop childbirth care based on the lived experiences of women" (Bondas, 2011, p. 15-16), thus aligning the philosophical methodological underpinnings of phenomenology with the feminist perspective. Phenomenology "does not ask 'why'; it does not problem-solve, explain or seek to control" (Smythe, 2010, p. 38). Out-of-hospital birthplace decisions is not a problem waiting to be solved but rather, greater

understanding of this phenomenon leads to a growing body of knowledge and to increasing respect and unbiased support for women to make decisions about where they choose to give birth.

The phenomenon in question for the present study is the experience of a woman's decision-making process about where she plans to give birth. The research question for this thesis fits well with the IPA methodology because it focuses on each individual person, recognizing that people are not only subjects but are also interrelated with the phenomenon. As such, it seeks to give voice to the participants (Larkin, Watts, & Clifton, 2008), inviting them to become co-researchers. IPA seeks to find divergent and convergent ideas attempting to create a tapestry of experiences rather than generalizations (Smith et al., 2009). Using a phenomenological epistemology creates the space for depth of description and simultaneously validates the woman's experience and avoids power and controlling influences. Idiographic methodologies such as IPA value the individual life experience and thus parallel feminist theory that recognizes oppressive behaviours of exclusion of outliers common in nomothetic generalization. IPA invites the women to find meaning in and make sense of their own experience throughout all the phases of the data collection. In choosing the IPA methodology, there is a commitment to explore, describe, interpret, and situate each woman and her process of understanding of her experience (Larkin, Watts, & Clifton, 2008). A feminist perspective brings forth recognition of each person, gives an audience and interpretation to voices and experiences, and aims to break cycles of oppression. Telling one's story, as in phenomenology, can have an empowering effect for the storyteller (Snow, 2009). By using IPA for this study, women told their stories, explored their own contexts, found and described the meaning of the decision-making experience applying it to their lives and understanding.

Carrying Out the Study

Ethics. Research ethics includes (but is not limited to) themes of honesty, objectivity, integrity, carefulness, confidentiality, non-discrimination, respectfulness, openness, and minimizing harm (Shamoo & Resnik, 2009). The research design attempted to incorporate feminist ethical

principles and the methodology aimed to be systematic and fair in its process of recruitment, data collection, analysis, and dissemination. Research ethics approval was granted by the University of Manitoba Joint Faculty Research Ethics Board, the WRHA Research Review Committee, and the Women's Health Clinic Research Review Committee.

As a researcher who is also a midwife, I carry pre-conceived ideas of the research topic based on personal experience. Within this context I have attempted to maintain what Van Manen (1990) identified as "hermeneutic alertness" in that I have continually taken a step back, have practiced reflexivity, and have sought to focus only on the women's descriptions. Furthermore, I ensured that I was at arm's length from this particular study in that I did not have past clinical experiences with any of the women interviewed in the study. I have also been out of active clinical practice since August 2011 and I had not yet practiced midwifery at the Birth Centre at the time of the interviews. However, because I am a midwife there was a commonality of experiences that allowed for the establishment of rapport in the interview context, allowing interviewees to talk openly about their understandings of influences on their decisions.

Recruitment methods. Passive and active recruitment methods were used for this study. The researcher met with WRHA midwives, presented a summary of the research proposal, and requested their support to circulate the invitations to all women who met the eligibility criteria. All midwifery practice groups were invited to participate in recruitment. Passive recruitment happened through invitational posters that were posted in midwifery clinics (Appendix A) and on a facebook page that had the same images and wording as the poster. Active recruitment occurred through direct distribution of postcard invitations by the midwives in the final postpartum visit. The postpartum period was chosen to be the recruitment time-frame to ensure that women did not feel obligated to participate in the research while actively receiving care from the midwives particularly in response to the active recruitment of midwives handing out study invitations to the women.

In keeping with the theoretical framework, there was an attempt to ensure women were not excluded from contributing to the study. According to the College of Midwives of Manitoba, exclusion occurs through both limited inclusion and through lack of awareness (Policy on Equity and Access, 1998). Thus, a key goal for the recruitment was to reach out to and invite a diverse group of participants, specifically defined as a range of parity, ages, postal codes, and practice groups. These indicators for diversity were used because this information is collected in the midwifery intake process and questions regarding these indicators can be asked over the telephone during the recruitment process. Detailed information was requested on the demographic face sheet at the time of the interview to provide greater information. It was important that voices of women from different life experiences were heard to maintain alignment with the feminist perspective of this study and at the same time to ensure a consistent experience of choosing the Birth Centre.

Women responded to a variety of recruitment methods: handbills, posters, and social media. A facebook page was created in accordance with the initial research proposal and the ethics approvals. The facebook page was posted on the researcher's homepage and shared with all facebook contacts that were connected to childbirth-related community groups in Winnipeg. The facebook page was viewed by over 1300 people and at least twenty-five women responded through this medium. All respondents received personal communication from the researcher thanking them for their interest, confirming that they had planned to give birth at the birth centre at the onset of labour, and stating that the study was looking for a diverse group of women with different parities, prenatal clinic sites, and from different community areas in Winnipeg. Of the seventeen participants, twelve women found out about the study through facebook, three took a tag off of a poster, and two responded to the handbills that were distributed by the midwives.

In addition, a cash gift of $25 was given to all women who were interviewed. The researcher kept a volunteer log recording attributes of volunteers (age, postal code, number of babies, and location of prenatal care) throughout recruitment in order to meet the diversity goals.

When fifteen interviews were completed, all print recruitment material was removed; however, two more women from one of the target postal codes came forward after the material was removed. These two additional volunteers responded to the facebook page and were included in the sample.

Sample size. One area of concern identified by the researcher reflecting on the study design was the issue of inclusion and sample size. In many IPA guides, eight to ten interviews are recommended to provide sufficient depth of data (Smith et al., 2009; Smith & Osborne, 2008). A larger sample of ten to fifteen was recommended by the thesis research advisory committee to ensure that the sample would be characteristic of the women who used the Birth Centre. In actuality, this study included seventeen participants – this larger sample size did ensure greater representational diversity (different ages, parity, postal codes, and place of prenatal care). Smith discusses the idea of homogeneity applied to the study sample, cautioning that if the sample group has too many diverse factors, a larger sample size is required in order to identify comparisons (2009, ch. 3). The notion of representational diversity and the directive for homogeneity came together in this sample through being a purposive sample (not randomized) with a focused inclusion criteria for all women to have made a decision to plan a birth at the Birth Centre.

Data collection. The researcher led each participant through the informed consent document at the outset of interviews (Appendix B) and obtained signed consent. The most common method of data collection in IPA is through semi-structured or in-depth interviews (Smith et al., 2009, ch. 4; Smith & Osborne, 2008). Semi-structured interviews were used in this study using the interview guide (Appendix C). Seventeen interviews were conducted between October 3, 2013 and January 9, 2014 and ranged in length from thirty minutes to one hour thirty minutes depending on the participant and her baby. The interviews were digitally recorded. The interview guide included descriptive, structural, narrative, comparative, and evaluative questions (Smith et al., 2009). Some of the questions were open and non-directive asking for an overall description of the decision-making experience including the feelings and meanings of the decision, and probing

the women for more reflection on the meaning of their answers and experiences. There were also directed questions in the interview guide regarding safety, the Place of Birth Handbook, the postpartum stay, how the woman weighed her choices in terms of risks and benefits, and the role of others. The researcher engaged with the participant conversationally and attempted to use exploratory probes to support the participant to explore her own experience and its meaning in a deeper way.

Sixteen of the interviews were in the women's homes with the baby present (sleeping, being held, breastfeeding, or playing). One interview was at a woman's place of employment in a private office. At the end of each interview, each participant was offered the opportunity to complete a demographic face sheet (Appendix D). All participants agreed and filled in the face sheet which I reviewed with them together.

Throughout the interview, I attempted to facilitate a re-telling of the participant's personal experience, more as a guide than a director, exploring the different turns that a woman took through her story. The interviews were semi-structured and usually followed the progression of the questions on the interview schedule.

The last interview (with Avigail) presented some data collection challenges. The participant was behind schedule; I offered to re-schedule or cancel, and although she wanted to continue, she was called by one of her children in school to be picked up about twenty minutes into the interview. At the same time there was a technology malfunction and the interview recording was not saved. For this interview, I noted these interview challenges and took field notes immediately after, writing down as many verbatim statements from the woman as were accurately remembered. Later that day, I spoke with the participant and acknowledged the error, reviewed my notes, and she confirmed and added a few more thoughts. This woman added a unique perspective on her life experience and her decision-making process; these notes were applicable and were included in the analysis.

I transcribed the first four interviews in order to increase self-reflection on my interviewing technique. The remaining interviews were transcribed by a contract transcriptionist who has worked for the university, has completed the Personal Health Information Act requirements, and has signed a confidentiality form. Verification of transcription was done by the researcher through listening to the recordings with simultaneous document review. The transcriptions were first printed and stored in a locked filing cabinet in a private office along with the informed consent and the demographic face sheets. The interview transcriptions were later all loaded into NVivo 10 software on a password protected computer.

Excerpts from the verbatim transcripts firmly grounded the findings in the experiences of the women to provide convincing evidence of the analysis (Elliot, Fisher, & Rennie, 1999; Smith, 1996). The interviewer's responsive language, (e.g. "yeah", "go on", "for sure") were excluded from the verbatim quotations. However, if the interviewer interjected with a question or interpretation, then this was included in the report to demonstrate prompting or leading questions. An ellipsis was used to remove unrelated script while ensuring that it did not obscure the meaning or misrepresent the woman's account.

On using code-names. I intentionally chose to use code-names from the beginning of my analysis. I wanted to ensure that I remained dedicated to a feminist perspective that valued the voice of each individual. Guenther, in discussing the politics of names, contends that

> Names are powerful, choosing to use—or to alter—them is also an act of power. Especially scholars committed to moving beyond positivist, objective social science must grapple with the issue of naming, balancing the rights and wishes of respondents with ethical obligations, personal values, and a commitment to analytic rigor and disseminating accurate accounts of our findings. (2009, p. 413)

For these reasons, I invited participants to give themselves their own pseudonym on their demographic face sheet that was completed after the interview. Four participants gave themselves

a pseudonym. I chose the remaining thirteen names from a name website, finding names that were different but had similar meanings. In typing the transcriptions, I used numbers to represent the individuals. When the files were imported to Nvivo I used the pseudonyms on each of the women's interview files. Using a name for each participant grounded the research in an idiographic perspective that valued the voice of each person throughout the analysis. I was never reading about "Interview-1"; I was reading about Alex. I was immersing myself into Alex's life and Alex's understanding and meaning of her experience. By re-naming the women from the outset, there was greater certainty of anonymity. I no longer thought of the participant by her real name but by her pseudonym as I engaged in her transcript and recalled our interview through field notes.

Field notes and research journal. Field notes were used to record dates, times, places of interviews along with unspoken and emotional responses of the women in the course of the interview. I used a research journal and practiced reflexivity to allow deeper critical thought to emerge (Smythe, 2011; Van Manen, 1990). Interpretive phenomenological data collection is a discussion of ideas, where the participant reflects upon her memory and interpretation of her experience, and the interviewer listens and interprets these ideas (double hermeneutics). Reflexivity is acknowledging personal perspectives, positions of power and bias, and continually reflecting on the research experiences to ensure that all aspects of the research are guided by a feminist perspective as discussed above. By keeping a reflective research journal, I attempted to practice self-awareness in a meaningful manner (Wall, Mitchinson, & Poole, 2004). In my interviews and immediately after, I continually reminded myself to listen carefully, make room for silence and thought, and to keep my views to myself. In the first few interviews, I, the interviewer, said too much, occasionally trying to interpret what the woman was saying as she went along. I attempted to correct this with on-going reflective practice, reflexivity, and a research journal. The research journal was started at the outset of the study, and continued through the data collection, analysis and writing in order to "catch the developmental process and leave a transparent path of

learning and understanding" (Jarrett & Johns, 2005, p. 178), thereby also aiding the trustworthiness of the study.

Aggregate data review. Data from the Birth Centre logbook of the first two years of operation, December 1, 2011 to November 30, 2013, was made available by the Women's Health Clinic in early July 2014. This aggregate data is used in the section below to situate the sample within the context of the population of women who were admitted to the Birth Centre. Aspects of the aggregate data are also included in the Discussion chapter to draw out meaning of some of the findings. In the first two years of operation 306 women were admitted to the Birth Centre and 242 births took place there. The data that was taken from the Birth Centre logbook included overall admissions, parity, midwifery practice group, and transfer rates (from Birth Centre to hospital). The midwife was named on the logbook and a comparative contact information sheet of midwives was used to identify the practice groups from which they came. The question of parity and practice group related specifically to the inclusion criteria of the sample. Not all of the women in the study were actually admitted to the Birth Centre. Two women in the study who planned to give birth at the Birth Centre at the onset of labour were assessed at home in early labour and were found not to be within the eligibility criteria for Birth Centre admission. As well, two women in the study who gave birth at the Birth Centre were transferred to the hospital in the immediate postpartum for a non-urgent concern (complicated laceration repair).

The women in the study. The goal of IPA research is to focus on individual people's experience of a specific phenomenon. In this study, all of the participants went through a birthplace decision-making experience and chose to plan to give birth at the Birth Centre in Winnipeg. In qualitative research, specific factors are not tested and controlled to identify a model that identifies levels of significance controlling for different factors. Each woman's specific demographics are important in this study to provide context to each of their experiences. Yardley (2000) suggested that acknowledging each woman's context is a method of ensuring credibility.

Purposive sampling is used in IPA to find a fairly homogenous sample (Chapman & Smith, 2002; Smith, 1996; Smith et al., 2009). To be useful and consistent with the IPA method, the central focus of choosing the Birth Centre was the common experience for all of the women in this study. It was a goal for this study to have a group of participants that would be parallel to the actual users of the Birth Centre. The demographic diversity of this sample strengthens the use of the findings and the study recommendations.

The unifying experience in the inclusion criteria for this study was that all women started labour with the intention of giving birth at the Birth Centre. A primary recruitment goal was to have a representational group in relation to women who use the Birth Centre. This diversity was hoped to be represented by where the women lived, where they went for prenatal care, and how many births they have had. This goal was realized. The women who participated represented a cross-section of community groups, income categories, ages, education experience, number of past births, marital relationship status, and midwifery practice groups (see Table 2).

Table 2: Attributes of the women in the study

Home Community	Income (in $10,000)			Parity (number of past births)					Prenatal Clinic*		
	<39	40 to 79	>80	0	1	2	3	≥ 4	BC	MCC	ARE
Northend	●●●	●		●	●			●●	●●	●	●
St. Boniface			●●●	●	●			●	●●		●
Windsor Park			●●●	●	●	●			●●		●
Osborne	●●			●	●					●	
Downtown		●		●					●		
St. James			●		●				●		
Selkirk		●						●	●		
Fort Garry	●			●						●	
East St. Paul			●				●		●		
Total	6	3	8	6	5	1	1	4	11	3	3

*BC= Birth Centre; MCC= Mount Carmel Clinic; ARE= Access Rivereast

A question about ethnicity was asked on the demographic face sheet and sixteen women answered this question. Fourteen responded that they were Caucasian and one identified as Franco-Manitoban. One woman was Aboriginal; she left the spot blank on the form but when we reviewed the form together she answered "Oh, I'm native" (from field notes).

The women came from eight community areas in the city of Winnipeg and one was from the Interlake region. One of the goals in the recruitment was to have at least three women from community areas (postal codes) known to be in a lower socio-economic category. There were four women in the sample from R2W (north end) and one from R3C (downtown). Six women reported to be in the lowest income category. Eight women were in the highest income category with a household income greater than $80,000 per year; three were in the middle income category ($40,000 to 79,000). Nine women were married, four were common-law, and four were single. Five women were 35 years old or older, seven were between 30 to 34 years old, five were between 25 and 29 years old, and one woman was between 20 and 24 years of age. Six women had university degrees. Seven had attended some post-secondary education. The highest completed education for three women was high school and one woman had only completed grade eight.

Eight women in the study reported in the intake process to midwifery care that they wanted to have their baby at the Birth Centre. Four said they wanted to have a homebirth. Three said they wanted a hospital birth. Two were unsure of what they had written. Two of the women's babies were born more than a year before the interview. Fifteen of the women's babies were between four weeks and a year old.

The parity of the women in the sample was representational of the aggregate data from the Women's Health Clinic Birth Centre logbook (2014). In the sample six women had never given birth previously, five women had one previous birth, and six women had already given birth at least twice. The aggregate data similarly demonstrates that a third of all admissions were nulliparous, a

third had one previous birth, and a third had at least two previous deliveries (Women's Health Clinic, 2014).

Eleven women attended their prenatal clinic at the Birth Centre, three from Access Rivereast and three from Mount Carmel Clinic. The aggregate data of the Birth Centre revealed that out of the 306 admissions in the first two years, 60 women were admitted by midwives who did not work at the Birth Centre; eighty percent of all admissions were under midwives who conducted prenatal clinical care at the Birth Centre (Women's Health Clinic, 2014).

Data analysis. The process of text analysis into emergent themes began on paper by making notations and highlighting phrases that appeared important from the words of the participants in their individual contexts in relationship to the decision-making experience. Identifying emergent themes came through a series of different activities first on paper and then on the computer. The following four steps were a collaboration of different techniques to engage a creative and reflective analytical process, activating multiple ways to think about each woman's experience.

The first step of the analysis involved listening, reading, and mind-mapping. The interviews were played as the typed transcripts were printed and read. In order to support a focused and creative process using various ways of hearing and thinking about new information, I mind-mapped the ideas on paper and highlighted the text as I listened and followed along (Braun & Clarke, 2006; Komarraju, M., Karau, S., Schmeck, R., & Avdic, A., 2011; Tattersol, Powell, Stroud, & Pringle, 2011) (Appendix E). I then re-read the text aloud as I reviewed the mind-map. At the end of each interview, I listed a summary of themes that emerged based on the mind-mapping process.

In the second stage, the data and analysis were moved into the Nvivo 10 software program. I again re-read each transcript individually, highlighted the text, creating new nodes, and coding into existing nodes as meaningful text appeared. "A node in Nvivo is a way of bringing together ideas, thoughts and definitions about data along with selected passages of the text" (Gibbs, 2002, p.

31). Nodes represent concepts and ideas. Memos and annotations in Nvivo were continuously recorded to leave a clear trail of the analytical process and to continuously record my interpretive thoughts of the women's interpretations of their experiences.

In the third step, the mind-map thematic coding was compared with the Nvivo coding, highlighting the similarities and differences in words and thoughts between the two methods to ensure that the experience of each woman was fully and accurately represented in the emergent themes in the form of Nvivo nodes. Nodes were renamed and additional excerpts from the transcripts were coded based on this comparison.

The fourth analytical step was to merge nodes where ideas and themes repeated themselves. This process made the themes into a more manageable group. Fifty-five nodes from seventeen interviews were merged into about 35 nodes without losing essential meaning. Coding was a creative and evolving process where the meaning of the codes naturally evolve as understanding of the data grew (Braun & Clarke, 2006). At the same time the interpretation of the women's meaning was continually rechecked for contextual consistency. Individual verbatim excerpts were occasionally coded into multiple nodes because they represented several different meanings. None of the quotes were used twice in the findings. When quotes seemed to have multiple meanings from one experience they were further analysed. Merging codes and identifying multiple meanings was tracked in Nvivo memos attached to the codes or interview annotations by noting the transition of the ideas and thinking about the reference. Memos and annotations were re-read along with the references to ensure that key ideas were captured and not lost in this process.

Emergent themes were then further analysed by looking for patterns and connections between them to identify superordinate themes. Superordinate themes are general concepts that represent sub-themes as a group. To identify patterns, note connections, and bring forward important findings, Smith and colleagues suggested the following ways to inspire analysis:

abstraction, subsumption, polarization, contextualization, and numeration (2009, ch. 5). These five suggestions were intentionally applied in the analysis, after initial coding of all the ideas that appeared to have meaning. The following paragraphs describe these suggestions with an example on how I used each in my analysis.

Abstraction is the process of conveying a general theme by selecting common ideas from different women's individual experiences. This method was applied in grouping all of the experiences that related to the physical space and named the group "interacting with the physical space" theme. Subsumption brings two ideas together using deductive reasoning. For example, feeling respected, having self-confidence, and exerting self-determination were subsumed into the theme of "exercising personal agency". The concepts of beliefs, values, and hopes were connected through deductive reasoning to identify the concept of ideology. In this analytical decision, it was recognized that women had beliefs, values, and hopes that were connected in a similar way and through the many dictionary definitions about these words, ideology emerged as a descriptive word that encompassed beliefs and values. The concept of hopes was included because hope is an active expression of one's beliefs and values. Identifying the contrasts within and between the cases is a process of polarization. Within the superordinate theme of "fitting into eligibility criteria" a significant contrast was identified between women who "fit" into the criteria and other experiences that didn't fit into the criteria. These different experiences were compared and explored.

Viewing the woman's meaning in the context of her life was integrated throughout all of the analysis. The woman's parity, her past experiences, her relationship status, and her actual birth experiences all had an influence on her experience. Contextualization was an integral part of the process throughout the analysis. For example, contextualization was used in interpreting Ruth's experience—a woman who was a grand multipara and had midwifery care for all of her births. Ruth's history provided context to interpreting her experiences.

Frequency and repetition of a concept was used in some ways for bringing together every superordinate theme in this study. Through numeration, the frequency of a similar response to the physical design was recognized. As well, the theme of personal agency was a robust finding because it was represented strongly in each woman's experience. It was important that every woman had some connection to each of the superordinate themes. Repetition was initially noted by comparing the initial mind-mapping codes and through being immersed in the transcripts of each woman's experience. In the findings, some verbatim quotes that are very similar are stated one after another, to demonstrate the consistency of the finding between women. Numeration was not used to prioritize the superordinate themes in levels of significance or importance.

In this IPA methodology the superordinate themes are all considered important and representative to the findings. For the purpose of the study, all significant experiences that women discussed were connected to themes identified. I used the sorting and query tools in Nvivo to ensure that every superordinate theme encompassed some part of each woman's experiences. Some of the themes have more subthemes and more content of quotations than others; this denotes the complexity and layers of the experiences rather than levels of significance. The lack of prioritizing themes represents the idiographic phenomenological methodology and the feminist theoretical framework aiming to give each woman a place as the subject and expert of her experience.

Validation. Quinn and Clare (2008) recommend that to maximize credibility a summary of themes be taken back to the participants for further comments. Participants who were interviewed were asked on the informed consent document if they wished to review a summary of the initial analysis in order to provide input into the analysis. Sixteen of the seventeen participants said they did want the opportunity to provide feedback. A document briefly describing the themes and inviting feedback was prepared, reviewed first with my research advisor, and then circulated by email to the study participants (Appendix F). Four of the sixteen women responded saying that the

themes did represent their experience. The participants were invited to email their phone number if they wanted to talk more about the study findings. No one requested a phone call. The research advisor provided another exercise in trustworthiness by reviewing the initial stage of the transcript analysis (mind-mapping and initial noting on paper) feedback and suggestions were made on how to continue the analytical process. The research advisor reviewed the first draft of the findings and provided feedback on the interpretation and presentation of the findings.

As I delved deeply into implementing the methodology, I became acutely aware of the large sample size and the variations in parity within the sample. I was concerned that these two factors would get in the way of interpreting the results accurately. With these concerns in mind, I chose to further analyse the sample by breaking the findings into smaller groups of parity. This exercise broke the large sample of seventeen women into three groups based on their parity (the number of times they had given birth). Surprisingly, this grouping resulted in similar size and characteristic sub-samples. Five women had had their first baby. Six women had given birth to their second child at the Birth Centre; all of these women who were para two previously had given birth at the hospital and only one had previously been in the care of a midwife. Of the six women who had three or more births, only Karin (para 3) had not had midwifery care previously. Four out of six women who were at least para three had previously had midwifery care in hospital and two had had at least one homebirth.

Using the sorting tools in Nvivo, I was able to verify that the themes were adequately represented consistently across these smaller groups. The sample size and the variation in parity did not change the findings. I had expected that there might be a unique variation of findings specific to the subgroups; however, this was not the case. All of the women, across parities, shared experiences that fit within the superordinate themes of the findings. There was at least one person in each group who had come into the study wanting a home birth. Two of the women in the para one group did not know that they had any birthplace options when they started care.

Yardley (2000) outlines four elements of quality control in qualitative research including sensitivity to context, rigour, transparency, and results that have an impact. All four of these elements were attempted to be upheld in carrying out this study; the quality of this research has its limitations and strengths that will be outlined in the last chapter. It is hoped that this research will provide input into the on-going woman-centred care at the Birth Centre and more generally to women choosing birth centres in other locations. There are many new findings in this study that have implications for practice.

CHAPTER FOUR

Findings

Interpretative phenomenological analysis has two key aims. The first aim is to try to understand the participant's experience and lifeworld (Larkin et al., 2006, p. 104). This chapter will fulfill this first aim by sharing and interpreting the women's experiences. As an idiographic process it is important to ask, "What was the decision-making experience like for Avigail?", "What did choosing the Birth Centre mean to Leah?" and so on, for each individual woman who shared her subjective world of decision-making. The findings in this chapter relied heavily on verbatim excerpts from the women's experiences to understand more about each one's personal subjective account of what it meant to choose the Birth Centre. The second key aim for IPA is to interpret and analyse these experiences, situating them into a social, cultural, and theoretical context (Larkin et al., 2006). This second aim will be fulfilled in Chapter Five discussing the findings in relation to current literature and identifying implications for practice.

There were six superordinate themes that bring form and organization to the emergent themes from the women's experiences. These six themes characterize some aspect of each woman's experience: 1) Exercising personal agency; 2) Decisions are made in the context of relationship; 3) An expression of one's ideology; 4) Really thinking it through; 5) Fitting into eligibility criteria; and 6) The psychology of the physical space. The themes represented how women recounted their lived self, lived relationships, and their lived interactions with both the space and with the guidelines that govern its use. Lived experiences are essentially holistic and complex and as such, these six themes are overlapping and interrelated. The research questions were applied to each theme: How did the women choose the Birth Centre and what did that decision-making experience mean to her?

Introducing the Women in the Study

Dorothy Smith (1987) charged the researcher using a feminist perspective with the responsibility of creating a knowledge that is *for* women, where "women are located as subjects and as knowers of their everyday world" (p.153). This responsibility in conjunction with the idiographic methodology of IPA is the basis for extensively grounding the findings in the voices of women which was the key consideration in the writing of this chapter. Each woman's context was forefront in interpreting and analyzing the results from the study. In keeping with the woman-centred and feminist approach guiding the study, each participant is recognized as a unique and individual contribution to the whole. The following section introduces each of the women who were interviewed, giving a brief context to their lived experiences which will be discussed more fully within the following thematic findings. In an effort to maintain anonymity, details of where the women live, their ages, income categories, and educational backgrounds are not included in the introductions.

Alex was pregnant with her first baby. She had a boyfriend during her pregnancy and birth who was also the father of her baby. They separated soon after the birth. Alex wanted a homebirth. Her boyfriend at the time did not. They decided on the Birth Centre in early pregnancy, but she felt that that she compromised her own preferences to her ex-boyfriend's wishes.

Christina had never considered anything but hospital births. When she was accepted into midwifery care for her first pregnancy, the midwives told her she had a choice. They took her on a tour of the Birth Centre with her partner. She started asking questions of her midwives, researching the topic, and finally decided to plan for a birth at the Birth Centre.

Leah had originally planned a homebirth for this, her first baby. She developed a risk factor in the pregnancy that led to her planning a hospital birth. When she went into labour her midwife came to check her at home, the risk factor had resolved, and she was in active, progressing labour. Because Leah lived close to the Birth Centre, which had a room ready and set up for a birth (the

midwife had not been anticipating a precipitous nullipara), they went to the Birth Centre for the delivery.

Katelyn was unaware that she had birthplace options until she received a positive pregnancy test result at the Women's Health Clinic for her first pregnancy and was told about midwifery and about the Birth Centre. She said that she makes decisions on her instincts and that the Birth Centre felt like the right choice.

Lara tried to have a natural approach to her health. She had a family doctor who did not do obstetrics. She had wanted to plan her first birth at the Birth Centre before she was even pregnant. She did not get into midwifery care until 6 months, but when she did she knew from the outset she would plan to deliver at the Birth Centre.

Chelsea decided on the Birth Centre when she got into midwifery care (at 6 months). She had had a previous normal birth at the hospital and she thought the Birth Centre would be the best place to have another normal birth.

Elodie had her first baby in the hospital by induction for post-dates after planning a homebirth. This time she was not sure initially where she would plan to have her baby. She recalled walking into the Birth Centre the first time and feeling like she just knew that is where she should go for the birth.

Gwen knew she wanted to be at the Birth Centre in the two years leading up to its opening. Her first baby was born at the hospital without complications. At the hospital, she had felt safe but that the space felt unfamiliar and unnatural.

Holly had her first baby normally at the hospital. After that experience she decided she wanted something more "low-key" and she thought that the Birth Centre would be perfect for her. She had a strong belief that her body was capable of giving birth normally.

Jersey wrote down on her intake form that she wanted a Birth Centre birth for her second baby. It was only after she got into midwifery care that she really let herself decide that she would go there. She did not want to feel too disappointed in case she did not get a midwife.

Teagan had considered a homebirth for her second baby but said that she did not feel strong enough about homebirth to go through with that plan. She felt the Birth Centre was even more private than home since her dog would not be around and her neighbours would not need to wonder what was going on.

Juliette's last birth had been very difficult and at some points in this last pregnancy she thought she might want to go to the hospital for the birth. She had also been considering staying home. She said that she was never really sure where she was going to have the baby. When Juliette started early labour and her midwife asked her to come to the Birth Centre to get checked, she knew she would stay there to labour and deliver.

Karin thought she was finished having babies. She had two natural births at the hospital with doctors. Every time she drove past the Birth Centre in the last few years, she wished that she could have birthed there. When she found out she was pregnant again, she was excited that she would have the chance to use the facility.

Ruth had a history of home and hospital births. She loved midwifery and wanted to support and be an advocate for the Birth Centre.

Avigail was not planning this pregnancy. She had wanted a homebirth with her previous births. Over the course of her pregnancy she considered the logistics of her home with her other children around and her boyfriend's comfort level (it was his first child and he was not comfortable with homebirth). She did an online tour and decided she would go there for the birth.

Lissa had previous births with a midwife at the hospital. When she was pregnant this time, she went to the Birth Centre for all of her visits. Her midwife took her on a tour and talked to her about her options and the risks. Lissa decided on the Birth Centre.

Brielle had been learning more about childbirth and took a doula course after her last baby was born. When she became pregnant again she wanted to have a homebirth, but her husband did not feel comfortable with that idea, so they decided they would go to the Birth Centre.

Theme – Exercising Personal Agency

Agency means that a person is an active agent in leadership, social change, and decision-making rather than a passive recipient of help (Sen, 1999, ch.8). As stated previously, all of the themes and findings from this study were interdependent and it was clear that exercising personal agency was related to other themes. The women in this study who experienced personal agency exercised self-determination as primary decision-makers, active in their own pregnancy care and birth planning. They were not passive patients in the birthplace decision-making experience. They felt in control and were resilient and flexible in change. Confidence, feeling in control, pride, strength, independence, empowerment, and making one's "own choice" are expressions that characterized the women's experiences of personal agency. Agency in this study was directly related to feeling control, confidence, and respect being expressed through making choices.

Exercising personal agency was a robust finding demonstrated throughout most of the interviews (see Appendix G for a list of verbatim quotations). Numeration, contextualization, and identifying contrasts were used in the analysis of this theme. Out of the seventeen interviews, sixteeen women expressed a significant experience of feeling "in control" and confident in the decision-making process. A few of the women voiced a lack of personal agency both relating to the subtheme of "not fitting into the eligibility criteria" discussed below. The contrasting finding for these two women will be discussed contextually later in this section.

Having control meant that women felt empowered. Some of the women identified feeling empowered through self-reliance, proving one's strength and confidence to others, and by having choices. Holly's feeling of empowerment came from her reliance on her own body, not relying on pain medications in the labour. Holly went on to say, "so, that was putting a lot of confidence in my

body and my body's ability to – to tolerate what's probably the most extreme pain you'll ever experience in your life." Chelsea described how it was important to prove to others that she was strong in her self-confidence:

> It was empowering to be able to show, like, people that I know and people around me that I can, that it was okay. Like, sort of show them that I know that I'm gonna, I don't know, that everything's gonna go okay, and that I can make that decision and be confident in that decision and confident in myself, that I can do this, and show them that I can do this. (Chelsea)

Having choices gives strength. Katelyn reflected on her experience of personal agency, self-confidence, and strength.

> 'Cause a lot of people were, like, "Oh, really? You're gonna have it at the birth centre with no drugs or anything?" Ha! Ha! Well, good luck with that." And it's, like, you know what? I did it. So shut up. [chuckling] (Katelyn)

A sense of personal agency and confidence was apparent throughout Katelyn's reflections on her experience. She repeated this same sentiment of pride in her accomplishment again later in the interview.

> But now, it's like – I don't know what pregnancy – having a baby has done. But I'm just, kind of, like – You know, I'm gonna do this because it works for me. And if you don't like it, well, guess what? You don't have to stick around. So… [she held up her middle finger]. (Katelyn)

Katelyn's birth centre decision meant that she was in charge of her choices as an individual and this has extended to how she feels as a mother. Lissa, a quiet, shy participant who smiled and blushed when asked about what it meant to her to have had her baby at the Birth Centre replied, "I felt proud. I felt happy." The birth centre decision meant pride. Reflecting on her experience, Gwen whispered, "It's 'cause I'm awesome. [Switched to a normal voice.] No, it's just 'cause I'm normal,

right? Like, that's it. It's just 'cause I'm normal." Most of the women felt fantastic about themselves and their decision to plan a birth centre birth. This was expressed through smiles, laughter, and sitting up straight.

Stoljar (2014) contends that within the feminist perspective of relational autonomy, preferences within intimate, interdependent relationships can be just as autonomous as preferences for self-reliance. Ruth primarily felt confidence in her midwife and in their relationship. A key theme in Ruth's experience was that she didn't feel so strongly one way or another about her birthplace decision but rather she relied on her midwives' knowledge and experience (discussed more in the "in relationships" theme). Ruth said that she had had great hospital births and homebirths, all with midwives. Ruth felt confidence in her midwife.

> So yes, I think my midwife – I – you know, right or wrong or whatever, I think I do, and have since the beginning, put a lot of trust and faith in them . . . yeah, I know midwives never guarantee anything and they can't. But somehow I just wanna trust them, anyways. [Chuckling] So ultimately, that's what makes me feel brave. (Ruth)

The decision-making experience for Ruth was less about place of birth and more about her relationship with midwives. However, based on the idea of relational autonomy, the essence of Ruth's experience could be agency; although she doesn't express self-reliance, she does express her capacity to choose what is right for herself.

Not exercising personal agency. One woman (Alex) did not feel that she was able to exercise personal agency and another woman (Lara) intentionally attempts to remember her overall experience as positive, but she did have an experience in labour where she felt that her agency was taken from her. Both of these women had experiences that demonstrated polarization to a dominant finding.

Alex's inability to express confidence and control was significant in her experience and needs to be viewed within the lens of her individual context. Alex laboured at home and then, due

to prolonged rupture of membranes and a non-progressing labour, went to the hospital. At first glance we could rely on this circumstance to explain her lack of feeling control; however, this experience started in early pregnancy with the birthplace decision-making process. From the beginning of her pregnancy, Alex's experience of birthplace decision-making was characterized by lack of choice. Compared the other women's experiences, exemplified in the table above, Alex did not have that same experience. To begin with, Alex's choices were reduced and she didn't have the power to choose her preferred option. She had wanted a homebirth but settled on the Birth Centre because of her partner's wishes.

> I feel like I gave him a lot more respect in that situation than he'd given me. I said I wanted a home birth and he just made it clear that that wasn't something he was comfortable with. I felt – I think I still felt like I maybe still wanted one. But just, I wasn't arguing with him was just, like, a big pain in the butt . . . I think, every once in a while, I would have that nagging feeling, like, "What you really want was a home birth." Like, I didn't forget what it was that I really wanted. Such is life; you don't just, like, erase your true wants. (Alex)

When Alex started her labour with prolonged rupture of membranes, her role in decision-making was further detached from her control and her expectation of being able to take care of herself was unmet. Alex did not feel respected or supported in her decisions in labour. Alex reflected later in the conversation that she felt that the people around her disconnected her from her body, "I was just like a body and they were, like, making decisions about what was happening" (Alex). This statement contrasted the holistic and feminist perspective that Alex had hoped to experience. Not experiencing agency or control in decisions means that women feel detached, feel regret, and feel disrespected.

Lara recalled her prenatal decision-making experience as positive where she felt like she was the primary decision maker. However, when faced with a decision to transport in the second

stage of labour (thirty minutes before the birth), Lara found the conversation about the decision fear-based and disempowering—less about choice and more about a declaration of dissent. She spoke with distress in her voice:

> And then there were, like, leading questions. And it was, kind of, like, rather than saying, "You know, you have this choice," it was, like, clear what their expectation of me was. And they were saying things. Eventually, when I was asking questions, they just kept pushing me, saying, "Are you refusing medical advice? Are you refusing medical advice?" (Lara)

Lara concluded this part of her story by saying that in her present everyday life, she tries to remember the times when she felt control.

> So it wasn't an altogether positive experience. But what I really try to come away with is: You know what? That was less than 30 minutes of my experience. And I try to remember that I had, you know, 4 or 5 months of prenatal care that was amazing. Most of the birthing there was great. (Lara)

Leah recognized that a safe and healthy birth and baby are central to the childbearing experience, but she highlights what many of the women expressed, that dignity is paramount as well.

> But it's about so much more than that, you know? It's about – like, it is obviously – that's your end result. But it's also about, you know, how – how you felt about the process, you know, if you felt respected during labour. (Leah)

Teagan related safety with having choices and exercising personal agency, for her personal choice meant feeling safe.

> I felt control over, what I do and what I'm able to say and that kind of thing. That would be some – a way that I feel safe . . . And so, that kind of leads into how I felt safe at the Birth Centre, is that I chose to be there. (Teagan)

An environment of respect and individual autonomy created what Holly called "emotional safety." Having choices, control, and being able to exercise personal agency in the decision-making process meant positive experiences for most of the women in this study. When agency and autonomy were not present, as in the case of Alex or, in part, for Lara, the experience was remembered as difficult and adverse. The theme of personal agency represents both the women's active role in birthplace decision-making and the subsequent confidence-building impact of that decision. It must also be recognized that agency is a relational experience linked to the feminist concept of relational autonomy with an understanding that "an agent's social relationships influence the development of autonomy" (Stoljar, 2014). This understanding recognizes that people do not gain agency in isolation, but are enabled to make decisions in the context of supportive relational environments.

Theme – Making the Decision in the Context of Relationships

Relationships had a significant role in women's experiences of birthplace decision-making. Feeling safe, being on the same page, exchanging information, and feeling supported were experiences that emerged for women in their relationships with their midwives, their partners, their mothers, and in their social circles. This theme really expresses answers to the question of how women made the birth centre decision; women made the decision in relationship with others. This finding also means that in supportive relationships women feel stronger and they make decisions that represent their personal choices.

Relating with others was intricately connected with exercising agency and the concept of relational autonomy. This finding begins with the women's relationship with their midwives as a supportive experience. In some of the other experiences (with partners, mothers, or social networks), women may have had to defend their decisions. In relationship with their midwives, women felt safe and found inner strength to make their own decisions. It is significant to note that all of the women experienced a normal birth influence through relationships.

Relationship with the midwife. Women consistently talked about their midwives and

recognized that their midwife had an important role in their decision-making experience. The Philosophy of Midwifery (CMM, 1995) identifies trusting relationships as a foundation of the profession. The relationship with the midwives had a narrative: women felt known, trust grew, the midwives' skills and knowledge were demonstrated, and women felt safe.

Midwifery relationships started with time. Women felt like they were treated as the centre of the decision making process; they didn't feel pressured for immediate responses. The relationship was characterized by time. Jersey didn't feel like she was being moved through a checklist, "with midwifery care, like, you have time. It's not like all of a sudden, 'Okay, these are the lists'" (Jersey). Lissa also experienced patience in the midwifery relationship, "she didn't do much really, just basically asked me where I wanted to give birth . . . Yeah she just waited for me to make my own choice" (Lissa). Midwives facilitated a space where women could think and consider their options. Discussions and revisiting ideas and decisions were invited in the midwifery relationship.

> We have the opportunity to have concepts introduced and we were asked what our position was. And then, we didn't need to make the decision now. And then, we have time to do research on it and come back to [baby distraction]. Yeah. So I think a lot of what the birth centre has is that it creates a space and it creates the time. (Lara)

The philosophy of women-centred care that exists in midwifery care meant that women took time to make their own decisions. Holly talked about "having long, meaningful conversations with [her midwives]."

"Being known" was an experience that meant a deeper level of understanding. Through time and inquiry, women and midwives became known to each other; women's beliefs, values, and life experiences were shared with the midwife. This depth of understanding had a strong impact and made women feel safe: "so part of that sense of safety was being known by your care providers" (Juliette). Holly agreed with this experience saying that the midwives "knew me as a person, not just as a patient so, that made it, I think, more physically and more emotionally safe for me." Being

known by the midwives meant that women's individuals plans and preferences could be activated, "like, they know me; they know what I wanted" (Chelsea). "Because they – they knew what I was – what I was hoping for. And they were gonna do their best to make that happen for me" (Holly). In this way, there is an interaction between the themes of expressing one's ideology and relating with others. Katelyn recognized the importance of an equal and cooperative relationship.

> But I think we kind of work together. I kind of had my own thoughts, feelings, beliefs, etc. And I kind of laid them out with the midwife and she worked with me on that. She didn't really overtake the decision. She kind of asked me what mine was, and then we worked on it together. So we were at the same level. It wasn't like midwife-person down here, kinda thing. It was—we were very together on the same page. (Katelyn)

A sense of safety came from the midwifery relationship that was connected to individualized care, being known, knowing the midwife, and being on the same page with the midwives.

> So I had a lot of support there. And, like for me, it's the relationship that makes me feel safe. So, like, knowing that [the midwife] was there . . . knowing that this person that I have gotten to know, that I trust, is there, like, definitely makes me feel safe. (Gwen)

There was a strong connection between feeling known by the midwife and feeling safe.

The relationship was built on a foundation of trust. Women made the Birth Centre decision as a result of trusting relationships.

> Then, as my visits went on with my midwife, I just developed such a relationship with my midwife on more of a personal level. Because you've spent so much time with your midwife, you can talk to your midwife about anything. And so, I think, upon developing more of a relationship with my midwife, it made me more comfortable and more trustworthy in my midwife's ability to deliver my baby safely. So I think that was how I came to it. So it didn't take long before I was, like, "Oh, this is what I want. I wanna deliver at the birth centre". (Christina)

> But, yeah, they were focused on getting to know you. And that's kind of, I guess, where I got the trust. (Katelyn)

Gwen said that the decision-making experience felt like "it came together on both ends" where the midwives "always had my best interest at heart."

Katelyn also referred to this concept of mutuality in a non-authoritative decision-making experience where they "came together" and made the decision. This element of trust was expressed through characteristics of the shared decision-making model and demonstrated aspects of relational autonomy as discussed in the literature review. Women also trusted and relied on the skills and knowledge of their midwives.

> Like my midwives and attendants are experts. And that made me feel safe in my birth experience because I'm – I sort of feel like women can give birth and they do give birth. But if something were to go wrong, there was someone who knew something more than my body was able to handle, you know? (Teagan)
>
> What I've always liked about her is that I feel like she's – she's very skilled. Like, she just would be able to do what needed to get done. She's not a real big risk-taker. (Ruth)

Women felt confident knowing that the midwife would create a safe environment, recognizing and responding to risks or complications if they arose. Women made their place of birth decisions in relationship with their midwives. This relationship meant that women felt known and safe.

Role of her partner. The interactions between women and their partners were varied. For some women, the decision-making process involved convincing the partner on the decision, for others the process was about coming to consensus about the decision to plan a birth at the Birth Centre and for still others, the partner acknowledged the woman as the primary decision-maker and felt that because it was the woman's body and therefore the woman's choice.

For the women who had wanted homebirths but their partners didn't (Alex, Avigail, Brielle, and Teagan), there was a sense that the Birth Centre became "a happy medium" (Alex) for the

partners. Teagan described her experience of coming to an agreement on place of birth with her husband, moving from homebirth to the Birth Centre:

> My partner and I were discussing it all the way through. He was much less comfortable with the idea of home for various reasons . . . I was able to convince him that I was comfortable safety-wise and that kind of thing. But he was, sort of, going along with and it wasn't as 100% support whereas I would have liked. If I was going to have a home birth, I would have really wanted him to be more, like, gung-ho about it. (Teagan)

When Teagan and her partner decided on the Birth Centre she expressed a mutual experience, "Yeah. And he was happy with it and I was happy with it."

Avigail decided to have her fifth baby at the Birth Centre but had initially wanted a homebirth. It was her boyfriend's first child. He was nervous about homebirth and she thought the Birth Centre would make it easier on him. Brielle had wanted to plan a homebirth. She described her process with her partner as being a compromise.

> I would have actually had a homebirth. My husband was a little bit more nervous about that, though. So we kind of compromised [on the Birth Centre]. I had, you know, tried to inform him of all the things that I knew and why I was okay with it and, you know, that would maybe help him be more okay with it. It took a long time to get him kind of on board. (Brielle)

Brielle had to take on the role of being the knowledge translator for her partner in the process of working to convince her partner. Alex experienced a deep sense of regret from going along with her partner's wishes, putting his wishes before hers. The Birth Centre decision represented a struggle for these two women.

Lara knew that she was "somebody who tends to be compliant." She went on to express that she "was worried that [she] would be swayed into—by [her partner] and his fears." At the

same time, Lara felt that it is important that her partner also make a decision for the Birth Centre. When Lara's husband first walked into the Birth Centre, he was "sold on it." This progressed into a very supportive decision-making partnership. It was significant for Lara that her partner had bought into the Birth Centre decision and it made her feel valued by her partner. "Cause he just, I think, saw – he knows me and my tendency for anxiety. And I think he just thought, 'Wow, this would be such a great place for Lara. And she's gonna feel so calm here.'" Lara expressed relief, "so it was wonderful. And I had been a little nervous about that cause I wanted to be on the same page as him" (Lara). Lara also acknowledged that if her partner hadn't been supportive of the Birth Centre, she would have convinced him of the decision, "I think I would have pushed him…Because I am somebody that, if I have enough time and – and feel some safety, I eventually do get there; I will voice my – my opinion."

For Gwen and her partner "the decision itself was made between the two of us" (Gwen). In contrast, Katelyn didn't feel a need to convince her partner about anything. "It's not like, 'Oh, we both have to make the exact same decision.'" Women and their partners have many different expectations of shared and individual decision-making. The decision-making experience for some women was less about agreeing with their partners and more about the partner going along with the woman's decision. Holly's partner had more of a supportive role than an influential role: "he would have done whatever I wanted to do." Similarly, Chelsea's partner supported what she wanted. "I guess we talked about it. And [he] was fine with whatever I wanted to do." When asked who participated in the birthplace decision, Ruth responded about her partner, "I'm trying to remember now. But I know he was never against it. I don't think."

Katelyn recognized herself as the primary decision-maker.

> For the first couple of appointments, I went by myself. And so, it was just kind of [me and the midwife] and – it's not that [my boyfriend's] opinion didn't matter; it's just, for me, like, I'm the one who's gonna be having the baby. So it's really my safety and my

> preference. (Katelyn)

Christina had a similar experience with her husband.

> My husband is supportive through and through, whatever I wanted. He wanted to know the facts, too. But, ultimately, he was, like, "You're getting this baby out of you. You're carrying this baby. Ultimately, it's up to you". (Christina)

Jersey, who had broken up with the baby's father in early pregnancy, identified that his role in her first birth was controlling. Notably, Jersey also accredited the Birth Centre decision-making experience as a way of exerting her own will, strengthening herself to avoid going back to him. Making the decision autonomously and finding strength through this experience gave Jersey self-confidence.

The experience of making the decision may have involved the father of the baby, a husband, a boyfriend, or someone with no committed relationship to the woman. In some relationships, the woman was the primary decision-maker when it came to her body and birth. In some relationships, the decisions about maternity care—the woman's body and her birth—were considered as shared decisions between the woman and her partner. The woman wanted to be supported in her decision; she saw herself as the primary decision-maker but wanted support from her partner. Other times, the value that was expressed within the relationship was about coming together, not just appeasing one person. Women in this study recognized the role of their partners in their decision. To conclude this section on the role of partners, it is important to acknowledge Jersey's message to others, speaking from her personal experience, she wanted others to know that the Birth Centre is for everyone, "you may not have, like, the perfect supports. But you can, you can still have a really good experience."

Interactions with their mothers. The opinions of the women's mothers were noted by half of the women as part of the decision-making experience. In some cases, the women's mothers were hesitant about the birth centre decision but then later "did a 180" as Gwen said. Chelsea's

mom turned her observations of her daughter's experience into vocal support of normal birth, "Like, I'm sure my mom must have shared my birth story more than I did [laughing] to, like, all her friends. And, like, spreading the word that we can – we [women] can do it ourselves" (Chelsea). The fact that women acknowledged the role of their own mothers is significant to recognize because it isn't acknowledged in other studies on birthplace decision-making. It is important that women raised the discussion of their interactions with their mothers without any prompting in the interviews. For Christina, her mom and her grandmother had a huge influence on her.

> Especially my Mom; I have a very close relationship—once I gave her, like, the facts and my view and this and that, then she was very supportive. 'Cause she also delivered her babies naturally . . . Yeah. I think the #1 kicker was that my omi – so my grandma – had ten babies all at home, I think, without anything, right? (Christina)

Christina's mother came from a normal birth perspective as did Leah's:

> My mom and dad were really, really open, certainly to homebirth. I mean, my Mom had two, two un-medicated births . . . I sort of grew up hearing those stories about, you know, when we were born and about, you know. (Leah)

Karin also acknowledged the support from her mother, "my mom was – she's pretty old-fashioned so she was – she's all for it, you know, just letting your body do what it needs to do" (Karin). For Jersey, it was her mom who suggested midwifery care in the first place; she "was the one who kind of introduced me to that side of things. It was [Jersey's] mom who said, 'Why don't you try to get a midwife?'" Mothers own births and life experiences slanted the way they viewed birth for their daughters. Teagan heard her mother's opinions but made a different choice, "I just sort of saw things differently, I guess. It was in opposition to, maybe, her viewpoint" (Teagan). Women's interactions with their mothers played a role in women's decision-making experience.

Social Circles. A common assumption for birth location is hospital. Women have to be able to feel comfortable and convinced about their own decisions whether they face support, questions, or adversity from partners, mothers, family, or acquaintances.

> No-one knew about the Birth Centre [at my mom's groups]. I always had to explain. You know, the education – there was just no – no-one knew about it. No-one knew about it. Everyone I talked to was, like, "What's the birth centre? Where is that? What do you do there? Are there doctors there?" So I think more normalized – like, it'll be nice when it's – when women know – when it's an actual option. (Christina)

Katelyn's experience started with negative ideas and fear about birth from other people but she turned that negative influence around through choosing not to have one those "horror story" experiences by deliberately choosing the Birth Centre in order to increase her chances for normal birth. Christina's brother, a paramedic, expressed concern about her choice. Speaking about the effect her brother had on her she said, "And so, he made me, for sure, very nervous." Teagan had a similar experience of being questioned by family members:

> I have a lot of people in the family in the medical field, there are some nurses and some doctors. And I felt like there was some unsaid, like, questioning going on. So I didn't talk with them at length about that. Like, and sort of the older people in the family didn't maybe understand . . . "Why do out-of-hospital when you could be totally safe in hospital?" And that was their point of view. (Teagan)

Teagan's decision-making experience included people who had different perspectives on safety and birth. Teagan went on to identify that her social circles evolved as a parallel to her own choices and preferences.

> And I think, when I first, when I had my son, maybe, I actually didn't know as many people that had done out-of-hospital births. So I felt more defensive about – like, even just wanting to have a natural birth without drugs. People were, sort of, "why?" And

> then, just as my different friendships have evolved over the years, I just have made different friends, I guess. (Teagan)

Teagan naturally shifted her social circle into friendships that shared more similar viewpoints. Katelyn recognized the pressures that came from other people, but then she resolved that she had to stay true to herself. For Katelyn this meant that some of her relationships were lost.

> When I started shoving [everybody's opinions] away, ignoring it – I just lost contact with people – like, I don't talk to that many people anymore because they got too in my face about things. And when I started going with my instincts, then everything just went so much better and a lot more smoothly. And I'm actually enjoying motherhood now, as it is, just doing my own thing. (Katelyn)

Making a choice that is not common created a sense of difference and may be a barrier in women's birthplace decisions. On the other hand, being different or choosing the Birth Centre also made many women feel proud that they had overcome barriers and challenges. A sense of accomplishment was revealed through the decision as highlighted in the theme of "exercising personal agency". At the same time, some women faced this barrier by not sharing their birth centre decision with everyone,

> We kept the idea of a [out-of-hospital] birth quiet from some people. There are some people we knew would be very supportive of it. But we also understand, you know, the politics of it, as well, too. And so, you know, we were sort of careful about who we chose to share that information with, as well. (Leah)

> For my husband, his best friend is a doctor. And he was very against it. And he like, the doctor goes, "You don't wanna do that. Why would you wanna do that? It's so much better at the hospital." I went, "I'm not –". I wasn't gonna have that conversation with him. But, like, there was – for me … I didn't want to have to feel like I had to justify my reasons for it. (Brielle)

Social influences had a significant role in many of the women's decision-making experiences whether it was through feeling supported, confronting the social norms, or being questioned or challenged. When Holly's friends and family asked, "'what if something goes wrong and you're not at the hospital?' That kind of opened up the conversation of, what happens if something goes wrong?' That probably did help me feel more confident in my decision." The decision-making experience built confidence by discussing the possibilities amidst social questioning.

> I think, for me, it was empowering to be able to show, like, people that I know and people around me that I can, that it was okay. Like, sort of show them that I know that I'm gonna, I don't know that everything's gonna go okay, but that I can make that decision and be confident in that decision and confident in myself, that I can do this, and show them that I can do this. (Chelsea)

The decision-making experience meant feeling supported with like-minded people and it also meant going against people's opinions and staying true to one's own values, beliefs, and hopes. The decision was never made in isolation but always meant some level of community involvement.

The normal birth influence. For of the women who participated in this study and chose the Birth Centre, there was a normal birth influence within their social circle and life experience. This influence primarily came through relationships of friends, family, midwives, and childbirth education. Normal birth influences had significant impact on women's beliefs, values, and hopes for their births.

Stories that were shared between friends, acquaintances, and in social circles were influential. When social circles normalize birth and midwifery care, the choice isn't an isolated, fringe experience. Being supported and influenced towards normal birth by friends helps to reinforce one's decision, "it's just sort of, yeah, it's been the norm." (Alex). This is an important notion that a sense of like-mindedness in the woman's social circle normalized birth. Leah said that her and her partner's friends and family have made "similar decisions" and Elodie acknowledged

that her social circle is "like-minded". Elodie reflected that her friends set an example of normal birth and that "it's not necessarily like a peer pressure" but rather a positive influence on how one thinks about birth. A sense of safety came from being surrounded with like-minded people who had a normal birth perspective, "having people sort of on the same wavelength, almost little mirrors of me [chuckling] –makes me feel safe and makes me feel like, you know, I'm in the right place" (Karin).

At the Birth Centre, women experienced a community where everyone was working together for a common goal: "it was a community all there for the same thing" (Karin). Women made their place of birth decision in the context of their relationships with their midwives, their partners, their mothers, and social circles. Within the context of relationships, women who chose the Birth Centre experienced a social influence and understanding that birth is normal.

Theme –The Decision was an Expression of One's Ideology

This superordinate theme started out being described as a list of beliefs, values, and hopes. As the theme took greater form, it became clear that beliefs, values, and hopes are all connected to one's ideology. Personal ideology is a set of ideas, beliefs, and values that guided the women's decisions and significantly influenced these women's lives and experiences. The women may not have articulated "ideology" with such theoretical language, but they clearly made a connection between their beliefs, values, and hopes within the decision-making experience. For many of the women, the birth centre decision was a process of coming to realize their own ideology. Some of the women came to the birthplace decision self-aware of their beliefs and values, yet for other women in the study, the decision-making experience was a time of reflection and self-realization.

> I was thinking – with my second pregnancy – was more thinking about just what kind of experience that I wanted, instead of just going along with what everybody else had done. Yeah. Like, "What do *I want* this experience to be like?" Instead of "I just - I have to do this, this is where they told me to go." (Chelsea)

This theme of expressing one's ideology demonstrated a progression of beliefs, values, and hopes. Beliefs are the root of this theme and become articulated in a woman's values, then expressed in their hopes. Values are based on beliefs. For example, when a woman believed that birth was normal, she valued a low intervention, natural approach, and then she hoped that her beliefs and values would be expressed in a normal birth experience.

One of the core beliefs shared by many of the women was that their bodies were made for birth, "I trusted my body. I knew that it was – you know – could do what it needed to do" (Brielle). Holly observed her own transition in thinking about birth, where she seemed to develop greater faith in her body over the course of her pregnancy leading to her birth centre decision.

> I kinda had that moment where I put birth, labour and delivery on the same level as every other function that my body can naturally deal with, my body's built for this. I had to have a lot of faith in my—yeah—in my body's ability to do that before I was able to commit to going to the birth centre. (Holly)

Some women noted what they saw as a cultural and societal myth about the human body and about birth, "that people's bodies are broken. And I just don't think that's correct" (Leah). The women recognized the cultural environment of fear around birth. Gwen recognized a cultural connection between birth and fear and she wanted everyone to "just let birth be okay" (Gwen). Leah countered a fear of birth with her belief in birth.

> We just live in this culture of fear about birth, I think. And again, you know, I do recognize that sometimes situations do happen. But just the way that people perceive it, I think: it's this terrifying, horrible, nasty, painful, excruciating event. And I just – I just never really believed that. And then, it turned out that my experience affirmed that, as well, too. (Leah)

As evidenced in the findings above, a counter-response to fear was to believe in birth. Christina equated her belief in God with her belief in birth as a response to a culture of fear saying,

"but I am a believer of God; I am a Christian. And so, God made me this way to deliver a baby. I should be able to, then, deliver a baby." Leah had a foundational belief that birth was normal and that it was hospitals that made birth into "a scary medical event" and she believed that "in an ideal world, like, there wouldn't even be babies in hospitals." The women in this study had a belief in the body's ability to give birth physiologically. They expressed their beliefs and their values by living holistically and wanting to avoid medical intervention. Essentially, this shared ideology was based on the principles of normal birth as opposed to an obstetrical ideology that recognizes that birth is considered normal only in retrospect, rather than in anticipation of the process. Another way of seeing this contrast between normal birth and the medical model of care was through women's desires for natural health care, "the less you can intervene, it's probably better" (Holly).

Katelyn was self-reflective in expressing her values and beliefs through her own actions. She said, "I wasn't a big fan of sort of, over-reacting to medical situations. That's just how I am; I don't like anything to interfere" (Katelyn). Jersey demonstrated a personal progression in her beliefs and values around health, "like, the older I get and the more, like, I start raising my kids, the more natural I want it to become. And, like, water birth seems natural."

The women's beliefs and values became expressed in their hopes and plans for their births. For some women, there were many years of hoping for an out-of-hospital birth. Avigail, pregnant with her fifth baby, had wanted homebirths for her first four births, but at the time when they were born, she was living in a place where midwifery wasn't funded and finances deterred that possibility. Her decision to have a Birth Centre birth was a fulfillment of many previous unfulfilled desires. Other women chose the Birth Centre because they wanted a natural birth: "I think I knew that because I just wanted – I kinda went in thinking I'd have more of a natural delivery. I didn't wanna go the drugs route" (Christina).

Teagan made an insightful statement about her belief in humanity and the disconnection between pain and life that comes with anaesthetizing physical experiences.

> I just think that we can become disconnected from, you know, our experience as women or as even human beings through, like, the medical field sometimes. There's that tendency to want to, like, you know, use narcotics and not feel pain and those things. And we shy away from maybe experiencing things that are supposed to be experienced, maybe? (Teagan)

Teagan believed that it was important to feel a connection with her experience of labour and birth. Women recognized their own beliefs, values, and hopes within their decision-making experience. Through expressing their personal ideologies, women made decisions that represented who they were or who they wanted to become.

Theme – Really Thinking it Through

This superordinate theme of "really thinking it through" encompasses a number of rational thinking processes. In many ways this theme aligned with the midwifery informed choice model where there is a time for deliberation of the current evidence on the risks and the benefits. The interview guide did not specifically ask about women's "informed choice" process, but it was very clear that the women had an understanding of the concept and applied it to their own experiences. The experience of thinking it through incorporated many aspects of the decision progression: both a rationale and comparative process of considering the options, weighing the risks and benefits, and incorporating personal preferences based on past experiences or acquired knowledge. The decision-making process occurred over time and was not a quick decision for any of the women.

Learning about the options. For some women having midwifery care was their first exposure to the birthplace options. They either did not know there were options available or had not considered where they would give birth: "like, I think that before I didn't even realize 'not hospital' was an option, right?"(Jersey). Chelsea recognized that with her first birth, when she was twenty one years old, she didn't know that there were birthplace options and she wanted to follow a mainstream model.

> For [my first birth], like, we didn't really even think about having a home birth or even have it, like, didn't really think that we had much options. We just, sort of, wanted to just do it how everybody did it. (Chelsea)

Katelyn was also twenty one years old when she found out that she was pregnant with her first baby. She went to the Women's Health Clinic for pregnancy testing where the options were explained and she was able to ask questions.

> I don't know if I asked them or if they had just kinda told me about [the Birth Centre]. I think that we were discussing the options for the birth. So they [explained about] the hospital and they went through the Birth Centre, and they were talking about, you know, everything about it . . . And I just kind of asked questions: "Well, you know, do they do this? Do they do that? You know, do they have any medications there?" (Katelyn)

After Christina had her first appointment with her midwife she said, "I talked about it with my husband and did a bit of my own research and thought more about it. And I guess, at that point, I thought, 'Oh, maybe this is an option'". Both Katelyn and Christina were pregnant for the first time when they chose the Birth Centre. Their experiences included initial exposure to the options followed by inquiry and asking questions, demonstrating that the decision-making experience started as a rational thinking exercise.

Brielle suggested that place of birth decisions should be raised with every woman and then maybe more women would say, "'I didn't I realize I had an option or I didn't know about this before.' Or people would just say, 'tell me more about it'." Lack of initial awareness of the options was a significant aspect that some of the women experienced; awareness was a first step in thinking it through.

Comparing and contrasting the options. As options were presented, women compared and contrasted their choices based on a variety of factors including their own context, their

previous experiences, cultural norms, and what they knew they wanted based on their past experiences or their beliefs about birth. Part of their process of contrasting and comparing their options was ruling out what they did not want. Some of the women did not want a hospital experience. Christina watched a documentary on birth; she remarked that, "like, the chance of you going in and being induced and all that just – I didn't want to be a part of any of that. So then, the birth centre became: That's where I was gonna go." Recognizing what she did not want meant that she was able to decide what she did want.

At the same time for other women "home was not an option" (Chelsea). When Elodie was comparing her options, she said "I wanted to be somewhere where I felt comfortable. And I'm not sure that – I wasn't sure that my home was that place but I knew I didn't need to be in the hospital." Women compared their options and may have felt strongly about what they did or did not want. In contrast, Teagan said that part of her experience choosing the Birth Centre instead of a homebirth was she didn't feel "strong enough to go through with home birth."

Ruth, who previously had both home and hospital births, said, "home birth/hospital birth – I don't know. I didn't see what the big deal was." Ruth had experienced all of the birthplace options. All of her births had been normal with midwives. Ruth's most prominent theme in her decision-making experience was her relationship with her midwife.

Comparing and contrasting the options included identifying preferences, reflecting on past experiences or on advice and counsel from others, weighing the risks and benefits, and in the end, women considering the Birth Centre as the "best of both worlds" (Elodie). Teagan used the compare and contrast process in her personal research; she "wanted to know what the difference in terms of - like, say, if things were to go wrong, what's the difference between [home] and the birth centre?" Seeking and questioning was an important aspect of how women thought through the decision.

Women were serious and intentional in the informed choice decision-making and they felt a great deal of agency throughout the process. As previously discussed, Alex did not feel respected in most aspects of her experience, but she responded to feeling disrespected by defending herself and proving that she made decisions based on a rational exercise of being informed.

> I wasn't just an idiot who just decided not to have [a hospital birth] you know? Like, I did have informed choice and I did, I was very informed. I'm, like, I'm really anal; I take a lot of care to research everything that I do, especially when it's something so important. (Alex)

The decision-making experience meant that women felt smart and confident in making their choice.

The women used different sources of information for their research process. Some women relied on the Place of Birth Handbook, a document that was developed by the regional health authority to explain the risks and benefits of the different birthplace options. Chelsea responded to a question about the Place of Birth Handbook:

> It was good to read it, for sure, and know, like, logistics of, like, how things would go or what's available. So it was good to read through it. So I did sit with it and think about it myself. I'm pretty sure all the statistics that they tell you at that time are also in the booklet that you receive. (Chelsea)

Some of the women didn't remember receiving the Place of Birth Handbook or only vaguely recalled the document. Many of the women remembered having to sign a form to agree to a Birth Centre birth and they equated this as "just, sort of, them crossing their t's and dotting their i's – so this is whatever – I must sign. So that's how I kinda took it" (Teagan).

Women became informed about choices and research on choices through childbirth education classes, books, and movies. Women used the internet as a source of information. Teagan reported researching out-of-hospital births:

> I was doing research on the internet, too. And I came across a study that was – I don't even know which one it was. But it was this one that said if you took into account all the people planning to have out-of-hospital births, that the outcomes were similar or better for having out-of-hospital births as hospital. So that really convinced me that I was comfortable. (Teagan)

Christina emphasized that the internet was a starting point for information gathering and learning what kinds of questions to ask.

> It was totally a Google search, which I'm pretty good at. I do it; I Google search everything. But I also take everything with a grain of salt. I don't - I don't take this is the 'for sure' thing. I do not do that. I guess my research really just made me formulate my own questions. Then I came back to my midwife with these questions. (Christina)

Christina went on to report that she didn't rely fully on the information she found; she critically analysed the information, identified her questions, and sought more answers. Juliette said that she relied on the evidence in her decision-making experience, "I really rely on, sort of, the evidence … when it comes to risk, I think that you have to weigh, sort of, the actuality of evidence that's behind it" (Juliette). This was Juliette's fifth baby; her first child was born in hospital followed by three births at home. She took the birth decision seriously and reconsidered choices based on her context. The decision for out-of-hospital birth evidence was considered carefully by all of the women. From this process of becoming informed and questioning the information, the women decided that the Birth Centre was a safe place to have a baby and that they were comfortable with the evidence. Leah concluded that having her baby in an out-of –hospital setting was "the sensible thing to do. I mean, if – if it's – you know, I wanted to be where it was going to be safest. And at the time, I think . . . it's all equally safe" (Leah). Brielle stated that, for her, the decision was based on being "informed and educated." The women interpreted the research based on their understanding

of what each of them considered to be safe. When asked what made her feel safe, Jersey simply responded, "knowledge."

Considering the risks. The experience of considering the risks was astonishingly similar for all of the women. There was repetitive language of the "what if's"—"if this happens, then what?" The consistency of the language that women used to describe their experiences of thinking through the possibilities of complications is significant. Table 3 is a series of "what if" questions that the women recalled discussing with their midwives during their decision-making experiences.

It is noteworthy to identify that in Lara's account of her difficult second stage experience of the decision to transport due to the presence of meconium, she did not recall talking prenatally about the possibility of meconium in labour and the associated protocols for transporting to hospital. Lara's contrasting experience emphasizes the importance of "what if" conversations in birthplace decision-making and planning.

Table 3: The "what if" questions

I would say, "So, like, what happens if – whatever happens?" (Gwen)
If we had the water birth, this is what's gonna happen. And if I had a hemorrhage, this is how we're gonna deal with it. (Jersey)
So I'm – I really like having a lot of information. I like knowing "What if?" The what-if's and, sort of, that flow chart of: if it goes in one direction, what's gonna happen? And if it goes in the other direction, what will happen?"… And I knew the steps of, like, you know: What's gonna happen if A, B and C happen? What's next. (Juliette)
So what happens if *this* were to happen? So then, she really went into more detail as to the equipment that they carry, the emergency protocols, what they do if something were to happen, how close a hospital is – that sort of thing. (Christina)
What do we do if this happens? And what are all my options to have, if anything goes wrong? That was pretty much my main focus. And so, we went through that the last month I was pregnant. That was pretty much all we talked about when I went to my appointments, just to make sure everything's covered so that, when I'm at home and if something goes wrong, then I know who to call and I know where to go. (Katelyn)

Having "a good working knowledge and a really good base knowledge of what to expect" (Juliette) made women feel safe with their decisions. Jersey felt confident that she understood that "there was a plan for every possible" outcome. These "what if" discussions were an essential part of how women chose to plan their births at the Birth Centre. Knowing the risks and the possibilities meant that women knew what to expect if anything happened. The possibility of needing to go to the hospital was an essential consideration specifically mentioned by all of the women interviewed. The Birthplace study in the U.K. reported 23% transfer rate from birth centres to hospitals (Rowe, et al., 2012). In the Birth Centre's first two years of operation, one in four of all women admitted subsequently went to a hospital by car or ambulance sometime during labour or the immediate postpartum (WHC, 2014). When the Birth Centre was being planned, a key location criterion was proximity to emergency transport services and to hospitals. Emergency transport protocols have been established, simulation of possible cases has been rehearsed with midwives and paramedics, and relationships between the Birth Centre staff and paramedics have been built.

Ambulance availability and emergency transportation meant different things to different women. For Gwen, the ambulance availability represented an extension of her personal agency in the experience, she said "I know that, if it got really bad and I had to pull the pin, that I could say, 'That's it. We're getting in an ambulance. We're going to the hospital and I'm gonna get an epidural'." The ambulance represented a safety net, "Gosh, you know, what if something happens? You know? But I realized that I could get to the hospital pretty quickly, you know? So it was okay. It was good to know" (Karin).

The presence of an ambulance close made some women more confident in the birth process and the possibility of complications less fearful. When asked about what made her feel safe, Chelsea responded, "Having access to an ambulance or transportation if you needed that." The possibility of an ambulance may have decreased some women's concerns, but it also signified that something might be wrong. Even though it was important that the ambulance was close by to feel

safe, a transport also represented a deviation from normal, "the biggest concern with, if something went wrong, was the, the transport, right?" (Lara). When Ruth expressed a fear of meconium-stained fluid and the possible adverse outcomes associated, she was reassured by her midwives that "if there's any meconium, they call right away. They call the ambulance right away." Teagan also stated that she was confident that if there was any need to go to the hospital, "nobody would hesitate" to call for an ambulance. The availability of ambulance services represented a vital safety plan to the women.

By really thinking it through, women were able to reflect, go back, reconsider, ask more questions, and ponder the possibilities. "I think, as we talked about some of the risks, there were moments, I think – there were some moments where we went, Oh, okay. Are we still comfortable having it here?" (Lara). Chelsea also reflected on her decision, "So I did sit with it and think about it." Really thinking it through meant that women took the decision very seriously and they came to their conclusion and choice knowing the facts and accepting the risks based on what they knew was the best decision for their own life experience.

Theme – Fitting into Eligibility Criteria

Fitting into the eligibility criteria was an essential factor in the women's birthplace decision-making experience. It is an area that women have minimal control over. The Birth Centre exists for normal birth; healthy women expecting a low-risk labour and delivery. Women who are admitted to the Birth Centre have healthy pregnancies and normal previous births. With careful review of women's histories, midwives provide thorough prenatal care and exercise the principles of woman-centred care with the goal of ensuring that the Birth Centre meets its intended purpose: normal birth. Women in this study who had previous normal births were more confident in their own likelihood of normal birth the next time, "It's the benefits versus the risk for me, I guess. I felt that the benefits would be better for me and my risk was so low" (Holly). Women self-identify as fitting into the eligibility criteria and as being low-risk, "it was my third one and my labours are pretty

straightforward, right?" (Karin). In a conversation about safety, Chelsea talked about feeling safe with normal birth. "I was probably, like, I was more confident that everything was gonna be fine, that it was gonna be normal, 'cause most births are normal." Chelsea felt safe at the Birth Centre because she was healthy, had a previous normal birth and was confident that most births are normal in that scenario. She felt safe knowing that she fit within the eligibility criteria.

Holly had a normal first birth in the hospital but felt that it was not treated as a normal birth. In response to her first experience, Holly chose the Birth Centre for her second birth. Past experiences influenced some women to want a different environment to reduce the possibility of repeating that previous experience. For women who chose the Birth Centre after difficult experiences, one of their goals was often to try a more natural approach. Gwen stated that "the decision-making process really was based on my first daughter's delivery and things that we think could have been better or different and wanting something different." Even though Gwen's first birth was normal, it felt medicalized and institutional to her and she wanted something different.

The women recognized the possibility that their labour might not fit into the eligibility criteria. Katelyn thought back to how she prepared herself for this prospect.

> No, like, I'm pretty open-mided and flexible with certain things. Like, as much as independent and hard-headed as I am, there's still some room for, you know, changes and such. Like, I understand, like, life happens. And I understand – I totally understand that. So I kind of have to keep that mindset with everything, you know? (Katelyn)

Christina stated that she was healthy and believed that she would have a normal birth but yet acknowledged the possibility of complications: "I should be able to, then, deliver a baby. I know there are complications. And there are things that can happen." Gwen thought about the duality of a woman's choice when it came to the reality of the birthing experience, "because you've got control but you don't have total control."

Not fitting into the eligibility criteria. Despite women's goals and decisions to have a

normal birth at the Birth Centre, health conditions may have arisen in their course of care that influenced their birthplace plan. One of the women developed mild hypertension prenatally, an indication for a hospital birth, thus changing her plans because out-of-hospital birth would not be an option if her blood pressure didn't resolve.

> So just a few days before that, you know, they were starting to kind of talk about induction because of the blood pressure. And I said, "You know, we definitely can't have it here. Like, obviously, health and safety is the most important thing. (Leah)

Another woman with a higher BMI wanted a waterbirth. When the issue was raised by her midwives in her prenatal care, it affected her experience by making her feel like she would have an unrealized goal that was out of her realm of control. She couldn't do anything in her own power to make the dream become a reality.

> Oh, I was upset. Yeah. Yeah, I was pretty devastated. I mean, like, it was – I know where they're coming from and I know that the birth centre has a lot of, like, pressure to – they really can't have complications or anything go bad. I mean, I've read the news and stuff. But it was – like, if my weight were gonna inhibit me from having the birth that I wanted, that was kind of – and there was nothing I could do with – do about it. It wasn't like, "Well, let's stop this. I'll go back, lose weight and start again". (Jersey)

In the end, Jersey did go on to have a Birth Centre birth that was a positive experience for her. Health and physical circumstances are often beyond anyone's control and can limit choices. Objective clinical indicators set parameters on decision-making which leads to the practitioner having the ultimate word or authority on the decisions when it comes to eligibility for going to the Birth Centre in labour.

Ruth, who was grandmultiparous (had more than five births) and had two babies at the birth centre, acknowledged her history of normal births which gave her both confidence and doubt, confidence that she was likely to have another normal birth, but at the same time some doubt,

wondering if her "number was up." Ruth questioned her own fit into the normal critieria for out of hospital birth.

When Lara's water broke with meconium stained fluid after an hour and a half of second stage labour, she was faced with a circumstance where she did not know her options or the protocols and timing for a decision to transport. She did not recall a prenatal discussion of the possibility of meconium and what that would mean in terms of protocols. This combination of being close to giving birth, having an indication for transport to hospital (meconium stained fluid), and not expecting this as an indication for transport, with the need for an urgent decision, was very distressing. Lara felt her control and agency in the decision-making process swept away from her due to the external influence of her physical circumstance (meconium) and the protocol for transport overtook the process of informed choice. Lara summarized her experience, "When they saw the meconium, I felt they moved into process over person. I felt like they were, like, "We have a process, protocol. This is what we follow when we see meconium." (Lara)

Alex's labour excluded her from having a Birth Centre birth; her decision-making power was lost to the physiology of labour and the protocols that aim to keep birth safe.

> I don't remember, like, the decision actually being made . . . I was just, like, "Oh, okay. So this is how it's all gonna go." And I was really disappointed. That it was just, like – it was a chain of events that was just continuing to, like – you know, the waterfall in my life. (Alex)

For the women who had intrapartum indications to avert their Birth Centre plans (Lara- meconium in labour; Alex- prelabour rupture of membranes without onset of active labour; Brielle –prelabour rupture of membranes with meconium), the experience meant a loss of control. Interestingly, Brielle, who had a caesarean section, felt the best about her experience of these three women. Brielle recalled feeling like her midwives advocated on her behalf, whereas both Lara and Alex felt that it was themselves against the protocols and the health care providers, and they felt

disrespected for their decisions. Alex said that it seemed that everyone caring for her thought she "was making silly decisions because – just for the sake of whatever" (Alex). Lara experienced a similar situation: "the message I got is: 'You're risking your child's life if you choose to continue to birth here.' Which I don't think was necessarily what - and I – yeah. So it wasn't an altogether positive experience" (Lara).

These experiences represent the importance of communication, advocacy, and support even in times when the protocols and eligibility criteria guide care plans. This actual transition for women was accompanied by loss of expectation, interpersonal communication challenges, and a struggle to maintain a woman-centered approach. In order for the Birth Centre to fulfill its purpose, the physiology of labour has to stay normal. Once the health situation reached the point of deviation from normal, whether that was early or late in the pregnancy or labour, the choice of place of birth was no longer the woman's choice to make. Women who had normal pregnancies, normal previous births, and normal labours fit into the eligibility criteria and have a choice for birthplace decision-making.

Theme – The Psychology of the Space

The presence as well as the physical design of the Birth Centre had an impact on the women in this study and on their thinking about birth and the options available to them. For the women who planned Birth Centre births, the space and interacting with the space formed an integral part of their decision-making.

> I just can't overestimate or overemphasize how valuable it is to – that - having a centre and having just a physical place. There's something about there being a physical place that makes it a more tangible and real option 'cause so much of our psychology is around structure and space. (Lara)

In this superordinate theme of interacting with the physical space, women described how their experiences were influenced directly by the physical space and design of the Birth Centre. Design

has an impact on emotional and mental experiences. The phrase "our psychology is around structure and space" captured the impact of the Birth Centre. The physical structure of the Birth Centre, its carefully chosen spaces inviting openness, significantly affected the women's birth experiences and their choices. Christina recalled her experience touring the Birth Centre, "I was, like, 'I could have my baby here? Are you serious? And have this room all by myself?' I mean, that was a huge contributing factor to my overall labour and delivery." Women recognized the in-person and online tours as important aspects of the decision. Christina suggested that tours be mandatory because the tour had a significant impact on her: "it should be mandatory to go take a look at it and – because that was totally a deciding factor for me" (Christina).

The women's initial impression when entering the space affected them in such a powerful way that they reported making immediate decisions.

> The first time we were in the place—I knew. (Chelsea)
>
> As soon as I saw the facility, I fell in love with it. I knew that that's what I wanted to do- I just knew. (Holly)
>
> I had a tour at the birth centre and I found it to be very comfortable so then I decided to give birth there. (Lissa)
>
> And I knew – I knew that that's where I wanted to be from the minute that I walked in for the first time. (Elodie)
>
> As soon as I walked in here – because I had said I wanted – "This is where I want it to be. I feel comfortable here. I feel happy here." You know? (Brielle)
>
> And so, then I went on a tour and it was beauu-ti-ful. So that was, like, "Oh, my gosh! Deliver in here? Yes." (Christina)

Evoking such immediate responses in women was an essential aspect of the decision-making experience and encapsulated the influence of the physical space.

Space created a sense of safety through familiarity, comfort, privacy, and welcoming the woman's chosen support people. The Birth Centre alleviated logistical issues that women

perceived with the alternatives. It is a space that was created for celebrating birth and welcoming life. The women recognized that the focused purpose of the place had an impact on how they felt about the birthing process.

Waterbirth. Waterbirth was an aspect of the Birth Centre that was a significant factor for women. For many women, having a waterbirth fulfilled a dream they had had for a peaceful, hands-off birth. Lissa and Jersey spoke the same sentence, "I always wanted to have a waterbirth." Karin had a waterbirth and she caught her own baby, something she had hoped for. Labouring in water gave women a sense of personal agency and autonomy. It supported a woman's ability to cope with labour and its intense physical demands. Holly advocated for waterbirth saying, "whenever I have sore muscles or something, I take a hot bath, so it makes sense." When asked what made her feel safe, Juliette replied, "the tub." The birthing tubs held a lot of meaning for the women since they represented safety, fulfilled dreams, and personal autonomy and gave the women the opportunity to have their beliefs, values, and hopes validated.

So clean, no mess. When asked about the birth centre decision, many of the women compared their choice to the other options available. Some of the women who had considered homebirth but ultimately chose the birth centre, identified that the need to clean their home, both before the birth and after the birth, made the Birth Centre a more appealing choice.

> Honestly, it's because I didn't wanna have to deal with the potential mess in my house. That's really all of it. That was the only reason. It's messy. And so, if I can take that somewhere else where someone else has to deal with the messy part [chuckling], that' great . . . yeah, in the end, the fact that I didn't want to clean up after kinda trumped all of that. (Holly)

The Birth Centre also represented a clean environment in terms of infection control.

> And it looks sanitary. You know, it's not – like, that's one of my – that was one of my concerns… There's boxes of gloves. And there's signs about washing your hands

> [chuckling]. So that makes it feel like one of those places where you're medically – like, I'm not gonna get all germed-out there, right? (Elodie)

Elodie went on to say that cleanliness meant safety for her.

Other logistics that the women considered were having a quiet space free from home-life distractions of dogs, neighbours, and the demands of parenting other children. There was a recognition that the women wanted to be free of external responsibilities in their birthing experience. This was reinforced by some women who likened the Birth Centre to a hotel, a space that gave respite from everyday life. Avigail, mother of five, said, "I looked at pictures on the website and it felt right. It felt like a hotel. And I thought that looks like a place I would feel comfortable."

Set-up for normal birth. Women considered the space and the relationship that space has to normal birth. Chelsea felt reassured by the medical supplies set up and ready to go.

> And, like, they have medical supplies there – like, some for the baby, in case he wasn't breathing or –I guess seeing that – I don't know if seeing that made me less fearful. I was more confident that everything was gonna be fine, that it was gonna be normal, 'cause most births are normal. (Chelsea)

The space created protection for normal birth by having all of the amenities that support physiological labour such as the tubs, the showers, the space, the "special room", access to outdoors, natural lighting, and physio balls. At the same time, the supplies for basic birth emergencies were also present (instruments, neonatal resuscitation equipment, dopplers).

Familiarity. Both Brielle and Ruth recalled their prenatal experience of choosing the Birth Centre. Brielle said that she doesn't feel safe when she is somewhere unfamiliar.

> Feeling comfortable where you are – that you feel safe, knowing I'm somewhere that I either am unfamiliar with or I don't know very many people, then I don't feel as safe. So as long as I kinda feel comfortable with my surroundings (Brielle)

Elodie remembered her sense of familiarity walking into the Birth Centre in labour. Her immediate reaction was to undress in the hallway, knowing she was in a space where she felt totally at home, "When I walked in, I started – I literally just started stripping, as soon as I walked through the front door" (Elodie). Being able to undress in a public space, albeit in labour, does represent a deep level of comfort, a lack of inhibition, and a feeling of safety. Gwen recalled that at her first birth at the hospital, she felt "safe" but she "didn't feel comfortable". She compared this to her Birth Centre experience where she felt very comfortable and safe.

Holly recalled her first birth at the hospital "it was all very clinical and bright lights and tons of people. So I decided, next time if it was possible, that I wanted to try the Birth Centre." Bright lights and tons of people do not facilitate a sense of protective space. There were many design features of the Birth Centre that worked specifically to create a sense of protective space, with warm colours, private rooms, and warm lighting. Lara self-acknowledged a connection between noise and anxiety. The Birth Centre created an environment of safety through quietness and decreasing anxiety triggers.

Familiarity that came through tours, on-going prenatal care, or knowing the people contributed to the decision-making experience for every woman in the study, "I'd been going there. I felt comfortable there. I felt really relaxed and comfortable at the Birth Centre" (Juliette).

Support people invited. The Birth Centre invited and welcomed women to bring their own support people to their births. Chelsea talked about having enough space and invitation for her family: "Having my family there, having my mom there and having my partner there, and having [my partner's] mom there if I needed her support, as well. 'Cause oftentimes in birth, you don't know who you're gonna need"(Chelsea).

The Birth Centre space represented a place of comfort, familiarity, safety, privacy and respect. Women interacted both physically and emotionally with the space and design of the facility. "And you're, sort of, like, in a bubble there" (Teagan). Women felt a sense of personal

territory within this public facility. There was protection around the normal birth experience in the Birth Centre as a physical structure. The theme of interacting with the physical space was unique to the Birth Centre experience and was an important influence the birth centre decision.

Summary of the findings

The purpose of this study was to explore and learn from women's experiences of decision-making; how they made their choices and the meaning of the process. The methodology started with an individual perspective and moved the individual experiences into a collective interpretation. In particular, this study aimed to understand how women made an uncommon choice and the meaning of this decision-making experience. In the decision-making experience of choosing the Birth Centre, women felt that they had agency. They felt confident and they made their own choices. A few women recalled not feeling in control or respected at specific times. Women's relationships with their midwives was highly valued and esteemed as part of the decision-making experience. Women made decisions in the context of their relationships with their midwives, partners, friends, and mothers. The women's male partners had varying roles in the birthplace decision; they were collaborative, supportive, or they influenced women away from homebirth and towards the Birth Centre. The role of the women's mothers was also identified as part of the decision-making experience.

Women interpreted the research and considered their options through the lens of their ideology. The informed choice process of considering risks and benefits (thinking it through) was framed by the experience of personal agency, the value of holistic health, and a preference to avoid medical intervention. Women carefully considered the possibility of complications or needing to go to the hospital. They asked questions, did personal research, talked at length with their midwives, and felt prepared for the possibilities.

For all of the women in this study, there was a normal birth influence that came primarily through relationships that may have been confirmed by a woman's beliefs and her past experiences.

The normal birth influence may have been present in the women's lives prior to the pregnancy or it may have emerged during the pregnancy. The women who chose the Birth Centre had relationships with friends, family, midwives, or childbirth educators who viewed birth with a normal and health-oriented lens rather than as a problem waiting to happen. The outlook that birth is usually normal resonated with the women who chose the Birth Centre as they simultaneously recognized the potential for complications to arise and maintained a belief that women's bodies give birth naturally most of the time. The normal birth perspective was also evident in the themes of expressing one's ideology, really thinking it through, fitting into the eligibility criteria, and through the physical space of the facility. When women had previous normal births, they viewed birth from that perspective. The women wanted a normal birth by avoiding intervention or wanting to do things naturally. They believed that their bodies were capable of normal birth. The facility was acknowledged as facilitating normal birth through physical design features. The physical space had an impact on the choice. Women recognized that the building design, the cleanliness, the tubs, the readiness for emergency or urgent concerns, the privacy and quietness of the space was an appealing factor that supported their decision. Women interacted with the space both emotionally and rationally; there was a psychology that came from the physical space. The themes were interconnected as many of the findings in one theme were influenced by findings in other themes. The women's relationships with their midwives influenced their experience of agency. The beliefs, values, and hopes and the "thinking it through" process were symbiotic in many ways. The decision to plan a birth at the Birth Centre was a fulfillment of hopes and an expression of autonomy and choice that came through supportive relationships.

CHAPTER FIVE

Discussion

Pregnant women today have options regarding where they will give birth. Place of birth decision-making was the overall theme of this study with the purpose to explore the experience for women who chose to plan their births at the Birth Centre, Winnipeg, Manitoba. The purpose of the study was to understand how the choice of the Birth Centre as their preferred place of birth was made, and to ascribe meaning to the decision-making process.

Through semi-structured interviews women shared their experiences, discussed the role of significant others, identified their own beliefs and values, and described their process of making an informed choice. The women's responses were further analysed, resulting in the findings presented in Chapter Four. The findings confirm previous knowledge about women's experiences choosing out-of-hospital births, suggest new insights from the women's lived experiences, and give direction for future research, policy, and midwifery practice. As stated at the outset of the findings chapter, the first aim of the Interpretive Phenomenological Analysis (IPA) methodology in this study was to unfold the experience of the birthplace decision-making and try to understand what it meant to the individual. The second aim for IPA is to interpret and analyse the participants' experiences, situating them in the social, cultural, and theoretical context (Larkin et al., 2006, p. 104). This discussion chapter will fulfill the latter aim by discussing themes that were addressed explicitly and implicitly in the findings.

Safety and comfort

The concept and experiences of safety and comfort were identified within every superordinate theme, yet because safety and comfort were not identified as a theme unto themselves, a discussion of these notions is warranted. Safety and comfort both relate to a woman's expectations and the degrees of uncertainty that she experiences. Safety and comfort are

encountered holistically in many situations but are individually defined and connected to a person's ideological perspective, beliefs, and values.

The women were asked a direct question about safety in the interview: "What about the Birth Centre makes you feel safe?" There was a marked diversity in the responses. Some women talked about feeling safe because they had a choice, while others talked about feeling safe in the trusting and supportive relationships both with the midwife and with their partner or support people. Some also stated that the availability of transportation to the hospital made them feel safe. A dedicated space for normal birth that is prepared for emergencies was a key aspect of safety considerations. The fact that safety was experienced in so many ways suggests that a heuristic algorithm of safety based solely on the evidence of clinical outcomes cannot be applied to all women's decision-making experiences.

The literature review that introduced this study acknowledged that the evidence and research on birth outcomes at birth centres and out-of-hospital births supports the understanding that birth centres are "safe" in terms of standard clinical indicators (Birthplace, 2011; Dixon, 2013; Hutton et al., 2009; Jannsen et al., 2002; Vedam et al., 2012). However, the results of this study show that safety has a deeper meaning for women than simply quantitative maternal-child outcomes. This is supported by the concept of biopsychosocial safety, a term that emerged in the 1970s as a response to the traditional biomedical model approach to health (Buultjens, Murphy, Robinson, & Milgrom, 2013). The biopsychosocial model is person-centred, utilizes shared decision-making, and has available both medical and natural health modalities. The term was highlighted by Davis-Floyd in her salient discussion of technocratic, humanistic, and holistic approaches to childbirth (2001). Newburn (2010) furthered applied the biopsychosocial concept to describe women's experiences of biopsychosocial safety in birth centres in the U.K.

An integrative review of twenty-one research papers on women's perceptions of their right to birthplace choice (Hadjigeorgiou et al., 2012) found that women's perception of safety is a

common theme in birthplace decision-making experiences. A key phrase characterizing this theme is "perceptions of safety" where feeling safe is based on women's personal lived experiences of safety. This integrative review further categorizes women's perceptions of safety in terms of transport accessibility, normal birth model of care, midwives having expertise, a belief that homebirth is safest, and women's autonomy as integral in perceptions of safety. Lothian (2012) contends that the goal for midwifery-attended births is to enhance safety through woman-centred care that is evidence based. Dixon goes on to say that "women worldwide cite the loss of personal autonomy and increasing use of interventions in hospital birth as unsafe for both them and their babies and see this as an unacceptable risk" (2013). The findings in this study confirm that women experience safety in a multitude of ways, yet central to both the current literature and this study is that autonomy, respect, and choice are essential to the meaning of safety.

One example from the study which stands out in this regard is that of Lissa who, in recalling her Birth Centre decision, simply said, "It was my choice. I guess I just took a chance." When asked what made her feel safe, Lissa said that she did not know but that she felt good, proud, and happy about her decision. Lissa had only an eighth-grade education and does not fit within the common demographic categories of women who make out-of-hospital birth choices in North America (Murray- Davis, 2012). Yet her short answer was profound because it reflects the autonomy, respect (her midwife let her make her own decision), and choice that are essential elements in women's perspective on birthplace safety which also aligns with Edward's theories on birthing autonomy (2005).

Safety is a significant social, cultural, and political issue in childbirth where the political and cultural discourse often forms the basis of the debates and the lens by which the research is interpreted (Coxon et al., 2013; Sandall, Morton, & Mick, 2010). Women who make out-of-hospital decisions are influenced by social, emotional, and relational factors while simultaneously motivated by the desire for a safe birth and a healthy baby. The results from this study confirm that social,

emotional, and relational factors played a primary role in thinking through the safety aspect of the decision-making process. The holistic environment of the Birth Centre increased the expectations and the certainty of having fewer interventions which led the women to feel they would experience a safe birth.

Comfort gives women a sense of ease and reduces tension. Physically, comfort is related to privacy, familiarity, and ease of movement through a space. Emotionally, comfort is related to trusting relationships and feeling respected. Mentally, comfort means that anxiety and worries are eased. Comfort within midwifery care usually refers to comfort measures used in labour such as a massage or a shower (Schuiling, 2013). Interestingly, women spoke about feeling comfortable with their choice. The word comfort was discussed frequently by the women in terms of their own self-identity and agency in their decision-making experience. Although the women anticipated that the Birth Centre would be a comfortable place for labour, it was primarily the sense of psychological comfort that came with trusting the midwives, having enough information, and knowing that normal birth was the cultural expectation of the Birth Centre that gave them their greatest comfort. Katherine Kolcaba, a nursing research theorist developed a holistic definition of comfort as "the immediate state of being strengthened by having the needs for relief, ease, and transcendence addressed in the four contexts of holistic human experience: physical, psychospiritual, sociocultural, and environmental" (2010). The holistic context of comfort as defined by Kolcaba (2010; 2003; 1992) was fundamental and explicitly represented in all the themes of the women's experiences during their decision-making process.

Fahy and Parrot (2006) suggest that "the more comfortable and familiar the environment is for the woman, the safer, and more confident she will feel" (p. 46). In such an environment, the woman will have optimal physiological function and emotional well-being. The concept of safety is interpreted through personal meanings of risk within a woman's ideology of childbirth beliefs and values that relate to her own sense of feeling comfortable.

Findings and Implications for Future Research and Practice

Birth centres are relatively new and unstudied in Canada. The fact that many of the themes in birth centre decision-making align with homebirth decision-making experiences is a significant relevant finding on its own. The following section will progress through each of the main themes that were identified in the study discussing them in the context of what is and what is not yet known, and suggest implications for practice and future research.

In the study of the first 500 women who experienced planned homebirth in British Columbia, the authors found that women who had homebirths felt that "the confidence arising from their intense preparation and partnership with their midwives permitted them to choreograph their birth experience to a degree that would not be possible in a formal setting" (2009, p. 297). At the time of Janssen and colleague's study, homebirth had only recently been introduced in the health care system and the only formal setting for comparison available was hospitals. There has been some concern that birth centres may limit women's agency because they are institutional facilities, like hospital settings. However, the findings confirm that choosing the Birth Centre, a formal institutional setting that is midwife-led, does facilitate confidence, agency, and autonomy.

From the feminist perspective, an agent's autonomy is the opposite experience of oppression (Sherwin, 1998; Stoljar, 2014). Thackuck (2007) addresses the concept of relational autonomy in midwifery care and proposes that "shifting the notion of autonomy and respect for the individual away from an atomistic perspective, and recognizing the broader narrative of women's lives all serve to facilitate self-directed choice" (p. 53). For Thackuk relational autonomy refers to the woman feeling comfortable and safe in the relationship with the midwife, to a degree that she can exercise self-determination. The findings confirm that women's relationships with their midwives were central to their experience. There were four elements that described the theme of relating with midwives: a) they feel known by the midwife; b) they trust the midwife; c) the midwife is skilled and knowledgeable; and d) the midwife protects normal birth. The women in the

study trusted and recognized their midwives' knowledge, skills, and judgment, confirming other studies about women's trust in their midwives' competency (Sjoblom, Idvall, Lindgren, & the Nordic Homebirth Research, 2014). It is essential that health services and midwives continue to recognize the importance of the midwife-woman relationship. Midwifery education programs must continue to hold students to high standards grounded on a foundation of woman-centred care, relational care, and normal birth.

In some intimate partner relationships, the woman was the primary decision-maker. When it came to her body and birth the partner fully deferred to the woman's autonomy in making the birthplace choice. In other relationships, the experience was coming to consensus in a mutual, shared decision between partners that demonstrated a principal of relational respect that came out of a commitment to share life together. At other times, the decision was experienced as a compromise to the partner's desires and comfort level. This latter finding is consistent with previous research into the views and perspective of fathers on birth place where fathers ensure that their opinions have more precedence over the woman's preference (Bedwell, Houghton, Richens, & Lavendar, 2011). From a feminist perspective, these themes correspond to Dorothy Smith's (1987) sociology of "the everyday as problematic" in that there are ruling relations that impact a woman's autonomy and realm of influence. These relations may come from a desire to reduce or avoid conflict. There may also be a desire to support one another and make sure there is a level of comfort for both the woman and her partner. However, in the case of some of the women, the comfort level of the partner trumped the comfort level of the woman in the decision-making process. The role of partners in birthplace decision-making has not been well-studied. Women were asked directly what role "others" played in their decision, whoever that "other" might be, and almost all of the women acknowledged the role of their partner. The data from this study could be investigated further to identify what the role of partners meant for women in their decision-making experience. The literature review on birthplace decision-making research did not identify the

specific role of life partners or fathers (Boucher et al., 2008; Lothian, 2013; Murray-Davis et al., 2012). Particularly, from a feminist perspective, it is imperative to investigate the role of partners in women's decision-making experiences.

Women acknowledged the role of their mothers in the decision-making experience. Mercer, (2004) in her proposal for a theory of "becoming a mother", acknowledges that the relationship a woman has with her mother impacts her own experience of becoming a mother and bonding with her baby. In 1975, Levy and McGee found that a woman's mother's birth experience impacted a woman's anticipation for her own birth. It is postulated that a woman's belief that birth is safe or risky "originates in their 'natal' family" and determines women's freedom to choose place of birth, questioning if women are even able to make decisions that conflict with their immediate cultural reference point (Coxon et al., 2013, p. 64). The experiences of the women in this study both support and deviate from this suggestion in that some women's mothers supported their decision to birth at the Birth Centre and other mothers did not, but still the women went through with their choice. The role of a woman's mother in place of birth decisions has not been studied and there is minimal research into the role of women's mothers in any other aspect of the prenatal and childbearing experiences.

The normal birth influence occurs when the socio-cultural-physical factors that surround a woman have normalized birth. The normal birth influence is experienced when family and friends do not fear birth, but rather promote normal birth as the mainstream perspective. Although normal birth and out-of-hospital births may not be mainstream in the broader socio-cultural environment, within each of these women's spheres of influence, birth was normalized. Although Coxon and colleagues (2013) found that birth is considered risky and unsafe in the dominant discourse of western societies, this study found that there is another narrative that has impact in our society—a normal birth influence. The normal birth influence is a new and significant finding that has implications for practice and research. The perception that birth is a normal, healthy life

experience may not be expressed by the dominant discourse, but it does have a strong influence when it is present in a woman's life and social support circles.

Gillespie and Strauss (2007) contend that few women ask questions and make an effort to learn about birth beforehand. This was not the case for women who chose the Birth Centre. Zadoroznyj's study (1999) found that middle-class primiparous women actively sought information and were involved in making birthing decisions more often than lower-class primiparous women. In this study, both middle-class and lower income primiparous women actively sought information . Most of the women in this study had "information literacy" that includes skills of

> general awareness of where to find information, information retrieval, understanding the context of the information being provided, and interpretation and communication of that information in the context of health-care decision-making. (Henwood, Wyatt, Hart, & Smith, 2003, p. 599)

Internet information sources have a strong influence on women's decision-making and midwives must partner with women in the search for information (Lagan, Sinclair, & Kernohan, 2011). As discussed earlier, the models of decision-making – both informed and shared models – imply knowledge transfer from care provider to woman. Seeking information was in the context of both individual research and an exchange of information, as well as active questioning in discussions with the midwife. The aspect that is significant in the theme of "really thinking it through" was the "what if… then what?" dialogue. The women wanted to know the potential concerns and complications that might arise and the actions that would be taken for each of them; they needed to know that emergency transportation was available since one in four women who are admitted to the Birth Centre will end up moving to the hospital (WHC, 2014). This high number makes it imperative that further research be done into the experiences of needing to go to the hospital for all variations of indications (meconium-stained fluid, prolonged labour, request for pain medication, neonatal distress, postpartum hemorrhage, or repair of significant laceration). Conversing about

the possibility of complications helps to create an environment of certainty where expectations are clearly discussed in advance, and processes are reviewed. It is essential that the Birth Centre continue to enhance communication and clarify women's expectations for birth and the processes and protocols that are implemented to keep birth safe in all of its expressions. This leads to an implication for practice: a discussion tool to support the deliberation process that clearly identifies the common indications for needing to go to the hospital in labour from the Birth Centre and the corresponding care plans to support women through those experiences.

The theme of "fitting into the eligibility criteria" is a new finding within birthplace decision-making research. In this study, women personally identified what made them fit or not fit into the eligibility criteria. They recognized that the Birth Centre was a place for normal birth and that a healthy body, uncomplicated pregnancy, and normal labour were requisite for normal births. Likewise, the experience of not fitting into the eligibility criteria has significant implications for midwifery practice. Fahy (2002) found that power relations in midwifery are normally unseen and not demonstrated until women resist advice or medical protocols, at which time controlling power dynamics surface. Minkoff and Effer (2013), in a recent edition of *Clinical Ethics,* highlight the ethical dilemma that presents when women make decisions that are clearly not in line with standardized protocols for their health situation. A usual threat if a woman does not comply with accepted interventions is that she is putting her infant at risk, thus pitting herself against her baby. Fahy postulates that women are most vulnerable to this power dynamic when they are in labour or have a health concern. Fahy's theory proved true for both Lara and Alex: the impact of the power dynamic was upsetting, experienced as disrespectful, and created a sense of feeling no control.

A number of areas for future research arise from these women's experiences. Looking deeper into women's experiences of transferring to hospital or when they have indications for transporting could provide insight on how to best provide care for women who encounter such situations. How to maintain a woman's dignity in terms of respect and autonomy, for example, how

to ensure that these women do not feel disempowered even if their decision to give birth at the Birth Centre cannot be upheld—these are areas that require further study. Another element of the "birth sanctum" is the feeling of safety in contrast to experiencing fear or relational stress. By feeling safe and reducing stress and fear, labour progresses in a more natural and physiological way with a greater likelihood of a normal birth. The physiology of hormones and neurotransmitters are essential aspects to a labour progress; when women feel safe in a space surrounded and cared for by people with whom they know and trust, endorphins are secreted leading to oxytocin release and labour progress (Kirkham & Jowitt, 2010).

It is noteworthy that pain and fear did not figure highly in the birth-place decision-making experiences in this study. Epidural and opiate pain management is not available at the Birth Centre, even though the epidural rates in Canada as of 2010-11 are at 56.7% (CIHI, 2012, p.3). The lack of consideration of pain management in the birthplace decision-making process is a prominent finding. Certainly further investigation of women's birth-planning experiences for un-medicated birth is warranted.

A key finding from the present study was the response evoked upon entering the space. The sense of "knowing" that the Birth Centre was the right place as soon as they entered the space is a dramatic finding that speaks to factors that should be further studied specifically in this building. This fast, automatic response seemed to emerge almost subconsciously in the women's experiences. It relates to Kahneman's theory (2011) of thinking fast and slow, describing an automatic and unconscious process (system one) along with a slower and more deliberate thought process (system two). Applying the "thinking fast and slow" theory to the Birth Centre decision is particularly interesting in that Kahneman explains system one (thinking fast) as operating instinctually, seeking information that is vital for survival and reproduction, seeking safety and avoiding perceived dangers. When many of the women entered the building, they immediately and instinctively felt that it was a safe, comforting place.

The literature review compared and contrasted the decision-making models and demonstrated that the midwifery model of informed choice integrated steps from both the shared and informed models (Charles et al., 1997; 1999; 2006). It is clear that women's decision-making experiences demonstrate the elements of the midwifery informed choice model and the relational model of decision-making. The College of Midwives of Manitoba Policy on Informed Choice contains a statement about the involvement of family, recognizing the relational aspect of decision-making that should be kept in the policy. Considering the inclusion of the woman's values and preferences into the process could be a potential addition for the midwifery informed choice policy. Charles and colleagues (1997; 1999; 2006) caution care providers on the use of linear checklists, recommending that providers must incorporate a discussion of values and preferences. Within the decision-making discussion it is important for each woman to be self-reflective and consider where she feels safe. Women are informed decision-makers who incorporate their own ideology into their decision-making and make choices in concert with midwives, partners, mothers, and others. The findings from this study have implications for a future review of the College of Midwives of Manitoba Policy on Informed Choice and for on-going integration into midwifery practice.

Criticisms of planned homebirth continue (Chevernak, McCullough, Grünebaum, Arabin, Levene, & Brent, 2013) in light of a 20% increase in out-of-hospital birth rates in the United States in the last ten years, though this still only accounts for 1.36% of all births in the U.S. (MacDorman, Matthews, & Declercq, 2014). In studying birthplace decision-making in and out of hospital, it has been found that "women in fact seek control over birth in diverse ways" (Coxon et al., 2013, p. 63). The Birth Centre has not yet reached its capacity and the vast majority of women continue to choose hospital birth. In order to learn more about birthplace decision-making, it would be imperative to understand how women choose hospital birth. There are many questions that could provide insight into how to expand the reach of the Birth Centre to a broader population of women. Many proponents of hospital birth suggest that there should be an effort to make hospital birth

more attractive and less medical (Minkoff & Ecker, 2013, p.211). Recently, a study was published on how and why women in Ontario chose home or hospital birth finding that beliefs and values and desire for pain relief are factors in the decision-making process (Murray-Davis, McDonald, Rietsma, Coubrough, & Hutton, 2014). From a normal birth perspective, gaining a better understanding of women's hospital birth decision-making experiences might help in understanding how to present all the birth setting options.

In a recent broad American survey, "Listening to Mothers", 25% of women who had given birth in hospital in the previous twenty-one months said they would definitely want to give birth in a birth centre for their next births and another 29% said they would consider it (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2013, p. 53). This data has not been collected in Winnipeg; however, it is very possible that many more women would like to use the Birth Centre. The U.K. Birthplace study proposed that all women should be offered choices for place of birth (Rogers, Yearly, & Littlehale, 2012). In fact, choice in childbirth is a fundamental reproductive right for women, states Sherwin (1998). To make this choice real and informed, it is paramount that the availability of midwifery services be ensured for all women. This researcher recommends no less.

Strengths and Limitations

This is the first completed study on birthplace decision-making for a birth centre in Canada and the first completed research on the Birth Centre in Winnipeg. The diverse sample group (parity, educational level, income, relationship status, and ages) validate this qualitative study as situated within a realistic representation of women who use the Birth Centre. One limitation of the sample was that all of the women in the study who were in relationships reported their partners to be male, an aspect that is not fully representative of women who use the Centre.

The interviews were all retrospective. Women's reflection and memories of the decision-making process would likely be interconnected with the actual birth experience influencing the memory of the decision-making experience. The time between the birth and the interviews ranged

from four weeks postpartum to twenty-one months after the baby was born. This range in time may have impacted the women's recall and recounting the experience, yet it is interesting to note the consistency in the themes regardless of the time between the interview and the birth.

There were other elements of diversity in the sample group that deviated from the IPA methodology of having a focused experience for each participant. Two of the women did not make their final decision to go to the Birth Centre until labour started. Two of the women were never admitted to the Birth Centre; they had started labour planning to go to the Birth Centre but complications presented prior to admission. This diversity could be seen as a limitation in its uniformity with the IPA method, however it also provided greater depth to the findings and the single phenomenon of choosing the Birth Centre was present in the experience.

My experience as a midwife has influenced my understanding of the data; however, it is important to note that the IPA methodology affirms that having an "insider perspective" is a strength in understanding the experiences of the women in the study (Smith et al., 2009). The reliability of the interpretation and interview skills by a beginner researcher likely limited the depth of data collection, analysis, and interpretation. Single researcher interpretation is another limitation of the analysis. At the same time, the multiple stages of analysis used for identifying superordinate themes give credibility to the findings. Many of the findings could be further investigated for deeper meaning or tested for application. This study focused on a single facility; multi-site research could result in a broader understanding of birth centre decisions.

Conclusion

Involvement in decision-making is one of the primary factors that influences birth experience (Hodnett, 2002, p. S171). Women who made the decision to plan a birth at the Birth Centre had an experience that let them exercise agency, have control, and build their confidence. Women who chose the Birth Centre did so because it is a space that protects normal birth and makes women feel safe, comfortable, and in control of their environment. The decision meant that

women made a choice that represented their beliefs that birth is normal and that a woman's body is capable of giving birth. Woman-centred care was the essence of the birthplace decision-making experience.

There are many applications for practice and implications for future research that arise from the findings of the study. It is clear that the model of midwifery practice that emphasizes continuity of care relationships where the woman feels known and trusts her midwives is an essential part of the decision-making process which must be upheld. The midwifery model of informed choice should be reviewed and must consider the relational model of decision-making and the shared model of decision-making, while aiming for an experience of relational autonomy. Midwives must incorporate each woman's unique values and preferences in the informed choice decision-making process. The findings support that in many ways, these elements are already in practice; however, the written standards and policies guiding midwifery should reflect these elements of evidence-informed and woman-centred models of decision-making.

Women's relationships play a key role in their decision-making experience. Of particular interest from the findings was the role of partners and mothers in the decision-making experience. It is up to midwives to facilitate dialogue, provide education, and invite family members to visit in order to better support a woman's relationships in connection with her decision-making experience. Further research into the dynamics between women and their partners, mothers, or friends could reveal important considerations of ways to mitigate conflict and support current evidence and information about out of hospital birthplace options.

Educational tools could be developed to address the "what if" questions that women consider in order to ensure that all the topics are covered with consistency in information between practitioners while promoting an understanding of the many possible outcomes for labour and birth. Considering the possible complications is essential in the birthplace decision-making experience. Women experience a greater sense of control when they know the possible responses

to complications and trust the environment and systems in place that will be enacted if needed. In order to provide accurate information and education in response to the "what if" questions, data from the Birth Centre should be analysed and disseminated from a salutogenic framework (Perez-Boella, Downe, Meiere Magistretti, Lindstrom, & Berg, 2014). Salutogenesis theory applied to maternity care research interprets health in a continuum that includes both health and illness, rather than a sole focus on pathogenic outcomes.

The normal birth influence should be spread through the media, childbirth classes, and midwife-woman discussions. The sphere of the normal birth influence needs to continue in relationships. Women who have experienced a normal birth should be encouraged to share their story with their friends and family. Offering tours and visits to the Birth Centre for all eligible women should be considered for all women in midwifery care as well as to the broader community. Although many women identified that they wanted to plan a birth at the Birth Centre on their intake form, it appears that some only came to consider the Birth Centre option once their midwife started talking about the options or took them on a tour. Due to the fact that most women who have had Birth Centre births also had prenatal care at the Birth Centre, finding ways to expose more women to the space who don't attend prenatal care at the facility might be important.

Further research into women's experiences of not fitting into the criteria for the Birth Centre and transferring to the hospital should be pursued to find ways to support women who must go through this vulnerable and uncertain experience. With one in four women transferring to the hospital in labour, further research to understand more about the experience is warranted. We must learn from women the factors that relate to both positive and negative experiences in order to identify best practices related to changing location and calling for emergency services when there are risk factors.

The Birth Centre is an out-of-hospital setting that is prepared for normal birth but has systems in place to respond to urgent concerns and emergency transportation to the hospital if

needed. Women compared and contrasted their birthplace options and considered the possibility of complications. Women chose the Birth Centre over homebirth for a variety of reasons including that it felt safer, was cleaner and more organized, and it had clearer expectations of the systems that would be activated in the event of complications. Women chose the Birth Centre instead of hospital births because they felt more familiar and comfortable in the space, they wanted a normal birth, and they felt more in control.

The key questions of the study asked: how do women choose the Birth Centre and what does the decision-making process mean to women? In summary, birthplace decisions are made in the context of relationships. In choosing the Birth Centre, women experienced relational autonomy with midwives where they were supported and encouraged to make decisions based on their own values and context, free from discrimination. Women made decisions in relationship with their partners with varying levels of autonomy and support. The normal birth influence was part of the woman's experience where she was influenced by messages from her social circles, family circles, childbirth educators, and midwives that birth is a normal physiological process that can occur naturally in an out-of-hospital setting. The decision meant that women felt agency, confidence, and respect while expressing their own values and beliefs. The decision meant that women trusted their midwives, they trusted their bodies, and they trusted the space.

Place of birth decision-making is a significant part of a woman's childbearing experience where life is celebrated and a new baby joins the family. Becoming a mother represents an important transition in a woman's life where she must step into a place of being fully responsible for the life of another human being. Choices about birth set the foundation for how women will experience this transition to this new chapter. Feeling in control and confident, safe and comfortable, supported and encouraged, as well as prepared and informed, are all elements which are essential to women's experiences of giving birth safely and transitioning into life as a parent.

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Appendix A: Recruitment Materials

Appendix B: Research Ethics – Informed Consent

LETTER of CONSENT

Project Title: Choosing the Birth Centre: Exploring women's experience of birthplace decision-making
Researcher: Rebecca Wood, Family Social Science Masters Student, University of Manitoba
Research Advisor: Dr. Javier Mignone, Family Social Science, University of Manitoba

Researcher Background
I am a graduate student interested in how women make the decision to plan a birth at the Birth Centre. I am also a Registered Midwife, but I am currently not practicing.

Purpose of the Study
1. To understand women's experience making the decision to choose the Birth Centre.
2. To share these experiences with the health care community, policy makers, and midwives.

What to Expect
1. You will be asked to share your experience of deciding and planning your birth at the Birth Centre.
2. The interview will take about 1 to 2 hours in a location of your choosing.
3. The interview is audio-recorded.
4. You will be asked some personal description questions that you can choose to answer or decline.
5. If you choose to do the interview, before we start you will receive $25 to thank you for your time.
6. You may stop the interview at any time and you do not need to give back the thank you gift.
7. You can withdraw from the study at any time and you do not need to give back the thank you gift.
8. If you experience any stress or unexpected emotions from the interview, I will provide you with a list of mental health resources where you can seek further support.
9. If we meet after the interview out and about in the community, I cannot speak to you about the research.
10. After all of the interviews have been analyzed, I will attempt to re-connect with you to share a summary of the analysis. If you have comments or questions, I will take back your suggestions as I complete the final report (March 2014).
11. The findings of this study may be presented orally to the health services policy makers and the midwifery community, both locally and nationally. Reports of my research findings will be submitted to midwifery journals both nationally and internationally.

Your privacy
1. Your midwife will not know that you have joined this study.
2. All notes and other data will be kept in a locked filing cabinet or password-controlled computer that only I have access.
3. I will privately store all interview transcriptions for up to two years after my thesis has been completed. If I publish or present any of the findings, I may need to look at these. At that time all confidential data will be destroyed (Aug 2016).
4. I will use a code-name if I refer to anything you have shared directly (direct quotations).
5. If my results are published, only code names will be used in the reports.
6. There is a possibility that if I share your experiences in writing or presentations, people who know of your unique experience may be able to identify you even if a code-name is used. You may read the academic thesis report with knowledge of your code-name. Then you may request that I do not use anything that you find breaks your anonymity in any publications or presentations.

Your rights

1. If you join the study, all of your legal rights will be respected.
2. You may choose to withdraw from this study. However, you must notify the researcher by January 2014 to withdraw. If you withdraw, I will destroy your contributed information, interview tapes and transcriptions, and remove any related comments from my notes. As with all aspects of the study, withdrawing will be entirely confidential.
3. You may read the full final report and have a short summary sent to you (please indicate below).
4. At the anytime, you may choose not to answer a question. Please tell me and we will move to the next question. You may end the interview at anytime.

Who to contact

If you have any questions at any time during the interview, you should feel free to ask. If you have any questions or concerns after the interview, you may contact any of the following:

1. Beckie Wood, researcher, xxx-xxx-xxxx
2. Dr. Javier Mignone, research study advisor, xxx-xxx-xxxx
3. If you want to talk to someone else, please contact Margaret Bowman, the UM Human Ethics Coordinator, Maggie Bowman at 204-474-7122

This consent form, a copy of which will be given to you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at the research records to see that the research is done in a safe and proper way. This research study is approved by the University of Manitoba Joint-Faculty Research Ethics Board, the WRHA Research Review Committee and the Women's Health Clinic. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204-474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Your consent

I agree to being audio-recorded.
Yes or No
I would like to receive a summary about the study findings before completion. Yes or No
I would like to review the thesis report. Yes or No

I would like to receive this information by:

Email (address): _____

Mail (address): _____

_____ _____

Participant Signature Printed Name Researcher Signature Date

Appendix C: Interview Guide

1. Describe how you decided to plan a birth at the Birth Centre.
2. When did you decide to plan a birth at the Birth Centre?
3. Who participated in your decision to plan a birth at the Birth Centre? How did others participate or influence your decision-making process?
4. Can you describe your feelings while you were deciding and after you chose to plan a birth at the Birth Centre?
5. Can you describe how you weighed your options of birthplace choices? Probe: what made you decide to choose the Birth Centre instead of home or hospital?
6. One of the following questions will be asked depending on the woman's actual place of giving birth. How did giving birth at the Birth Centre impact you? OR How did planning a birth at the Birth Centre impact you?
7. Do you think that the birth centre was a safe place for you to plan your birth?
8. How was the birth centre safe?
9. What does safety mean to you?
10. What does it mean to you to have planned/given birth at the Birth Centre?
11. Is there anything else you would like to share with me about your place of birth decision-making experience?

Smith recommends minimal prompting (2008). Possible prompts include: Can you tell me more about that? What do you mean by that?

Use the field journal to note the body language and additional observations of unspoken responses.

At the close of the interview, ask the participant if she is willing to complete the participant information sheet with the participant's pseudonym.

Appendix D: Participant Information Sheet

UNIVERSITY OF MANITOBA

Choosing the Birth Centre

Participant Information Sheet

1. Name:
2. Pseudonym:
3. Postal Code (where you lived when your baby was born):
4. Year of Participant's Birth:
5. How do you describe your ethnicity?
6. What is the highest grade of education you have completed?
7. Would you consider yourself to be single, OR are you married or common-law?
8. What household income bracket do you consider yourself to be in?

☐ Less than $39, 000 per year

☐ $40-79,000

☐ Greater than $80,000

9. Did you attend prenatal visits at the Birth Centre? If not, where?

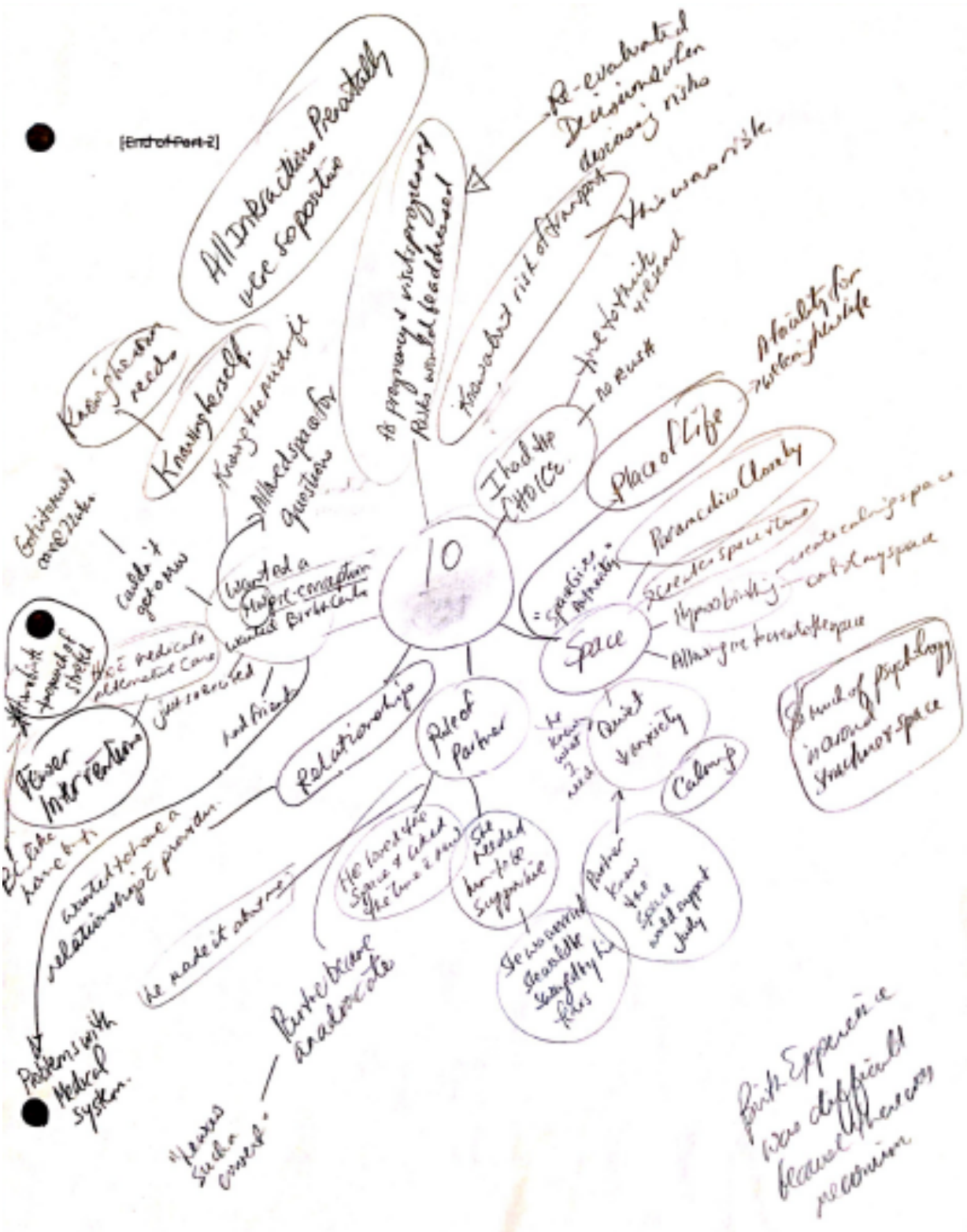
10. How many times have you given birth (including this last one)?

11. Where did you give birth to previous children (if applicable)?

12. What did you write on your midwifery intake form in regards to your requested birthplace?

13. Where did you give birth to this baby?

Appendix E: Mind-map data analysis example



Appendix F: Participant Verification

Participant Verification

Do you remember our interview about choosing the Birth Centre?

I said that I would send you a summary of my findings before I finish the project to check and see if you agree with my findings.

Now, I want to hear from you!

I interviewed 17 women from all over Winnipeg. Everyone had planned to give birth at the Birth Centre. A few women were transferred to hospital in early labour or immediately after the birth. This is a qualitative and feminist research study. This means that I have typed out your interview and analyzed your transcript. I read through each of your stories individually and I found themes and ideas that relate to your birthplace decision-making experience. Then I compared everyone's themes and found patterns and connections. Sometimes, the connection meant that there was a similar experience. At other times, there were different experiences between women. On the next page, there is a summary and definition of the themes. As you read through these themes, ask yourself:

- **Do these themes represent my experience? And how?**
- **What are my thoughts and comments about these themes?**

Call or text Beckie: xxx-xxx-xxxx **Email:** choosing.thebirthcentre@xxxx.xxx

You can call or text me, email me your phone number and I will call you, OR you can write down your comments in an email.

Looking forward to hearing from you,

Beckie Wood

Please reply by June 20, 2014.

Participant verification p. 2

As you read through these themes, ask yourself:

Do these themes represent my experience? And how?
What are my thoughts and comments about these themes?

Here are the major themes:

Experiencing a sense of agency. Agency means that you felt that you had control, you made choices, you felt confident, and you were respected. Almost everyone expressed that they felt a sense of agency. A few people recalled not feeling in control or respected at specific times.

Thinking it through. You considered the risks, the benefits and the options. When you thought about choosing the Birth Centre, you thought about home and hospital, the reasons to transport to the hospital, the ambulance, and a possibility of a change in plans.

Knowing what I believe, value, and hope. You talked about wanting a normal birth, avoiding intervention or wanting to do things naturally. You believe that your body has what it takes to give birth.

Relating with others. Your midwives, partners, friends, family, and the media had an influence on your decision-making experience. Trusting your midwife is important to you.

Interacting with the physical space. The building design, the cleanliness, the tubs, the tours, privacy and quietness of the space impacted your decision.

Fitting into the eligibility criteria. If you had a normal low-risk birth before, this helped you feel confident that you were low-risk again. For some, you had a risk arise in the pregnancy or in labour that affected your decision and the experience that you wanted.

Call or text Beckie: xxx-xxx-xxxx **Email:** choosingthebirthcentre@xxxx.xxx

You can call, text, or email me your phone number and I will call you.

OR you can write down your comments in an email.

Please reply by June 20, 2014.

Appendix G: Verbatim quotations demonstrating "Exercising personal agency"

It was, like, a confidence-builder. I'm confident; I have–feel confident enough that I can do this… It just makes you feel like, "Wow, I can do this and I am capable of this. And nobody's gonna tell me otherwise." You just – you have the strength and you have the courage. (Brielle)

I felt so educated and just in control. (Christina)

I think, for me, it was empowering to be able to show, like, people that I know and people around me that I can – that it was okay. Like, sort of show them that I know that I'm gonna – I don't know that everything's gonna go okay, but that I can make that decision and be confident in that decision and confident in myself, that I can do this, and show them that I can do this. (Chelsea)

And that was the most important part for me – was that I actually got to – I felt strong and I felt good. And I was in total control… It was just awesome to be able to decide . . . I feel really proud that I was able to – like, I felt like such a warrior. (Elodie)

I knew that I could feel in control of what was going on while I was there. (Gwen)

It's empowering, knowing that you don't have, sort of, what you had in the hospital – that safety net of, like, the drugs. (Holly)

I think, like, it's empowering to be able to have choices, too. Yeah. (Jersey)

And I felt good about it. I felt, you know, absolute – like, totally, 100% comfortable and confident - with the decision to go down there. (Juliette)

I was absolutely proud of myself for doing all three births drug-free. And just the last one was the best out of all of it. Because, I mean, I got to – it was amazing. I got to catch her. I got to – like, I did everything myself. (Karin)

They're just, like, "here's your options. You can choose whichever one you want. Whatever you choose, we're gonna be with you 100%" . . . That really made me feel comfortable. And it didn't really make me feel like I was making the wrong decision or like I was being judged . . . It may sound a little selfish but I kinda put my preferences first. (Katelyn)

'Cause I think one thing that's great is that it was my decision and I had a choice, you know? (Lara)

Yeah she [my midwife] just waited for me to make my own choice… I felt proud. (Lissa)

I felt that I was able to choose. And so, I guess 'empowered' is the word I would use. Because I was able to decide for myself . . . I felt control over, you know, what I do and what I'm able to say and that kind of thing. That would be some – a way that I feel safe… And so, that kind of leads into how I would feel safe at the birth centre is that I chose to be there. (Teagan)