Maternity Customer Insight Desk Research
'The Role of Communications in Extending Maternity Choices'

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Background

The Department of Health are currently preparing a communication strategy around the increased range of choices in the provision of maternity services to women. The four 'national choice guarantees' set out in Maternity Matters (DH, 2007) are due to become available in late 2009. In order to prepare the strategy, DH are reviewing the current attitudes and information needs of the three key audience groups for the strategy: women, their partners, and healthcare professionals. As part of the process of drawing together relevant evidence, DH (in association with COI) commissioned Andrew Darnton and Jake Elster Jones at AD Research & Analysis to undertake an authoritative review of the existing research data.

Objectives

The overall aim of the review was to synthesise the current evidence on the knowledge and attitudes of women and their partners, as well as healthcare professionals, in relation to their choices in maternity provision. Within this aim, the review was required to address the following objectives:

i) Outline the views and experiences of maternity services held by women, their partners and healthcare professionals; within this, describe the differences in views and experiences between subgroups of these audiences (eg. women of different minority ethnic groups), highlighting implications for strategy and messaging.
ii) Explore the concept of 'choice' in maternity provision, as perceived (and experienced) by the different audience groups.
iii) Identify the principal sources of parenting and breastfeeding advice used by the different audience groups, and their views of these sources.
iv) Identify the principal sources of maternity information used by the audience groups, including both formal and informal channels.
v) Assess the influence of media presentation of issues around maternity and maternity provision in shaping the audience groups' views.

Having brought together and synthesised the evidence on the objectives outlined above, the review was also required to identify gaps and weaknesses in the evidence base, and make recommendations for further research. Finally, recommendations were also required for ways forward in communicating with the audience groups around maternity provision, in support of the development of the communications strategy.

Methodology

A three-stage methodology was applied to the review, in keeping with AD's standard methodology.

i) Data Gathering

Sources were gathered by three routes: those suggested by the COI and DH project team; those suggested by AD; those identified by external experts and stakeholders. In the last route, a call for information was agreed and sent out to a wide range of experts across central government and associated agencies, NGOs, academic centres and commercial organisations. Those contacted were also invited to share the call for information with well-placed colleagues; in total, 95 individuals in 57 organisations responded to the call – a far larger response than had originally been envisaged.

ii) Identifying Content

The sources identified in the data gathering phase were prioritised in terms of relevance to the brief, and the key content in each was noted out against the objectives set for the review. This body of evidence was discussed at an initial interim debrief to the project team on 19th November 2008; following a delay to the schedule, a second interim debrief was also held on 12th March 2009. Further correspondence with key contacts, and gathering and reviewing of incoming sources, continued across this period. Finally, from a long list of 151 sources of potential relevance, 90 sources were selected to form the references for the final report. Again, the extent of the material under review exceeded that which had originally been anticipated.

iii) Reporting

This document represents the final report from the review; it opens with an overview of the key findings from the review. The main body of the report takes the form of a commentary, synthesising the evidence in the selected sources, and referencing each point. The review closes with a set of recommendations on the policy objective of extending choice, and on the role of information and communications in supporting that agenda. Finally, specific recommendations for further research are provided, including ways forward for the potential development of a segmentation model of pregnant women.

The report closes with a section of Appendices, which list all the key contacts who contributed to the review, and the selected sources referenced throughout this report.

Executive Summary

The Audience of Pregnant Women

- Key variables within the population of pregnant women that influence experiences of maternity care and approaches to information and choice are parity (ie. whether the pregnancy is a woman's first or not), stage of pregnancy, socio-economic grade, and education.

- In addition, a number of priority subgroups are identified in the literature who have specific needs in relation to maternity services and information provision. These subgroups may present particular problems, in engaging them with maternity services, and in the potential for increased risk of adverse outcomes. These different subgroups can be grouped in the following categories: cultural backgrounds (both ethnicity and faith), socially vulnerable groups (eg. homeless or drug/alcohol dependent women), hard to engage groups (eg. teenage parents and fathers), and women with increased medical risk (eg. obese, or with heart disease).

- A number of relevant typologies have been developed to classify pregnant women, based on attitudinal and emotional variables. These include classifications by: approaches to information; anxiety and empowerment; the degree of support available to women. These provide useful insights into further key dimensions in understanding pregnant women's experiences of maternity care, choice and communications.

Service Experiences and Perceptions

- The birth rate in England stands at over 600,000 per year, and is rising. Among the headline statistics, it should be stressed that the vast majority of women give birth in hospital (98%), while only 2% give birth at home. An estimated 47% of NHS hospital births are defined as 'normal' (featuring minimal intervention). In 2006, 24% of births were by caesarean section, and this rate has been increasing (eg. from 9% in 1980). It should be noted that these data vary widely by NHS trust, and across different subgroups of women.

- Significant evidence exists about women's expressed views about maternity care. This needs to be read in light of key limitations inherent in measuring experiences and satisfaction, which include: the conservative tendency for pregnant women to assume that whatever care they have received is the best; and limitations of quantitative surveys to elucidate women's experiences because they miss important detail revealed by women's stories.

- The majority of women tend to be fairly positive about the maternity care they have received, both overall and when talking about specific aspects of care. However, unequivocally positive responses are only given by approximately 30-40% of women and more negative responses by a notable minority of 20-30%. Satisfaction with relationships with healthcare

professionals generally seems to be higher than that regarding other aspects of care. Some evidence suggests that women are least positive about postnatal care and least satisfied with the amount of information they receive from maternity staff.

- The evidence reviewed suggests the following factors as key in determining women's satisfaction with maternity care and other important outcomes:
  - the care received from, and relationships with, maternity professionals
  - empowerment, control and expectations – both during birth and antenatally
  - birth environment
  - place of birth
  - choice
  - the role of the baby's father
  - reassurance about medical care in case of emergencies

- There is extensive evidence of worse experiences and lower satisfaction among priority subgroups (eg. teenage parents). However, this is not universal and there are cases where some aspects of satisfaction are higher for certain subgroups (eg. Black and Asian women). Experiences of care from maternity staff also include some positive stories; overall, perceptions of care are shown to influence outcomes and experiences.

- Staff views provide important insights because staff can determine the experiences of women and the care they provide is often key to satisfaction. The majority of evidence here is from midwives with little from doctors or consultants. Much feedback from staff about maternity services relates to shortcomings and problems with care, including concern about high caesarean rates, lack of service capacity (including low staffing levels), and the inadequate training, skills and experience of healthcare professionals, coupled with the increasing social and medical complexity of the ever increasing population of pregnant women.

- Different cultures associated with different healthcare professions (essentially doctors and midwives) and different models of care are identified as a key and recurring point, with a medicalised 'illness-based' culture at one end of a continuum of care and a more holistic 'normalised' approach at the other.

Choice

- Choice is a contested concept that needs to be located as one aspect of women-centred care. Three styles of decision making – paternalistic, informed and shared – help illuminate the issue of choice in maternity care as a dynamic concept. No one style is ultimately preferred, and they can be equally appropriate depending on women's needs.

- Risk and uncertainty are inescapable aspects of maternity care which play a key role in maternity choices. Different approaches to the problem of

risk are associated with different models of care, which lead to different views on choice; interestingly, neither the midwifery nor medical models entirely supports free choice for women.

- In addition to the four 'national choice guarantees' set out in Maternity Matters (DH, 2007) the literature identifies a large number of choices along the maternity care pathway. However, research data suggest that many of these are 'non-choices' for many women, for example, because women are not made aware that they have choice at such points.

- Evidence about the choices offered to women and their views on choice in maternity care reveals notable shortcomings. For instance, of the three quarters of women who, when pregnant, first contact a GP, only 14% realise contacting a midwife is an option. Also, while 81% of women reported being offered choice of place of birth, only 57% were offered the option of a home birth.

- There is some evidence that important choices are often made very early in pregnancy, or pre-pregnancy. For instance, it is reported that many women have already chosen their place of birth, and preferred form of pain relief, before they have first access maternity services.

- Choices that some women make have the potential to run counter to attempts to change key aspects of maternity care, such as reducing caesarean rates. There is some evidence that women are increasingly likely to opt for a medicalised birth, if given a free choice.

- A wide range of factors can influence choice for women in maternity care. Personal factors include experience, the influence of family, friends and social factors, and skills, education and confidence. 'Extrinsic' factors relating to maternity services include the extent to which choices are offered, control and influencing of choice by healthcare professionals, available facilities and capacity, and institutional factors such as local policies. Wider influences on choice include cultural factors.

Information

- Women express a variety of information needs during pregnancy and new parenthood, with a focus on information relating to labour and birth (especially relating to anxiety about birth and pain, and practical techniques for labour); information to provide reassurance (especially about progress of pregnancy and well being of the baby); and postnatal information (the most frequently mentioned – especially practical baby care and transition to parenthood).

- Women from priority subgroups may have specific needs for information, but generally do not want to feel singled out or stigmatised and so prefer to have the same sources of information as other pregnant women; these need to be made more inclusive and extended to cover information

relevant to different subgroups. Fathers are a notable exception, tending to respond better to specifically tailored and targeted information.

- A number of key information needs emerge from the evidence that could potentially influence important outcomes. In particular, antenatal and pre-pregnancy information that provides women with confidence to give birth without medical intervention, and to expect normality could be important. Information to promote timely engagement with maternity care by priority subgroups is another important area.

- There appears to be a fair amount of dissatisfaction among women about the amount of information they receive during pregnancy, and again the picture is largely less positive for priority subgroups. In general, women tend to report wanting more in-depth information, although this varies widely (eg. by parity, and typology – see above).

- Information clearly plays an important role in choice but is only part of what is needed for good decision making; the provision of information should be best regarded as the starting point in a supported process of deliberation involving women and maternity staff.

- Key issues relating to handing over information to pregnant women include timing, allowing sufficient time for deliberation, ensuring that healthcare professionals have the skills to successfully communicate information and support decisions, and ensuring that information is in line with the reality of choices available (and supported by healthcare professionals in practice).

- An approach involving clearly signposting decisions, then 'staging and layering' information to meet the needs of specific women is suggested as effective for extending maternity choice.

- Among the evidence on formats and channels preferred by women, there is a strong preference for information delivered face to face, especially when it relates to the experiences of other women (and thus has emotional content). However, authoritative information is also valued, both that received verbally from maternity staff and in written formats (eg. DH's The Pregnancy Book). Emerging evidence suggests web-based communications have the capacity to combine the strengths of factual information with women-to-women support.

Media and culture

- Cultural norms can be seen to proscribe the range of choices taken by women, and to shape their expectations of the birth experience (thereby potentially influencing outcomes). The media is understood to play a key role in shaping cultural norms, and there is evidence that this effect is at work in relation to maternity choices, perpetuating a medicalised model of birth.

1. Introduction

Maternity care is a research area covered by an extensive body of evidence. This review has gathered together a substantial cross-section of this evidence from a wide range of organisations in central government, across the NHS, and in the NGO sector and academia (see Appendix i) for a full list of contributors).

The sources gathered include large (and some smaller) quantitative surveys investigating women's experiences and perceptions of maternity care and actual service provision. A number of major reports or reviews are available, covering specific topics such as perinatal mortality or caesarean sections. Guidance papers have been published by various professional bodies, for example covering the issue of pregnancy and disability. A significant number of large and smaller qualitative, or mixed method, studies provide feedback from consultations and focused insight into particular topic areas; such as healthcare professionals' views on safety in maternity care and the maternity experiences of various excluded groups. Qualitative studies also provide evidence about specific communications materials and campaigns. Finally, there is also a significant body of academic work. This comprises: large in depth studies on issues such as choice in maternity care; desk studies and reviews of specific areas of the literature; published papers on specific topics such as decision making, safety in birth and midwifery practice; and evaluations of specific initiatives and interventions. The field is dynamic and evolving, for example the current major prospective cohort study into planned place of birth (e.g. NPEU, 2008).

Overall, there is significant evidence about women's views. The views of and contribution to the evidence by, different healthcare professionals is however not balanced. There is significantly more evidence about midwives' views and very little from doctors and consultants, and midwives also contribute more to the academic literature.

Certain issues recur (being high on the agenda as a result of policy and/or their role in affecting outcomes), like choice, medical intervention in birth and different cultures within maternity services and healthcare professions. Timely engagement with services and specialist services is recurring theme in relation to certain subgroups of pregnant women. Choice has become a particularly dominant topic, following from its key place in policy, for example Changing Childbirth (1993) and Maternity Matters (2007). Normality in birth is also a key theme across the literature (both policy-focussed and academic) because of concern about the risks and resource implications of unnecessary medical intervention.

The focus of this review is on the role of information and communications in supporting the extending of the choice agenda in maternity provision. This particular focus is not reflected in any single existing source, and it calls for the synthesising of a wide range of evidence. This review is broad in scope,

but as it progress its single-minded focus on the implications of the evidence for communications will become apparent – both in relation to information and support provision direct to women from maternity staff, and nationally in relation to strategic communications from DH. The review opens by framing the evidence on choice within a consideration of the different subgroups in the audience of pregnant women, followed by a survey of the evidence on their experiences and perceptions of maternity care.

2. The Audience of Pregnant Women

Many studies report variations in the experiences and perceptions of maternity services across different groupings of pregnant women and new mothers. The most common dimensions in which such variation is described relate to socio-demographic and biological factors, such as education and parity. The evidence reviewed also identifies a number of other important factors and groupings which help to explain and predict differences in experiences and needs for different women, such as ethnicity and medical risk. Before setting out to review the evidence on women's experiences and perceptions around birth, this initial section outlines some of the key dimensions which underpin significant variations in women's choices and needs. Finally, this section introduces some of the more multifaceted segmentations and typologies of women that are relevant to helping understand the audience for this study.

2.1 Key Variables

'Parity' - whether the pregnancy is a woman's first or not is an important factor in many ways. When women are pregnant for the first time the whole process is new (although within this it can still be more or less of a 'known quantity' – for example where women have had previous second hand experience of pregnancy and babies through their family). For example, women who have not been through the maternity care system before are likely to be unfamiliar with how it works. 17% of women without a baby were found by one study not to know how quickly a woman should contact the health service after she discovers she is pregnant (Ipsos MORI, 2008). Primiparous women (ie. first-time mothers) tend to be more avid consumers of information. They may also be less discerning and not know what questions to ask or what information they need (Law et al., 2008; Kirkham and Stapleton, 2001).

Women who have already had a baby will have a different base of experience and knowledge (Redshaw et al., 2007), and may be less interested in new information. Previous experience has been identified as a key factor in determining women's decisions during pregnancy and birth, which was 'likely to take priority over other forms of evidence' (Stapleton 2004, cited in Law et al., 2004). However, multiparous women do often have information needs during pregnancy, birth and early motherhood, and it is important not to assume that they are not interested (e.g. Ipsos MORI, 2008). For example, many multiparous women still want antenatal classes (Nolan, 2008). Reasons for this include having had a long gap between pregnancies, changes in

maternity services and in the content of information over time (including as the science base evolves).

Stage of pregnancy – can influence, for example, women's practical and emotional needs, concerns and expectations (e.g. Rosenblatt, 2004; Bounty, 2008a). Bounty's (2008a) study of how pregnant women and new mothers use the internet, identified distinct patterns of information use which changed through different stages of pregnancy and early parenthood. Rosenblatt's (2004) study identified a variety of 'emotional need states' that women had during pregnancy, based on different combinations of anxiety and empowerment, discussed further below. They report that women move across these need states at different points in pregnancy and these influence, for example, their needs for information. A less anxious woman in early pregnancy may be interested in finding out more about a natural delivery, whereas someone feeling more anxious may be interested in pain relief. Later in pregnancy women may be interested in birth plans or what equipment they need for the new baby (ibid).

Education and socio-economic grade – Education and socio-economic factors can influence approaches to information during pregnancy. Basic issues of literacy and numeracy are obviously important in accessing information, with certain levels of literacy often assumed (Law et al., 2008). Law et al. (2008) also report a study which observed midwives giving more detailed explanations to articulate middle class women, and even more if they were accompanied by a partner who was a professional – and this could result in less time available for women who did not ask questions. Kirkham and Stapleton (2001) report a similar finding and they point out that this illustrates the 'inverse care law' – women most able to get information independently also take up more time from healthcare professionals. Redshaw et al. (2007) found that women living in the most deprived areas (measured by the Index of Multiple Deprivation) were less likely to have been able to talk over their birth with a health professional than those in the least deprived areas (although they were more likely to have been given (DH's) 'The Pregnancy Book' than those in less deprived areas – see Section 5 below). The women living in more deprived areas were also less likely to have attended antenatal education classes at a hospital or local clinic.

Soltani and Dickinson (2005) found that while 92% of the new mothers they surveyed said they had read most or all of the information they had been given during pregnancy, and 98% said that they understood most of all of it, there were major differences between women who said they understood all of the information they had been given. 72% of women in 'professional, managerial, or semi-professional' roles reported they understood it all, compared to 46% of those in 'skilled, semi-skilled or unskilled' jobs (this group also included students and housewives).

Rosenblatt, 2004 reports that women from ABC1 socio-economic groups have higher expectations then those from C2DE socio-economic groups, for example the former focusing on plans for a natural delivery and breastfeeding,

with women from the later group more focused on issues like the type of pain relief to chose and 'where to buy stuff' (Rosenblatt, 2004:15).

2.2 Priority subgroups

Beyond the key dimensions of parity, stage of pregnancy and SEG, a number of subgroups are identified in the literature as important in presenting particular needs from maternity care (e.g. EdComs, 2005, Ipsos MORI, 2008). EdComs (2005) groups together a range of subgroups - including Asian women from different backgrounds, asylum seekers, women living in travellers' communities and fathers - under the heading 'hard to reach' because they were identified by the House of Commons Select Committee on Health as being '*prevented by their demographic profile and situation from taking advantage of ante- and post-natal services*' (ibid:5). Ipsos MORI (2008) group together a slightly different selection of subgroups as 'vulnerable'. There are many overlaps between different 'priority subgroups ' in terms of experiences of, and needs from, maternity services, but all are of particular importance because they raise specific issues in relation to engagement with maternity care, and / or the potential for increased risk of adverse outcomes. In some cases, increased medical risk may follow from problems with engaging women from these groups with maternity services (e.g. EdComs, 2005). Looking across the evidence more widely, it is possible to identify the following general categories, which incorporate the key variations (albeit with potential for overlap):

- groups with distinct cultural backgrounds
- socially vulnerable women
- groups that are hard to engage with maternity services
- women at increased medical risk

Cultural backgrounds can have a variety of important impacts on experiences of and needs from maternity care. Cultural norms can play an important role in determining how women feel about accessing information, and the practicalities of doing so; ethnicity and faith are key dimensions in this regard (see Section 6 below for further discussion of culture). For example, women from **Romany** and **Asian Muslim** communities may not feel comfortable discussing women's health issues with men, and in some cases (especially **Somali** and Asian Muslim communities) they may not want to discuss pregnancy with health professionals at all because it is considered a very private experience (EdComs, 2005). Heads of households can control information flow, and women may often be accompanied to medical appointments by male partners – this further constrains how free they may be to access information, and has direct implications for the ways in which it should be communicated (EdComs, 2005). Women in some groups may rely on expertise and knowledge within their own community networks and hold culture-specific views on medical treatment (ibid). For example, some members of the Romany community were found not to agree with disease prevention (e.g. vaccination) (ibid).

Language issues are also an important consideration. For example, Ipsos MORI (2008) reported that not having sufficient English language skills could be a key barrier to making an initial maternity appointment, with important implications for the problem of late engagement with services. It was also reported to be a barrier to attending antenatal and parenting classes (Ipsos MORI, 2008).

Racism and stereotyping is a further issue relevant for women from different cultural groups. For example Law et al. (2008) list two studies where women from different minority groups reported (and were observed) being given less information than other women, which narrowed the choices available to them. Puthussery et al. (2008) noted the potential for stereotyping of women from minority ethnic groups to be stereotyped by maternity staff, thus influencing the type of information offered to them.

Socially vulnerable groups
Certain groups of women are in a particularly vulnerable position due to problems like **drug/alcohol dependence, homelessness, asylum seeker status, imprisonment** or **mental health** problems. Women in these groups are often dealing with very difficult and pressing personal problems leading to them neglecting their health needs and prioritising other day to day needs (like food and shelter) over their pregnancy (EdComs, 2005). Furthermore, women in these groups can often be anxious about being judged by medical professionals and about the involvement of social services (with the ultimate fear of having their baby taken away) (EdComs, 2005). As a result these women were reported often to use accident and emergency facilities rather than GP services, even for minor health problems (ibid).

Lack of continuity in living arrangements also increases the likelihood of inadequate contact with the maternity services and a lack of access to information. If women have to move frequently (for example, due to relocation by immigration services) they can fail to get letters about appointments (Taylor and Newall, 2008). Even getting to antenatal appointments can be difficult or impossible for some especially vulnerable women, such as immigrants classed as having ‘No Recourse to Public Funds’ - as they may not be able to afford bus fares (ibid.). Asylum seekers tended to show limited and infrequent use of health services, largely because they did not know they were eligible for treatment and thought they needed to pay for it. Their use of services tended to depend on the support they had received (either on arrival in the country or through asylum centres) – e.g. whether they had been informed about rights of access (EdComs, 2005). Another issue here is that women who are transient, were unlikely to be registered with a GP, and could not easily receive continuity of care (ibid).

Hard to engage groups
Teenage mothers face their own set of issues around maternity care and information, many of which overlap with those faced by other priority groups. Stigmatisation and discrimination is often mentioned by young parents. For example, teenage parents from Black and Minority Ethnic communities reported encountering discrimination in maternity services and from the public

at large, based almost exclusively on their age, not their ethnicity (Higginbottom et al., 2005). Confidentiality and fear of being judged can be significant concerns, making women from this group especially reluctant to use health services in some cases (e.g. EdComs, 2005). For example, some young mothers reported that judgemental maternity staff put them off attending antenatal classes (DH and DCSF, 2007). Finding information that is relevant, tailored and inclusive for young mothers can also be a problem. For example, in a small qualitative study, young mothers reported that they had stopped attending antenatal classes because they felt that the classes did not cater for their age and needs (GFS Platform, 2007). Teenage parents in another study noted the lack of content and images aimed at a young audience when talking about 'The Pregnancy Book' – see Section 5.

Fathers are also an important, and often neglected, group. Male partners / fathers (and especially young fathers) often feel significantly excluded by maternity services, and report feeling unwelcome or ignored, and not given enough information (Burgess, 2007; Working with Men, 2007). Evidence suggests that men tend not to use information sources that they perceive as being for women, and that tailored information may be more effective (EdComs, 2005; Fletcher et al., 2008). Their information needs may also be different because of different practical constraints that fathers often face. For example, fathers on average return to work sooner after birth than women (Fletcher et al., 2008).

Women with increased medical risk

Some women face increased risk in their pregnancies for pre-existing or indirect medical reasons, such as obesity, diabetes or heart disease. CEMACH (2007) identifies cardiac disease as the commonest overall cause of maternal death, and obesity as another important factor contributing to many maternal deaths. This source recommends pre-natal counselling for women with pre-existing medical conditions that could be aggravated by pregnancy and provides a list of the more common medical conditions that fall into this category, including epilepsy, diabetes, cardiac disease, auto-immune disorders, obesity and severe pre-existing or past mental illness. Some obese pregnant women report feeling stigmatised, and report concern about being judged and receiving pressure to change their lifestyle (Ipsos MORI, 2008). Healthcare staff report that some obese pregnant women can be very defensive about their weight, making it difficult to provide support (Ipsos MORI, 2008). Issues around stigma can be a barrier to engagement with specialist support or care. For example, medical staff report limited take up of services on offer to obese pregnant women, and one obese pregnant woman (ibid.).

2.3 Typologies and Segmentations

Having noted that the evidence observes different experiences and perceptions of maternity services by women according to different socio-demographic and related variables, and in specific priority subgroups, the sources under review suggest that other criteria may also be important in describing the information needs and practices of pregnant women. These

typologies and segmentations tend to classify women according to multiple variables which reflect their attitudes and emotional states, rather than their external characteristics. Many of these typologies have been produced in order to provide more targeted support to women, through policy or communications interventions. The sources under review include five typologies that relate to pregnant women; a further typology describes people depending on their responses to anxiety when obtaining information and making complex decisions (in the context of education and health fields, including maternity care) (IDeA, 2008). These typologies were all based on small sample sizes, and are not fully quantified, but offer practical insights.

Typologies based on approaches to information
The first two typologies were developed by Wiggins and Newburn (2004) specifically to describe pregnant women's different approaches to obtaining information, and how they intended to use it. Women were grouped as follows in relation to their approach to gathering information. These groupings were not quantified, although the authors estimated the proportion of their (small) sample that fell into each group:

- Voracious Gatherers – were a minority of the study participants, roughly one fifth. They invested a large amount of time and effort in finding the information that they felt they needed, including from libraries, discussions with specialists, antenatal classes and voluntary organisations. All the women falling into this group in this study were first time mothers.

- Readers – were a larger group, estimated at around a quarter of the participants. They wanted a lot of information and tended to get it by reading, often utilising a variety of different and sometimes conflicting sources (including leaflets, books and magazines), but mostly depending on what they were given. They were also enthusiastic users of antenatal classes. They were a mix of first time and second time mothers (some of these second time mothers had been Voracious Gatherers in their first pregnancy).

- Listeners – were the biggest group, accounting for around two fifths of the participants. They included primiparous and multiparous women. They had a quite relaxed attitude to information, 'taking it as it comes'. Most had read a few pregnancy and birth magazines and some leaflets and they may have one or two pregnancy books that they dipped into. Much of their information came from experience, and from family, friends and television. However, they also relied quite heavily on health professionals for appropriate information and reassurance.

- Old Hands – made up approximately one fifth of the participants, all having their second or subsequent baby. They were not very interested in information during pregnancy because they felt that they had heard most of it before and that their own experience and knowledge was more relevant.

- Waiters – about a tenth of the women were actively reticent about finding out a lot about pregnancy and birth, and especially did not want to know about unpleasant things that could happen. They tended to cope by waiting, not anticipating the future, and taking things as they came. Some of these women were less confident than other women that they could influence what happened to them, or the care they received. Others wanted to avoid the responsibility of making difficult choices.

The authors also noted another, more fundamental, distinction between women in relation to their attitudes to obtaining information, which depended on their feelings about the potential for choice or negotiation. Women who felt that they had alternatives to choose from were more inclined to want to obtain information to assist them in discussions with health professionals and decision making. Women who were less committed to obtaining information tended to be those who felt that they would be less actively involved in decision making: either because they felt they would just get on with what happened using what they knew already; or because they felt they would never become an 'expert' so it was better to take advice; or because they felt powerless to influence what happened (Wiggins and Newburn, 2004). Another reason women may not be expecting to be actively using information in decision making could be that they have already made decisions about aspects of their care. For example, as discussed below a significant majority of women report having made decisions about the place they want to give birth before engaging with maternity services (e.g. Hopwood and McDonald, 2006).

The second typology resulting from this study classified women depending on how they intended to use the evidence-based information that they had been given (Wiggins and Newburn, 2004). An underlying element in this typology is that of the expectation of conflict around applying evidence-based information in practice. Many of the study participants anticipated a struggle if they were to request choices, based on the information they had been given, that were at odds with standard practice in the setting in which they were giving birth. The typology describes women as follows:

- Crusaders – approximately one tenth of the participants were determined to use the information they had been given to obtain the reported advantages. They felt willing to challenge standard practice and 'do battle' with health professionals if necessary.

- Cautiously Optimistic - around a fifth of the women were interested in acting on the information they had been given and were willing to question health professionals and standard practice. However, they were also prepared to accept that it might not be possible to make their preferred choices in labour.

- Resigned but Regretful – approximately a third of the participants said that they would accept care provided by health professionals, but having read the evidence-based information leaflets may sometimes wonder whether the treatment they were being given was the best option. Many felt

powerless to change the course of events in labour, despite knowing that there may be advantages in a different approach.

- The Unmoved – a further third of participants reported that they did not anticipate any conflict or regret. In some cases this was because they were already anticipating a planned intervention (such as caesarean or epidural) that made the choices covered in the information irrelevant. Others felt sceptical about the information they had been given, or were simply content to be guided by healthcare professionals.

These related typologies immediately raise a number of implications that are worth noting in relation to communications: the importance of intermediaries (for example, the heavy reliance of 'Listeners' on healthcare professionals), the question of how to engage with women who have already decided they are not particularly interested in information; finally, the importance to consider variations other than parity when providing information to pregnant women, and to note that in some instances multiparous women can express the same needs as primips (see eg. the 'Readers' and 'Listeners' above).

The IDeA (2008) produced a typology of people based on their responses to anxiety when obtaining information and making complex decisions. They explicitly describe these as '*modes of response to anxiety*' (IDeA, 2008: 17) because of the key finding from this study that complex decisions have the potential to generate anxiety in the decision maker. Anxiety in relation to choice is a key consideration for maternity care as anxiety can be strongly related to outcomes, as will be discussed further in Section 4 below (e.g. Green et al., 2003). As well as the important role in generating or reducing anxiety that decision making can play, information can have an important role in reassuring women (see Section 5 below). The modes of response identified in the following typology are ways of operating, and individuals can switch from one to another in different circumstances (although they are likely to have an underlying 'default' response to anxiety). The typology identifies four groups (or modes of response) as follows:

- Active / negative – the individual is at worst panic stricken, frantically searching for information, advice and answers and never satisfied. They constantly search for more or better information and will be in contact with lots of people, and drawing from multiple sources and channels. They tend to spread infectious anxiety around. They never feel ready to make a decision.

- Active / positive – take a balanced, sensible approach. They proactively seek information but are able and willing to discriminate and choose between sources. Information gathering is well managed, and they are confident in their ability to make judgements and come to a satisfactory decision.

- Passive / positive – less proactive and more trusting / accepting. Able to find one person or organisation in which they can put their confidence (and likely to believe that that source knows more than they do). Able to

receive (make use of) information from that source. They will make a decision themselves, but are heavily influenced by their chosen source.

- Passive / negative – very closed to information, will metaphorically (or actually) close eyes or ears. Won't let people or information in and remain emotionally or mentally isolated. They suppress or deny their feelings. They also deny the complexity or importance of the decision, and ignore the need to make one.

Typology based on type of support available to women

Looking across the groups which EdComs defined as 'hard to reach', two important variables are identified which contribute to understanding the experiences and needs of women (EdComs, 2005). The first related to the amount and type of support that women from their social networks, which in turn determined their underlying approach to managing their health, and hence how they approached health services (ibid).

- 'Community-managed' approach to health – where women who were part of a strong community network tended to rely on their community to manage health issues (for example advice from family members). Respondents who fell into this group tended to be from minority ethnic groups including Romany, Somali, Asian Muslim (Bangladeshi and Pakistani in this study) and asylum seekers.

- 'Self-managed' approach – where women tended to be self-reliant as a result of exclusion from mainstream society, which affected their attitudes to and use of health services. Women falling into this group were mainly from the socially vulnerable grouping identified above, or teenage mothers.

The theme of support that underlies this typology is more widely applicable to all women, and recurs through a number of sources in this review. For example, Kirkham and Stapleton (2001) report that some women trusted their midwife to the extent that they did not bother getting much other information (than that provided by this trusted source), while others felt professionals were less reliable or consistent. Cragg et al. (2002) report that in general parents with supportive and available family were less likely to make use of written information than those that did not. Similarly, those with less contact with health professionals than they would have liked appeared to '*fall back*' on written information (ibid: 59). This point is further echoed in a review on information for parents by Darnton (2003) who notes that reliance on formal information depends on the extent of informal support networks.

Typologies based on anxiety and empowerment

The degree of anxiety felt by women during pregnancy is repeatedly identified as important with implications for experiences of maternity care, choices and birth outcomes, as discussed further below. It is the basis for two of the typologies found in this review.

The second factor identified by EdComs (2005) as important for understanding differences between women from 'hard to reach' groups was the extent to which they were content with, or anxious about, their pregnancy:

- contented – most women from the community-managed group fell into this group, as well as women from the self-managed group who felt content about their pregnancy (usually because they had planned it). These women tended to take a matter of fact approach to pregnancy and motherhood, and to get on with their lives as normal without dwelling on the pregnancy. This attitude was typical of women from minority ethnic groups (including Romany women), where the family was seen as a core part of a woman's life and motherhood marked an important life change and conferred increased status. Pregnancy was often expected, and in some groups thought of as a gift from God.

- anxious – women in this group viewed pregnancy and motherhood in relation to their personal circumstances (i.e. often adding to a multitude of existing problems). They often saw the prospect very daunting. Women who were extremely anxious about their pregnancy sometimes did not engage with maternity services until very late in their pregnancy. In some cases women went into denial if they felt they could not deal with the pregnancy. They were often anxious that their pregnancy would be disapproved of by health care professionals (and, in the case of teenagers, their parents).This attitude to pregnancy was typical of many women from the drug / alcohol user group, teenagers, homeless women and women with learning difficulties.

Rosenblatt (2004) also developed a typology of pregnant women in relation to two variables: their degree of anxiety and how empowered they are (which they relate directly to socio-economic factors, with more ABC1 women falling at the empowered end of the scale and more C2DE women at the less empowered end). This approach leads to the identification of key emotions and emotional need states experienced during pregnancy, which the authors suggest can change for individuals from day to day, as well as through different stages of pregnancy:

- less anxious, more empowered women are characterised as 'accepting' of pregnancy, with an associated need for independence
- less anxious but less empowered women are characterised as 'excited' and needing stimulation
- more anxious, more empowered women are 'unsettled', needing control
- more anxious, less empowered women are 'fearful', needing comfort

While the emphasis on empowerment and anxiety is the explicit focus of the Rosenblatt model, and is also prominent in EdComs' classification, it runs as a strand through the other typologies, for instance it is reflected in the positive/negative axis in IDeA (2008) and in Wiggins and Newburn's (2004) 'Waiters' and 'Resigned but Regretful'. The emotional aspects of women's experiences of pregnancy and maternity services recur throughout this

review, and form a potential focus for the strategic role of communications in extending maternity choices.

3. Service Experiences & Perceptions

3.1 Service Experiences

There is extensive evidence concerning women's experiences of maternity care, covering basic factors such as the number of births, different facilities available, and outcomes, to more detailed points like numbers of antenatal appointments, medical interventions in birth, choices of pain relief and specialist care services available for women with high risk pregnancies (e.g. HCC, 2008, TNS System Three, 2005, Redshaw, et al., 2007, Ipsos MORI, 2008, CEMACH, 2007, Newburn and Singh, 2005, NHS Institute, 2006). Some of these data also show how the details of service provision vary between different trusts and maternity units, and for different groups of women.

The evidence is based on extensive user surveys, figures reported by NHS trusts and, to a lesser extent, feedback from healthcare professionals. Two sources are key here:

- the Healthcare Commission's major survey of 26,000 women sampled from all women giving birth during two months at the start of 2007 in all but three NHS trusts in England (HCC, 2007);
- NHS Maternity Statistics recorded by all hospitals in England for the year 2005-06; these are the latest full figures available (Richardson and Mmata, 2007).

It is clearly not the job of this review to build a definitive picture of care provision, but it is important to present an outline of some key figures to provide context for what follows. Further data on the choices currently offered to (and made by) women are given in Section 4 below.

Birth rate

- HCC (2008) reports a birth rate of over 600,000 births per year in England, and this is rising, for example by 1.6% from 584,100 in 2004/5 to 593,400 in 2005/6.

First contact and 'booking'

- 52% of women had seen a health professional during the first 6 weeks of their pregnancy; 94% had seen one by 12 weeks (HCC, 2007).
- 34% of trusts promote a midwife as first point of contact with maternity services for pregnant women (HCC, 2008).

Place of birth

- 93% of women gave birth in an obstetric unit; 3% in an Alongside Midwifery Unit (AMU); 2% in a Freestanding Midwifery Unit (FMU); 2% at home (HCC, 2008).
- Two thirds of trusts had no AMU or FMU (HCC, 2008).
- The proportion of midwifery unit births in different NHS Trusts ranges from none to 36% of women; the proportion of home births ranges from none to 11% (HCC, 2008).

- The proportion of home births can be higher in specific areas or units; e.g. 23% of women in Torbay expecting normal births had their babies at home (Edwards, 2005), as did 43% under the care of the Albany Midwifery practice (Sandall et al. 2001).
- 82% of home births were to women who had given birth before (HCC, 2008).

Type of birth

- 53% of women had spontaneous labour and delivery (without induction, use of instruments or CS); an estimated 47% of NHS hospital births were 'normal deliveries' (defined as without induction, without use of instruments, not by CS, and without general, epidural or spinal anaesthesia – although it is unclear if episiotomy is also excluded) (Richardson and Mmata, 2007).
- Normal delivery rates (thus defined) ranged between 37% and 59% depending on the unit. Smaller midwife-led units delivering less than 550 women per year reported 'normal' delivery rates of between 89-100% (Richardson and Mmata, 2007)
- Downe, et al., 2001 reported that 62% of births recorded as 'normal', within the NHS maternity care system in one regional health authority, in fact involved some form of obstetric intervention. Less than 25% of women were experiencing spontaneous births with no obstetric intervention (ibid).

Caesarean sections

- In 2007, 23% of women had a caesarean section, ranging from 12% to 34% between trusts (HCC, 2008).
- In 2006, the total CS rate varied between different trusts, ranging from 15% to 30% (Richardson and Mmata, 2007).
- The caesarean rate has increased sharply from 9% of all hospital births in 1980 to 24% in 2006 (ibid.).

Pain relief

- 6.5% of women overall reported not using any pain relief during labour and birth (9.7% of multiparous; 3.5% primiparous), and over half used natural methods such as breathing (HCC, 2008).
- 82% of women reported using gas and air; 32% pethidine or a similar opiate; 30% epidural (HCC, 2008).
- Epidural rates are reported to have increased over time for all women: for primiparous women, from 19% in 1987 to 59% in 2000; for multiparous women from 4% in 1987 to 23% in 2000 (Green et al., 2003).

Induction

- 75% of women reported that their labour started naturally, with the remaining 25% having been induced (HCC, 2008).
- When women are induced, assisted vaginal birth is slightly more likely (19% compared to 14% when labour started naturally) (HCC, 2008).

Mortality and morbidity

- Maternal deaths are extremely rare in the UK, with a maternal mortality rate for 2003-05 reported of 14 per 100,000 births (CEMACH, 2007).

3.2 Women's Views

The sources under review present extensive evidence that gives us an insight into women's feelings about maternity provision, based on both large scale surveys of women's views and qualitative studies. This includes: information about levels of satisfaction with different aspects of the service (e.g. HCC, 2007, Soltani and Dickinson, 2005, TNS System Three, 2005); women's insights into issues such as what makes them feel safe while giving birth (e.g. Magee and Askham, 2008) and what facilities they particularly value (e.g. Newburn and Singh, 2005). It also provides us with information about how these views vary across subgroups , and with different models of care (e.g. HCC, 2008, Redshaw, et al., 2007, Newburn and Singh, 2005).

It is important to frame the consideration of women's reported satisfaction with maternity care, with a caveat based on Porter and Macintyre's 1984 paper 'What is, must be best' (Porter and Macintyre's, 1984). In this influential paper the authors presented evidence from a study of pregnant women's satisfaction with maternity care and innovations in care. The authors concluded that pregnant women appeared to assume that whatever model of care they had been receiving was the best for them. The results suggested that, when questioned by researchers, women were fairly uncritical; assuming that the care they received had been well thought out and hence was likely to be the best option. This held regardless of the actual care arrangements they had experienced, leading the authors to use the term 'What is, must be best' to describe the conservative attitude of the interviewees.

This finding has clear implications for how we read reports of women of satisfaction with care. Firstly, uncontrolled studies assessing preferences for specific types of care, or satisfaction with care will be hard to interpret and are likely to overestimate actual levels of satisfaction (Porter and Macintyre, 1984). Secondly, if women are asked to say what they think of new care arrangements that they have not experienced, they are likely to considerably underestimate how much they may be positive about the new system once they have actually tried it (ibid). This could lead to current systems of care 'reproducing' themselves as women opt for those aspects of care they have previously experienced - an important point in relation to any attempts to influence women's choices towards new models of care.

Another confounding factor in reading women's reported satisfaction with maternity care is that a positive outcome in the shape of a healthy new baby can overshadow any dissatisfaction or negative experiences that were experienced during labour and birth. For example, Magee and Askham (2008) report that '*Even where concerns were raised, an ultimately happy outcome still made women reluctant to describe their overall care as unsafe*' (Magee and Askham, 2008: 37).

The figures presented below often provide a fairly encouraging picture with a majority of women usually more positive than negative about their experience of maternity care services. However, it is also important to be aware of the

personal stories behind the statistics. For example concluding remarks in a large quantitative study by TNS System Three (2005) state:
'*…overall performance of maternity services was good:*
- *less than 1 in 10 rate services as poor but also less than a third use the top box rating of very good*
- *dissatisfaction was more likely to be with the giving birth stage than any other stage; it should be remembered however that this is an emotional time, and those who have had a less positive experience are likely to be quite vociferous…*' (TNS System Three, 2005: 59)

However, as well as these positive headline findings, the study also includes a list of verbatim comments from open questionnaire questions. These give a more negative impression, illuminating the individual stories and experiences of women which put these conclusions in a different light. For example:

'*….Never saw the same person twice and was always made to feel like I was wasting their time. I know they are busy but they made the birth of my child a nightmare that even eight months later it makes me want to cry when thinking about it.*' (ibid: 61)

'*I seemed to be completely abandoned after the birth of my baby…..I was offered no food, the bed was left in a high position and I wasn't shown the buzzer or told I could buzz. The side-car cot was not set-up for me. So I was left alone in the dark in the middle of the night with no support. It was terrifying.*' (ibid: 63)

'*I could not possibly list the improvements that would need to be made for the postnatal care to be even near satisfactory. I feel the whole system needs to be changed to be much more family friendly and for fathers or other support people to be present after birth.*' (ibid: 64)

Hence, it is important to remember that quantitative surveys tend to report women's experiences in one dimension at a time, and miss the richness and depth of experiences that can be provided by women's stories.

With these points in mind, we now present the evidence about women's views and satisfaction.

Overall views about maternity care
A majority of women express fairly positive overall views of maternity care. For example, the major HCC (2007) survey of women's experiences of maternity services reported that around 90% of women rated the care they received during pregnancy, labour and birth as 'excellent', 'very good' or 'good'. Another large questionnaire survey of pregnant women and new mothers for the NHS reported similar results, with 79% of women rating maternity services as a whole as 'very good' (28%) or 'fairly good' (51%). Only 15% rated them as 'neither good nor poor' and 7% as 'fairly poor' or 'very poor' (TNS System Three, 2005).

A smaller quantitative survey found that, aside from specific medical issues that prevented choice, 72% of women said that they were ‘definitely’ (34%) or ‘to some extent’ (38%) able to have the type of birth they wanted (Babyexpert.com, 2008). A further 28% said they were not. The same study also reported that 79% of respondents said that, overall, their maternity and childbirth experience was ‘definitely’ (42%) or ‘to some extent’ (37%) positive, with 21% saying it was not (ibid).

Looking across the survey data above, while the majority of women report broadly or definitely positive experiences, it can inferred that a significant minority of women – between 20%-30% - report more negative experiences.

As the introductory remarks above imply, the causes of dissatisfaction may be best revealed through qualitative research which can record birth stories. However one of the big quantitative surveys does ask women identify the elements of their care with which they were most dissatisfied (TNS System Three, 2005). When prompted with a list of six aspects including professionalism of staff, support given by staff, aspects of information given by staff, and flexibility of the service to meet the women’s needs, the two areas rated consistently lowest by respondents were ‘amount of information given by staff’, and ‘flexibility to meet your needs’.

Views about antenatal care
These overall levels of satisfaction are largely reflected when we look at a breakdown of experiences of different aspects of maternity care, starting with antenatal care. For example, the TNS System Three (2005) study found 83% of women said they were ‘fairly’ or ‘very’ satisfied (herafter grouped as ‘satisfied’) with antenatal care; this broadly relates to the 90% satisfied with care overall in the HCC survey (2008).

A large scale online questionnaire survey found a mix of views from women about the antenatal classes they had attended. These ranged from positive to dissapointed and even angry or frightened (Nolan, 2008). Perceptions of antenatal classes are discussed in detail in Section 5 below.

Views about perinatal care
89% of women in the HCC (2007) study rated overall care during labour and birth as ‘excellent’, ‘very good’ or ‘good’. 79% of women in the TNS System Three (2005) study said they were ‘fairly’ or ‘very’ satisfied with care during birth, with 14% saying they were dissatisfied.

In relation to pain relief during labour and birth, two different studies found 55% and 64% of women (respectively) saying they definitely got the pain relief they wanted, with 25% and 28% (respectively) saying they did ‘to some extent’ (Babyexpert.com, 2008, HCC, 2007). In the Babyexpert.com (2008) study, 17% of women reported that they did not get the pain relief they wanted, although for 8% it had not been possible for them to have it. The HCC (2008) reported that in a quarter of NHS trusts, the picture was considerably worse with 25% of women not feeling they got the pain relief

they needed (reflecting the significant variation seen between trusts in many aspects of maternity care, discussed above).

The birth environment is another important area, as discussed below (e.g. Newburn and Singh, 2005, Dykes and Silk, 2007). Cleanliness is one of the top issues for women (e.g. Newburn and Singh, 2003). In one major study, the percentage of women reporting that facilities were very clean was: 63% for the labour and delivery room; 49% for toilets and bathrooms on the delivery ward; 46% for the hospital room or ward after delivery were very clean; and 36% for toilets and bathrooms after delivery (HCC, 2007). As well as cleanliness, homeliness is another attribute which is widely-reported as being valued by women. In Newburn and Singh's 2005 study while 96% of women reported having a clean room, only a minority felt the room was sufficiently homely feeling, 58% saying it felt 'clinical'.

Views about postnatal care

The 2007 HCC survey found that women were slightly less positive about their postnatal care, with 20% rating this as only 'fair' or 'poor'. Similarly in the Babyexpert (2008) survey reported 28% of women rated their postnatal care as 'below average' or 'poor'.

Of the respondents in the HCC (2007) study who stayed in hospital after birth, 42% said they were not always given the information or explanations they needed. Just over 20% of women said that midwives or other carers had not given them consistent advice, practical help or active support and encouragement with regards to feeding their baby (ibid). 21% said that they would have liked to have seen a midwife more often after the birth of their baby (ibid).

Views of the care provided by maternity staff

The ratings for satisfaction with care provided by healthcare professionals generally appear higher than those for maternity care overall and many other specific aspects of care (although the methods and measures are not strictly comparable). For example, The HCC (2007) reports 68% of women 'definitely' and 27% 'to some extent' having confidence and trust in the staff caring for them during labour and birth. 70% of women said that the midwife care they received was 'excellent', and only 4% that it was 'not good' or 'not good at all', in Newburn and Singh's (2005) study. The Babyexpert.com (2008) study reported 74% of women rating the midwife care they received during labour and birth as 'excellent' or 'very good'. 16% rated it as 'average', and 9% 'below average' or 'poor'. 62% said that they 'definitely' had confidence and trust in the staff caring for them, 26% had 'to some extent' and 12% said they did not (ibid).

More specific feedback on the way women feel they have been treated by maternity staff is also reported. For example, in the context of antenatal care, labour and birth, over three quarters of women said that they had 'always' been 'spoken to in a way they could understand', 'treated with respect and dignity' and 'treated with kindness and understanding' (HCC, 2007). However, there was a noticeable drop in satisfaction with care from professionals

postnatally, when just under 75% of women said they had always been 'spoken to in a way they could understand', 66% felt they had always been 'treated with respect and dignity' and 63% 'treated with kindness and understanding' (ibid).

3.3 Factors that influence satisfaction with care and other outcomes
A number of the sources reviewed here provide valuable evidence about factors that influence women's levels of satisfaction. Some further factors are identified which also directly influence outcomes, and thus interact with the determinants of satisfaction, which themselves relate to outcomes.

Two sources in particular provide lists of factors influencing satisfaction and other outcomes:

- In reviewing evidence relevant to women's choice of place of birth, Kenyon and McCandlish (2008) identified four main factors suggested by the literature that predominantly influence women's experience of pain in labour and their feelings of satisfaction (discussed further below). Two of these relate directly to the women's experience of caregivers. The four are:
  - personal expectations
  - amount of support given by caregivers
  - quality of the caregiver-patient relationship
  - involvement in decision making

  The authors comment that '*most powerful influence is probably the attitude of the caregiver*' (ibid: 10). They also note that these factors appear to override the influence of others including age, ethnicity, preparation for birth, environment, pain immobility, interventions and continuity of care.

- The 2005 TNS System Three survey analysed how four different factors contributed to women's reported satisfaction:
  - the amount of encouragement given to the child's father by maternity staff had a noticeable effect, with an average score of 4.5 (out of a top satisfaction score of 5) from women who reported the father had had a lot of encouragement; 3.8 where he had had a little encouragement; and 2.8 where the woman had reported that the father had received no encouragement.
  - the extent to which women felt well-informed to make decisions about the type of birth they wanted also had a large effect. An average satisfaction score of 4.3 was found for those who did feel sufficiently well-informed, compared to 3.1 for those who did not.
  - continuity of care had a smaller effect with women whose baby was delivered by the same midwives who provided antenatal care scoring an average of 4.4, and those whose baby was delivered by different midwives 3.9.
  - of the factors analysed, place of birth had fractionally the smallest effect on satisfaction, with those giving birth at home having a mean satisfaction score of 4.2 out of 5; those giving birth in a general hospital

scoring 4.0 out of 5 and those giving birth in a midwife-led unit having a mean score of 3.9.

Looking across the sources under review, it is possible to identify the following list of factors that seem to emerge as important in determining satisfaction and other outcomes:

- the care received from, and relationships with, maternity professionals
- empowerment, control and expectations – both during birth (through, for example, involvement in decisions, being well informed and feeling in control of what medical staff are doing); and antenatally in terms of, for example, expectations about medical intervention in birth, feeling confident about giving birth naturally and anxiety about pain
- birth environment
- place of birth
- choice
- the role of the baby's father

If we also consider what makes women feel safe while giving birth, not just satisfaction, then the additional factor of having a good system in place to identify and respond to medical emergencies is also important.

Some overlap is evident between these factors (for example the type of relationship with maternity professionals and the birth environment may vary with place of birth). It is also worth noting that all of the factors listed above can have an effect on satisfaction via their effect on empowerment, control and expectations. For example choice can contribute to feelings of control or empowerment, and the way women are treated and made to feel by maternity care staff can play a key role in how in control and empowered they feel.

The detailed evidence behind each of these determining factors is summarised below.

Experiences of care from maternity professionals

Women's experiences of, and relationships with, maternity staff are repeatedly identified as being particularly important, a theme that is repeated through much of the evidence. For example, an investigation into women's views of safety in maternity care found that the women's "*feeling of safety was almost invariably based upon women's trust in the health professionals – in most cases midwives – caring for them"* (Magee and Askham, 2008: 9). As discussed above two of the four main factors identified by Kenyon and McCandlish (2008) as influencing women's experience of pain in labour and their feelings of satisfaction relate directly to the women's experience of caregivers (including that considered by the authors to be the most powerful determinant). They also report that the single most supportive thing women said midwives did for them during labour was provide motivation, encouragement and praise.

Newburn and Singh (2005) found that women who received more suggestions of strategies to cope with pain during labour were more likely to view the care received as excellent – and the more suggestions they received, the more

highly they rated care. Reciprocally, when women who expressed dissatisfaction in the TNS System Three study (2005) were asked an open question about what could have helped improve their experience, the top response in each case (i.e. whether antenatal care, postnatal care or care during birth) related to more support, or a better attitude from medical staff.

Continuity of care is another aspect frequently reported on. For example, when women had been cared for antenatally by the same midwife throughout, or the same team of midwives (whether this was a small team of 3 or less, or a bigger team) ratings for overall satisfaction stood at between 81-84% saying care was 'fairly' or 'very good', and 5% or fewer saying it was 'poor' or 'very poor'. However 51% of women who said they had been cared for by 'various midwives' rated care overall as 'fairly' or 'very good', and 24% as 'poor' or 'very poor' (TNS System Three, 2005). The difference between care with a single midwife, small team, or larger team is revealed when we look at the numbers scoring overall care as 'very good', which falls from 39%, to 26%, to 19% respectively (and 6% for women receiving care from 'various midwives').

Continuity of postnatal staff gives a similar, but slightly less drastic picture, with around 85% of women who were cared for postnatally by the same staff as antenatally or as during birth, rating overall care as fairly or very good. 68% who received postnatal care form a team they had not been cared for by before, rated overall care as fairly or very good (ibid). The large HCC (2008) study re-enforces this finding, reporting that a significantly higher proportion of women reported having confidence and trust in the staff caring for them if they had previously met any of them (HCC, 2008).

However, it is important to note that other sources question how important continuity of care per se. For example, Green et al. (2003) argue that the quality of interactions with maternity staff were more important than continuity of care, such that good relationships could be a more important overarching factor in determining women's satisfaction.

Empowerment, control and expectations

Green et al. (2003) report on two large scale questionnaire surveys that looked at women's expectations and experiences of birth (with particular focus on issues of control), one carried out in 1987 and the second in 2000. These studies allowed the authors to look at changes over time in women's experiences. They provide valuable insights not only into factors affecting satisfaction, but also how women's experiences and feelings interact with birth outcomes and impact on their subsequent psychological wellbeing. Some key findings from these studies include (ibid, Green and Baston, 2007):

- antenatal worry about pain and willingness to accept interventions were both associated with poorer postnatal emotional well-being (as well as higher rates of epidural use and lower rates of unassisted vaginal delivery)
- antenatal worry about pain was associated with women feeling significantly less satisfied than other women, and was the most significant of a number of independent predictors of postnatal emotional well-being
- factors associated with higer postnatal satisfaction scores included: a spontaneous vaginal delivery, no electronic fetal monitoring, involvement

in choice, feeling ‘calm’, ‘involved’ and ‘in control’ during labour, feeling in control of what staff were doing during labour

- lower satisfaction scores were associated with factors including: medical intervention in birth, lots of people coming in and out of the birth room, high levels of pain, feeling ‘frightened’, ‘out of control’, ‘powerless’ or ‘helpless’ in labour
- antenatal willingness to accept obstetric interventions is related to mode of birth; women with high ‘willingness to accept intervention’ scores are nearly twice as likely than those with low scores to have operative or instrumental births
- women with high ‘willingness to accept intervention’ scores were 2.5 times more likely to have an epidural
- women who had an epidural had nearly 6 times more chance of an operative or instrumental birth
- primiparous women were more than five times more likely to use epidural analgesia than multiparous women
- well educated and older women were less likely to accept intervention
- women were significantly more likely to have an epidural if their labour was induced

These findings directly show some of the aspects of expectations, empowerment and control that can affect satisfaction and other outcomes, however, the study provides more interesting insight when the results are examined further.

No overall difference was observed in women’s reported satisfaction with their birth experience, or in their postnatal emotional wellbeing, between the two surveys in 1987 and 2000 (ibid). However, significant changes had been taking place over this time, which illuminate a number of factors that have a key impact on wellbeing and satisfaction (ibid). The constant satisfaction and well being scores can be explained, despite considerable change in many factors, because some factors that increase wellbeing and satisfaction were improving, while others that decrease these measures were also increasing (ibid).

Thus, the negative effect on satisfaction scores associated with greater obstetric intervention and more epidurals, had been cancelled out by increases in women’s feelings of control over what staff are doing to them (which in turn is largely determined by being able to get comfortable, feeling treated with respect and as an individual and perceiving staff as considerate) (ibid).

With emotional wellbeing, primiparous women in the 2000 survey had significantly worse emotional wellbeing scores than multiparous women. No such difference was seen in 1987. The authors explain this difference by the difference in feelings of control of what staff are doing during labour (lower for primiparous women), and levels of epidural use (higher for primiparous). When these two factors are held constant the parity difference for emotional wellbeing disappears. In fact, if these two factors are held constant then an overall improvement in emotional wellbeing (and satisfaction) is seen from

1987 to 2000 (ibid). This finding suggests that there is potential to improve satisfaction and emotional wellbeing, rather than just hold them steady by addressing key issues of feelings of control and epidural use. These factors are in turn strongly influenced by how a woman is treated and made to feel by maternity staff, her pre-natal anxiety about pain, attitudes to obstetric interventions and feelings about how she will cope in labour. They also appear to relate strongly to the idea of empowerment and women's confidence in their ability to give birth naturally.

Taken together these findings illustrate the way in which antenatal expectations, anxiety and empowerment before and during birth all interact to affect birth outcomes and satisfaction, which in turn can affect longer term emotional well-being. They also illustrate the significant implications that different choices can have for subsequent experiences in labour and birth (as discussed further in Section 3 below).

Choice
The role of choice in satisfaction will be considered in detail in the next section, but it is important to note here the key point that choice can be strongly associated with satisfaction. For example, the HCC (2007) study found that 82% of survey respondents who said they had always been involved in decisions about their antenatal care, rated their overall maternity care as 'excellent' or 'very good'. This compared with only 25% of those saying they had not been involved enough in decisions about antenatal care. As discussed above, one of the factors having the biggest impact on satisfaction out of those looked at in the TNS System Three (2005) study was the extent to which women felt well-informed to make decisions about the type of birth they wanted.

Place of birth
Although place of birth was only found to have a small effect on satisfaction in the TNS System Three (2005) study, it was found to have significant effect in a large meta-study of evidence comparing different models of care. The majority of studies reviewed found that women's satisfaction with a range of factors (including information, advice, explanations received, preparation for labour and birth, choice of pain relief and the behaviour of carers) was higher for women giving birth in midwife-led rather than other models of care (Hatem et al., 2008).

Birth environment
Over 90% of women said that they felt the physical environment can affect how easy or difficult it is to give birth (Newburn and Singh, 2005, Dykes and Silk, 2007). The most important environmental factors that women said helped them have the kind of birth they wanted were sufficient space to move around, a comfortable adjustable bed and a private toilet facility. The environmental factors most hindering them were a clinical looking room and too little space to move around (Newburn and Singh, 2005).

Role of the father
The findings reported above shows the large impact that the amount of encouragement given to the child's father by maternity staff had on women's reported satisfaction (TNS System Three, 2005). Burgess (2007) reports a study that found that one of three predictors of a young mother's positive childbirth experience was her perception of a positive attitude toward the pregnancy by the baby's father. A range of other potential positive impacts of the father's involvement at birth were also reported (ibid). For example, when a woman's labour partner (which can include the father) knows a lot about pain control, women tend to have shorter labours and are less likely to have epidurals. When fathers have been prepared to participate productively in the labour, they tend to be more active participants and women's birth experiences tend to be better.

What makes women feel safe in labour and birth?
When discussing what made them feel safe in maternity care, we reported above that the most important factor women mentioned was the quality of care provided by staff caring for them, and this included adequate staffing levels (Magee and Askham, 2008). Other factors that women said were important included cleanliness, being well informed about what to expect, regular monitoring, availability of appropriate equipment, security on the labour ward, shared decision making, good communication between staff and early identification of, and immediate response to, problems (ibid.). From the point of view of most women in this study, having their baby in hospital reduced the risks and made both them and their partners feel secure knowing that there were professionals and facilities on hand to deal with any emergency. However, a small number identified the risks that could result from medical intervention, and one women (out of the 31 interviewed) said she would have felt safer at home (Magee and Askham, 2008).

3.4 Satisfaction reported by subgroup

Satisfaction can vary across the population of pregnant women according to a variety of factors. For example, age is reported as a clear factor affecting satisfaction in HCC (2008), with older mothers answering significantly more positively to most attitudinal questions. It is interesting to note that Green et al. (2003) report a range of determinants of higher satisfaction to be better for multiparous women, such as lower antenatal anxiety and lower use of epidurals. Although parity is obviously not a direct indication of age, and experience in birth is likely to be a key factor, this could still be a contributing factor in age differences.

There is also evidence that women from certain priority subgroups report different levels of satisfaction than women overall, for some aspects of their care, generally reporting more problems with care and lower levels of satisfaction; yet with some examples of similar or higher satisfaction (e.g. HCC, 2008, Redshaw, et al. 2007, EdComs, 2005).

As with all women, a key area affecting satisfaction is relationships, communication and interaction with healthcare professionals. Because

women from priority subgroups often had specific needs this key area could sometimes be even more crucial for them than for other women, and had the potential to significantly improve, or worsen a women's experience of maternity care (e.g. EdComs, 2005).

Examples of areas where problems or shortcomings are reported include: lower levels of confidence in staff providing care; women less likely to report feeling treated with respect and talked to in a way they could understand; lack of appropriate skills and knowledge from staff; feeling patronised and bossed about; discrimination and insensitivity to cultural needs (HCC, 2008, Redshaw et al., 2007, EdComs, 2005, Taylor and Newall, 2008, Ipsos MORI, 2008Law et al., 2008).

However, supportive, empathetic and knowledgeable health professionals were also reported, who made women feel well looked after and confident (EdComs, 2005). In some cases the relationship with a specific carer could have a key positive impact for women in very vulnerable circumstances (ibid). Other specific positive feedback was reported by HCC (2008) which found that many views expressed by women of Black or Asian origin about standards of care were similar to those reported by women overall, and in some cases women of Black or Asian origin gave more favourable responses. For example, women in these groups gave more favourable responses than the majority in relation to being treated with dignity and respect, and being given explanations they could understand, during postnatal care (ibid).

Women with learning difficulties and pregnant teenage women reported feeling out of place when they attended antenatal classes (EdComs, 2005). This finding is echoed by Tope et al. (2008) who report a study that suggests the main reason for some groups of women being reluctant to attend antenatal appointments is that some individuals believe they will not integrate into mainstream groups (Kurtz et al., 2005 in Tope et al., 2008). Other women reported not attending antenatal classes because they did not provide the necessary privacy (EdComs, 2005).

Also relevant for some groups are specialist, tailored services or information sources, and these can contribute to satisfaction and more positive outcomes. For example, Ipsos MORI (2008) reports that tailored antenatal sessions for teenagers were well received. A series of specialist information sources and channels were developed as part of a project to reach and engage women at increased risk of infant mortality including, peer support volunteers, a 'health wheel' that listed maternity services and contact numbers, and a dedicated free maternity help line staffed by trained midwives (Walker 2008). These were found to be successful in engaging target groups and positively changing behaviours associated with maternity outcomes.

Fathers

There is much less evidence about men's experiences and views about maternity services than those of women. As discussed above, fathers can often play an important role in contributing to outcomes and support for mothers, and many mothers actively want their baby's father involved in

maternity care (e.g. Burgess, 2007). Some key findings for this group in relation to satisfaction with maternity care are:

- Men gave similar responses to women in relation to satisfaction with different aspects of maternity care (including aspects that they rated worst), although the men's responses tended to be on average more positive (TNS System Three, 2005).
- The extent to which fathers felt they were encouraged by maternity staff was found to correlate with men's reported satisfaction (i.e. the more they felt encouraged by staff, the more satisfied they felt) (ibid). Men were again more positive than women here, tending to feel that they had been encouraged more than women felt their partners had. However, the amount of encouragement men reported receiving was significantly less at the postnatal stage (with an associated notable decline in satisfaction).
- The amount of encouragement men reported varied significantly by socio-economic grade, with 37% of men from the DE group reporting receiving no encouragement, but only 24% of C1C2 men, and 21% of AB men reporting this (ibid).
- Fathers often perceive maternity services (and information - as discussed below in Section 5) as being focused strongly on the mother and baby (ibid):

  '*You just feel like you are tagging along*'
  (Father from DE socioeconomic group – ibid: 57)

- Although there are examples of positive stories where midwives in particular were supportive, evidence from teenage fathers tended to show that they felt significantly excluded by maternity services and many maternity staff (e.g. EdComs, 2005, Working With Men, 2007). For example, young fathers reported feeling unwelcome, marginalised or uncomfortable (Working With Men, 2007; Burgess, 2007). Stereotypes of irresponsible, feckless young fathers were reported by one study as '*rampant*' among professionals working with young mothers (Working With Men, 2007: 11). Another study cited by Burgess (2007) found systematic exclusion of young fathers, mainly from a Black background, in a London hospital maternity service.

3.5 Staff Views

The views of maternity staff are important because staff can determine the experiences of women, and their partners and the information and care they provide is often key to satisfaction, as discussed above. As the interface between women and the maternity system, staff will have a pivotal role in determining the extent to which extended choice is offered to women.

As with the research on women's views, a mixture of surveys and qualitative studies provides the evidence about what maternity professionals think about maternity services, the women who use them, and the experience of working within them (e.g. Smith and Dixon, 2008, Tope et al 2008, Ipsos MORI, 2008, Law et al., 2008) . There is also a significant body of evidence from academic practitioners – mainly midwives – who provide some very valuable insights

(e.g. Kirkham and Stapleton, 2001, Edwards, 2005, Deery, 2008). An important point to note is that much of the available survey data comes from midwives, with very little from doctors. For example, in Smith and Dixon's (2008) survey of healthcare professionals, 80% of respondents were midwives and 3% obstetricians, despite '*extensive efforts to target doctors*' (Smith and Dixon, 2008: vii).

Staff Views of Maternity Services
The evidence reviewed predominantly introduces a range of concerns raised by maternity staff about maternity services, or shortcomings in services. Positive views are much less reported, although this could perhaps be influenced by the fact that at least some of the studies are focused on identifying, and looking for solutions to, any problems (e.g. Smith and Dixon's, 2008 study asked participants only about problems and potential solutions, not successes). Tope et al (2008) report that when 'key leaders in the field of maternity care' (Tope et al, 2008; p.34) were asked about which model of care from anywhere in the world they admired, although New Zealand and the Netherlands were most often mentioned, the UK system was also 'much admired', including by those employed within the NHS (Tope et al, 2008; p.37). This said, there is considerable evidence of problems and dissatisfaction expressed by maternity professionals.

A key issue, where there is significant agreement among healthcare professionals is that of caesarean sections (CS). Tope et al. (2008) report that just over half of consultant obstetricians in England, Wales and Northern Ireland believe that the caesarean rate within their departments is too high. The NHS's Institute for Innovation and Improvement's in depth investigation into caesarean sections reports '*wide professional unease at the continuing increase in CS rates …The majority of senior obstetricians and midwives believe that rates could and should be lower.*' (NHS Institute, 2006: 5). This professional view has since been incorporated in DH policy. 'Maternity Matters' builds on 'Focus on: Caesarean Section' in calling on commissioners to set targets for reducing interventions, noting that: *"High rates of interventions, such as large numbers of caesarean sections, could lead to worse outcomes for mothers and their babies, as well as being less cost effective for the NHS*." (DH 2007:21).

When it comes to the general issue of intervention more generally, there appears to be less agreement among staff. For example, one of the issues within current maternity care that midwife respondents felt was making the service less safe was the increased medicalisation of birth (Smith and Dixon, 2008). However, the small proportion of obstetricians responding to the same survey did not generally see medicalisation as a problem.

General concerns about capacity, funding and prioritisation of maternity services are also apparent. For example, a senior midwife in one review is reported observing '*all services completely overwhelmed'* (Tope et al., 2008: p.34), and concerns are also expressed about finance taking precedence as a driver over safety and choice (ibid.). Smith and Dixon (2008) also found

evidence provided by maternity staff that some managers were overly focused on finance compared with safety.

Other issues that staff identified as potentially affecting safety and quality in maternity services included:

- increasing medical and social complexity of the (ever increasing) population of pregnant women. Maternity services are seeing more women, and more of them have characteristics that can increase the risk of medical complications, like obesity, existing diabetes, and more older women (Smith and Dixon, 2008) At the same time, services are working with more women with complex social needs, such as substance abuse, mental health problems and asylum seeking status (ibid).

- inadequate training, education, experience and skills was seen as an important problem. For example, midwives are no longer trained as nurses, and have less hands-on training, and junior doctors have less experience than in the past (Smith and Dixon, 2008). Medical staff may also have problems spotting certain symptoms, such as mental health problems, and can be unsure about appropriate courses of action when they do see problems (Ipsos MORI, 2008). Lack of appropriate behaviour and sensitivity are often reported. Some staff report feeling increasingly challenged by the amount and complexity of evidence and information they are expected to communicate to women (Kirkham and Stapleton, 2001). Another important point here is that some midwives and a greater number of (especially junior) doctors are not experienced in natural childbirth (i.e. spontaneous vaginal delivery without medical intervention) (e.g. Law et al., 2008, Smith and Dixon, 2008, NHS Institute, 2006).

- low staffing levels and fewer experienced midwives was another problem raised by professionals (Smith and Dixon, 2008). Numbers of midwives (measured as full time equivalent) have remained almost unchanged over the past decade, despite a rising birth rate (Smith and Dixon, 2008; AIMS, 2008) and this has led to a national shortage (Law et al., 2008). There is a decline in more experienced older midwives, and nearly half of the current workforce are estimated to be likely to retire in the next 10 years (Law et al., 2008). By contrast, the number of consultants has significantly increased from 1,054 in 1997 to 1,605 in 2005 (AIMS 2008)

How staff view pregnant women

An important issue relevant to the care experienced by women, and for consideration in communications work, relates to how maternity staff view and relate to pregnant women. Stereotyping of pregnant women is mentioned in a number of sources (e.g. Kirkham and Stapleton, 2001, Green et al., 1990). Women can also be judged according to the choices they make in pregnancy and birth, with staff expressing disapproval about, or even trying to block, certain choices such as wishing to give birth at home (Law et al., 2008, Edwards, 2005, Kirkham and Stapleton, 2001).

Some staff expressed mixed feelings about women making choices. For example, some feel that women should not be asked to make choices if they do not have necessary information or experience (OLR, 2008). Others have spoken of feeling like they were 'walking a tightrope', having to balance the provision of information and facilitation of choice with the desire to protect women from harm, which could lead to their gate-keeping information (Law et al., 2008: 38). Others have admitted withholding information because it contradicted their personal philosophy, or local policies (Law et al., 2008).

Issues relating to working in the maternity system

A significant point which recurs through the literature is the fear of litigation, and the effect this can have on care provision and staff behaviour. For example, Kirkham and Stapleton (2004) suggest that the threat of malpractice has accelerated a trend towards more conservative and defensive clinical practice. Kirkham and Stapleton (2001) report that fear of litigation appeared to be a major factor influencing how choices are presented to women, and cite obstetricians who '*were of the opinion that it was fear of litigation, rather than striving for standards of excellence, which was currently the primary motivation for change in the maternity services*' (Kirkham and Stapleton, 2004: 120). Law et al. (2008) re-enforce this point when they report that choices could be seen as 'right' or 'wrong' depending on whether staff felt they offered them protection from litigation.

The evidence under review also touches on the experiences of maternity staff of working within the maternity care system. The 2008 HCC review of maternity services reported key differences between doctors and midwives ('*the two key professional groups employed in maternity services*' – HCC, 2008: 64). Midwives tended to feel more pressurised and frustrated, and expressed greater distress and unhappiness, than doctors. 28% of doctors and 58% of midwives responding to the staff survey in this study did not feel that the two groups (doctors and nurses) had shared goals (ibid.).

The hierarchical organisation of many maternity services often lead to midwives feeling less satisfied, and sometimes fearful of challenging senior staff, or feeling that they are compelled to follow protocols or 'normal' practice rather than provide more woman centred care (e.g. Law et al., 2008, Kirkham and Stapleton, 2001, Kirkham and Stapleton, 2004, Hastie, 2008). Midwives can feel stuck in the middle, torn between advocating for women and following authority and common practice within the care system (Kirkham and Stapleton, 2004).

Communication between midwives and doctors is also discussed, with evidence of midwives' clinical concerns being ignored by obstetricians (Kirkham and Stapleton, 2001). Only around a third of both doctors and midwives felt that a comprehensive set of information was routinely passed on at handover between staff (HCC, 2008). Hastie (2008) reports that a review of literature on the working relationship between midwives and doctors reveals a '*long history of rivalry, competition, ineffective communication and lack of collegiality*' (Hastie, 2008:18). More importantly, it also reports that poor

communication and collaboration between health professionals has been shown to affect both mortality and morbidity rates in maternity services (ibid).

There is some evidence that staff may have different experiences depending on the model of care they work in. For example, Wiggins and Newburn (2004) report midwives feeling more confident and less frightened by doctors in smaller maternity units, with flattened hierarchies and more trust and openness between midwives. However, other pressures can still operate in smaller units, such as burn-out from caseload midwifery (e.g. Sandall et al. 2001).

Cultures of maternity care
An important related issue that is repeatedly ascribed an important role in the literature, is the differences between underlying ‘cultures’ of different models of maternity care, which in turn is often determined by underlying philosophies associated with the medical / obstetric and midwifery professions. Essentially, the former is strongly rooted in a medical ‘illness’ based model of care, where normality of birth is only confirmed in retrospect – i.e. the focus is on medical problems (e.g. Law et al., 2008). Midwifery is based on a more holistic model of health where medical but also emotional and social outcomes are important, this model considers birth as normal until a problem arises (ibid).

Although these are probably most usefully thought of as two ends of a continuum (Hastie, 2008), this underlying difference can help understand tensions within maternity care provision, and differences between medical and midwife-led models of care. For example high quality medical care with high rates of medical intervention compared to birth promoted as normal with more women centred care (e.g. Law et al., 2008, Hastie, 2008, Tope et al., 2008, Kirkham and Stapleton, 2004).

This difference is well illustrated by the differences in responses by different staff to questions about safety in maternity care. Obstetricians tended to be most concerned about the increasing medical and social complexity of the pregnant population and low morale, whereas midwives were more focused on concerns about increased medicalisation - which they tend to view with suspicion while obstetricians see it as part of routine practice (Smith and Dixon, 2008).

The role of different cultures in influencing care recurs throughout the literature and operates on a number of scales. For example, the implications of different cultural factors associated with healthcare professionals and models of care for choice will be discussed further in Section 4 below. The effect of cultural and social factors operating at a wider level will also be discussed in relation to the role of media in Section 6.

4. Choice

The issue of choice has been given a high profile in maternity care, following its central place in policy (e.g. 'Maternity Matters' – DH, 2007), and its reported role in helping empower women and deliver more women-centred care (e.g. Law et al., 2008).

Most women want to be given choice and it is often associated with positive outcomes. For example, a questionnaire survey of pregnant women carried out as part of an investigation into choice of place of birth found 60% of respondents saying that they should be the one to make the decision about where to give birth. Less than 1% thought the decision should be entirely that of the doctor or midwife (Rogers et al., 2006).

As discussed in Section 2 above, greater involvement in decisions, and having choice, have been shown to correlate with women rating overall maternity care more positively. HCC (2007) found that 82% of survey respondents who said they had always been involved in decisions about their antenatal care, rated their overall maternity care as 'excellent' or 'very good'. In contrast, only 25% of those saying they had not been involved enough in decisions about antenatal care, rated overall maternity care as 'excellent' or 'very good' (ibid). Choice on where or when to have antenatal checks had a significant effect on overall satisfaction in the TNS System Three (2005) study, with between 87-90% of women who had choice about these rating overall care as 'fairly' or 'very' good, and around 60% who had not had these choices doing so. One of the factors having the biggest impact on satisfaction out of those looked at in the TNS System Three (2005) study was the extent to which women felt well-informed to make decisions about the type of birth they wanted.

A further good reason to be concerned with choice relates to the implications that certain choices can have for subsequent outcomes. For example, Green and Baston (2007) found that women with high 'willingness to accept intervention' scores were 2.5 times as likely as those with low scores to have an epidural. In turn, women who had an epidural were nearly six times more likely to have a caesarean section or instrumental birth. Implications extend beyond current pregnancies as women who have a natural birth in their first pregnancy are highly likely to do so again (NHS Institute, 2006). The implication of a choice for the potential to take up subsequent choices can be thought of as a 'choice cascade'.

4.1 The Nature and Value of Choice

Choice in maternity provision is only one element determining satisfaction and making up women-centred care, and it is a somewhat contested area. One review sets out some of the theoretical questions around informed choice (Law et. al, 2008) and many of these are apparent throughout the following discussion. However some additional points worth mentioning here are:

- Different authors approach the task of defining informed choice in different ways. For example: that decisions are based on relevant, good quality information and choices reflect the values of the decision maker (Demilew, 2004 in ibid); for choice to be informed alternative courses of action must be possible, and these need to be equally accessible, with reliable information about advantages and disadvantages available (Wiggins and Newburn, 2004 in ibid); '*a reasoned choice, made by a reasonable individual, using relevant information regarding advantages and disadvantages of all the possible courses of action*' (Bekker et al., 1999 in ibid). Our discussion about models of decision defined by Charles et al. (1999) below provides more clarity on this question.
- Others argue that the meaning of choice is ambiguous or even illusory, as it will inevitably be limited by different factors such as local facilities and confined to only options that the maternity services provide (e.g. Lindsay, 2006, Anderson, 2002 in ibid).
- Despite this, a respect for patient preferences has been described as a '*fundamental goal of medicine*' (e.g. Thomas and Paranjothy, 2001 in ibid). This point is discussed further, when we consider Charles et al.'s (1999) three decision making styles below .
- Some authors feel that the agenda of informed choice can lead to negative outcomes: for example, women may feel failed by healthcare professionals if their choices, which were made with the aim of maximising satisfaction, turn out not to be for the best (Lindsay, 2006 in ibid); or that women may be judged by others on the basis of the choices they make (Kightley, 2007 in ibid)

As well as these theoretical questions, women's own views also reveal the ambiguous nature of choice. For example, not all women want choices all of the time: note the less than 1% who thought that the decision of where to give birth should be entirely up to the doctor or midwife (Rogers et al., 2006). Kirkham and Stapleton's (2001) major study into informed choice found that many women did not see choice and control as the uppermost concerns, with the personal qualities and competencies of carers being more important to them.

As already discussed in Section 1 above, there is a notable group of women who are not interested in choice, or do not expect to be closely involved in choices around their care. This may be, for example, because they have already made their mind up about certain decisions, they are too anxious to want to think about them or feel that they will not be able to influence their care (e.g. Wiggins and Newburn, 2004, Hopwood and McDonald, 2006).

When we look at what women seem to want from maternity care (discussed in detail in Section 2 above), choice is only one of many aspects, and some of these appear to hold greater importance for women than choice. For example, relationships with, and treatment by staff play a key role in satisfaction, but also empowerment and other factors affecting outcomes (e.g. Green et al., 2003, Magee and Askham, 2008, Kenyon and McCandlish, 2008). Feelings of control are also important, and while this can sometimes be related to choice (and choice may be a pre-requisite for control – Green et al. 1998 in Law et

al., 2008), it is a wider concept taking in aspects like the extent to which women feel in control of what staff are doing during labour (Green et al., 2003). The relationship between choice and control is slippery; Law et al. (2008) discuss ways in which choice could reduce women's autonomy and control. This can be due to the fact that information provided can significantly determine some choices, but is often controlled by caregivers. Alternatively, choice could reduce control by increasing women's anxiety; this has implications for the extent and timing of information provision (see Section 5 below).

Some ethical concerns have been raised about a focus on patient choice, as its emphasis on the individual can potentially lead to the neglect of wider social implications (Parker, 2001). However Parker (2001) argues that choice, as part of patient-centred medicine, is ethically important as it can help even up the balance between individual patients and health care professionals, and guard the former against excessive paternalism from professionals. He further argues that a system that values patient autonomy and choice can be compatible with consideration of wider social implications, and this balance can be achieved in various ways including patient-practitioner consultation and the involvement of family members in decision making (Parker, 2001).

Following on from this, it is useful to draw on Charles et al.'s (1999) description of models of decision making in medical contexts (note that this framework is not specific to maternity care, although it has been widely taken up in this literature). These authors describe three main decision making styles; while these do not amount to a segmentation or typology of individuals, they help provide a clear underlying understanding of different approaches to decision making. These different approaches resonate with some aspects of the typologies discussed in Section 1 above, especially in relation to the extent to which women see the potential to engage in decisions, and the way information is shared and used. Decision making is characterised as a three stage process, involving information exchange, deliberation and the decision about treatment (ibid):

- Paternalistic model of decision making – where information exchange involves a largely one-way flow of medical information from physician to patient (often confined to what is legally necessary). Deliberation is by the physician alone (or in collaboration with other physicians), and the decision is made by the physician
- Shared model – both medical and personal information is exchanged in a two way process between the physician and patient. Deliberation involves both patient and physician (and sometimes others) and can involve discussion and feedback. The treatment decision is a shared one negotiated between the patient and physician
- Informed model of decision making – information flow in this model is again a one-way flow of medical information from the physician to the patient. In this case all relevant information for the decision is imparted. Deliberation is by the patient alone, or potentially in discussion with others (however the physician is not involved). The patient also makes the decision about treatment which should be accepted by the physician.

> Providing accurate information has been given, two different decisions made by two different people in exactly the same situation should both be considered correct and neither should be persuaded to change their mind.

Charles et al. (1999) point out that no one model is 'better' than others, and also that they represent a continuum rather than three discrete approaches; the choice of approach should be discussed with the patient, and will depend on the clinical circumstances.

Having a choice does not imply the mode of decision making used to make that choice. For example, a choice of place of birth could exist, but this does not automatically lead to empowerment or improved care for women, and the choice could be made entirely paternalistically by a caregiver. In Charles et al's model, informed decision making requires information to be given to the patient who then makes an entirely autonomous decision about care. This is clearly not how much decision making in the context of maternity care is carried out, with frequent descriptions of medical professionals involved in decisions: both in a way that tends towards the paternalistic with information withheld or scare stories used to sway women's choices (see below - e.g. Kirkham and Stapleton's, 2001, Edwards, 2005); and in a way that tends towards shared decision making with professionals (usually midwives) supporting women with decisions based on two-way exchange of information and development of trust (e.g. Edwards, 2005, Sandall et al. 2001, Page, 2000).

This may also help deal with the issue of different women wanting different levels of involvement in decisions (or the same woman wanting different involvement at different times). Charles et al. (1999(a) and 1999(b)) present the decision making models as a dynamic continuum, where the model used can shift depending on changing wishes of the patient and changing circumstances – for example if a patient decides that they do not want to make a decision on their own, then informed decision making can shift to shared decision making. This may be useful in the maternity context as the degree of autonomous decision making desired, important, or even possible, may change throughout pregnancy.

Law et al. (2008) discuss the relationship between choice and consent, and the danger of confusing the two. Making a choice is often closely linked to consent but does not automatically infer consent, and it is legally important for healthcare professionals to be clear about consent (Law et al., 2008). Another important dimension in understanding choice is that of uncertainty and risk (e.g. Leap, 2000, Edwards, 2008). Choices in maternity care can often be presented in terms of relative risk. However, a fundamental and inescapable fact about pregnancy and childbirth is that it always contains an element of uncertainty. Page (2000:373) describes childbirth as:

> *'…one of the most complex fields of evidence-based healthcare because, although a considered judgement can be made on the probability of adverse outcomes, adverse outcomes, including death and cerebral palsy, can never be entirely ruled out.'*

A linked point relates to the statistical information that is often used to inform choices. Statistics describe probabilities at the level of populations, yet women are making personal decisions about themselves as individuals, and population level information only has limited usefulness (Page, 2000, Edwards, 2008).

'*In practice an individual is not a statistic*'
(Page, 2000: 372).

What's more, safety or risk as presented to women is usually defined within the constraints of the healthcare system offering care, which carries its own problems:

'*The safety being defined here* [within the context of medical maternity care] *is safety within the context of institutionalised, fragmented, understaffed services that need to cut costs even further.*'
(Anon, 2008 in Edwards, 2008: 466)

This also applies because safety, risk and the outcomes aimed for are partly defined by society and the care system (e.g. Edwards, 2008). For example, physical safety defined as mortality and morbidity at birth is often the prime focus of maternity care. While this is clearly fundamental, important outcomes and aspects of safety defined by women themselves can give a wider picture, encompassing longer term emotional wellbeing, personal integrity and safety for the whole family, as well as these immediate physical outcomes (Page, 2000, Edwards, 2008).

As a result choice is often not at all clear-cut:

'*The uncomfortable fact is that no amount of screening and information giving can give pregnant women and new parents the complete certainty they seek or indeed the ability to make 'the right choice*'.
(Leap, 2000: 4)

Different responses to this fundamental uncertainty and risk underlying pregnancy and childbirth, and resulting approaches to choice, can be discerned by referring to the distinction between medical and midwifery approaches described in Section 2 above (while remembering that they are points on a continuum). Thus in the medical model, risk is likely to be scientifically and medically defined (e.g. Edwards, 2008). A response to risk in this context can be to reduce uncertainty by using standard practice, close monitoring and medical management of birth (e.g. Edwards, 2008, Page, 2000). The use of medical intervention as a prophylaxis against litigation is a further example for this possible response (e.g. Kirkham and Stapleton, 2004). In a midwifery care model, risk is likely to be more holistically defined with reference to women's longer term wellbeing and feelings of integrity (e.g. Page, 2000, Leap, 2000). Uncertainty is more likely to be accepted and addressed using a variety of approaches in addition to careful clinical examination and care, such as building the confidence and empowerment of

the woman, ‘watching’, trust in the woman’s own expertise in her and her baby’s health, and mobilising wider community support (e.g. Page, 2000; Leap, 2000, Sandall et al. 2001).

Approaches to choice follow from these different approaches; most interestingly, neither approach considers choice central, or entirely supports free choice for women.

For example, in the medical model context, choice can be seen as potentially risky if it goes against the standardised approaches used to manage uncertainty. As a result, local medical policy, standard practice, or professional opinions can define ‘right’ and ‘wrong’ choices (e.g. Kirkham and Stapleton, 2001; Law et al., 2008). Time and other constraints can also make choice difficult. For example, it may take time to properly inform women and support their decisions (e.g. Kirkham and Stapleton, 2001). There can also be problems in terms of service capacity to offer certain choices, such as home births (e.g. Rogers et al., 2006).

In a midwifery-led model, there can also be constraints on capacity to offer choices, such as continuity of care (e.g. Sandall et al., 2001). On the surface, choice in this model tends to be seen as less threatening and more desirable, and is supported as part of empowering women. For example, Law et al. (2008) report that more women-centred types of care facilitate choice the most. However, choice can also be seen as disempowering and Leap (2000) describes how ‘embracing uncertainty’, and following a ‘wait and see and keep your options open’ approach, can sometimes help empower women. Midwifery-led models of care can sometimes be seen as having their own agendas, and advocate their own ‘right choices’. For example, Sandall et al. (2001) report that in the evaluation of the Albany midwifery practice, some medical staff expressed concerns that midwives from the practice were expressing their choices, not those of the women receiving care. More fundamentally, a key element of the approach of the Albany midwifery practice to choice is their preference for encouraging women to leave decisions about place of birth as late as possible, arguing that it is only when in or near labour that women can know what they want (ibid.). It is notable that such a strategy contributes to the high levels of home birth achieved.

4.2 The specific choices in maternity care

‘Maternity Matters’ is the key document in defining policy around choice in maternity care, setting out ‘national choice guarantees’ that promised childbearing women four key choices (DH, 2007):

- choice of how to access maternity care;
- choice of type of antenatal care (essentially choice between midwifery care or care provided by a team including midwives and obstetricians);
- choice of place of birth *(‘depending on their* [women’s] *circumstances’* - ibid: 12);

- choice of postnatal care (essentially, the choice between receiving postnatal care at home or in a community setting).

However, beyond these core policy guarantees, there is a huge range of different choices potentially faced by pregnant women. The quantity of choices in maternity provision is another aspect of decision making which sets it apart from other areas of health care (Law et al., 2008). We list these now to demonstrate the significant task that we (let alone pregnant women) are concerned with when considering choice in maternity care. This is not an exhaustive list, but gives a good overview of the range of choice. Law et al.'s (2008) review includes a similar list of choices, identified as important to women in five sources in the literature (MIDIRS 2005a and 2005b, TNS System Three, 2005, Department of Health, 2007, NHS Choices, 2008 in ibid). Our list does not attribute choices to sources, but simply brings together all those identified in the available evidence. We star those common to Law et al.'s (2008) list and our own.

Antenatal choices (inc.)
Place of first contact – e.g. with a GP or midwife *
Place of booking interview
Antenatal classes – whether to attend these, and if so, which ones to attend
Place for antenatal check ups
12 week (dating) scan – whether to have the scan *
Anomalies scan – ditto *
Antenatal screening, for example for Downs Syndrome – both initial through combined blood tests and neuchal fold; and if a risk is identified, whether to have amniocentesis *
Attempting to turn a baby in breech presentation *
Intrapartum choices (inc.)
Place of delivery *
Mode of delivery
Assistance during birth, including healthcare professionals and partner or other birth attendants *
Fetal monitoring, and continuous fetal monitoring in labour *
Analgaesia – whether to have this, and what type *
Use of other pain relief, such as TENS machine, or breathing techniques *
Birth position and mobility during labour *
Whether to use water during birth *
Use of other special equipment, such as wall bars or birthing balls *
Birth choices when baby is in breech presentation *
Whether to choose to give birth vaginally after a previous caesarean *
Use of instruments during birth *
Use of episiotomy and stitching *
Whether to allow the presence of students *
Whether to give the baby a Vitamin K injection *
Whether to give the baby a blood spot test
How to respond if labour does not start on the due date *
Use of induction or acceleration, and methods chosen for this

Choices about the Third Stage of labour *
Whether to have skin to skin contact with the new baby *
Postpartum choices (inc.)
Whether to initiate breastfeeding or bottlefeeding *
When to leave the hospital
Postnatal choices (inc.)
Who will provide postnatal care and for how long *
Where to receive postnatal care

Within this longlist of choices, it is possible to bring together some of the figures that illustrate the availability of some choices and what women currently choose. Data are not available for all of the choices listed above, and the overview below focuses on those choices which can be deemed to be of particular importance (because they are related to outcomes and satisfaction).

Antenatal choices

At the start of pregnancy, 91% of women surveyed said they had been able to see a healthcare professional as soon as they wanted after they had found out they were pregnant (HCC, 2007). 78% reported going to see their GP first (ibid), with between 10-20% reporting they made contact with a midwife first (slight variation in percentage reporting this from: HCC, 2007 and TNS System Three, 2005). Of the vast majority who did not go to see a midwife first, only 14% said they realised that this was an option (TNS System Three, 2005). The fact that this option is not widely publicised is further illustrated by the fact that 48% of those who knew about this option, did as a result of a previous pregnancy (ibid.). HCC (2008) found that only 34% of trusts report promoting midwives as a first point of contact. However, there is evidence of demand for having initial contact with midwives, with 53% of women in another survey saying that they would like to see a midwife first (Soltani and Dickinson, 2005). Women in a number of subgroups (including BMEs, those living in most deprived areas and single women) were more likely to recognise pregnancy later, make first contact with a health professional later, and book for antenatal care later (Redshaw, et al., 2007). Teenage mothers also on average book for antenatal care later than other women (DH and DCSF, 2007). There is a clear case for increasing women's awareness of the opportunity to make midwives their first point of contact, if the first national choice guarantee of Maternity Matters is to be delivered (DH, 2007).

Notably, a significant proportion of women report not being offered NHS antenatal classes (36% reporting no offer in HCC 2007, although less than 30% reported this in Redshaw, et al., 2007). However, significant variation is seen both between different trusts (HCC, 2008), and depending on parity (14% primiparous and 76% multiparous women reported not being offered classes in the HCC, 2007 survey). The number of women who actually attend antenatal classes varies according to source with 61% of women responding said that they attended NHS antenatal classes in the HCC (2007) survey, but only 37% reported accessing them in the TNS System Three survey (2005). Uptake of antenatal classes vaired, being lowest among some subgroups . For example, 27% of women in the DE socioeconomic group access

antenatal classes, compared to 37% overall (HCC, 2008). Women from some groups seem less likely to be offered antenatal classes (e.g. BME women born outside the UK - Redshaw et al., 2007). Others, including single women and those living in the most deprived areas are as likely to be offered classes, but less likely to attend (ibid).

Two separate sources report significant proportions of women saying that they felt that did not have a choice about having the 12 and 20 week ultrasound scans (approximately 25% feeling this in both HCC 2007 and Redshaw, et al., 2007). However, 88% reported feeling they had a choice about the screening test for Down's Syndrome (HCC, ibid). In practice most women have these scans (e.g. 89% reported having the dating scan, and 98% the 20 week scan in the HCC, 2007, survey). HCC (2008) reports that women from a Black or Asian background are less likely to have a 20 week scan. However, for some subgroups of women who otherwise may be reluctant to engage with maternity services, scans can be the most used aspects of antenatal care, reported by these women to be because they provide valuable reassurance about the wellbeing of the baby (EdComs, 2005). This finding is significant as engaging women with antenatal care can help protect against negative outcomes.

Place of birth

By far the most detailed evidence relates to the choice of where to give birth. Initial impressions give a favourable picture with a good majority of women reporting being offered a choice of where to give birth (e.g. 81% of women in the large HCC, 2007 survey said they had this choice). However, this becomes more questionable when this figure is looked at in more detail. For example, Rogers et al. (2006) report that while 79% of the women they surveyed initially reported being given a choice, only 52% were offered more than one option for where to give birth in terms of the type of birthplace - i.e. only 52% offered more than a choice between two hospitals. Redshaw, et al. (2007) found only 10% of women reporting that they had been given a choice for place of birth that included a midwife-led unit or birth centre. This last result is perhaps unsurprising as only around a third of trusts have midwifery birth units (HCC, 2008), and Kenyon and McCandlish (2008) report that 54% out of 150 trusts reporting, had one obstetric unit only. There was evidence of variation by subgroup, with 39% of women from a Black background, 36% from an Asian background and only 26% overall, saying they had not been given a choice over place of birth, but would have liked one (Hopwood and McDonald, 2006). Redshaw et al. (2007) report similar findings, with 36.9% of white women reporting that they had only one hospital as an option, compared to 51.7% of Black and Minority Ethnic (BME) women and 58.5% of BME women who had been born outside the UK. A similar picture is reported for women living in more deprived areas, with 49.3% of women living in the most deprived 1/5 of areas (measured using the Index of Multiple Deprivation – ibid: 69) reporting only one hospital as an option, compared with 36.3% of women living in less deprived areas (ibid).

Home birth is also a restricted option, with only 57% of women offered this option (HCC, 2007). This figure (as many in maternity care) varies

significantly across different trusts, for example from 22% of women to 93% were found to be offered this choice depending on the trust (HCC, 2008). Only 19% of women surveyed across four trusts in South London reported being offered the choice of a home birth – although in this case around half of those not offered a choice reported not minding (Hopwood and McDonald, 2006). In this study, only 20% of those women who were planning a home birth said they felt fully supported in their decision, and 52% felt not supported at all (70% felt unsupported in one hospital) (ibid). Again there is evidence that this option is even more restricted for women from some subgroups . For example, 25% of BME women reported being offered home birth as an option, compared to 40% of white women.

Despite the fact that this is a fundamental decision, 37% of women in Hopwood and McDonald's (2006) study made their decision of where to have their baby at the GP appointment they had after first discovering they were pregnant (and 44% discussed place of birth at this appointment). 21% reported discussing birth place options at the booking appointment with a midwife and 14% made a decision about where to give birth at that appointment (ibid). As discussed above, flexibility about when this key decision is made could have an important role in helping empower women and even increase the rates of home births (e.g. Sandall et al. 2001, Leap, 2000).

Choices during labour and birth

70% of women in the HCC (2007) survey said that they had always been involved in decisions about care during labour and birth. It should be recalled that this correlates strongly with satisfaction (see Section 2). 61% of women said they could choose the position they wanted to be in 'most of time' during labour, with 24% saying they could 'some of the time' (HCC, 2007). 74% felt they could move around at least some of time during birth (although this varied between 57%-86% depending on the trust) (HCC, 2008).

With choices over induction there appears to be significant variation, with between 29% to 84% of women reporting that they had a choice about whether labour would be induced, depending on the trust (HCC, 2008). Redshaw, et al., (2007) report less overall choice in this area, with less than a third of the women they surveyed feeling they had a choice about induction. However, many of these women reported that this had not really been a 'choice' as the induction was deemed non-negotiable due to concerns over the baby's or mother's health. Less than 1% saw this decision as a real choice (Redshaw, et al., 2007). In practice, three quarters of women report labour starting naturally with the remaining quarter being induced (HCC, 2008). Official statistics report a slightly lower figure of 69% of labours starting spontaneously in 2005-6 (Richardson and Mmata, 2007).

Available choices of pain relief depended to a large extent on the place of birth, with only 8% of AMUs and no FMUs able to offer epidurals, although 80% of midwifery units can offer opiates (HCC, 2008). Even in obstetric units, choice could be constrained by provision as 7% of units reported having

problems offering epidurals at least once a week due to unavailability of clinical staff.

Only 6.5% of women overall in England reported not using any pain relief (this was slightly higher for multiparous women at 9.7%; and lower at 3.5% for primiparous) (HCC, 2008). Nearly half used natural methods of pain relief at some point in labour, such as breathing or massage, 11% used water or a pool and 21% a TENS machine. 82% of women reported using gas and air, 32% pethidine or a similar opiate and 30% reported having an epidural (ibid). Green et al. (2003) reports significant variation in the proportion of women using epidurals depending on parity, with 59% of primiparous and 23% of multiparous using this method of pain relief in 2000. There may be a variety of reasons for this disparity. For example, Green et al. (2003) report that primiparous women in 2000 were significantly more anxious about birth and this factor is in turn associated with higher rates of epidural use.

Richardson and Mmata (2007) report NHS maternity statistics showing 11% of women had an elective caesarean section in 2005-6, with an overall caesarean rate of approximately 23% (the same figure is reported in HCC, 2008). Again, significant variation is seen between trusts. For example, in 2004/05, 36 of 186 maternity units in England had CS rates below 20% and 26 had rates above 27% (NHS Institute, 2006). The highest rate reported by a trust in the HCC (2008) review was 34%. On average in England 32% of women reported having vaginal births after a previous caesarean (VBAC), ranging from less than 10% to over 60% by trust (HCC, ibid).

AIMS (2008) give an interesting historical perspective, presenting figures that show the rate of caesareans increasing every year (except one) from 1956 to 2005 – from 2.3% to 23.5%. The proportion of Instrumental deliveries also increased from 1956 (when it was 4.1%), 'peaking' in the mid 1970s at around 13%, and then remaining fairly steady since to 11.2% in 2005 (ibid).

The NHS Institute (2006) investigation into caesarean sections reports that there was a general belief among the healthcare professionals they spoke to, that applying best practice could achieve caesarean rates of consistently less than 20%, with an aspiration of reducing rates to 15%.

4.3 The Implications of Choice

Choice and change in maternity care

An interesting theme that can be identified within the evidence reviewed here relates to the way women's choices (or lack of choices) seem to have the potential to be at odds with attempts to change key aspects of maternity care.

One aspect of this is evidence suggesting that women may actively choose caesareans or medicalised birth. For example, Green et al. (2003) present evidence that women have become more willing to accept obstetric interventions over time. Downe et al. (2001) report anecdotal evidence that women are making choices for elective caesarean on demand, and mention the suggestion that has been raised (for example in media discussions) that

caesarean rates are increasing because women are making a positive choice for surgical birth. They present evidence that a majority (62%) of births recorded within the NHS maternity care system (in one regional health authority) as 'normal' in fact involved some form of obstetric intervention (ibid). Less than 25% of women were experiencing spontaneous births with no obstetric intervention (ibid). As, for example, Green et al. (2003) report, obstetric interventions are associated with lower satisfaction for women. Downe et al. (ibid) argue that since so many women are experiencing interventions this could be contributing to negative perceptions of 'normal' birth and hence driving active choice for caesareans as a preferable alternative:

'*If normal birth is actually obstetric birth, elective caesarean section may well be preferable for many women.*' (ibid: 605)

As discussed in Section 3 above, many women see having their baby in hospital as reducing the risks, making both them and their partners feel more secure due to the knowledge that there are professionals and facilities on hand to deal with any emergency (Magee and Askham, 2008). Only a small number of women in this study identified the risks that could result from medical intervention.

A further confounding factor could be the conservative effect described by Porter and Macintyre (1984), which means that women may be likely to be more negative about new care options that they have not experienced, than they would be if they had experienced them. A further conservative effect is likely to operate via social and cultural influences; social norms influence women's choices, as discussed below, and are by definition conservative. If medicalised birth and caesarean sections are widespread, and most commonly depicted in media representations of birth, then they could be having an influence on what women expect from birth (e.g. Law et al., 2008).

A possible implication here is that in theory, simply providing more choice could potentially have the effect of leading to higher rates of medicalised birth and caesarean section. In order to change important aspects of maternity care, it is likely to be necessary to do more than simply extend choice; expectations and norms around choice are also likely to need changing.

Satisfaction and choice

As introduced in Section 2 above, a number of sources report associations between women feeling involved in decisions, or that they had enough choice, and their satisfaction with care. For example, HCC (2007) reports a correlation between women feeling involved in decisions about care and their rating overall care positively as discussed above. Choice on where or when to have antenatal checks had a significant effect on overall satisfaction in the TNS System Three (2005) study, with 87-90% of women who had choice about these rating overall care as 'fairly' or 'very' good, and around 60% who had not had these choices doing so. Links with feelings of safety are also reported with interviews revealing that women see being able to determine the shape and progress of birth as one part of feeling safe (Magee and Askham,

2008). When women were asked which of a number of factors that they had identified as important in labour and birth, they thought was most important, the most commonly chosen factor was 'involvement in decision making' (chosen by 40% of women as most important) (Hundley, et al., 2001). Green et al. (2003) found that having choice was important for women, especially for women who didn't otherwise feel in control of what staff were doing. This study also found that women reported higher satisfaction scores postnatally if they had been able to make the choices that they wanted to make regarding pain relief, had been able to choose the position in which they gave birth, and had felt involved in non-emergency decisions.

The question to women of whether they felt involved in decisions about their care has been used in a number of surveys as a proxy for choice in maternity care (e.g. HCC, 2007, Hundley et al, 2001). However, as we shall see below, choice has more to it than involvement in decisions.

4.4 Factors affecting choice

As we have discussed, choice in maternity care is far from straightforward; the literature presents a wide range of factors that have an influence on women's choices in maternity care. Many of these will already have been touched on, and we will not provide an exhaustive picture, but it is a useful exercise to identify the range of key factors in order to help understand how communications could act on them. Law et al. (2008) produce a similar list, presented as intrinsic and extrinsic factors that can influence women making choices in maternity care. We will follow a similar scheme, considering first factors relating to women personally, then factors relating to the maternity services and then other factors operating beyond the individual and the maternity services. Finally, we will briefly present evidence about what women themselves say had the most significant influence on their decisions when asked this question directly.

Personal factors

When women were asked about what influenced their decisions about place of birth in two separate studies, they said themselves personally (i.e. their own views, beliefs and experience) was the biggest influence on their decisions (Rogers et al., 2006; Hopwood and McDonald, 2006).

A further finding that confirms the importance of personal influences on women's choices in maternity care is that 68% of women in one of these studies reported that they had already decided where they wanted to give birth prior to seeing a healthcare professional. Only 26% said they had not decided at the point of accessing maternity services (Hopwood and McDonald, 2006). Where women said they had already decided, 42% said their decision was based on their own experience, and 97% of multiparous women gave this reason for their choice (ibid).

Other evidence of the importance of personal experience includes the conservative effect coined 'What is must be best' by Porter and Macintyre (1984) – i.e. the observation that women tended to assume that the care they

had received was the best available, and hence be resistant to any new care options. Women who have had one caesarean may think that another is inevitable or preferable for subsequent pregnancies (although this is often not medically considered to be the case) (NHS Institute, 2006).

A woman's partner, family and friends can also affect their decisions. For example, a number of studies have shown the importance of the father's attitude and support in influencing women's decisions about breast feeding (Burgess, 2007). In Hopwood and McDonald's study of choice about place of birth (2006), women cited friends and family as the second biggest influence on their decision, and this was also cited as an influence by women in Kirkham and Stapleton's (2001) study of informed choice. In the Hopwood and McDonald (2006) study, 54% of women said that no factors other than people influenced their choice; many of the factors that shaped their choice of birth place were based on reported knowledge from others, including the reputation of different hospitals (ibid.). In that study, 36% of women also said they would be less likely to choose a hospital with a high caesarean section rate (Hopwood and McDonald, 2006).

The influence of family and friends is part of the wider influence of social and cultural norms and values, which can also have a strong influence on women's decisions. For example, Wiggins and Newburn (2004:156) state that much of the information that women value and feel they can rely on (for use during pregnancy and birth):

> '…*is the embodied knowledge they have from personal experience or see family and friends acting on and reproducing around them daily'*

IDeA (2008) report that informal networks and local, informally sourced, knowledge can play an important role, are often trusted over and above more official sources of information, and can influence major decisions.

A peer education and support project was developed as part of interventions to engage excluded pregnant women and reduce infant mortality, because women were found to particularly value the opinions of friends, family and neighbours (Walker, 2008). The NHS Institute (2006) notes the influence, from pre-conception, of messages that women are exposed to from family, friends and media. Page (2000) and Charles, et. al. (1999 (a)) both discuss the importance of women's values in the process of making decisions about medical care.

Since women can experience choice during maternity care as a 'battle' in which they need to struggle to get the options they want, personal assertiveness and confidence can be important factors in influencing choice for women (e.g. Wiggins and Newburn, 2004; Kirkham and Stapleton, 2001). This can have implications for equality as only confident, assertive or informed women will be able to demand certain choices, especially when these go against norms of local practice or policies (e.g. Kirkham and Stapleton, 2001, Law et al., 2008).

Personal awareness of the availability of choices is obviously important, which can relate to previous experience and information accessed personally. For example, the figure quoted above that 48% of the women who knew about the option of seeing a midwife first when accessing maternity care, did so as a result of a previous pregnancy (TNS System Three, 2005). Knowledge about choices can also depend on the information provided by the maternity services the woman has contact with.

Factors related to maternity services
Information can have an important role in decisions for women in maternity care determining whether they are aware of different choices, but also having an effect on the choices they make. Information can come from a variety of sources, with informal non-official sources playing an important role (as discussed above and in Section 5, e.g. IdEA, 2008). Information provided via maternity services can influence women's choices in a variety of ways.

Firstly, awareness of which choices are available is largely framed by the way they are presented by the service women access. For example, Law et al. (2008) discuss how some maternity choices seem to be more actively encouraged and facilitated than others on the NHS Choices website (with the examples of episiotomy, delivery of the placenta and presence of students given as those that appear to require some negotiation). Figures quoted above demonstrate how, for example, the choice of a home birth is immediately constrained for a large proportion of women who are not offered this option (e.g. HCC, 2007). Edwards (2005) also discussed the way women's view of whether home birth is a choice depends on how and if it is discussed by maternity professionals, suggesting that:

'*choice is limited to a predetermined obstetric menu available to some women in some circumstances'*
(Edwards, 2005; p. 214)

Information can also be controlled by healthcare professionals in order to control choice. For example, Kirkham and Stapleton (2001) observed healthcare professionals withholding certain of a series of information leaflets from women because they did not fit with the professional's personal philosophy, or local unit policies. As well as withholding information, healthcare staff can present information in a way designed to maximise the likelihood of women making certain choices. An example of this tendency can found in the reported use of scare stories by some healthcare professionals (e.g. Law and Thunhurst, 2008; Rogers et al., 2006). Information can also be of poor quality, or provided without any discussion which can make it much less useful to women (e.g. Kirkham and Stapleton, 2001).

At a more basic level than information, and the way it is mediated by maternity services and healthcare professionals, choices will depend on available facilities and capacity within the maternity service providing care. For example, the figures above starkly show how the choice of place of birth will inevitably be constrained, simply due to the lack of midwifery units in many trusts (e.g. HCC, 2008).

Equally important as the availability of physical facilities, is the capacity within maternity services to provide certain choices to women. This capacity can relate to staffing levels and availability of specialist services as discussed in Section 2 above (e.g. Tope et al., 2008, Ipsos MORI, 2008). It can also relate to the skills, knowledge and experience of healthcare professionals, also discussed above. For example, the lack of experience and training in natural birth for both midwives and doctors will inevitably affect options for labouring women (e.g. Law et al., 2008, Smith and Dixon, 2008, NHS Institute, 2006).

Stereotyping, racism and discrimination from healthcare professionals can influence choice, as discussed in Section 2 above. For example, the instance where a healthcare professional asked a teenage woman's partner what pain relief to give her (EdComs, 2005). Or the studies cited by Law et al. (2008) where women from different minority groups were given less information than other women, narrowing choices available to them.

In the case of disabled pregnant women, there is a legal obligation to provide equal access and not to discriminate against them (i.e. disabled people must not be treated less favourably than others on the grounds of their disability) (Rotheram, 2007). Thus disabled women have a legal right to the same elements of care that other women receive (ibid). UK law relating to consent is also relevant here (and more widely); legal requirements for consent apply to everyone who has the capacity to make decisions, including people with learning difficulties (ibid).

An additional factor affecting capacity to offer certain choices (that in fact originates outside UK maternity services) is the EU working time directive. This limits the length of shifts that maternity professionals will be able to work, with obvious implications for providing continuity of carer to women in labour (e.g. Law et. al., 2008).

Law et al. (2008) describe institutional policies in maternity services as '*Among the strongest influences on women making choices in childbirth*' (ibid: 34). These include, policies, protocols, local service norms and routine practice, such as risk categories that determine if women can access certain choices in childbirth (ibid). Opportunities for home birth can also vary significantly depending on local policies and norms (e.g. Edwards, 2005). Law et al (ibid) report midwives continuing with routine procedures even when women explicitly requested them to stop.

These institutional factors overlap with factors relating to relationships between different maternity professionals and cultures within maternity services. For example, the hierarchical organisation of a lot of maternity care can lead to constrained choices for women when midwives feel under pressure to follow local policies or obey senior colleagues rather than provide full information based on evidence (e.g. Law et al., 2008, Kirkham and Stapleton, 2001). The effect of different cultures within maternity services on choice is discussed in Section 3 above.

Wider influences on choice
'Macro' factors acting beyond the level of individuals or maternity services can also have an effect on women's choices in pregnancy and birth.

Social norms have already been discussed in relation to the personal level. In addition, messages from the media can affect women's choices by influencing their expectations and feelings about giving birth. For example, Green et al. (2003) question whether media portrayals of birth could be affecting women's pre-natal attitudes to medical intervention and levels of fear about birth. Davis Floyd (2004) offers a more radical analysis of the action of social factors on women during labour and birth, arguing that the whole system of medicalised maternity care has developed to fulfil a role that is as much to do with the cultural socialisation of women as with providing rational medical care.

These are broad themes, which will be further discussed in relation to the interaction between media and culture in shaping choice, in Section 6.

5. Information

Information is important during pregnancy, birth and new parenthood for women and fathers, and there is evidence that they can often want a lot of information at this time (e.g. Wiggins and Newburn, 2004; Bounty, 2008; Burgess, 2007). For example, women face a huge range of choices which require information and they want to know how their baby is developing and about what is happening in their pregnancy and birth (e.g. Kirkham and Stapleton, 2001; Law et al., 2008; Rosenblatt, 2004). After the birth, new parents want information about how their new baby is developing and often about aspects of baby care (e.g. Cragg et al., 2002; Nolan, 2008).

In this section we look at information and pregnancy; starting with a consideration of evidence about what information women (and fathers) want and need, what information they are getting in practice and their satisfaction with this. We then explore the relationship between information and choice (and women centred care more widely), including practical issues about how information is communicated and 'handed over' to women. Finally, we consider evidence about information sources and channels, including which women say they use and different women's approaches to using different types of information, which influence them most, and specific evidence about different channels and sources of maternity information.

5.1 Information needs in pregnancy and new parenthood

Women may want information on a wide range of subjects during pregnancy and early motherhood. For example, Rosenblatt (2004) lists a series of issues that women want information about, spread across a spectrum from more to less vital , which includes week by week progress of pregnancy, diet, bonding with a new baby, exercise, pregnancy fashion and shopping.

However, looking across the literature in this review, when women discuss what they want information about during pregnancy and early parenthood, the evidence seems to suggest three main areas of particular importance for women:

- **information related to labour and birth** - women have many questions around birth, which tend to focus on anxiety about the birth and pain, as well as practical questions about techniques for labour, such as breathing (e.g. Cragg et al., 2002, Nolan, 2008). Of the women who said they did not feel sufficiently well informed to make decisions about the type of birth they wanted in one study, the largest proportion (53%) said they wanted more information about pain relief, followed by 47% wanting more information about what to expect when giving birth and 36% who wanted more information about water birth (TNS System Three, 2005).

- **information to provide reassurance** - women often want information that provides reassurance, including about the progress of pregnancy, the wellbeing of the baby and that they are feeling and experiencing similar

things to other women (e.g. Bounty, 2008;Rosenblatt, 2004; EdComs, 2005).

- **postnatal information** - the issue that most frequently seems to emerge from the evidence we have looked at is the need for postnatal information. For example, when discussing what women want from antenatal education, Nolan (2008) reports that women are ‘as keen to learn about life with a new baby as they are about labour’ (Nolan, 2008; Part II p. 35). Needs for postnatal information seem to relate to two main areas: coping as new parents, including practical baby care; and the transition to a new family, including relationship issues (e.g. Nolan, 2008; Cragg et al., 2002; Deave et al., 2008). Nolan (2008) specifically identifies the first period following discharge from hospital until the first midwife visit as being a time for key decisions and therefore the need for reassurance that can come from good quality information. Nolan (ibid) specifically suggests a 24hr help-line may be useful at this time. Another important aspect of postnatal information raised in the evidence relates to postnatal depression. Cragg et al. (2002) report that a number of women in their study mentioned not realising how common post natal depression is and that the reassurance that might have been available hadn’t got through to them.

A more general point that emerges is that women often want more in depth, rather than shallower, maternity information. For example, women were most positive about courses of antenatal classes that ran over several weeks, with the worst criticisms being for classes that were perceived as being too brief, rushed or limited in scope (Nolan, 2008). A substantial majority of teenage mothers contributing to another study said they preferred more in depth information (Hill, 2007). Women commenting on a new publication providing maternity information criticised a lack of core information, commenting that communications need to be informative rather than just entertaining (Rosenblatt, 2004).

5.2 Information needs by subgroup

A number of differences, and specific information needs are identified in the evidence reviewed here for different subgroups.

The impact of various important cross-cutting variables on approaches to, and needs for information are discussed above in Section 2; including parity, stage of pregnancy, socio-economic group, education and degree to which women are supported and anxious. Section 2 also provides information about specific typologies of pregnant women and parents depending on their approach to gathering and using information.

More specifically, we can report a number of key information needs that are identified for specific priority subgroups:

- For women who are hard to engage with maternity services, their main need (and often main reason to engage) is often for information that helps

them understand how their baby is developing and that provides reassurance about this (EdComs, 2005).

- EdComs (2005) reports that most women from 'hard to reach' groups interviewed discussed feeling unprepared for birth and not knowing what to expect because they had received limited antenatal care, and many reported not knowing basic information such as breathing techniques.

- Informal sources can often be particularly important for some sub groups of women, and the EdComs (2005) study reports that while information sources and channels used varied across the groups they considered, very few relied on official sources. Darnton (2003) confirms that many parents are hard to reach through formal channels with informal channels often preferred by some sub groups, such as disadvantaged parents. However, these groups may still want factual and scientific information from more formal channels (ibid). Cragg et al. (2002) report that some groups, such as those living in more disadvantaged areas, can feel more at ease with media-based information because it gives them more personal control.

- For particularly vulnerable women, including women prisoners, homeless women and women with a history of substance misuse, dispelling myths and misconceptions can be important, for example, over involvement of social services (Ipsos MORI, 2008; Augood et al., 2008). The Ipsos MORI (2008) report also recommends that vulnerable women need to be made to feel they are not alone (for example if they are suffering from domestic violence), and that they need information about specialist services available and entitlements (e.g. for milk tokens and vitamins), as well as more information and support to help address fears and anxiety over pregnancy and childbirth.

- Providing information in different languages will also obviously be a common need (e.g. Ipsos MORI, 2008). Friends or family members who act as interpreters for women who do not have English as a first language can play an important role in influencing the flow of information (Ethnic Dimension, 2008).

- In one study, teenage mothers identified that they wanted information about diet (specifically what was good for them to eat) and exercise (specifically how they could safely do so when pregnant) (Hill, 2007).

- Pregnant disabled women identified the need for support and information to be available in accessible formats, and to specifically address their needs (Rotheram, 2007; Killick, 2007).

- Simple awareness of choices available during maternity care can be important for all women, but has been identified as an especial issue for women from the C2DE socio-economic group (Rosenblatt, 2004).

- Fathers report that there are few sources of information intended specifically for them, yet they are often reported to be resistant to information that is seen as being for women, and may need specially tailored information (e.g. Darnton, 2003, Burgess, 2007). Many fathers who have had a previous child are particularly resistant to information (ibid). Other specific information needs for fathers include information about bonding with and caring for a new baby, and the time around the birth of a new child is identified as a key point to influence changes in behaviour for men, for example supporting them to quit smoking (Burgess, ibid).

Two important caveats are worth making at this point. Firstly, as mentioned in Section 2, although certain subgroups of women clearly have some specific information needs, there is evidence that that on the whole most women do not want to be singled out and find it important to feel the same as other pregnant women (Ipsos MORI 2008). Most women prefer to have the same sources of information as all pregnant women, but want these to be made inclusive so they cover their specific needs and are designed to show that they are for all women (e.g. with photographs of all different kinds of women) (e.g. Darnton, 2003; Killick, 2007).

Secondly, one source of evidence leads us to suggest that care should be exercised when considering recommendations for what women information want that does not come directly from the audience in question. Hill (2007) reports feedback from both teenage mothers, and front line health professionals (working directly with pregnant teenagers) about what information pregnant teenage women want, and in what format. The responses from health professionals differ from those of the teenagers themselves to a fairly significant extent. For example, 27% of teenagers contributing said exercise was the health topic they would be most interested in knowing more about while pregnant, compared with around 2% of front line staff and other professionals choosing this topic. Similarly, 27% of professionals and staff suggest that delivering information to teenage mothers via text services would be preferred, while only 4% of teenage women chose this route. 68% of teenagers said they favoured in depth information provided by a book, while some professionals commented that printed information should be brief and not presented in too much depth (ibid). This finding suggests the importance of identifying (or at least checking) information needs directly with the specific target audiences.

5.3 Information that could affect outcomes

A number of recommendations or implications emerging from the evidence reviewed here identify information that has the potential to help determine important choices and outcomes in maternity care.

For example, the NHS Institute's (2006) in depth report on caesarean sections notes the importance of providing information to women who have had a caesarean section as soon as possible after the birth in order to help explain what happened, and why, and implications for future births, including that

another caesarean section is often not inevitable or preferable (ibid). The aim here is to try to increase rates of vaginal birth after a previous caesarean (ibid).

In discussing the need to promote normality in pregnancy and birth, the same study notes that:

'*The pathway for women in their first pregnancy and labour starts even before conception. Women are exposed to messages about pregnancy and childbirth through friends and family, through the media and through existing contact with health and social care professionals.'* (NHS Institute, 2006: 9)

A possible implication is that pre-pregnancy information relating to expectations of normality could be important. This is also an implication emerging from Green et al.'s (2003) finding that increased antenatal willingness to accept interventions affects birth outcomes (discussed in Section 4 above). Levels of prenatal anxiety are also shown to have important implications for birth experiences and outcomes in this study, and the authors draw the implication that women need antenatal education that gives them confidence in their ability to cope in labour without epidurals (ibid). Another implication from this study is that women need to be made aware of the implications of pre-natal attitudes to intervention, and different choices in labour (e.g. the significantly increased risk of caesarean following an epidural) (ibid).

Another important source, dealing this time with perinatal mortality, recommends pre-conception counselling for women in certain high risk groups, especially obese women and those suffering from past or pre-existing severe mental health problems (CEMACH, 2007).

Timely engagement with maternity care can have an important protective effect against adverse outcomes for some groups and is identified as a key issue for many priority subgroups of women who may not engage with maternity care services for a variety of reasons (as discussed in Section 1 above) (e.g. EdComs, 2005, Ipsos MORI, 2008). For example, teenage mothers and their children are more likely than older mothers to experience poor outcomes, such as higher infant mortality, pre-term birth and poor mental health after birth (DH and DCSF, 2007). However, *'once engaged with services there is evidence that the risk of poor outcomes is significantly reduced'* (ibid: 30). Information promoting early engagement and making engagement more accessible may therefore be important for several priority subgroups.

Brenda van der Kooy (2008) suggests that a national media campaign is needed to help inform women about their right to choose who they make contact with when first finding they are pregnant. One key recommendation from Law et al.'s (2008) review of choice in maternity care is to '*market the services of the midwife as the first point of contact and the lead in normal pregnancy and childbirth*' (ibid: 54).

Another important element of maternity care for many women from priority subgroups can be access to specialist care services, such as tailored antenatal sessions or referral to specialist midwives trained to support women with substance misuse problems (e.g. EdComs, 2005, Ipsos MORI, 2008, Walker, 2008). Hence a number of sources specifically recommend information about specialist (and mainstream) services available, and how to access them, as an important need for many priority subgroups (e.g. EdComs, 2005, Ipsos MORI, 2008, Walker, 2008).

A recurring piece of evidence about breastfeeding is that anxiety about insufficient milk can be a key reason for women stopping breast feeding (e.g. Soltani et al., 2008). A possible implication for communications is that information designed to give women an accurate picture about this issue could help.

5.4 Information received and satisfaction

Overall, there seems to be a fair amount of dissatisfaction with the amount of information received during maternity care. TNS System Three (2005) found that women consistently rated the amount of information provided by staff as the least satisfactory part of maternity services at all stages of care (although this study found that women rated many specific sources of information fairly well). When pregnant women were asked whether they had been given enough information in the large HCC (2007) survey, approximately 56% said ‘yes, always’ during pregnancy, 71% said ‘yes, always’ during labour and birth, and 58% after birth.

This picture of dissatisfaction was found in relation to most aspects of information and advice in maternity care reported on, including: having enough information to make choices about place of birth (as few as 20%, and no more than 50%, of women reported definitely having enough information in this respect - HCC, 2007; see also Hopwood and McDonald, 2006, Kenyon and McCandlish, 2008); postnatal information and advice about baby care and women’s postnatal recovery (HCC, 2007).

However, there is some suggestion that satisfaction with the amount of information has improved over time, with Green et al. (2003) finding that women were more likely to be satisfied with the amount of information they received in 2000, than they were in 1987. There are also a few exceptions for specific aspects of care where satisfaction with amount of information seems high; most notably around antenatal tests, scans and screening (e.g. Redshaw, et al., 2007, HCC, 2007, TNS System Three, 2005).

Satisfaction with information may vary with model of care. For example, Hatem et al. (2008) found that women reported higher satisfaction with information, advice and explanations received (as well as other aspects of care) in midwife-led care compared to other models of care.

Information received and satisfaction by subgroup
When we look at the picture for a range of subgroups , the picture is again predominantly less positive. For example, none of the particularly vulnerable immigrant women with 'No Recourse to Public Funds' interviewed in Taylor and Newall's (2008) study reported being systematically informed about the availability of, or their entitlements to, maternity care. The EdComs (2005) investigation into access to maternity services for 'hard to reach' groups reports that maternity information is largely inaccessible to women from the groups considered, and that:

> '*a lack of information about what to do at the birth meant that some women had to make quick and ill-informed decisions that resulted in subsequent health problems*' (ibid: 43)

Many of the criticisms made of maternity services by teenage Black and Minority Ethnic parents in one study related to lack of information sharing and explanation (Higginbottom et al., 2005).

Only 61% of trusts report sometimes or always giving mothers who mostly speak a language other than English, information or explanations in their language, antenatally (HCC, 2008).

5.5 Information and choice

Information is clearly important in relation to choice; at the very least women need to know what choices they need to make, and are likely to need information to help them make decisions. Some of the ways in which information can influence decisions is discussed in Section 4 above.

Having enough information can improve overall satisfaction with maternity care and increase feelings of involvement with decisions (TNS System Three, 2005, HCC, 2007). Information can also influence important choices in maternity. For example, Law and Thunhurst (2008) report evidence that women wanting the fewest interventions in birth were those who had amassed most information (usually through their own efforts).

However, information is only part of what is needed for effective decision making and women-centered care, and good decision making does not necessarily follow from information gathering (e.g IDeA, 2008). Here we discuss various factors that interact with information in order to support decision making for women in maternity care.

Types of information
A key point here is that multiple sources of information both written and spoken are likely to be needed (often as part of a package of interventions) in order to noticeably affect choice – single sources of information, and especially single written sources are rarely enough for most women (Kirkham and Stapleton, 2001, Rogers et al., 2006, Soltani and Dickinson, 2005). For example, Kirkham and Stapleton's (2001) in depth study investigating the impact of informed choice leaflets on choice found: '*no evidence that the*

leaflets had an effect on informed choice' (Kirkham and Stapleton, 2001: 43). Although it has achieved good results in offering women centered care and has been described as 'Rolls Royce' maternity care (Sandall et al. 2001; p.29), there is no difference in the content of information that women received in the Albany midwifery practice compared to other maternity care in the same trust (ibid). We discuss the relative influence of different sources of information on choices further below.

The role of maternity care professionals in providing information to support choice

Midwives are particularly important here, being identified as '*the key health professionals, offering a continuous and consistent message prior to labour'* (NHS Institute, 2006: 9). The way information is handed over is important in supporting decision making and ensuring women take in and understand information, and this is influenced by the relationship and degree of communication between healthcare staff and pregnant women (Kirkham and Stapleton, 2001). For example, women who said they had seen the same midwife 'every time' for antenatal check ups, were more likely to report that they had 'always' been given the information and explanations they needed (HCC, 2007).

Maternity care professionals need to have the necessary skills to communicate information successfully, and support women to make choices, including:

- listening and deliberation skills, and skills in facilitating decision making (e.g. Leap, 2000, IDeA, 2008);
- the ability to identify and respond to individual needs for information and support (e.g. Cragg et al., 2002, Leap, 2000);
- the ability to understand apply and communicate evidence based information including statistical information so that women can make sense of it for their own individual choices (e.g. IDeA, 2008, Page, 2000, Edwards, 2008);
- the ability to provide information to and support women from specific priority subgroups, including: the knowledge to identify issues and refer to specialist care where appropriate; sensitivity to, and understanding of different cultural needs and circumstances faced by socially vulnerable women; understanding issues relevant to providing information and support for disabled pregnant women (e.g. EdComs, 2005, Rotheram, 2007).

Professionals also need to be enabled to provide information and support choices. Key here is having enough time to explain and discuss information and choices sufficiently (e.g. Deery, 2008; Kirkham and Stapleton, 2001, Hopwood and McDonald, 2006). For example, Wiggins and Newburn (2004) identify time pressures as one of two key factors that led to midwives failing to discuss the contents of informed choice leaflets with women.

Questions about timing and flexibility of information provision

Timing is also important for communicating information. For example, Hill (2007) discussed the problem of how to get vital information about diet to

teenage women early enough in pregnancy to influence outcomes, when many of these women present late for maternity care. IDeA (2008) reports that the timing with which information is provided can be important in making complex decisions more or less stressful.

Information needs to be provided in different ways, at different times during maternity care, and flexibly in order to meet the needs of different individual women and subgroups. For example, some sources suggest the importance of providing information as early as possible – for example pre-conception counseling or information to increase women's likelihood of expecting normality during pregnancy and birth (e.g. NHS Institute, 2006, CEMACH, 2007, Green et al., 2003). Others suggest that information should be presented to women throughout pregnancy, staged and layered in response to women's expressed needs for information (e.g. Kirkham and Stapleton, 2001, IDeA, 2008). A third theme in the literature reviewed here questions some fundamental aspects of information provision in pregnancy, including: the applicability of statistical evidence for individual women; the idea that information should flow as much from women to healthcare professionals as the other way round; and the idea that embracing uncertainty (rather than trying to predict it using information or evidence) could be empowering for women (e.g. Leap, 2000).

How information is provided and handed over

IDeA (2008) suggest a practical framework for providing information to support complex decisions in maternity care, with the following key elements:

- Clear signposting of the various stages and decision points within the maternity 'journey' (healthcare professionals may need to define key facts and decision points, as women may not know what they need to know, but that there should also be room for customer input).
- Information should then be 'staged and layered', by providing it routinely throughout pregnancy as appropriate to key decision points. Key facts should be provided at each stage, key decision points should be flagged and further information signposted.
- Women should be taken through information not just handed it, and supported in accessing more information if they want it. Kirkham and Stapleton (2001) suggest a similar approach where information is 'prescribed' according to the woman's need. They also discuss the issue of information leaflets being obscured among other information. Jigsaw (2008) reports that there is strong evidence that removing information leaflets from Bounty Packs increases awareness.

Another point worth noting is the potential for information to be seen by women as coercive, which tends to antagonize women rather than support positive decisions. A key area where this issue is repeatedly raised is around breast feeding (e.g. Soltani et al., 2008, OLR, 2008). For example, Nolan (2008) reports that antenatal education which is overly focused on breast feeding to the exclusion of bottle feeding can be counter-productive.

Information needs to be in line with local service provision
A final, but vital point about presenting information on choices, is that the information needs to be in line with the reality of choices available; both in terms of what is practically available (e.g. epidurals or birthing pools), but also in line with what healthcare professionals and local systems of care are willing and able to provide. This follows from discussions elsewhere about the way in which local service norms and policies, and the views of individual healthcare professionals, can constrain choice for women (e.g. Law et al., 2008; Kirkham and Stapleton, 2001; Pilley Edwards, 2005). Other examples include the way in which some midwives, while responding positively to the idea of the Pregnancy Planner, expressed scepticism about having enough time to go through it properly with women (DH, 2008b). Rogers et al. (2006) report the importance of involving, engaging and 'winning over' healthcare professionals who will be involved in delivering information to women, so that they felt happy with and supported the information being communicated.

5.6 The channels and sources of information women use

An initial overarching observation about types of information used and valued, seems to be a distinction between information that is factual or medical, and that which is more emotional. Clear distinctions seem to be made about these two types of information especially in studies focusing on parents of older children (e.g. Darnton, 2003; Cragg et al., 2002), with related preferences for different channels depending on the type of information in question. Thus, parents tend to prefer formal, official, channels for factual information, and informal channels for emotional and behavioural information (Darnton, 2003). Cragg et al. (2002) add to this distinction by explaining that parents tend to see problems (with parenting) falling into two main categories; those (especially medical issues) requiring external input, and those where what was needed was more a sympathetic ear and the benefit of someone else's experience.

This distinction would appear to be useful for pregnancy, birth and new parenthood. However it is clear from the discussion above that parents' needs for information can be particularly acute during this time, and are likely to cover a mixture of overlapping medical / factual and emotional issues. Cragg et al. (ibid) report that pregnancy and early parenthood are exceptions to the general rule that parents are resistant to the idea that they can be taught parenting. Parents feel particularly in need of external information and learning at this time (ibid).

Several of the reports under review provide evidence on the sources of information that pregnant women and new parents report using (Soltani and Dickinson, 2005, IDeA, 2008, Deave et al., 2008, Kirkham and Stapleton, 2001); these sources of information include:

- healthcare professionals
- friends and family, or other women
- written information from books, magazines and leaflets
- the internet
- television and videos

- parenting / antenatal classes

As discussed in Section 3 above, women also report relying heavily on their own knowledge and experience when making decisions about place of birth (Rogers et al., 2006; Hopwood and McDonald, 2006). In one of these studies, 71% of women said that they used no sources of information other than people (whether it was themselves, professionals or family and friends) when making the decision about place of birth (Hopwood and McDonald, ibid). This strongly supports the idea that it will be important to use intermediaries in communicating with many pregnant women.

Preferred channels can vary depending on the information required, and a mixture of channels is often used. For example, women preferred face to face information about breastfeeding, but backed up with written information (IDeA, ibid). Postnatally women reported using a mixture of face to face information from professionals, written information provided by professionals, websites, baby magazines and other written materials (ibid). Health professionals involved in providing support and information to women echo this point. For example, that printed information can only do part of the job of supporting breast feeding and needs be provided together with face to face support from professionals (Cragg Ross Dawson, 2007).

Here we provide a brief overview of evidence relating to different specific channels and sources of information:

Healthcare professionals tend to be a key source, and the focus tends to be on midwives and doctors, although some women also reported getting information from others such as ultrasonographers (Kirkham and Stapleton, 2001) and health visitors could be an important source postnatally (e.g. Cragg et al., 2002). Deave et al. (2008) report that midwives were generally seen as a reliable source of information and someone who woman could turn to for advice and support, a point echoed by Law et al. (2008). However, Kirkham and Stapleton (2001) report women feeling that they had no choice but to rely on other sources because healthcare professionals failed to meet their needs for information. Bounty (2008a) also reports a range of negative feelings from women about healthcare professionals, including that they can be rushed, distant and lacking in empathy. Women can also report significant fear of being judged or regarded as not coping by healthcare professionals (ibid).

Informal information from friends, family and other women can be seen by women as a valuable source of information (Soltani and Dickinson, 2005, IDeA, 2008, Kirkham and Stapleton, 2001).

In terms of how women like to receive information, face to face discussion seems to be one of the preferred channels, along with written information (e.g. Soltani and Dickinson, 2005, IDeA, 2008). However, informal ‘word of mouth’ is also a very important source (e.g. IDeA, 2008).

Informal information from friends, family and other women is usually used for accessing experiential knowledge, although some women also reported

accessing knowledge about procedures in maternity care from other women with recent experience (Kirkham and Stapleton, 2001). Deave et al. (ibid) found that women's own parents' (especially their mothers') knowledge often appeared to be valued even though it was not usually current. Bounty (2008a) also reports that mothers can be seen as having 'forgotten a lot', while female friends and sisters with children are more likely to be seen as being 'in the same boat' and being able to engage in natural, two-way information exchange. In the wider context covered by the IDeA (2008) study, informal networks were reported to be an invaluable source of information, often trusted over and above official sources, and influencing major decisions. Many of the decisions investigated in this study (including ones related to maternity care, such as picking place of birth):

'*seemed to be made on the strength of locally sourced/ informal knowledge and locally held reputations….. often gleaned from informal sources'* (IDeA, 2008; p.23)

Informal word of mouth information from can be especially important for women from Minority Ethnic groups, low income women, and drug / alcohol dependent or homeless women (EdComs, 2005, Jigsaw, 2008).

Law and Thunhurst (2008) report a study that found some midwives expressing reservations about the information provided to pregnant women via birth stories of other women.

Written / printed information was another significant source, reported by Kirkham and Stapleton (2001) to be that accessed most often during pregnancy. A recurring theme is that women tend to value more in depth information more (e.g. Kirkham and Stapleton, 2001, Hill, 2007, Rosenblatt, 2004). Of the 'hard to reach' groups investigated by EdComs (2005) teenagers and some Asian Muslims especially valued written sources of information. Other women from this study reported finding written sources hard to access, for example due to poor literacy skills or being put off by the format (ibid). In another study, teenage mothers also reported widely using many pregnancy books but felt they could often be made more relevant and accessible, for example by including specific information and images designed for their audience (Hill, 2007). Darnton (2003) reports specifically that NHS branded information books for expectant and new mothers were regarded as excellent.

DH's 'The Pregnancy Book' was '*universally commended*' by women in one study (Kirkham and Stapleton, 2001; p.85), and this finding is regularly repeated. For example, Darnton (2003) reports that it is commonly cited as the single most useful source of maternity information with additional symbolic value as a shared and initial point of reference for all mothers to be. Women also often report keeping The Pregnancy Book for a long time, for ongoing reference (sometimes between pregnancies) (ibid). HCC (2007) reports that 75% of mothers said they had been given a copy of The Pregnancy Book, with the proportion saying they had not had a copy significantly lower for primiparous (18%) compared to multiparous women (32%). Women from

Black and Minority Ethnic backgrounds and more deprived women were more likely to be given The Pregnancy Book than other women (Redshaw, et al., 2007). However in the EdComs (2005) study a fairly large proportion of women participating reported not having received it. Women from this study who did receive the pregnancy book said they had found the information in it extremely useful and comprehensive. However, many reported finding the format and design uninviting. For example, it was unavailable in different languages, daunting for those with poor literary skills, and caters only for mainstream audience. Teenagers especially noted a lack of information or pictures for their age group, which could lead them to feel that it was *"not for us"* (EdComs, 2005:53).

Emma's Diary on the other hand received consistently negative responses in Kirkham and Stapleton's (2001) study with women describing it as patronizing and demeaning. However, a small number of women from 'hard to reach' groups in the EdComs study mentioned Emma's Diary and were positive about the friendly format, the fact it is written from perspective of another pregnant woman, and the information on weekly stages of pregnancy. As a rule, no one source of information is likely to work for everyone, and different women have different views on preferred sources of written information (although the Pregnancy Book is fairly universally liked, as discussed above).

IDeA (2008) reports that women use the Bounty Packs postnatally, but also that commercial sources were sometimes distrusted. Despite the finding about information often being lost when included with bundles of information like the Bounty pack (discussed above in Section 3), one source suggests that the Bounty Pack could be a useful way of distributing some information to pregnant women. When asked how they would like to receive information on maternity rights, 40% of women responding in one study suggested the Bounty Pack (FDS International, 2007)

Bounty (2008a) suggests that magazines and newspapers can become an 'early casualty' of becoming a mother due to time and money pressures and new parents being too tired.

In house / locally produced literature
A number of references were made to poor quality locally produced literature designed to provide information to pregnant women. Problems included photocopied sheets with blurred print, spelling mistakes and the inclusion of claims that were not backed up by evidence (Law et al., 2008, Kirkham and Stapleton, 2001).

Online information and discussion forums
Compared to other formats, the internet has the advantage of being able to provide two distinct types of content together:

- Access to information - the internet may be a useful source of information as it is able to provide layered information so individuals can access more or less detail. For example, Fletcher et al. (2008) suggest that the internet

can serve the needs of fathers well, as it can provide the tailored information they tend to want.

- Access to social networks – the internet also provides access to informal, experiential information from peers. Evidence has already been discussed showing how important informal, experience based information can be in influencing people. Bounty (2008a) reports 800,000 members on the Bounty.com website and 18,000 posts (comments from users posted on the forum) every day on their forums.

However, there are issues around accuracy and control over information (especially in forums). For example, Law and Thunhurst (2008) report a study that found some midwives expressing reservations about the accuracy of information provided to pregnant women via the internet.

The evidence on which subgroups this source of information may be most appropriate for is mixed and this may need further investigation. For example:

- EdComs (2005) reports that the internet is particularly used by teenagers and some Asian Muslims for maternity information. However, while one study found that 77% of teenage mothers reported using the internet, most did not do so frequently, and few cited it as a preferred source for information, leading the author to conclude that this is not a good channel for communicating with pregnant teenagers (Hill, 2007).

- Jigsaw (2008) reports that there is little evidence that low income mothers use the internet for networking on the subject of pregnancy, although they occasionally use it as a source of medical and financial information. However, Bounty (2008b) reports that 83% of traffic to the Bounty.com web site is from parents from the C1C2DE socioeconomic grades (and that parents from these groups also make up over three quarters of the traffic to other major online parenting sites).

Bounty (2008a) provide a detailed description of how women's use of the internet changes through pregnancy and early parenthood, which provides useful information about changes in patterns of, and approaches to, the use of online (and potentially other) information through pregnancy. Women in their second trimester were found to be using the internet in familiar ways, as part of normal work and social routines. However they were starting to look at parenting sites, following recommendations for 'must use' sites from friends and family, and undertaking wide exploration to discover what information was available. Later in pregnancy (third trimester) they were found to be using websites heavily for information and support, and using the internet to keep in touch socially. They started whittling down their use of sites to a few core ones they used most and started 'bonding' to particular sites. Once the baby was born internet usage became much more time-pressured, with women using it in a very task-focused and pragmatic way (though also continuing to use it for communicating and getting support socially). They now tended to establish routines and stick to 'tried and tested' sites, with much lower tolerance when surfing.

Television tended to be occasionally referred to as a source of information, and Darnton (2003) suggests that it has important potential especially for communicating with parents with limited literacy and from lower socioeconomic groups. Bounty (2008a) discusses changes in women's viewing habits as they become new mothers with the TV sometimes talking on a bigger role in their lives, as background noise, a key part of their routine, and an on demand distraction for children. EdComs (2005) identifies the television as a particularly relevant channel for teenagers and women with learning difficulties.

Law and Thunhurst (2008) report a study that found some midwives expressing reservations about the information provided to pregnant women via the television.

As well as providing information directly, it is apparent that television can have a more indirect effect on women in relation to information about maternity. Television can convey wider social values and norms around pregnancy and childbirth and influence women's expectations and attitudes to maternity choices (e.g. Law et al., 2008, Green et al., 2003). This wider social impact will be discussed further in Section 5.

Telephone helplines
Darnton (2003) reports that very few parents say they would consider using helplines as a source of information. This is partly because of very low awareness of many of the helplines available. More fundamentally, using helplines was often seen as a last ditch action that was essentially an admission of failure (ibid). NHS direct is something of an exception, with higher awareness and being liked by those without informal support networks, or not wanting to go to a GP straight away (ibid). Users of the National Childbirth Trust's (NCT) breastfeeding information line largely reported feeling fine and confident about accessing the helpline (Augood and Newburn, 2008). The fact that the information was given over a phone and not face-to-face was actually reported by some users as helping with their confidence in seeking help (ibid). The principle negative comments from users mainly related to incidences where they actually needed further hands on support (ibid).

Antenatal Classes
Antenatal classes can be a very important source of information and support prior to birth (e.g. Nolan, 2008). HCC (2007) reports around 60% of women attend antenatal classes provided by the NHS, although there is evidence that some subgroups access antenatal classes less. For example, Redshaw et al. (2007) found that women living in more deprived areas were less likely to have attended antenatal education classes and some young mothers report that judgemental maternity staff put them off attending antenatal classes (DH and DCSF, 2007). Another study reported young mothers saying that they had stopped attending antenatal classes because they felt that they did not cater for their age and needs (GFS Platform, 2007). EdComs (2005) also reports that feelings of not fitting in at antenatal classes could apply to other subgroups such as women with learning difficulties. Primiparous women are

more likely to attend antenatal classes, with around 80% (of those who wanted to) attending classes (HCC, 2008). However, multiparous women often want to attend antenatal classes too (Nolan, 2008).

As discussed above, a number of studies show that antenatal confidence, empowerment and expectations can be important in determining birth outcomes and satisfaction (e.g. NHS Institute, 2006; Green et al., 2003). Antenatal information, education and support (which includes antenatal classes) are seen as playing a potentially important role in affecting these factors (ibid). Attending antenatal classes can have an important positive impact on women and parents, for example, providing skills to help women in labour and also to help fathers support women in labour (Nolan, 2008). However some women also reported a negative effect, with some saying that they had come away from classes feeling frightened and less positive about birth than before (ibid). The important role of antenatal education is confirmed by the finding that many participants in the EdComs (2005) study reported feeling unprepared for, and more anxious about, birth – for example not knowing what was expected of them in labour or not knowing breathing techniques – as a result of receiving limited antenatal care, including antenatal classes.

Women tend to see antenatal classes as important opportunities to meet and learn from other mothers in a similar situation to them, as much as a source of information (Nolan, 2008). The key information and support most women want to get from antenatal classes is practical self-help techniques for labour and education on practical baby care. Many women also report appreciating a tour of the labour ward if this is included (ibid). Women tend to prefer antenatal classes that provide in depth information over a wide range of topics, so often prefer courses of classes. They also put significant importance on good quality trainers / facilitators (ibid).

Good antenatal classes could have a significant positive impact for women but some women reported coming away from antenatal classes less positive about birth and parenting that they had been before (Nolan 2008). One of the most significant things that women said they wanted to get out of antenatal classes was the opportunity to socialise and make friends with other pregnant women. Classes were often highly praised when they offered opportunities for group interaction, and women tended to link learning with talking to other pregnant women (ibid). Women tended to prefer courses of classes that ran over several sessions and covered a range of different content and their most serious complaints were about classes that were too brief, rushed or limited in scope (ibid). Women also reported being keen to be taught practical parenting skills and are 'as keen to learn about life with a new baby as they are about labour' (ibid: (2)35).

Health visitors (Postnatal Support)
The stage of transition to new parenthood is a very important time for parents and families, with important implications for the parents, relationships between parents and their children, and infant development (Deave et al., 2008). YouGov also suggest that it is a '*golden moment*' (YouGov, 2007: 1) when

families are particularly open to advice and help. However, evidence also suggests that this is a time when parents, and especially fathers, can feel unsupported and insufficiently prepared (e.g. Deave et al., 2008).

A key aspect of postnatal support is that of health visitors. A large survey of parents revealed that the majority (76%) want parenting support and advice from a trained health visitor (YouGov, 2007). This study reveals that parents say they want information and support via a personal relationship as well as written sources, and the authors cite other research that they say shows that parents go elsewhere for this personal support (such as to GPs or Accident and Emergency departments) if they do not get it from health visitors (ibid). This finding is supported by evidence that families who received an enhanced health visitor service through the 'First Parent Health Visitor Scheme' consulted with their GP less often than those not receiving the service (Deave, 2003). The YouGov study for the NFPI (YouGov 2007) reports that the support and information most wanted from health visitors is: health advice and practical parenting advice; someone to talk to if the parent is worried; regular child development checks; and information about local services.

Parents from 'vulnerable and hard to reach' (sic) families may be less likely to accept support from health visitor unless it is seen as universal entitlement (YouGov, 2007). Those who are most needy and least confident may be the most wary of health visitors and some (in this study, particularly teenage parents) see them as being there to 'police' or check up on them and point out mistakes (ibid).

6. Media & Culture

Section 5 has described how different channels and formats play a role in providing information to influence specific maternity choices. For instance, a 'staged and layered' strategy is able to provide enough information to women at the right moments to support them in making complex choices (IDeA 2008). In targeting specific subgroups, TV has been highlighted as an effective channel, for instance in providing parenting information to teenage mothers and those in lower socio-economic grades (eg. Darnton, 2003). TV and other media channels are also cited as increasing awareness of NHS services among specific BME groups (Ethnic Dimension, 2008). However there is also some evidence in the sources reviewed here that, over and above providing information to support specific choices, the media sets the context within which women develop expectations of what the birth experience will comprise, and how they will relate to the maternity services throughout the process. The role of the media in shaping women's expectations is important, and as has been discussed above, expectations are shown to affect outcomes: those who are fearful and anticipate needing pain relief appear more likely to go on to experience intervention during labour, and decreased satisfaction and poorer outcomes (Green et al 2003).

A significant number of sources in this review discuss the role of media in creating, communicating and perpetuating social and cultural norms around pregnancy and childbirth. For example, as quoted above in Section 4, the NHS Institute (2006) investigation into caesarean section rates talks about the influence of media on women from pre-conception. The report explicitly cites distorted views of pregnancy and birth via the media as a barrier to an increased focus on normal birth. Similarly, Law et al's review cites a source which argues that society and media are partly to blame for women perceiving labour and birth as impossible without clinical interventions, and that the media perpetuate this through dramatic portrayal of birth in TV programmes such as 'ER' (Shallow 2004 in Law et al, 2008). They also cite a study which suggests that women may feel 'short changed' if they do not have the interventions promised through such medicalised portrayals of birth (Kightley 2007 in ibid.). In presenting this evidence the authors discuss the 'commodification' of birth, and draw a parallel between the birth experience itself and the "*baby and maternity paraphernalia*" around birth, which women are encouraged to consume via the media (ibid.:35).

Such perspectives on the role of the media in shaping expectations and choice situate the media within a wider cultural context. Culture is a difficult concept quantify, but it can be best understood as a set of evolving and intertwining strands (see eg. Darnton, 2009). 'Consumer culture' is one of the more widely-reported forms of culture, which is in large part determined by the media and advertising (as well as the retail-dominated environments in which we live). 'Consumer culture' can act as the frame within which the 'commodification' of birth occurs. 'Celebrity culture' can be regarded as a related strand; a number of the contacts consulted during this research noted the influence of celebrity culture, in terms both of an emphasis on pain-free

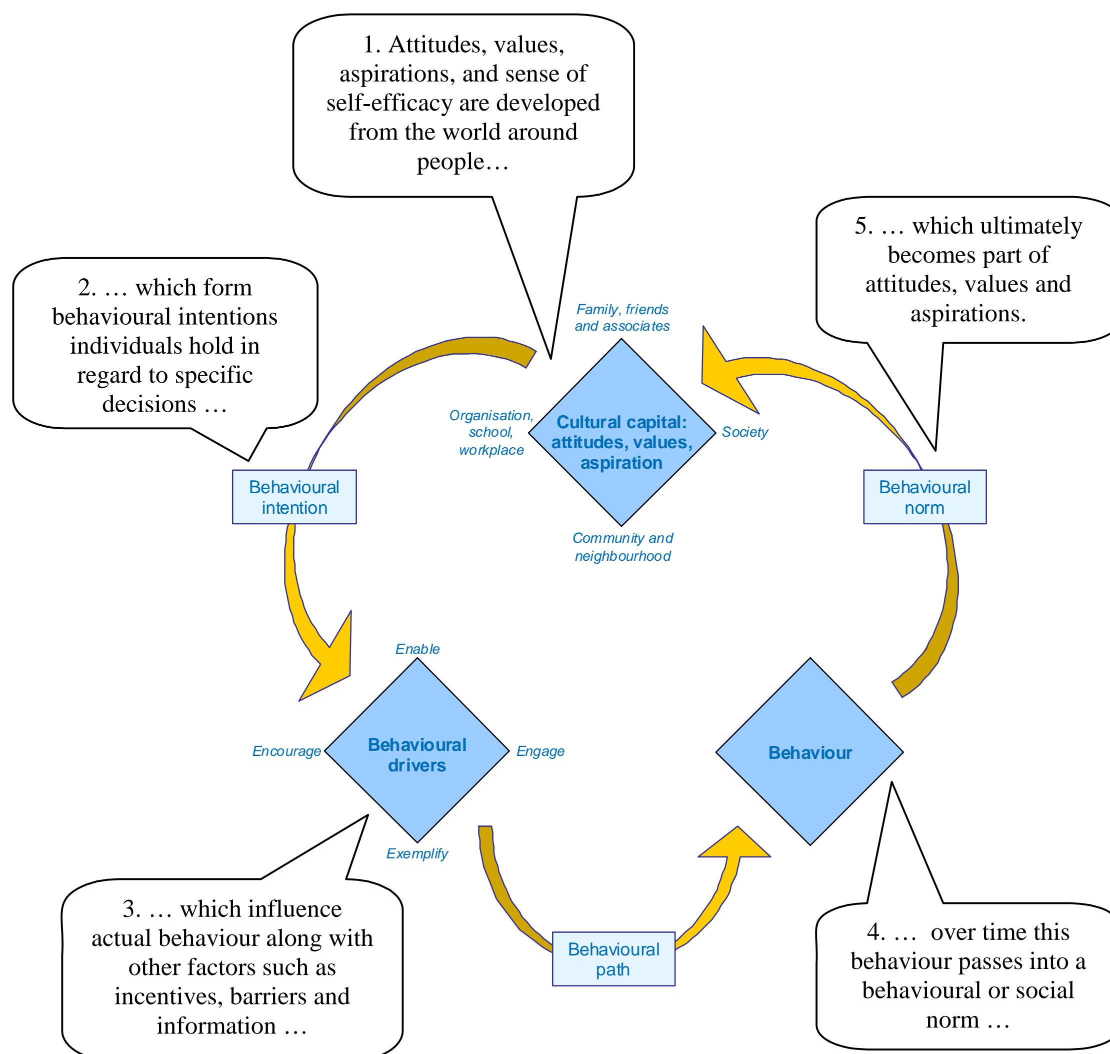
births and pre-booked caesareans, and in the apparent prioritising by some new mothers of ‘getting back in their jeans’ over bonding with their baby and engaging in breastfeeding (eg. Lizzie Smith pers. comm.).

The possibility is raised in the sources under review that communication via media may be able to have an influence on women’s choices, expectations and outcomes in maternity care, via its influence on norms and expectations. For example, Van der Kooy (2008) suggests that a national media campaign could be used to communicate the message to pregnant women about choice in maternity care. She suggests that as well as the direct informational effect, such a campaign could also serve to indicate to women that they are ‘allowed’ to exercise choice – that it is encouraged by the government. She argues that this may help empower women to challenge situations where they are not offered full information or choice – i.e. it could create the expectation that choice is a right that women would then exercise in practice (ibid). In an example showing how the media can have such a positive influence on expectations, Kirkham and Stapleton (2001) discuss women who actively questioned some routine practices in maternity care; those who did so almost always credited the media (and very occasionally the internet), as the source of the information that they used when questioning these practices.

The capacity of the media to shape cultural norms and expectations around maternity choices is consistent with the wider policy agenda on behaviour change. In a report for the Cabinet Office Strategy Unit, David Knott and colleagues situate individual behaviour within the wider context of culture (as ‘cultural capital’) (Knott et al 2008). Knott’s argument is that social context prevents individuals from changing their behaviour, so interventions must also address social and cultural norms to enable ‘catalysis’ of individual behaviour to occur. Knott lays out his thesis for individual change within cultural change, in the shape of a model (see Figure 1 – over).

The model does not specifically identify the role of the media within culture, but talks instead of the collective influence of “*the world around people…*”. However it is possible to position the media within ‘society’, which shapes culture along with ‘community’ and ‘family, friends and associates’. This generic approach to behaviour change is mirrored in the literature on maternity choices. For instance, the 2006 ‘Focus on: Caesarean Section’ report highlights the influence of messages from friends, family and wider society (via the media) on women’s expectations and views relating to normality in birth (NHS Institute 2006).

Figure 1: Knott et al's Cultural Capital Framework (2008)



In a specific example of the influence of family and friends, Cragg Ross Dawson (2007) report that the most significant and widespread barrier to more breast feeding for 16-25 year old women from the DE socio-economic group, is that for these women bottle feeding is the norm – several of the women from this group said they had never seen anyone breast feeding (ibid). The influence of 'communities' on maternity choices is particularly apparent in the context of BME communities, as discussed in Section 1 above. Communities of faith and ethnicity provide some of the most unambiguous examples of the influence of culture; in the context of maternity choices, for instance, 'traditional culture' can lay out inflexible gender roles which determine both the flow of information, and the relationships between women and maternity staff.

The implication of this perspective on the literature is that different forms of culture can limit women's capacity to make choices in maternity provision, and thus interventions to extend choice should also address wider societal

influences. While changing culture is easier said than done, owing to its resilient complexity and deep-rootedness, communications appear well-placed to address some of the prevailing strands shaping normative expectations, notably media and advertising. However, the precise ways in which media and advertising influence women's maternity choices are not currently well evidenced, and undertaking more research in this area is seen as a priority. For instance, Jo Green explicitly calls for further research into media representations of childbirth in relation to women's antenatal attitudes and expectations (Green et al. 2003).

Finally, while communications techniques could influence normative expectations of birth and maternity provision, experience is likely to remain the strongest determinant of women's views. The conservative effect described by 'What is must be best' is likely to operate, with women who have received one model of care more likely to feel (and hence communicate to others) that it is superior to other models of care (Porter and Macintyre, 1984). Thus while the medicalised model applies to the majority of births, a reinforcing loop (or vicious cycle) will continue to operate, with medicalised birth appearing to be the cultural 'norm'.

7. Recommendations

i) Principles of Choice

- Choice should not be seen as an end in itself, or as the sole answer to the challenge of improving maternity provision, but as one aspect of delivering improved, women-centred maternity care. Other factors which are known to increase women's satisfaction with maternity care should also be prioritised in service design, most notably improving the relationships between women and staff (this in turn will interact with increased choice). The ultimate aim of extending choice should be to meet the needs of all women; an important element in this is increasing women's sense of empowerment and control. These are both key determinants of satisfaction with maternity care; and more importantly, of various outcomes including the type of birth experienced and longer term emotional wellbeing.

- Promote as full a range of choices as possible across the maternity pathway. This review has identified numerous moments in maternity provision which could (and should) be positioned as choices; by making these explicit, women's capacity for satisfaction can be increased, as a result of increased sense of control over decision making (the reverse could be construed as the removal of control). All choices should be made available to all women, thus increasing the sense of empowerment most among those subgroups who currently tend to have the narrowest range of choices. By presenting choice in this way, the message is given that women are in charge of their own birth experience, with the maternity services supporting them as they need.

- It should be remembered that choice is not construed as a good thing per se in either the medicalised or normalised model of birth. In order to decrease the likelihood of unnecessary intervention, choice should not merely be extended but must also be shaped, in order to minimise the likelihood of women simply requesting more intervention (a possibility suggested by the current research evidence). Changing women's expectations of birth experiences suggests a role for broad-based communication activity (see below).

- Ensure that all the choices offered are genuinely available. This may be the most difficult challenge, but is necessary in order to ensure that extending and managing choice succeeds in supporting the improvements in maternity care being aimed for, in practice. This includes making sure that the service has sufficient capacity to deliver the choices women make, which includes physical capacity (such as the ability to provide pain relief chosen or support home births), and making sure that local policies and procedures support and accommodate the choices on offer.

- In connection with the above, ensure that maternity staff support the range of choices of offer and are trained and resourced to support both the

decision making process and the eventual choices women make. This recommendation is likely to require building staff capacity in terms of skills and experience of healthcare professionals (such as knowledge about turning breech babies or experience in normal birth). Training in supporting decision making will also be required, including facilitating and listening skills; staff will then need to be provided with the necessary time in their daily tasks to put these skills into practice in supporting the decision making process.

- Information should be positioned (both to staff and women) as the starting point in the process of decision making. Staff should not use written information as a substitute for a deliberative process, and women should not be encouraged to make quick decisions. Staff should be able to support a range of decision making styles (paternalistic, shared and informed - Charles et al 1999), adopted flexibly to meet the needs of women. Overall the balance of power in decision making should be redistributed towards the woman.

- Extending choice will entail providing women with both information and support throughout the decision making process. However, as well as providing training to staff, women should also be provided with training to ensure that they have the skills necessary to support themselves in undergoing normalised birth. Antenatal classes are likely to be key to providing such skills, and ensuring that they are universally available (and increasingly engaged in) is a key challenge in extending choice.

- As is the case with antenatal provision, strategies for extending choice should be differentiated to meet the needs of women in specific subgroups, and prioritised according to need (see below).

ii) Information for Specific Audiences

- Tailored engagement strategies should be designed for key subgroups of women, informed by the existing evidence base on each subgroup (which may need reinforcing with further research – see research recommendations below).

- A focus should be placed on what have been termed here ‘priority subgroups’, with the overall aim of making information universally accessible, and services approachable to all (this will require reciprocal refinements to service provision and staff skills). Distinct strategies should be developed for each priority subgroup reflecting their distinct needs and preferences as identified through research (eg. homeless women, asylum seekers, Asian Muslims).

- Fathers should be included among the priority subgroups, with a particular focus on young fathers. Tailored information and support should be provided for them across the maternity pathway.

- Ensure that multiparous women are not overlooked by information and support provision. Tailored strategies and materials are likely to be of value here in order to ensure that those who are less proactive in seeking support are also engaged. Within this subgroup, specific strategies will also be required for women who have previously experienced birth by caesarean section.

- Finally, women who have already decided on their preferred mode of birth, and feel they do not need more information, should also be considered for tailored support, in order to ensure they are not excluded from a decision making process about their care. Similarly to multiparous women, such groups are likely to be hard to engage in an extended choice agenda.

iii) Information on Specific Choices

- Evidence suggests that a 'layered and staged' approach may be appropriate for providing information on specific choices along the maternity pathway. This approach appears to have potential to realise a women-centred strategy, in which women can draw down information in as much detail as they choose, and at the points in time when it is most appropriate.

- However, it is also advisable to provide an initial 'route map' to women to make them aware of their upcoming choices at an early stage in pregnancy. This technique appears necessary as without it it is impossible to introduce the concept of a 'choice cascade', ie. that choices taken early in the pathway impact on subsequent choices (e.g. that epidurals increase the likelihood of caesareans). Such information is vital in order that women who wish to can weigh the pros and cons of each choice, not just in terms of its inherent risks, but also its subsequent implications. The downside of a 'route map' approach is that in setting out all the choices facing women throughout pregnancy, women's levels of anxiety may be increased, with according negative effects on likely outcomes. Further research is required on how to inform women about the full range of choices without increasing anxiety (see below).

- Within the wide range of specific choices which could be highlighted, certain key choices stand out as in particular need of promotion:

  - the benefits of prompt registering with maternity staff (particularly for those in priority subgroups);
  - the opportunity to access midwives as the first point of contact (addressing current low levels of awareness among all women, and with potential benefits for the normalisation of subsequent choices);
  - universal access to antenatal classes (and encouragement to take up the offer);
  - choice of place of birth including home birth, and mode of birth (again, addressing a shortfall in awareness among all women);
  - choice of pain relief (including skills for natural methods, and the 'cascading' implications of choices).

- In terms of the channels to be used to provide the above information, face to face methods appear to have the most impact, both through formal and less formal routes. In terms of media channels, the internet appears to offer multiple benefits. Online content has the advantage of being 'layered and staged' by the user who chooses what content to access. Such provision may also be in line with the preferences of the current generation of mothers, as suggested in some research. Online provision can also provide both factual content (such as that in The Pregnancy Book) and material grounded in the experience of other women, through the social networking aspect of maternity websites. While such forums are immensely popular with mothers, DH should design their own protocols for hosting such user-generated content with care, in order to ensure a close fit with the strategic objectives of their wider 'maternity choices' communications.

- Finally, the evidence on the specific choices highlighted above suggests that many of them are either 'non-choices' for some women (ie. they are subject to low levels of awareness, or are not offered to women), or they are less open choices, in that they are taken pre-pregnancy or in early pregnancy (eg. where to access maternity services, or what type of birth to have). This finding suggests that information should likewise be provided to women pre-pregnancy or in very early pregnancy, in order to influence 'pre-decision making'. This, plus the need to influence cultural norms, argues for a more broad-based communications strategy, as well as targeted approaches for specific subgroups.

iv) Information on Expectations

- Information on specific choices should be integrated within a communications strategy which sets out to influence women pre-pregnancy. Such communications should aim to shape expectations of birth experiences, and to seed ideas of how to access services, and of the possibility of exercising choice when engaging with those services.

- This wider communications strategy should promote normal birth as the initial assumption for all women, realised in the context of a range of settings (not just home birth). Communications activity should underline that support mechanisms are in place to ensure safety in all settings. Campaign messages may be effective if based upon social norms, making the reality of diverse satisfactory birth experiences explicit to future mothers. Such messages should also incorporate an empowerment strand, encouraging all women to believe that they have the capability to choose and achieve a non-interventionist birth, if that is what they want, and that whatever they choose they will be supported all along the maternity pathway.

- At the same time, the communications strategy should aim to counteract cultural norms of medicalised birth. This aspect of the strategy will require more than advertising, and involve embedding messages and influencing

techniques across diverse media channels. Stakeholder partnership and social marketing techniques are likely to be required in such an approach, which should ultimately aim at culture change; further research is likely to be beneficial here (see below).

v) Recommendations for Further Research

- As mentioned above, research will be required to develop and refine engagement strategies (including information and support provision) for the different priority subgroups under consideration.

- Research will also be required to explore the impact of providing information on the full range of maternity choices in the form of a 'route map' to women early in pregnancy. In particular, the possibility of balancing increased empowerment against the risks of increased anxiety should be explored across different subgroups.

- Additional secondary (desk) research, and potentially subsequent primary research, should be undertaken to explore the influences on cultural norms and expectations in relation to maternity choices. Such research should be designed to support the development of marketing and media strategies to bring about a culture change in normative expectations of birth experiences.

- Finally, the value of developing a quantified segmentation model of pregnant women should be further explored. Existing evidence suggests that attitudinal factors (in relation to interest in information) and emotional aspects (eg. in relation to anxiety) can add value to classifications of women simply based on parity or socio-demographic groups. Existing typologies, such as that provided by Wiggins and Newburn 2004, show potential as templates for further model development and quantification; for instance, the 'Unmoved' segment appear to represent an important subgroup for targeting with 'extending choice' strategies. A full quantified model could have value both in supporting central communications strategy, and in helping maternity staff to identify women's needs and tailor their provision on the ground. However, fundamental questions remain to be answered about the shape and feasibility of such a quantified model (for instance, how would stage of pregnancy be made to run across the segments?). It is recommended that a separate scoping exercise be conducted as the next stage in progressing such a model.

Appendix i) Organisations & Individuals Contacted

95 individuals representing 57 organisations contributed to this review; they are listed below.

The project team's sincere thanks go to all those who took part in the study, who were generous with their time and expertise.

Organisation	Key Individuals
AIMS (Association for Improving Maternity Services)	Beverley Beech (chair)
Birmingham Heartlands & Solihull NHS Trust	Fay Baillie (Midwifery lead) Lizzie Smith (Teen pregnancy)
Bliss	Peder Clark
Bounty	Paul Smith (rsh) Vicky Cateleigh (Rsh Mgr)
Bournemouth University (Health and Social Care)	Paul Lewis
City Hospital Sunderland	Sheila Hardy
Community Practitioners and Health Visitors Association (CPHVA)	Cheryll Adams Obi Amadi Indi Mungasighe Khalda Parveen
Coventry University	Susan Law
CSIP (Care Services Improvement Partnership)	Linda Jordan Janis Stout (workforce lead) Cynthia Fletcher
DCSF (Department for Children, Families and Schools)	Janet Ellis (Customer Insight) Joanna Thomas (Baby's Here leaflet) Robert Drake (TPU)
Disability Pregnancy and Parenthood International (DPPI)	Rosaleen Mansfield
East Kent Hospitals University Trust	Sally Moore (Head of Midwifery)
Family and Parenting Institute [formerly NFPI]	Clem Henricson (rsh mgr) Shuby Puthussery (snr rsh fellow)
Family Planning Association	Natika Halil
Fatherhood Institute [formerly Fathers Direct]	Duncan Fisher (chief exec) Adrienne Burgess (rsh mgr)
Gloucestershire PCT	Michelle Poole Marit Dykes
Government Equalities Office	Fiona Laming
Homerton University Hospital	Jane Kennedy Jane Walker

Organisation	Key Individuals
Imperial College NHS Trust	Maggie O'Brien (director of midwifery)
Independent Midwives UK (IM UK) [formerly IMA]	Brenda Van Der Kooy
Johnson & Johnson / www.BabyCentre.co.uk	Denise Young (rsh) Sasha Miller (editor – BabyCentre) Sam Seal (sales – BabyCentre) Chess Thomas (rsh editor)
Kings College London	Jane Sandall
Kings Fund	Anna Dixon Alex Smith
Maternity Services Alliance, Children's Centres Plymouth	Wendy Johnson
N3rn (Neonatal Nurses Research Network) – at NPEU	Breidge Boyle
National Collaborating Centre for Women's and Children's Health	Martin Whittle
National Perinatal Epidemiology Unit (NPEU) Oxford University	Mary Logan (admin) Peter Brocklehurst (director)
NCT (National Childbirth Trust)	Mary Newburn (Research) Lynn Balmforth (Info) Belinda Phipps (Comms) Anne Fox (co-ordinator, Maternity Care Working Group) Louise Brant (Secretariat, MCWP)
NHS East Midlands	Melanie Thwaites Shirley Smith
NHS East of England	Susan Osborne Christine Griffiths Ruth Ashmore
NHS Institute for Innovation & Improvement	Helen Bevan
NHS London	Margaret Richardson Trish Morris-Thompson
NHS North East	Sam Cramond Kath Mannion
NHS North West	Ann Hoskins Eustace de Sousa Mary Bell
NHS South Central	Sue Sylvester
NHS South East	Sue Webb Nicky Mason Helen O'Dell
NHS South West	Mandy Cox

Organisation	Key Individuals
NHS West Midlands	Julie Grant Louise Jackson Julia Holding Sue Hatton Maureen Brown
NHS Yorks & Humber	Jean Hawkins
NICE	Thara Raj (Implementation Lead)
NSPCC	Eileen Hayes (Parenting Adviser)
Nursing and Midwifery Council (NMC)	Michelle Lyne
Patient Opinion	James Munro
Picker Institute	Sally Donovan Esther Howell Tim Markham
Procter & Gamble	Marian Baker (press office)
Royal College of General Practitioners	Judy Shakespeare
Royal College of Midwives	Sue MacDonald (rsh manager)
Royal College of Nursing: Midwifery Society	Donna Kirwan
Royal College of Obstetricians and Gynaecologists	Professor Arulkumaran (President) Beryl Stevens (vice chair/corporate affairs) Gerda Loosemore Reppen (Consumer forum)
Sheffield Hallam University	Hora Soltani
Sheffield University	Nadine Pilley Edwards
St Mary's London Birth Centre (also RCM, Cemach)	Pauline Cooke
Tommy's	Susie Hill (rsh)
University of Huddersfield (Division of Midwifery)	Ruth Deery
University of Worcester	Mary Nolan
University of York (Health Sciences)	Jo Green
UWE	Toity Deave

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