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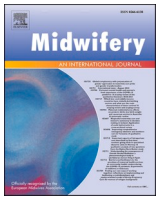

Research Article

Researchers' perspectives of self-agency within a context of violence and harm in maternity care

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ABSTRACT

Problem: There is an increasing awareness of the prevalence of obstetric violence within maternity care and that some women and birthing people are at greater risk of experiencing violence and harm.
Background: Supporting self-agency for women and birthing people in maternity care may be a way of addressing the disparities in vulnerability to violence and harm.
Aim: To explore researchers' perspectives of self-agency for women from different backgrounds, what inhibits and prevents self-agency, and how self-agency can be enabled.
Methods: A qualitative research design was undertaken underpinned by a reproductive justice framework. Group interviews were held with researchers working with perinatal women/birthing people with histories and experiences of violence and abuse. Reflexive thematic analysis using Bronfenbrenner's ecological systems theory was undertaken.
Findings: 12 participants took part in two group interviews. Two themes were developed: '*defining self-agency*' and '*ecological influences on self-agency*'.
Discussion: The findings identify how self-agency should not be perceived as an intrinsic attribute, but rather is underpinned by exogenous and endogenous influences. Whether and how self-agency is enacted is determined by interacting factors that operate on a micro, meso and macro level perspective. Self-agency is undermined by factors including immigration policies and sociocultural perspectives that can lead to under-resourced and judgemental care, other intersectional factors can also lead to some individuals being more vulnerable to violence and harm.
Conclusion: Implications from this work include strategies that emphasise woman-centred care, staff training and meaningful organisational change to optimise positive health and wellbeing.

Introduction

Awareness and evidence of violence and abuse, also known as obstetric violence, experienced by women and birthing people accessing maternity care is increasing globally (Chadwick, 2021; Kuipers et al., 2022; van Der Waal et al., 2023). Obstetric violence is described as a 'specific form of violence against reproductive subjects' (Chadwick, 2021, p.104). It is a feminist activist term designed to highlight structural problems in reproductive health from a service user perspective (van Der Waal et al., 2023). Obstetric violence encompasses a wide range of behaviours and practices such as physical, verbal, sexual, structural, and epistemological forms of violence including failing to get informed consent, neglect, and discrimination (Bohren et al., 2015; van Der Waal et al., 2023). It also encompasses gender- and race-based violence (Cohen Shabot, 2016) that specifically affects minoritised birthing communities (Davis, 2019; Perrotte, Chaudhary, and Goodman, 2020). Obstetric violence is a human rights violation that impedes women and birthing people's autonomy, individual agency, and control over their bodies (Pickles and Herring, 2019; Vedam et al., 2019). The most recent Birthrights inquiry, based on 300 testimonies in the UK, found experiences of dehumanization, lack of physical and psychological safety, being ignored and disbelieved and a lack of choice, consent and coercion (Birthrights, 2022). Cohen Shabot (2021) also argues that obstetric violence happens to a woman in a specific state of embodied vulnerability that can destroy relationships and interdependence between labouring women and their significant others during childbirth.

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Studies reporting drivers of disrespect, mistreatment and obstetric violence suggest that participants' backgrounds can position them at intersections which increases their vulnerabilities to experience harm and violence during maternity care. This may include their education, mental illness, socioeconomic status, histories of trauma and abuse, marital status, religion, caste, class, language, parity, religion, and age (Vedam et al., 2019). Pregnant women who present with female genital mutilation/cutting (FGM) can also experience stigma, a loss of agency, shame, and alienation as part of their maternity care (Scamell and Ghumman, 2019). *The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* [MBRRACE] *Report* that reviews maternal deaths in the UK, presents race as well as poverty as key indicators driving inequities in maternal health outcomes. This report shows that Black women are four times and Asian women are twice more likely to die than White women, and that women from the 20% most economically deprived areas are twice as likely to die than those from the 20% least deprived (Knight et al., 2022). Minoritised ethnic women and those living in poverty are at higher risk of experiencing premature birth, stillbirth, or neonatal deaths (Knight et al., 2021). Furthermore, there is strong evidence that women with histories of violence and abuse have increased risks of having babies with a low birth weight, and evidence of associations with pre-term labour, miscarriage, fetal death (Feder et al., 2009) and maternal death (Boy and Salihu, 2004). Perinatal women with histories or experiences of violence and harm can also experience a wide range of short and long-term morbidities such as post-traumatic stress disorder symptoms, difficulties bonding with the baby, breastfeeding cessation, and negative impacts on future reproductive choices (Perrotte, Chaudhary, and Goodman, 2020). There are also issues about help-seeking behaviours for women and birthing people with experiences of trauma or harm due to a lack of trust in care providers (Scamell and Ghumman, 2019), concerns about reprisals or social stigma (Rayment-Jones et al., 2019), or not knowing where or how to access support (Jankovic et al., 2020). Authors argue that challenges in help-seeking are magnified for women who are more vulnerable (due to histories of trauma, abuse, mental illness, etc.), as well as those who have experienced institutional racism (Hulley et al., 2023; Smith et al., 2019).

A potential antidote to women's vulnerability during maternity care is self-agency. Self-agency – also referred to as 'the phenomenal will', 'personal agency' or 'the power within' (Kabeer, 1999) – relates to the meaning, motivation, and purpose of individual activities (Kabeer, 1999); it is the power and ability to think and advocate for our needs. Terms such as agency and control can be used interchangeably, and while they are related concepts, they have distinct meanings: agency is about the capacity to act and make choices, while control concerns managing or directing these actions or choices, either within oneself or the external environment (Kabeer, 1999). Agency concerns freedom and empowerment about what one needs, and control is about influence and regulation. While self-agency is influenced by individual and sociocultural factors such as education and cultural practices (Hart, 1995; Hart and Foster, 1998), it is argued that women and birthing peoples' ability to perform self-agency is essential for improved maternal and infant health outcomes (Kabeer, 1999; Shahil Feroz, 2022). A focus on self-agency also arguably aligns with the 'humanizing birth' movement that seeks to place women as central decision-makers (Gonzalez-Flores, 2015; Perrotte, Chaudhary, and Goodman, 2020). Currently, while there is broad consideration of how women's sense of 'control' influences childbirth (Meyer, 2013), there is little insight as to what self-agency specifically means for women and birthing people in the context of violence and harm during maternity care.

Research staff from the University of Central Lancashire were commissioned to explore self-agency in a maternity care context. The intention was to work with researchers with expertise in working with perinatal women with histories and experiences of violence and abuse. The study aimed to understand researchers' perspectives of what self-agency means for women from different backgrounds, what inhibits and prevents self-agency, how self-agency can be enabled to prevent harm and abuse, and how self-agency can be encouraged to facilitate help-seeking and needs-led care and support. It was felt that these perspectives could illuminate the impact of different structural and sociocultural factors on women and birthing people's ability to enact self-agency and to identify strategies for how self-agency can be facilitated.

Methods

Design/theoretical framework

A qualitative approach underpinned by a reproductive justice framework was undertaken. This human rights framework was developed by women of colour in the 1990s to highlight how intersecting forms of oppression affect reproductive health and autonomy: it emphasises the importance of addressing social determinants of health and the interconnected nature of reproductive oppression (Collins, 2019; Crenshaw, 2013; Ross, 2020). This framework was used to help frame the interview questions and to interpret the data: to understand how systems, structures, and mechanisms of power interconnect (Avery and Stanton, 2020) to influence self-agency amongst women and birthing people within a context of violence and harm.

Recruitment

Email invitations were sent to ~20–30 researchers with expertise in this area to participate in a group interview. Potential participants included researchers already known to the study team. Other participants were identified via searches (i.e., Google Scholar using terms such as 'reproductive justice') and snowballing. If participants wished to take part, they completed an online consent form and provided their contact details to the research team. Once a consent form was completed, the participant was provided with a list of potential times and dates to take part in a group discussion.

Data collection

Two group interviews took place on Microsoft Teams. The interviews were audio and video recorded and both were between 50 and 60 mins in length. Group interviews were chosen as they allow for deeper insights to be captured, compared to focus groups where the emphasis is on participant interaction (Morgan, 2002). The interviews were facilitated by a Black community worker who works with perinatal minority ethnic women, supported by the research team. This decision was aligned with a reproductive justice lens whereby the facilitator also represented the views of marginalised population groups and could probe issues of inequality from a more situated perspective (Pratt, 2019). The group interviews explored:

1. Defining what self-agency means for women and birthing people in the context of maternity care.
2. How self-agency differs for women and birthing people from different backgrounds (those who are vulnerable and/or from marginalised backgrounds such as histories of trauma and abuse, mental illness, age, ethnicity, etc.)
3. What are the barriers to exercising self-agency in a maternity care context (e.g., marginalised position of individual, time point in the maternity care journey (childbirth), biases of care providers, etc).
4. How self-agency can be supported throughout the maternity care journey (e.g., to prevent or minimise opportunities for trauma and abuse, and to enable help-seeking) and for women and birthing people from different backgrounds and who have different needs.

The group interviews were audio and visually recorded and transcribed in full for data analysis purposes.

Data analysis

A reflexive thematic approach was adopted that involved centring researcher subjectivity, and deep reflection on and engagement with the data (Braun and Clarke, 2022). Both transcripts were uploaded to MAXQDA (qualitative software programme) for analysis purposes. When reading and re-reading the transcripts, and from a reproductive justice lens perspective, the interconnected individual and environmental influences on self-agency were apparent. Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1999, 2005) was therefore used as a theoretical and deductive lens to help interpret the findings: to understand how interconnected systems interact to influence whether and how self-agency could be enacted. This approach is similar to the work of Liddell & McKinlay (2022) who used the reproductive justice framework and Bronfenbrenner's ecological systems theory to contextualise and understand reproductive disparities and oppression. In this study, the findings were mapped to three key components of Bronfenbrenner's theory (Bronfenbrenner, 1999, 2005) to identify micro, meso and macro levels influences on self-agency. Both authors were involved in data analysis, and the findings were shared with all the participants for member-checking purposes; all feedback indicated that the interpretations were authentic representations of the discussions.

Reflexivity

Both authors are White and identify as women. One has a psychology academic background, and the other is a historian. Both have long careers (between 15 and 25 years) of undertaking research into women's experiences of perinatal care, particularly with marginalised populations such as ethnic minority women, women living in poverty, incarcerated women, and refugees and asylum seekers. Both were aware of and have done previous research which engages with issues of how maternity care can discriminate, judge and 'other' women, particularly those with complex backgrounds and needs, and the impact this has on women's physical and mental well-being. Both authors reflected on these pre-understandings throughout the interpretive process. As the authors' ethnicity impacted their understandings of the lived experiences of minoritised ethnic women, the findings were discussed with the group facilitator, and before being shared with the study participants.

Ethics

Ethics approval was obtained from the authors' University ethics committee (project no: 0424). All participants were provided with an information sheet that detailed why the study was being undertaken, what it would involve, confidentiality and how the data was to be used.

Findings

Two group interviews were held ($n = 3$ participants in the first group and $n = 9$ in the second). The researcher participants were from different disciplines including sociology, midwifery, nursing, bioethics, public health, social policy, and health research. Ten women and two men participated: four of whom were from a minority ethnic background. Here we report on two themes. The first *'defining self-agency'* offers the researchers critical insights into how self-agency needs to be situated as a concept underpinned by exogenous and endogenous influences. The second *'ecological influences on self-agency'* describes the micro, meso and macro level factors that interact and influence whether and how self-agency can be enacted. While enablers of self-agency were identified during data collection, these are considered in the discussion section, contextualised by the wider literature.

Defining self-agency

Participants offered different descriptions as to what they felt self-agency meant for women and birthing people. Overall, self-agency was inextricably linked to feelings of power and control. They described it as an ability to '*stand up for yourself*', '*to say no*', '*to express what I want and how I want it to be*'. Also, rather than self-agency being an intrinsic-related attribute, whereby the *'pressure is on individuals' to advocate for themselves'*, participants emphasised the need for self-agency to be recognised as a concept that is influenced by individual and external factors:

> I thought about self-agency in this context as the ability of a birthing person to control their experience through an expression of their self-will and to be within the conditions that enable them to do that. (Participant 3_Group interview 1)

Others also explained how they considered self-agency to be a negotiated process that involved decision-making and feeling able to ask for evidence, while situated in a partnership model of care. One participant described it as:

> Classically, it tends to be thought of as the ability of an individual to express, negotiate, articulate, and push for the things that they want for their care and that are important to them. To push for their need to be front and central in how their care is structured, but also involved in discussions about what might happen in different scenarios or what might happen now. (Participant 1_Group interview 1)

One participant emphasised both exogenous and endogenous influences on self-agency when highlighting the biological basis of childbirth. This participant considered how women's and birthing people's, *'stress needs to be low for oxytocin to flow and you need to feel trust and not to feel fear, for things to progress normally and for labour to progress well*' (Participant 2_Group interview 1). Being pregnant and giving birth was described as an *'intrinsically embodied experience'* (Participant 1_Group interview 1) - actions or behaviours which disrupted these processes and undermined self-agency had psychosocial consequences. These consequences involved leaving women with negative memories to *'take through their life'* (Participant 1_Group interview 1) and having lasting impacts *'on their lives, and lives of the family and other members'* (Participant 2_Group interview 2).

Ecological influences on self-agency

The researcher participants described various factors that influenced women's and birthing people's ability to exercise self-agency which we interpreted using Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1999, 2005). We discuss macro-level influences first, as they provide the wider contextual background from which micro and meso-related issues emulated.

Macro-level influences were highlighted in terms of the complexities of immigration policies *'interacting with health policies'* that could limit what women and birthing people are entitled to (Participant 5_Group interview 2). Societal expectations around pregnancy and how pregnant bodies become a focus of scrutiny and judgement were also raised. One participant reflected on how:

> There is a huge amount of pressure coming from not just the world in general, but literally to the case of someone in a coffee shop who sees you are pregnant and says: "oh, you shouldn't be having that", just out of nowhere. (Participant 3_Group interview 1)

Participants expressed concerns about the *'sexist, paternalistic'* nature of the UK healthcare system – a system developed on '*reams and reams of research about men'* that has extended into maternity care and is predicated on '*not listening to women'* and '*not expecting them to be masters of their own body'* (Participant 1, Group interview 2). Some reflected on how obstetric violence was a direct result of women and birthing people receiving maternity care within a *'hierarchal, violent gendered system'* (Participant 3, Group interview 1). One participant also considered that these systemic issues challenged the notion of self-agency to prevent

obstetric violence from occurring, when situated in a care system that suppresses women's capacity for agency and control. Participants also raised issues about the current context of litigation and indemnity and outcomes from recent national maternity reviews. They argued that these reviews fail to acknowledge that *'unfortunately these things* [bad outcomes] *happen'* (Participant 4_Group interview 2) and rather led to midwifery staff being vilified and blamed.

From a micro perspective, self-agency was perceived to be influenced by intersecting issues such as class, race, culture, disability, and language. An individual's sociocultural background – *'family rules, values, customs, traditions, and socialisation'* (Participant 2_Group interview 2) – was felt to make an individual more or less likely to experience self-agency. One participant considered self-agency to be more evident amongst *'those who can most easily demand it'* such as *'middle-class white women'* (Participant 3_Group interview 1): this was because these women have a better understanding of maternity systems and an ability to articulate their needs. Whereas, for example, asylum seekers and those who were unable to communicate in English and/or *'haven't experienced* [UK-based] *maternity care at all'* (Participant 2_Group interview 2) could struggle to express their care needs or refuse care due to lacking understanding. Those who could speak English had opportunities to consult with multiple providers and seek information via other means, such as the Internet. Whereas non-English speaking populations often relied on an interpreter to translate *'what that one clinician is saying'*, making it harder to *'navigate the system'* (Participant 4_Group interview 2) and limiting opportunities for informed choice. One participant spoke of an asylum-seeking woman being provided with a birthing pool during labour, and while this action was likely underpinned by positive intentions, for the woman it was *'really frightening''* (Participant 1_Group interview 1).

Other participants referred to specific populations where self-agency was lacking due to social isolation or fear of judgement. These populations included women made pregnant through sex trafficking, those with histories of trauma, or even those choosing care that was perceived to be *'against the grain of what is normal'* (Participant 3_Group interview 1). It was also recognised that some women and birthing people were not aware of how their histories of violence and abuse would affect them, which could impact their abilities to advocate for their needs.

Meso-level influences relate to community-level influences operating from within a familial and maternity care context. From a familial context, issues were raised from a South Asian perspective whereby an extensive level of family involvement could be both positive and negative. While the availability of support could be positive, it could also limit an individual's agency to *'exercise her own beliefs and thoughts and opinions and have that confidence to speak up when there are family members that are making decisions*' (Participant 3_Group interview 2).

More commonly, meso-level barriers to self-agency were associated with maternity care. The macro-level influence of a lack of value for '*gendered caring'* translated into insufficient monetary support for maternity services. In turn, this instilled fear and pressure among maternity professionals working in systems that were under-resourced, devalued, and perceived *'differently'* and *'less protected'* when compared to other aspects of health care. Midwives were described as '*dehumanised and underpaid'* and not having '*the time or emotional capacity to see people as individuals'* (Participant 2_Group interview 1). This was believed to lead to *'compassion burnout'* in midwives, creating *'a potentially toxic place for good practice to flourish'* (Participant 2_Group interview 1). High-level data metrics highlighting low maternal mortality rates in the UK were also believed to compound these issues, as '*it's harder to say we need to change things because they can come back at you that the data says it's fine*' (Participant 3_Group interview 1).

Notwithstanding these provider-related issues, women and pregnant people in general were perceived to be *'situationally vulnerable'* due to being '*at the mercy of the people who are giving care'* (Participant 3_Group interview 1), particularly those giving birth for the first time. One participant described the notion of vulnerability as a *'thorny topic'* that could induce a paternalistic response of '*we* [maternity providers] *need to look after them and we can do that by telling them what they should do'* (Participant 3_Group interview 1). Another participant described a perception of *'staff getting away'* with disabling self-agency amongst those who were unable to express their needs:

> You certainly see, like when I was working, there was a lot of missed treatment of women who the staff thought they could get away with it, particularly women who didn't speak English and though they couldn't speak English to complain. (Participant 3_Group interview 1)

Participants considered how pregnant women and birthing people, particularly those with additional complexities, could be deferential during interactions with maternity care staff. Maternity care professionals were perceived as having the *'power'* due to owning *'more knowledge or because they have the education or qualification or the clinical experience'* (Participant 3_Group interview 2).

A further issue concerned the biased and judgemental attitudes of maternity care staff. Participants described self-agency being undermined for trans and non-binary communities due to the misgendering and *'microaggressions'* towards birthing people and their partners (Participant 3_Group interview 1). Maternity care professionals could lack understanding of women and birthing people's legal, cultural and/or individual (i.e., emotion-based) needs. Participants also referred to maternity care professionals displaying judgemental and arguably racist beliefs when the *'demands'* of birthing people were condoned or vilified based on race:

> Also, the stereotyping and the way that one person is, again like the middle-class white woman who is demanding certain things. It might be seen as normal behaviour for middle class white women, but if a working-class Black woman does the same thing she would be seen as a troublemaker, someone who's aggressive and someone that creates a very different dynamic between the staff and the patient. (Participant 3_Group interview 1)

Participants also highlighted organisational and management-related barriers within maternity care, which related to the need for a *'smooth functioning system'* that was less concerned with individual-level care. This could involve coercive procedures, e.g., *'a vaginal exam as gatekeeping',* or coercive language *'you can always play that dead baby card and it gives you an awful lot of power when you say: "but do you want this baby to survive*? (Participant 2_Group interview 1). These meso-level barriers placed limitations on what care women could receive (e.g., due to staffing issues) or where to give birth (e.g., due to a lack of space):

> For example, some people want to be on the labour ward earlier than others, to feel safe. Some people want to be in the birthing centre at a point where at a system level, the system might prefer that person isn't there now, because they're not the person who needs the care the most. (Participant 1_Group interview 1)

Discussion

To the best of our knowledge, this is the first study to focus on self-agency from a researcher's perspective. This study aimed to help understand how self-agency is defined and what influences how self-agency is enacted in maternity care, particularly within a context of violence and abuse. The finding highlighted how participants situate birthing people's self-agency as a concept that is influenced by internal and external factors. The definitions of self-agency emphasised the perceived interrelated nature of agency and control, whereby women's ability to achieve their needs depended on exogenous and endogenous factors (Kabeer, 1999). As well as how the physiological processes underlying pregnancy and childbirth render women more vulnerable to external influences. In line with the reproductive justice lens adopted, this work highlights how various social, political, and economic

phenomena interact to influence women's reproductive health and autonomy. Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1999, 2005) has been used in broader perinatal studies, such as helping to understand the influences on women/birthing people's experience of infant feeding (Thomson, Ingram, et al., 2022) or access to antenatal care (Sword, 1999). To our knowledge this is the first time it has been used to identify the micro, meso and macro factors that influence self-agency.

In this study it was important to position macro level issues first, to outline the wider factors that underpinned micro and meso-related influences. Macro influences related to challenges associated with immigration policies, reflecting how these policies disproportionately affect migrant/minority women (Higginbottom et al., 2013). Sociocultural perceptions of parenting, as reflected in the work by Burton-Jeangros (2011), were also highlighted to emphasise how societal views of risk and moral expectations of motherhood influence birthing people's self-agency. Macro level influences also related to a litigation culture (Alexander and Bogossian, 2018) and medical paternalism that can instil unethical care that impacts on women's autonomy and agency (Newnham and Kirkham, 2019).

Micro level influences concerned intersectional factors. Individuals who are more vulnerable to violence and harm (due to lacking English skills, being trafficked, histories of trauma, etc.), were believed to be less likely to hold beliefs about being able to influence outcomes. These insights reflect the work of wider sociological thinking in how there needs to be consideration of contextual factors in understanding how individuals develop and exercise self-agency in the face of adversity (Ungar, 2011). Meso level influences concerned familial-level influences and the provision of maternity care. Maternity care professionals' capacity to facilitate self-agency was felt to be compromised or undermined due to working in under resourced and devalued settings that were focused on 'safety' rather than individualised care. The findings also highlight how maternity care staff can demonstrate paternalistic and judgemental attitudes, particularly towards those with complex needs. These insights echo the work of Kabeer whereby the use of coercion and control of other actors (such as family members, midwives) can override the agency of others, leading to 'non-decision' making (Kabeer, 1999). They also reflect those of Hall and colleagues whereby women's agency was comprised by hospital routines and unresponsive caregiver practices (Hall et al., 2018). The finding that maternity care staff can be perceived to 'blame' vulnerable women for their situation aligns with the work of Frith: if individuals are held accountable for their situation, it legitimises their behaviour being managed through punishment or reward (Frith, 2014).

In line with the calls to support greater maternal agency over the childbearing process, (Miller et al., 2016), not simply as an ethical concern, but to improve population health (Declercq, Sakala, and Belanoff, 2020), our work uncovered essential implications for practice. First, there is an obvious need for interpreters, and information to be available in key languages so women can communicate their needs and understand the basis of care provision (Thomson, Cook, et al., 2022). However, it is equally important for maternity care professionals to listen to women and birthing people's voices to promote autonomy and self-agency (Kehoe-O'Sullivan and Weir, 2017). This needs to happen as part of usual care practices, and for their experiences to be shared as part of midwifery or obstetric training and/or as part of continual professional development. This could help raise awareness of how self-agency is experienced from different perspectives and to enact moral and ethical change in maternity care (Cellissen et al., 2022). Listening to women/-birthing people's voices is important to raise awareness of cultural sensitivity for woman-centred care to ensure maternity care professionals understand, communicate, and address diverse needs (Bohren et al., 2015). Continuity of carer, a mainstay of positive maternity care, is also essential for women to build trust with their caregivers and to share and express their needs (ten Hoope-Bender, 2013). Continuity of carer is also particularly important for those with complex and challenging histories, such as FGM, seeking asylum, and those with histories of violence and harm are unlikely to make disclosures to a 'stranger' (McKnight, Goodwin, and Kenyon, 2019). A further implication is for trauma-informed training to be provided to all maternity staff. This is essential to help maternity professionals understand the impact of trauma histories, how maternity care can trigger or exacerbate trauma symptoms, and to help create a collaborative care partnership (Sperlich et al., 2017). A trauma informed approach is considered vital to enable maternity care providers to create a safe, supportive environment that promotes agency, healing, resilience, and a positive birth experience (Sperlich et al., 2017). Strategies that may help address pervasive and racist hegemony in maternity care include ensuring the maternity workforce is properly funded and diversified, and for the World Health Organization (WHO) guidelines for respectful maternity care (Organization, 2014) to be embedded within practice. Further engagement with peer mentoring and voluntary/third-sector organisations that already work to enable women to exercise self-agency could also support meaningful change (Balaam et al., 2016).

The strengths of this study are that it used a novel approach of drawing on the perspectives of researchers with expertise in working with perinatal women with histories and experiences of violence and abuse. The number of participants recruited was low, despite ~30 being invited to participate, and most were White-British. A further limitation is that the group-based nature of the interviews may have restricted what was shared. While the group interviews were facilitated by a Black community worker, which may have biased the discussions, other research staff were present to ensure a more balanced discussion was held. Despite these limitations, this work generated rich insights into what self-agency is and how it can be enabled. Further research should explore whether women from different socioeconomic backgrounds share the same perspectives as those generated in this study.

Conclusion

This study was the first to explore researchers' perspectives of self-agency in maternity care within a context of violence and abuse. While further work is needed, important insights into what facilitates and impedes self-agency were identified. This work highlights how self-agency was perceived as being influenced by internal as well as external factors, and how these factors operate on a micro, meso and macro perspective. It identified challenges to self-agency associated with immigration policies, sociocultural perspectives, litigation, paternalism, and how this translates into under-resourced and judgemental care provision. It also emphasises how intersectional factors, which render individuals to be more vulnerable to violence and harm, need special consideration. Recommendations from this work include woman-centred care, staff training and meaningful organisational changes to optimise positive health and wellbeing.

CRediT authorship contribution statement

Gill Thomson: Writing – review & editing, Writing – original draft, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Marie-Clare Balaam:** Writing – review & editing, Writing – original draft, Project administration, Formal analysis, Data curation.

Declaration of competing interest

The authors have no conflict of interest to disclose.

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