

**Women's Experiences of Attempted Access
to Alternative Birth Models in
Contemporary Ireland**

**A thesis submitted to the University of Dublin,
Trinity
in fulfilment of the degree of
Doctor of Philosophy in Midwifery**

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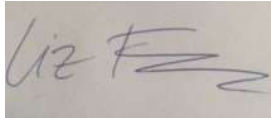
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SUMMARY

Background and impetus for the study: Maternity care in contemporary Ireland is situated within a medical model of birth that conceptualises pregnancy and labour as potentially pathological and inherently risky. Grounded within this paradigm, maternity services are consultant-led and hospital-based. However, mirroring international trends that promote service user choice and woman-centred care, the Irish Department of Health launched the National Maternity Strategy in 2016. The strategy, with a ten-year implementation period, attempts to organise maternity service provision around women's preferences and optimise choice for childbearing women. It remains Ireland's most progressive maternity policy document to date, outlining a pathway for women to give birth at home or in yet-to-be-built Alongside Birth Centres as an option for healthy women. Thus, on the surface, alternative birth models are a more legitimate and potentially more available option than was previously the case. However, continued low home birth rates and the fact that not a single Alongside Birth Centre has yet been built, as outlined in the strategy, means that access to alternative birth models remains constrained, even for childbearing women classified as low-risk. Therefore, I have captured, during the strategy's implementation period, the phenomenon of women's lived experiences of attempted access to these options. In doing so, I address the ways in which dominant biomedical ideologies around childbirth and the female body continue to collude with State and hospital policies to regulate women's reproductive choices and restrict access to alternative maternity care options. This specific topic has remained significantly under-investigated and thus my study contributes new knowledge to this area.

Aim of the study: The aim of the study is to develop an in-depth understanding of women's lived experiences of attempted access to alternative birth models within contemporary Ireland. In doing so, this research will add significant knowledge to the national and international body of midwifery research regarding the provision of information about alternative birth models during the antenatal period and barriers women in Ireland may face while attempting to give birth at home or an MLU. This knowledge in turn will provide valuable insight into whether women's lived experiences mirror the greater emphasis on choice and birth

options theoretically available to women through the publicly funded maternity services as outlined in the National Maternity Strategy.

Methodology and methods: This hermeneutic phenomenological study is based on the work of Heidegger and van Manen, which emphasises the importance of lived experiences and the social context in which they take place. This research is also situated within the larger feminist project to highlight women's experiences as a valid source of information in the production of knowledge. Purposeful and snowball sampling were used to recruit a total of 28 participants. These participants were each interviewed once using unstructured or semi-structured techniques. Data was analysed according to van Manen's methods, namely, Hermeneutic Phenomenological Reflection, which requires an iterative, circular analysis of the data. This type of analysis also involves the contemplation of themes, which are used as tools to understand the meaning and structures of an experience.

Findings: Findings from this study demonstrate that while recent policy documents, particularly the National Maternity Strategy, emphasise choice as a pillar of modern maternity service provision, women's access to alternative birth models remain constrained by the current medical model of birth that relies on obstetric metrics of safety and risk, and women's embodied knowledge remains suppressed by obstetric authority over birth. Furthermore, maternity services in contemporary Ireland are situated within a social and cultural context that is steeped in patriarchal and scientific notions regarding women, and the female mind and body. In particular, women attempting to access pregnancy and intrapartum care that is situated within the social model of birth are confronted with a maternity service that continues to devalue and dismiss women's choices, even while promoting pro-choice rhetoric. Medical hegemony was also exposed when participants were confronted with the notion that their decisions to birth outside the medical model were dangerous or risky. In the context of pregnancy and childbirth, this notion casts women as poor decision makers in relation to the foetuses growing inside us. For my study participants, this idea took on particular significance within the context of the Eighth Amendment, which equated the right to life of the foetus with that of the mother. For the participants, these obstetric and patriarchal conceptualisations of the female body and decisions meant that women's access to alternative birth models was constrained by policies regarding acceptable timeframes in relation to the length of pregnancy and birth.

Furthermore, access was dependent on medical definitions of risk, as seen in the process of the consultant “sign off”, and not situated within the participants’ personal barometers for health and wellbeing. Finally, access to alternative birth models was influenced by the quality (or lack of) information provided to participants by healthcare professionals during the antenatal period, and the lack of knowledge demonstrated by healthcare professionals regarding birth at home or an MLU. In order to counteract this lack of information and dismissal by providers, women gathered information from sources outside the clinical encounter.

Conclusion: Despite the fact that contemporary national Irish maternity care policy highlights choice as a key priority, women’s access to alternative birth models remains inconsistent and constrained. This continues to be the case despite the fact that the National Maternity Strategy was launched six years ago. Constrained access also remains *in situ* despite the fact that researchers, policy makers and birth activists have long highlighted the advantages of midwifery-led care and critiqued the negative impact that the medical model of birth, as well as scientific and patriarchal conceptualisations, have had on women and infants. However, through ensuring that birth choices as set out in the National Maternity Strategy are accessible, committing resources to the improvement of services and incorporating the social model of birth into maternity care provision, it is possible to create a service that is woman-centred and provides consistent access to midwifery-led, non-hospital-based models of care.

DEDICATION

To Scarlett, my warrior princess, and Dylan, who reminds me to keep my standards high.

To you two, all my love, always.

To Mary, mi media naranja

and

To Maria, who helped me catch my babies

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Chapter 1: Situating access to alternative birth models in contemporary Ireland

“Women must have power and control over their own sexuality and reproductive capacities and they must be guaranteed dignity and respect throughout every stage of pregnancy, delivery and the postpartum period.”

- Kennedy 2002, p 13

1.1 Introduction

This chapter provides an overview of this hermeneutic phenomenological inquiry into the lived experiences of women attempting to access alternative birth models in contemporary Ireland. I first set out the background and context for this study by outlining historical and social developments within Irish maternity care and the significance that moving birth from home to hospital held for birthing women and attendants. I also discuss the social model of birth, as well as the medical model, which has become dominant in most Western countries, particularly Ireland. I follow this by describing the implications of obstetric risk discourses on women's experiences of choice and access to alternative care models and define key terms that will be used throughout this thesis. I then present the research question, aim and objectives and situate my study within existing research, highlighting the unique insights that my research adds to feminist and midwifery discourses on women's reproductive choices and access to care. I also present a preliminary justification for my choice of theoretical framework and methodology before concluding with an outline of the subsequent chapters contained within this thesis.

1.2 Contemporary maternity care in Ireland: Historical and social context

1.2.1 The hospitalisation of birth in Ireland

Throughout much of human history and in most countries around the world, the healthcare of women and children has resided largely with the female community and has been provided within the context of an informal system that stressed continuity of care and health as a social product (Oakley 1976). Within this context, birth was largely a social event that took place within the home, attended by midwives and other women (Tew 1998). With the rise of the medical profession in

Western countries throughout the 18th and 19th centuries, birth was brought into the remit of medicine and increasing numbers of women gave birth in hospital, attended by male doctors (Murphy-Lawless 1998). However, it was in the latter half of the 20th century that maternity services in Ireland and other Western countries underwent a seismic shift, undergoing significant changes within a relatively brief period of time (Kennedy 2002). It was during these decades that the number of women giving birth outside the home rose dramatically, cementing the hospital as the primary place of birth and the position of doctors as the primary birth attendants (Begley *et al* 2009). This meant that birth was transformed from a domestic event that took place at home under the management of women into a procedure under complete medical oversight that occurred within institutions under the control of men (Edwards 2005). Obstetric technologies developed in tandem with this, and medical interventions became routine (Henley-Einion 2009).

The years 1955-1970 in Ireland, in particular, marked a time of dramatic change. In 1955 there were a total of 61,612 births in Ireland (Kennedy 1998). This included 20,665 births at home and 40,957 in hospital. By 1970, just 15 years later, there were a total of 64,382 recorded births. Of these, 1,883 were born at home and 62,499 born in hospital. By 1980, the number of babies born at home was 202, while there were 73,862 born in hospital, for a total of 74,064 births. According to the Health Service Executive (HSE) Planned Homebirths in Ireland Annual Report 2016, 120 births took place at home that year (Meaney *et al* 2018), out of a total of 63,841 live births (CSO 2016). These figures indicate that, since the 1990s, more than 99% of births have taken place in hospital (O'Connor 1998, Meaney *et al* 2016), cementing the near-complete hospitalisation of childbirth (Kennedy 2002).

The movement of birth from home to hospital was part of the larger process of the medicalisation of childbirth (and other natural events, such as death) (Conrad 1992) and the rise of the medical profession and obstetric control over childbirth that took place within industrialised countries in the 17th and 18th centuries (Henley-Einion 2009, Murphy-Lawless 1998). These changes, in turn, were situated within the Scientific Revolution and the increasing authority placed in scientific and medical knowledge (Davis-Floyd 2018, Newnham *et al* 2018).

Within a European context, the Irish maternity services have been, and continue to be, particularly embedded within a medical framework. This, Murphy-Lawless (2011) writes, is due to a unique combination of women's subordinate position

within a conservative and patriarchal Irish society, as well as an ongoing and powerful alliance between the Catholic Church and the medical profession (Wren and Connolly 2019). The interests of these two organisations have been co-aligned throughout the history of the Irish state and is exemplified in the religious orders' provision of healthcare when the State could not afford to do so (Wren and Connolly 2019) and opposition to proposals for universal healthcare for women and children, which were dismissed in favour of the Maternity and Infant Care Scheme (MICS) (Kennedy 2012), discussed below in Section 1.2.2. For women, the Church-Medicine alliance has enacted medical dominance over childbirth and restricted access to both reproductive healthcare services in general (McAvoy 2015, Wren and Connolly 2019) and midwifery-led care specifically (Stach 2020).

1.2.2 The Maternity and Infant Care Scheme

Modern Irish maternity services operate on the basis of legislation dating back to the 1950s. The 1953 Health Act legislated for the Maternity and Infant Care Scheme (MICS), under which women can receive free antenatal care. This differed significantly from the original Mother and Child scheme initially proposed by then Health Minister Noel Browne in 1948. Through this scheme, Dr Browne hoped to introduce maternity care for women and universal primary care for children. However, this was opposed by the medical profession, concerned about profits (Wren and Connolly 2019), and the Catholic Church, concerned about losing its hold over women and reproduction (Kennedy 2012). While antenatal care was free for all women under the MICS, women still had to pay for birthing in hospital. This meant that giving birth at home became the “poor woman's option” (Kennedy 2012, p 380), while consultant-led private pregnancy and intrapartum care, paid for via private insurance, became increasingly sought after, so that by 1996, over 25% of all women were receiving private care, with 66% of this group being university graduates (Wiley and Merriman 1996, pp 108-109). Free hospital birth became available to all women under the 1991 Health Amendment Act (House of the Oireachtas 1991).¹ However, this did not stem women's engagement with private antenatal and intrapartum care for a significant proportion of the population, as it still carries the cachet of escaping overcrowded public clinics and wards, even though this option leaves a woman paying out-of-pocket for between €2,000 and

¹ Free primary care for children, as originally proposed by Noel Browne in 1948, would not be available to young people for another 60 years (Burke *et al* 2016, Wren and Connolly 2019).

€4,000 (Pope 2017) and midwives, not consultants, will provide the majority of care.

The MICS earmarked General Practitioners (GPs) as the antenatal gatekeepers to maternity care, establishing members of this profession as the first point of contact and as the primary caregivers for pregnant women, alongside hospital-based consultants (Kennedy 2012). Under the scheme, GPs have agreements with the Health Service Executive (HSE) to provide services to pregnant women, providing an initial consultation before 12 weeks and then a further six during pregnancy, which alternate with visits to a hospital maternity unit. The GP also meets with the mother and baby for two postnatal visits. This is known as “combined care” and remains in place as the dominant mode of engagement in maternity services today if women opt for public care. In establishing consultants and GPs as the primary providers of maternity care, combined care as envisioned under the scheme undermined midwives as the primary profession providing maternity care for all those giving birth within the hospital system (Kennedy 2012). Thus, the MICS supported the medical model of birth and hospital-based obstetric-led care and hindered the development of non-hospital-based services and midwifery models of care in Ireland (Stach 2020). In doing so, it provided a framework that led to the sharp decline in homebirths in the second half of the 20th century and shaped a maternity service that continues to constrain women’s choices in relation to place of birth and the type of care provided (Kennedy 2012, p 382).

1.2.3 Cementing medical dominance over childbirth

The two decades following the introduction of the MICS saw the introduction of legislation and the publication of two reports that further reinforced medical dominance over birth and inhibited the development of out-of-hospital healthcare services. The Health Act, 1970 (House of the Oireachtas 1970), which was introduced in a year that saw just 3% of women (n. 1,883) giving birth at home, further emphasised the provision of hospital-based healthcare already established through the MICS (Kennedy 2012). Within the context of maternity care, the Act provided a further legislative framework that upheld the dominance of a centralised, consultant-led maternity service and ensured that birth settings other than the hospital need not be developed (Stach 2020). Along with this legislation, the medicalisation of childbirth was further institutionalised following the publication of two reports, namely, the 1968 Fitzgerald report and the discussion

document on the Development of Hospital Maternity Services in 1976 from the regulatory body for hospitals, Comhairle na nOspidéal (Kennedy 1998). Both the Fitzgerald report and the document from Comhairle na nOspidéal recommended that all women and infants should have access to care at a consultant-led obstetric and neonatal unit. The 1976 report in particular was guided by the obstetric belief that consultant-led hospital birth equates to optimal maternity care to ensure low mortality rates for babies (Murphy-Lawless 1998)². As such, it outlined a plan for the provision of maternity care within a consultant-staffed obstetric/neonatal unit for all women, on the basis of the welfare of the infant³. Infant welfare was to be ensured, according to the report, by the high-tech expertise available within larger medical facilities. As part of this, the report considered smaller maternity units, which catered to less than 1,500-2,000 births per year, to be below the standards required for the practice of modern obstetrics. This additional focus on combined neonatal services, as well as medical expertise and training opportunities for trainee medics, led to the closure of these smaller units, which could not fully provide the neonatal expertise available in larger hospitals (Kennedy 2002). It is important to note the “complete invisibility of women and midwives” within the 1976 report, demonstrating the priorities and presumptions of policy makers at the time (Stach 2020, p 26).

1.2.4 Developments abroad and the Active Management of Labour in Ireland

The economic recession and subsequent cutbacks to the healthcare sector that Ireland experienced in the 1980s is arguably another contributing factor to the continued medicalisation of birth. The UK, at the start of the 1990s, was re-thinking and re-shaping its maternity care policies, following the Winterton (1992) and the *Changing Childbirth* (1993) reports, which highlighted choice, continuity and control for childbearing women (Coxon *et al* 2017, DoH (UK) 1993, NICE 2014) – or “The Three Cs” (Tracy and Page 2019). In Northern Ireland, these reforms led to the establishment of 11 midwifery-led units, and reflected political interest in other English-speaking countries in providing alternative maternity policies, which

² Contrasting notions of safety and risk will be discussed further. However, it is important to note here that Tew’s 1998 analysis of infant mortality rates in the late 20th century showed that it was not the large-scale hospitalisation of birth that led to declining mortality rates but instead was improved nutrition and sanitation for the general population.

³ It was seven years after the publication of this report, in 1983, that Article 40.3.3, known as the Eighth Amendment, was inserted into the Constitution. This equated a foetus’s right to life with that of the mother. While the amendment led to the banning of abortion, it also had implications for women choosing to remain pregnant, in instances where clinicians believed the welfare of the baby was at odds with the wishes of the mother. This will be discussed in Chapters 3, 7 and 8.

came in response to concerns regarding the over-medicalisation of birth, public interest in greater options and research supporting the advantages of midwifery-led services. However, at the same time, the Republic of Ireland was struggling to recover from an economic recession that saw massive cuts in public spending, as well as mass emigration (Burke 2009). This meant that far-reaching healthcare reforms, such as those happening in the UK, were not on the political agenda.

Another contributing factor to the medicalisation of, and obstetric authority over, childbirth within the Irish context was the widespread adoption of the Active Management of Labour (AML) protocol in maternity hospitals (Murphy-Lawless 1998). This labour management system was introduced by Dr Kieran O'Driscoll, then master of the National Maternity Hospital in Dublin, in 1963. It consisted of strict criteria for the diagnosis and monitoring of labour and included routine interventions if women did not give birth within predetermined timeframes. These interventions included the routine rupture of membranes on admission and the routine use of oxytocin when a woman's labour was considered to be progressing too slowly. AML was claimed to be developed as a system with which to "enhance the experience of childbirth for mothers" (O'Driscoll 1994, p 1015) by decreasing maternal fatigue and trauma and to address the bottleneck of women birthing within the hospital's limited labour ward space. In 1972, as part of the AML approach, a 12-hour timeframe for labour was introduced, which meant that medical and pharmacological interventions are routinely introduced even before this limit, to ensure birth occurred within 12 hours.⁴ O'Driscoll et al (1993, p 35) describe the system, writing:

A formal decision was taken on 1st January 1972 to restrict the duration of labour to 12 hours. After this date, no provision was made on the official record for labour to last a longer time. The result is a well-established policy, of which all expectant mothers are fully aware, not to expose anyone to the stress of labour for more than 12 hours. Meanwhile, in excess of 150,000 babies have been born and every mother not close to a vaginal delivery after 12 hours has been submitted to caesarean section.

⁴ The 12-hour timeframe for the progression of labour is based on the work of Emmanuel Friedman, particularly his research in the 1950s and 1960s (Friedman 1978). Known as the Friedman curve, this approach divides labour into stages, maintaining that cervical dilation should progress at one centimetre per hour during active labour (Oladapo *et al* 2018). However, Oladapo et al (2017) demonstrate that this timeframe does not reflect the reality of labouring women and leads to unnecessary medical interventions. This will be discussed further in Chapter 8.

It is noteworthy that, under AML, the decision to “submit” mothers to a surgical birth after 12 hours of labour does not appear to be based on the clinical needs of individual women but instead is based on hospital policy and routine practice. Stach (2020) writes that in attempting to contain labour within the 12-hour timeframe, AML and its architects hoped to systematically control the pace and length of each woman’s labour. Thus, the routine correction of the natural pace of labour, when “lack of progress” was attributed to inefficient uterine activity, was a core characteristic of AML (Stach 2020, p 28).

Following its introduction at the National Maternity Hospital, AML was adopted at maternity units throughout Ireland and indeed throughout the world (Murphy-Lawless 1998). However, although AML continues to be routinely used in Ireland, many other countries have since discarded rigid labour timeframes and the routine medical interventions embedded within it, as these are no longer believed to be based on best practice, or to promote woman-centred care (Oladapo *et al* 2017). Indeed, its continued use in Ireland has been criticised, with a major review of the maternity services in Dublin noting that AML does not represent best practice (KPMG 2008).

The introduction and continued use of AML has had significant practical and conceptual implications for birthing women, both in terms of medical interventions and in terms of authority and power over birth. It has consolidated and perpetuated the use of medical and technological interventions in childbirth, such as the routine use of oxytocin and electronic monitoring of labour in order to achieve a clinically desired rate of progress (Stach 2020). The routine use of medical and pharmacological interventions during labour in turn perpetuated the routine hospitalisation of women during childbirth. In upholding these biomedical practices, AML reinforced obstetric authority over birth, as women became merely the recipients of treatments or interventions designed to make labour and birth fit within obstetric metrics (Stach 2020), and clinical measures and demarcations overrode women’s knowledge of labour and birth.

1.2.5 Reforms at home: The National Maternity Strategy, 2016-2026

Reforms aimed at providing choice, continuity and control in the maternity services in Ireland lagged behind those in the UK, and the reasons for this will be discussed in greater detail in Chapter 2. However, it is important here to note the publication of Ireland’s first National Maternity Strategy (NMS), which took place in January

2016. Emphasising the notion that birth is a normal physiological process, the 10-year strategy states that the current maternity services in Ireland have incorporated an over-medicalised model of childbirth for low-risk women and currently feature a lack of choice in models of care (DoH 2016, p 50). It recommends that services be improved by facilitating choice and providing options for models of care. The strategy further recommends that community and home-based care should be expanded to ensure greater access to midwifery-led services. However, within the strategy, women's choices and access to midwifery-led models of care are supported within obstetric conceptualisations of clinical need, risk and safety. The problematic nature of providing services that remain bounded by obstetric definitions and clinical outcomes will be discussed further below in Section 1.4 and in Chapter 8.

1.3 Models of birth

1.3.1 Defining models of birth

Above, I have briefly outlined the historical context that has created and perpetuated medical authority over pregnancy and childbirth in Ireland, which has led to the near complete hospitalisation of birth and obstetric-led maternity services. I have also highlighted the publication of the NMS which, while it marks a significant attempt to reform the Irish maternity services, continues to situate birth firmly within the medical model. However, at this juncture it is useful to discuss the broader conceptual context in which the development of the maternity services has taken place. With this in mind, I will first discuss the medical model of birth and then outline the social model of birth. Engaging and aligning with a specific birth paradigm is a crucial component of the decision-making process when women are choosing a model of care, and shapes the information they access, the options they choose and the ways in which they justify their choices (Yuill *et al* 2020).

For the purpose of this thesis, I employ two definitions of the term "model". The first is to indicate a paradigm, a value and belief system, through which something – in this case, reproduction and birth – is viewed. The second definition of "model" that I use for this study refers to care options within a system, for example, "alternative birth models" or "midwifery models of care". Below I will be using model as it refers to a paradigm, and later in this chapter I will discuss it within the context of care models. Throughout this thesis I will use both definitions but will make it explicit within the context of my writing which definition I am employing at the time.

1.3.2 The medical model of birth

The dominant medical model privileges pathology over the physiological, psychological, social and sexual aspects of birth, risk management over individual choice and is based upon a Cartesian dualism that emphasises a split between mind and body (Newnham *et al* 2018, p 89) (see Chapters 2 and 3 for further discussion). This model incorporates biomedical beliefs and metaphors around health, which include mechanistic conceptualisations of the body and its repair, as well as the authority of technological progress (Craven 2005). Within this paradigm, pregnancy and birth are thus viewed as potentially pathological medical events that can only be classified as normal in retrospect, and childbearing women as problems to be solved (Kennedy 2002). Indeed, O'Driscoll *et al* (1993, p 15), in their treatise on the Active Management of Labour (AML), suggest: "It is in completely normal women that most of the problems of labour arise." Thus, due to its potential pathology, birth is thought to be best managed by doctors and should take place within a hospital setting. Critics of the medical model have suggested that the construction of birth as pathological has served to justify and legitimate the expansion of medicine's jurisdiction to include childbirth (Beckett 2005, p 254).

For obstetrics, which is situated within the medical model, concerns in relation to childbirth centre around maternal and infant mortality and morbidity (Wagner 1994, Plested and Kirkham 2016). Mothers and infants are constructed as distinct entities and often viewed by maternity services as two separate patients (Duden 1993, Houd and Oakley 1983, Rothman 1989) (see Section 2.2.3 and 3.4.5). In an effort to prevent adverse outcomes and forestall or irradicate uncertainty, obstetrics focuses on clinical performance and the medical-technological management of birth (Downe and McCourt 2019). This focus has led to the development of a plethora of birth technologies and medical interventions, such as routine foetal heartrate monitoring, instrumental or surgical births and the routine use of analgesia and medications for labour augmentation (Davis-Floyd 2018), which together are used to monitor and manage a woman's labour. The routine use of AML, discussed in Section 1.2.4, is an example of such an approach to birth. The dominance of the obstetric model over childbirth means that for the vast majority of women today, the act of childbirth takes place within a medical context, surrounded by the symbols and instruments of the medical profession (Henley-Einion 2009). Furthermore, the obstetric conceptualisation of childbirth as a medical event has meant that national maternity services across Europe and North

America largely dismiss the idea of pregnancy, childbirth and parenthood as an ongoing process embedded within the totality of human social life (Houd and Oakley 1983).

1.3.3 The social model of birth

In contrast to the medical model, the social model views childbirth within a holistic context, “encompassing woman as a social, emotional, physical entity. It views woman in biographical terms, a person with a past and a future and as part of a larger social structure” (Kennedy 2002, p 17). Within this model, childbirth is viewed as a physiological and social event in a woman’s life, and women are upheld as competent birthers and attendants (MacDonald 2018). In the latter part of the 20th century, in response to the medicalisation of childbirth, many midwives, doctors and mothers sought to situate birth within a social model (Davis-Floyd 2018), emphasising the importance of treating birth as a significant life experience and family event rather than a medical emergency (Beckett 2005). Today, women who situate themselves within this model often choose to give birth at home (Davis-Floyd and Davis 1997) or in another out-of-hospital setting, such as a birth centre (Andrews 2004a, 2004b, Borrelli *et al* 2017).

In contrast to the Cartesian dualism supporting the medical model of birth, women and practitioners who situate themselves within the social model believe the mind and body are interdependent, viewing pregnancy and birth as natural states of being, not illnesses (O’Connor 1998). They do not conceptualise their bodies as sites of danger but instead as those undergoing a natural, organic event, and view midwifery care models as opportunities to maintain their physical agency (Yuill *et al* 2020, p 356). Furthermore, mother and child are conceptualised as interdependent beings who should be supported as one entity.

The social model of birth emphasises the normality of reproduction, pregnancy and birth, and supports maternity systems that provide woman-centred care and prioritises primary, community-based care over acute or emergency services. Midwifery care, situated within the social model, focuses on providing care to childbearing women that is socially and culturally sensitive, woman-centred and respectful, and which optimises biological and psychological processes, reserving medical interventions for when they are indicated (Perez-Botella *et al* 2019). As a social movement and profession, midwifery has long advocated choice and access to information for women (MacDonald 2018). Midwifery care models, in particular

those that offer continuity of care and carer, are associated with better clinical and psychological outcomes and with fewer medical interventions (Sandall *et al* 2016).

Within the culture of healthcare, in the provision of services and in the literature, there is often a clear demarcation between midwifery and obstetrics, with midwifery situated within the social model and obstetrics aligned with the medical model (Henley-Einion 2009). Within midwifery discourses, natural childbirth and the social model have been associated with feminism, and concerns over the ways in which patriarchal power structures and ideologies permeate reproductive healthcare services, including the maternity services. While these assumed alignments are often accurate representations, it is important to note the contributions a number of contemporary medical professionals have made to the natural childbirth movement and the advancement of the social model of birth, including obstetrician Grantly Dick-Read (1942/2006), who is said to have coined the term “natural childbirth”, physician Frédérick Leboyer (1974/2009), who advocated for gentle, non-medicalised birth, Michel Odent (1984), a surgeon who developed a special interest in the environmental factors affecting labour and Marsden Wagner (1994/2008), a paediatrician who subsequently trained in public health and perinatology and, from his position in the World Health Organisation, was supportive of both homebirth and midwifery models of care. Flax (1990) and Annandale and Clark (1996) warn of the dangers of binary demarcations, as these can lead to simplistic or inaccurate and inappropriate representations. Thus, it is important to recognise that healthcare professionals, whether they are midwives or obstetricians, can adhere to either the social or the medical model, and individual practitioners can operate within either (or both) paradigm(s) (Stach 2020).

1.4 Risk and Choice

1.4.1 Risk assessments within the medical and social models

Integral to the dominant medical model of birth is the notion of risk and risk management. The general concept of risk is deeply embedded within contemporary Western culture and permeates all aspects of society (Edwards 2005, Henley-Einion 2009). In his seminal work, *Risk Society: Towards a New Modernity*, Beck (1992) writes that since the Industrial Revolution, the production of wealth has been systematically accompanied by the social production of risk. As risk discourses permeate all aspects of modern society, so too is risk a key

concept in the organisation and provision of contemporary maternity care (Chadwick and Foster 2014, Scamell *et al* 2019). In fact, Smith *et al* (2012) suggest that nowhere in healthcare provision is the pervasiveness of risk more apparent than in the sphere of pregnancy and childbirth, as obstetrics focuses primarily on the risks of potential mortality and morbidity and maternity care is organised primarily around the avoidance of such risks. Specifically, risk management strategies are largely based on exceptional and singular incidents with very poor outcomes, which leads to the problematic situation where routine maternity care for all women and babies is based upon provision for a small number of exceptional cases (Scamell *et al* 2019).

In both pre-industrial and modern societies, childbirth has always carried with it the possibility of uncertainty and risk, including death, though both mortality and morbidity have diminished greatly in high income countries with improvements in nutrition and sanitation (Tew 1998), as well as access to education, health services and improved social and economic conditions (CSO 2000). Throughout history, different cultures have taken diverse approaches to managing the potential risks associated with birth (Murphy-Lawless 1998), with risk having multiple meanings for different individuals and demographics (Smith *et al* 2012). Two such contrasting cohorts include obstetricians (and sometimes other healthcare professionals), situated within the medical model of birth, and pregnant women, whose bodies, as the site of contestation (Oakley 1980, Rich 1986), often situate themselves within the social model of birth, or straddle both models. Within biomedical discourses, pregnancy is constructed as a time of risk (Edwards and Murphy-Lawless 2006), with obstetric maternal health indicators focusing primarily on maternal and infant mortality and the prevention of these through medical management. Thus, medical technology, interventions and the hospital environment connote security, safety and quality of care and opting for medicalised, hospital-based care represents the ultimate act of risk management (Yuill *et al* 2020).

For women aligning themselves with the social model of birth, however, medical management and hospital-based care represent danger and risk (Yuill *et al* 2020). They suggest that obstetric concerns do not often encompass social concerns (Edwards 2005) or other issues such as the woman's birth experience, the ability to exercise choice and autonomy, or access support for her emotional and mental health (Bohren *et al* 2019). Pregnant women share a concern with obstetrics regarding the potential harm to themselves and their babies, and strategically draw

on obstetric technology to manage this uncertainty (Chadwick and Foster 2014). However, women's considerations of risk also include emotional, cultural, psychological and relational concerns (Edwards 2005), along with concerns for the birthing female body and its treatment, particularly within a medical setting (Chadwick and Foster 2014). Writing about women's concern regarding physical autonomy in hospital, O'Connor (1998) notes that homebirth mothers are often criticised for supposedly privileging their "comfort" above concerns over safety⁵. She writes, however, that for birthing women, "knowing one's own body will not be subjected to repeated internal examinations from strangers is comforting" (O'Connor 1998, p 57). Thus, women negotiate the liminal space between medical and social models to construct a unique and individualised risk assessment (Smith *et al* 2012).

Medical and State officials have historically constructed women who wish to give birth outside the dominant biomedical model as "bad" mothers who, through their "pathological" practices, fail to accurately assess the risks associated with childbirth and therefore take unnecessary and dangerous risks in relation to the foetuses inside them (Craven 2005, 195). In doing so, mothers are said to privilege their own experiences over the safety of their unborn children. By accusing women of bad behaviour in relation to their children, obstetrics contends that it is better equipped to make "good" decisions regarding childbirth that minimise risk than the women they deem to be delinquent. Medical officials thus insist that they are more competent than women in judging the best interests of the foetus. In contrast, women who wish to engage in alternative birth models view themselves as good mothers who choose to give birth outside the hospital in order to protect their babies and themselves from unnecessary medical interventions, and thus view alternative birth settings such as the home as the safest option (Craven 2005).

1.4.2 Impact of risk discourses on access to alternative birth models

The ubiquity of obstetric risk as an organisational concept and a dominant discourse within maternity services impacts the provision of alternative models of care (or care options), determining the behaviour of childbearing women, their access to alternative models and dictating pathways of care (Scamell *et al* 2019). This can be seen at a number of stages throughout the provision of antenatal and

⁵ While pregnant with my first child, a consultant told me that giving birth at home was "an aesthetic choice".

intrapartum care (Edwards 2005). It begins with the initial antenatal assessment (known in Ireland as the “booking visit”), when a woman is assessed by a healthcare professional to be low, medium or high risk, based upon clinical metrics (DoH 2016). For 87% of women in Ireland, their GP or family doctor is the first healthcare professional they see when they believe themselves to be pregnant (NWIHP 2021). This initial assessment influences the choices available to women throughout pregnancy and birth (Bryers and van Teijlingen 2010), as only women who are obstetrically low-risk are considered eligible to give birth outside the hospital setting. This means that eligibility for alternative birth models, such as giving birth at home or in a birth centre, are determined not by the pregnant women but by healthcare professionals determining eligibility through obstetric metrics (Houd and Oakley 1983) (see Section 1.5.3 for a definition of alternative birth models). A woman might consider herself eligible for alternative models but the power to make such a determination lies in the hands of healthcare professionals, often the ones that she meets during her initial antenatal visit (Wood 2017).

In Ireland, the initial assessment process is outlined and sanctioned in the National Maternity Strategy (NMS) (see also section 1.2.5 and 1.5.1). A pillar of the strategy is determining whether a woman is low-risk (or what the strategy refers to as “normal risk”), medium-risk or high-risk. This initial risk assessment is made by gatekeepers, generally medical doctors, GPs or obstetricians, “in line with the clinical needs and best practice” (DoH 2016, p 84). This assessment plays a critical role in determining a woman’s choices in relation to where and with whom she can give birth. Mirroring maternity policy across Europe (Houd and Oakley 1983), the NMS asserts that homebirth should only be available to low-risk women. Wickham (2010, p 50), discussing the implications that risk assessments have for access to birth models, writes: “It is increasingly common that women are denied the right to birth in particular settings as a result of being deemed ‘at risk’.” Thus, risk assessments, particularly those that take place during the initial antenatal period, are conducted by healthcare professionals who act as gatekeepers, playing a strong determinant role in a woman’s choices and her ability to access to alternative birth models. In defining women within obstetric metrics and limiting choices to only those sanctioned by the medical model, maternity care has largely deprived childbearing women of the right to self-determination (Houd and Oakley 1983). Instead, services have assigned this right to the medical profession, governments and the law.

Beck (1992) writes that within modern society, the definition of risk is based upon the beliefs and value system of the dominant group. However, statements of risk, made by members of the dominant group, are not simply statements of fact but instead contain value judgements, with causal interpretations created or implied. As such, risk becomes socially constructed by the experts (Beck 1992). Within this context, the definition of risk is not necessarily based upon evidence or reflective of the lived experiences of the majority of individuals but instead is designed to perpetuate the power of the dominant group. Thus, the construction of certain practices as “risky”, and particular individuals as “at risk”, supports existing power structures and a dominant group’s authority (Newnham *et al* 2015).

The authoritative power that a dominant group holds in relation to the creation of knowledge and social structures will be discussed further in Chapter 2, while the social construction of reality, and conceptualisations of risk and choice, will be further explored in Chapter 3. For now, it is important to note that, within the Irish maternity services, where the obstetric profession is dominant, risk is defined within obstetric parameters. This definition of risk, as noted above, directly impacts pregnant women during their initial antenatal care, their choices and the options that are accessible to them throughout pregnancy and birth.

1.4.3 Choice in the maternity services

Like risk, choice has become both a pervasive term and a popular concept within contemporary Western society (McAra-Couper *et al* 2012). Similar to Beck’s (1992) conceptualisation of risk, choice is both an overarching concept within modern society, and is also constructed on an individual level, with responsibility for making choices (and “good” choices, specifically) assigned to individuals (McCabe 2016). Choice is linked with modern social trends in which an individual’s ability to exercise choice across a broad range of everyday issues is valued and expected (Begley *et al* 2009). These trends are linked to a neoliberal framework, dominant within Western societies since the 1970s (Sherlock 2015), which supports the dissolution of public health, welfare and education infrastructures, while enabling the market to subsume these aspects of social organisation (McCabe 2016). Within this ethos, individuals are conceptualised as consumers who can, and are expected to, exercise choice by choosing from a pre-determined menu of options (Tracy and Page 2019). As outlined above, the notion of choice has gained traction within maternity care since the 1990s (Begley *et al* 2009) and

is now a central tenet of maternity services in most Western countries (McAra-Couper *et al* 2012).

In tandem with the rise in consumerism and neoliberal definitions of choice, many feminists and other groups advocating for social change have, since the 1960s, defined choice within a rights-based framework (Solinger 2005). In particular, feminists have used this rights-based concept of choice in relation to reproductive healthcare and argued in favour of a woman's "right to choose" in relation to such reproductive issues as birth control and abortion. For many feminists, situating choice within a rights-based framework means that the "right to choose" is not aligned simply to satisfaction as a consumer – it is also linked to notions of social justice (McCabe 2016) and personal autonomy, a recognition that women are the experts in relation to knowledge of our bodies and access to options (Beckett 2005, MacDonald 2018). Tracy and Page (2019, p 140) explain: "Choice points to the personal autonomy that is fundamental to the rights and wellbeing of women. This right to choose is linked closely to being in control of your own body." Thus, for many women, one's ability to exercise choice is inextricable from personal autonomy, recognition of women's expert knowledge in relation to our bodies and access to services.

1.4.4 The problem with choice as experienced by pregnant women

While the word "choice" has become prevalent within modern society and contemporary maternity services, the concept remains problematic in relation to women's reproduction, pregnancy and birth for several reasons. First, utilising the language of choice can be problematic when it is exercised from a position of oppression (Sherlock 2015), when a woman is making a decision within a patriarchal social structure that is determining the parameters of choice. Included in this tapestry of oppression are the economic and racial structures that constrain many women in their attempts to exercise choice (Sherlock 2015) and access healthcare and information (McCabe 2016). Patriarchal power structures position women as subordinated decision-makers in relation to every aspect of our lives, including reproduction (Young 2005). For women situated within different intersections of society and identity, including race, socio-economic status, differing abilities, immigration status and sexuality, there are additional barriers that, alongside gender, compound their ability to access information and choices (Crenshaw 2017).

Within maternity care provision, the medical model imposes limitations on choice for service users, as noted in Section 1.4.2. This is true even for those with low-risk pregnancies, as recognised by the Irish Institute of Obstetrics and Gynaecology in a review of maternity services:

The dominance of a medically led, hospital-centred model of care provides effective services for women with non-routine clinical conditions. However, approximately 60 per cent of women experience a normal pregnancy and birth. It does therefore limit the choice for women whose routine clinical needs could be provided for in a wider range of settings (IOG 2006, p 8).

As indicated in this review, and discussed in Section 1.2, the dominance of the medical model has led to a lack of community midwifery care and a lacuna of non-hospital-based birth environments in contemporary Irish maternity care provision.

The presence of the biomedical hegemony and obstetric risk discourses over birth leaves women with little power to negotiate their preferred choices (Plested and Kirkman 2016). As hospital-based, medicalised birth is considered to be safest within the dominant framework, obstetric risk discourse constructs birth outside the hospital as risky (Edwards 2005). This discourse makes it difficult for mothers choosing alternative models to escape blame or the assignation of bad mother (Yuill *et al* 2020). Meanwhile, the use of medical interventions, such as epidural analgesia, means a woman making that choice moves from a low-risk to a high-risk category (Newnham *et al* 2018). When this occurs, women can no longer access midwifery-led care within the current system because high-risk births fall under the remit of obstetricians. In her study of epidural analgesia and hospital birth culture (Newnham *et al* 2015/2017/2018), Newnham found that using water for pain relief, which lies outside obstetric practice, was constructed by the dominant medical and hospital culture as “risky”. At the same time, the anaesthetic risks to women associated with epidurals were acknowledged but downplayed in patient information handouts, while potentially negative effects on the process of labour were ignored (Newnham *et al* 2015). This meant that while labouring women, in theory, had the choice of using water for pain relief, their ability to access that option was limited. Women cannot exercise informed choice when the information given regarding birth choices is restricted and represented in such a weighted manner (Henley-Einion 2009). Thus, the fact that birthing practices are firmly situated within the medical model has meant that the maternity services only offer women what Henley-Einion (2009, p 165) calls “an illusion of choice”. Given

the power imbalances inherent in this model, choice continues to be defined by policymakers and medical professionals (Yuill *et al* 2020).

Within a specifically Irish context, O'Brien *et al* (2017/2018) write that the country's highly medicalised maternity system diminishes women's choices. For example, in practical terms, "choice" is often reduced to whether a woman wants to give birth – in hospital – via the public system or pay for maternity care privately (Begley *et al* 2009)⁶. The ways in which the medical hegemony constrains women's birth choices and access to care models can also be seen within the National Maternity Strategy itself. As discussed above, the strategy highlights choice as one of its four key priorities, stating: "Pregnancy and birth is recognised as a normal and physiological process and, insofar as it is safe to do so, a woman's choice is facilitated" (DoH 2016, p 82). While this would initially seem to support choice, it would also indicate that women's choices regarding care remain bounded by the obstetric model of safety and, following on from that, the imposition of obstetric categories on the matter of place of birth. Concomitantly, it would appear from the strategy that a woman's choices may not be facilitated if her preferences move outside obstetric definitions of safety. Thus, childbearing women "are exposed to frameworks of choice rather than being explicitly able to formulate their own choices" (Fitzgerald *et al* 2015, p 414). These issues will be discussed further in my findings and discussion chapters (Chapters 6, 7 and 8).

1.5 Situating this study

1.5.1 The impetus for this inquiry and new contribution to knowledge

Above, I have outlined the historical, social and conceptual background that forms the context for contemporary Irish maternity services and this study. Below, I will discuss this research project in greater detail, outlining my aims and objectives and the knowledge gap this study fills, and then situate this study within the larger feminist project of the production of knowledge based on women's experiences and voices.

This study originates from my experiences as a woman who gave birth at home. Reinharz (1992) suggests that for feminist researchers, one's research question begins with a personal problem, with Hines (2015) writing that feminists have long

⁶ A woman paying privately through her insurance company can receive care from a consultant, no matter her risk category, and can, subject to availability, spend her postnatal time in hospital in a private single room or with a limited number of other service users.

connected theory and action. For the births of my two children, I wanted a physiological birth and the support of an experienced female birth attendant who knew me well and respected my bodily autonomy. For me, this meant that I wanted to birth at home. I did this while living abroad, and both births were empowering experiences, from which I continue to draw courage, power and strength. However, as I returned to Ireland and attended mum and baby groups here, I heard stories of disempowerment, disrespect and dismissal. Why was this, I wondered? Why was I the only woman I knew who had an empowering birth experience? Is there something about the Irish hospital maternity services that disempowers women? Is there something about birthing at home that empowers women?

These personal musings coincided with the introduction of the ten-year National Maternity Strategy (NMS) in 2016. As discussed above, the NMS was, and remains, Ireland's most progressive national maternity policy document to date, in that it outlined a pathway for women to give birth at home or in yet-to-be-built alongside birth centres as an option for healthy women. Thus, on the surface, alternative birth models are a more legitimate option and potentially more available than they were previously. However, continued low home birth rates (Meaney *et al* 2018) and the fact that not a single new Alongside Birth Centre has yet been built means that access to alternative birth models remains problematic, even for childbearing women classified as low-risk. Therefore, I have captured, during the strategy's implementation period, the phenomenon of women's lived experiences of attempted access to these options.

Furthermore, the opinions of childbearing women are essential to identifying aspects of maternity service provision that can contribute to improved care and experiences (Daly *et al* 2021), and the NMS recognises this critical role: "The woman's voice is essential to evaluate and inform the care given, to guide quality improvements and to inform quality improvement initiatives at a local and national level" (DoH 2016, p 71). Thus, during the implementation phase of the NMS, as work is done to improve the maternity services, I have captured women's evaluations of their care and experiences.

I was led by these factors to consider women's lived experiences of attempts to access to alternative birth models, particularly within a contemporary Irish context. This specific topic has remained significantly under-investigated in Ireland, although several studies have examined related topics. For example, Marie O'Connor conducted a study into homebirths in Ireland in 1992. Commissioned by

the Department of Health and the Coombe Maternity Hospital, this remains the only Irish study to date on homebirth based on national birth registration data. O'Connor, whose report, *Women and Birth*, remains unpublished, found the majority of reasons cited by women in her study for choosing a homebirth were related to unease or previously negative experiences with maternity hospital policy and practice (O'Connor 1998). Participants in her study did not necessarily conceptualise birth as a positive, empowering experience, as many women hoping to give birth at home do now, but believed that birthing at home instead of in hospital might lessen the trauma and pain of birth (O'Connor 1998).

My study contributes to the body of knowledge generated by other researchers from the School of Nursing and Midwifery at Trinity College Dublin, who have previously investigated alternative birth models and choice within the Irish maternity services. Although these studies have taken on different foci to my own, they have none-the-less significantly informed my own research. For example, my primary supervisor, Dr Colm OBoyle, has conducted research into independent midwifery in Ireland. His ethnographic study examined the working lives of independent midwives attending homebirths in Ireland and investigated the ways in which these midwives negotiated professional and legal requirements alongside their relationships with the birthing women they supported. Likewise, the work of my adjunct supervisor, Dr Liz Newnham, and her research on choice and conceptualisations of risk in the maternity services has significantly informed my own research. In relation to other types of out-of-hospital births, Prof Cecily Begley and colleagues published, in 2009, their evaluation of the Midwifery-Led Units (MLU) at Our Lady of Lourdes Hospital, Drogheda and Cavan General Hospital. This randomised trial evaluated the effectiveness of midwifery-led care in the two MLUs. The study found that maternal and infant mortality outcomes for women birthing in the MLUs did not statistically differ from those who attended the attached hospital's consultant-led unit, and that women who births in the MLU were less likely to have medical interventions. More recently, Dr Gosia Stach has conducted research into women's experiences of technology in maternity care (Stach 2020), while Dr Margaret Dunlea has investigated choices in antenatal care. Meanwhile, sociologist and activist Dr Jo Murphy-Lawless, formerly of the School of Nursing and Midwifery, has written extensively on the challenges to choice and autonomy faced by childbearing women negotiating the Irish maternity services. Thus, my own research is informed by these previous investigations within my own School,

while building on and adding new knowledge relating specifically to women's lived experiences of access to midwifery models of care, from a feminist standpoint.

My study also spanned a crucial period in Irish history and the development of women's reproductive rights in Ireland. In 1983, the Irish public voted to insert article 40.3.3, known as the Eighth Amendment, into the Constitution. The amendment read: "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right." This amendment equated a foetus's right to life with that of the mother, effectively banning abortion (Bacik 2015). It also affected women who remained pregnant, as it meant healthcare professionals could make decisions regarding care based on a perceived risk to the foetus. However, on 25 May 2018, the Irish public voted in a referendum to repeal the Eighth Amendment, paving the way for existing barriers to accessing this aspect of reproductive healthcare to be removed. With data collection taking place between 2017 and 2018, my research gives a unique insight into the experiences of childbearing women as they negotiated bodily autonomy and alternative birth models during this significant transitional period in Irish reproductive history.

In 2002, Patricia Kennedy published *Maternity in Ireland*, a socio-historical analysis of the Irish maternity services and policy. In that book, she lamented the lacuna of analysis regarding maternity service policy and its implications for women in Ireland. The gap in knowledge regarding women's birth choices and experiences is mirrored internationally. For example, Borrelli et al (2017), in their research examining mothers' birth choices in England, suggest that women's experiences of accessing alternative modes remain under-investigated. While the research from Trinity College Dublin has gone some way towards addressing this, there remains a gap in knowledge regarding women's lived experiences of attempted access to alternative birth models, particularly in the current decade of implementation for the National Maternity Strategy. My study, therefore, contributes new insight into what and how antenatal information regarding birth options are provided to women by healthcare providers, how obstetric conceptualisations of risk continue to affect women's choices, and reveals how the maternity services is perceived to facilitate choice, but this is rarely borne out in practice. In doing so, my research contributes to a deeper understanding of women's lived experiences of accessing – or their attempts to access – alternative

birth models in Ireland. Finally, this inquiry adds valuable information for policy makers and healthcare professionals that can be utilised to facilitate and improve maternity services and women's access to alternative models of care.

1.5.2 Research question, aim and objectives

Research question

Based on these considerations, the research question for the study is:

What are women's lived experiences of attempted access to alternative birth models in contemporary Ireland?

Aims and Objectives

The aim of the study is to develop an in-depth understanding of women's lived experiences of attempted access to alternative birth models in contemporary Ireland and in doing so fulfil the following objectives:

- Investigate women's lived experiences of seeking access to alternative birth models in the context of contemporary Irish maternity services, and whether they face any barriers in doing so
- Understand women's antenatal experiences of obtaining information regarding alternative birth models
- Ascertain whether the experience of access to alternative birth models for women classified as having a low-risk pregnancy mirrors the choices mapped out in the National Maternity Strategy 2016-2026

1.5.3 Defining “alternative”

Within maternity care, obstetrics is regarded as the mainstream, or “male-stream”, paradigm (Henley-Einion 2009, p 181). Therefore, alternative knowledges are marginalised and birth models situated within them are considered “alternative”. In Ireland, the normative model, or paradigm (see Chapter 1, Section 1.3.1), within maternity services is the medical one, with the consequence that maternity care is hospital-based and consultant-led (Begley *et al* 2009, HSE 2016, Murphy-Lawless 2015). In Ireland, midwives attend all births and, if a pregnant woman is designated as low-risk and does not receive any medical interventions intra- or postpartum, it is possible she will receive all of her care from midwives. However, the services

remain consultant-led in that the consultant is considered to have the ultimate clinical authority over a woman's care. Furthermore, as the services remain based upon a medical model of birth and are situated primarily within medical settings, hospital-based midwives are expected to provide care that is aligned with hospital policies and protocols. Within this context, therefore, I use "alternative birth model" to indicate models of care that are non-hospital based and midwifery-led. Working within this definition, the two primary alternative models of care available to women in contemporary Ireland are planned birth at home with the support of a Self-Employed Community Midwife (SECM), or birth in one of the country's two Midwifery-Led Units (MLUs). There is also the option of unassisted birth, in which a woman births at home without the support of a healthcare professional, but this cohort has not been included within this study. Reasons for this exclusion will be discussed in Chapter 5, Section 5.4.2.

1.5.4 Defining "access"

Within this study, I employ two definitions of access. Primarily, I define "access" as a woman's ability to actualise her choices in relation to where and with whom she wishes to give birth. In doing so, I build upon the concept of access discussed by Dixon-Woods et al (2006), which recognises the myriad factors that influence access. Much of the literature on access to healthcare approaches the issue from the point of view of utilisation of services by members of the public (Bradbury-Jones *et al* 2015, Breckenridge *et al* 2014, Rayment-Jones *et al* 2017). Dixon-Woods et al (2006), however, suggest that an individual's ability to access healthcare services is more complex than the singular event of utilisation. Instead, it is a process that is negotiated between service users and providers, and strongly influenced by socio-economic factors. They write: "Accomplishing access to healthcare requires considerable work on the part of users, and the amount, difficulty, and complexity of that work may operate as barriers to receipt of care" (Dixon-Woods *et al* 2006, p 7). Therefore, for this study, I use the term "access" to indicate a woman's ability to actualise her choice in relation to where and with whom she gives birth. Within this definition, for example, if a woman decided that giving birth at home through the HSE scheme was the best option for herself and her baby, and then she gave birth at home through the HSE scheme, I would suggest that she was able to access homebirth.

Drawing upon this definition, a woman's ability to access healthcare services, and maternity care specifically, can remain hampered within the context of complex

maternity services and various socio-economic factors. For example, service users can experience barriers to access in the form of service costs (Dahlen *et al* 2011, D'Souza and Garcia 2004), government or hospital policy (Newnham 2014) and geography (Hennegan *et al* 2014, Hoang *et al* 2014). Another crucial component of access is information. Informed choice is considered to be a guiding principle of woman-centred care (Yuill *et al* 2020), and before a woman makes an informed choice and attempts to access healthcare based on this choice, she must have information regarding all options available to her. This information should be readily available and easy to understand, if the obtaining and understanding of such information is not to act as an additional barrier to access. If a woman wishes to give birth at home, but she cannot because she was not provided with adequate or understandable information, she could not afford to do so, or hospital policies prevented her from doing so, I suggest that she was not able to access homebirth, under my primary definition. The relationship between access, choice and information will be discussed further in Chapters 3 and 8.

However, I also employ an additional understanding of access, one that encompasses the lived experience of attempting to access alternative birth models. Under this definition, access includes the journey a woman traverses in attempting to actualise her wishes and desires in relation to birth. Thus, access is not simply the accomplishment but also the process of seeking access. I employed both these definitions as I undertook this project investigating women's lived experiences of access to alternative birth models.

Another issue arises from the literature in relation to access that does not fall within my definitions but none-the-less plays an important role in women's experiences. If a woman is able to access the type of care she believes is most appropriate for her and her baby, it follows that she is also free to decline care options that she deems inappropriate. Much of the research focusing on the utilisation of services assumes that non-utilisation is a reflection of a non-offer by the healthcare professional or an inability to engage on the part of the service user (Dixon-Woods *et al* 2006). However, this form of analysis fails to acknowledge that people may choose to refuse offers of care or treatment, instead relying on "a largely untested set of normative... and somewhat questionable assumptions about the 'correct' level of utilisation, and on a difficult-to-measure (or conceptualise) estimates of need" (Dixon-Woods *et al* 2006, p 6). Within the context of maternity care, women can attempt to access alternative birth models. Because they are doing so within

the context of a medicalised system, they are also negotiating their non-eligibility for medical attention and interventions in the face of healthcare professionals or policies that are asserting the need for medicalised care and interventions. Thus, while I continue to define access as encompassing a woman's ability to realise her birth choices, or to indicate her journey of pursuing them, it is important to note the role that the ability to decline services assumes in the experiences of women attempting to give birth within an alternative framework.

1.6 Feminist research and this study

1.6.1 Selecting a feminist lens to frame this inquiry

Situated within an epistemological paradigm of constructionism, this study adopts a feminist qualitative research design and draws upon feminist theory to provide a framework with which to view the privileging of scientific knowledge and biomedical conceptualisations of the female body and choices throughout pregnancy and birth.

From a feminist perspective, gender is the defining factor that shapes women's lives (Hesse-Biber 2014), and women experience discrimination based on gender (Delmar 1986). Many feminists suggest that patriarchy – the systematic male dominance of women – is universal and exists across all societies and historical periods (Hines 2015). However, gender in itself is a socially and culturally constructed concept that gives rise to distinct roles and identities within different societies and cultures (Hines 2015, p 23). Thus, the ways in which patriarchy impacts women's lives are socially and historically specific. Integral to the feminist project, then, is the recognition of the ways in which these gendered concepts and the social structures based upon them discriminate against women and impact our lived experiences.

With the emancipation of women from patriarchal oppression as its core agenda (Newnham *et al* 2018), feminism suggests that radical changes to current patriarchal social, economic, cultural and political structures are needed in order to redress the inequalities that discriminate against women. These changes, Rich (1980a) suggests, must begin with women's rejection of, and liberation from, the patriarchal worldview that excludes and dismisses women's knowledge and experiences:

Feminism means finally that we renounce our obedience to the fathers and recognise the world they have described is not the whole world. Masculine ideologies are the creation of masculine subjectivity, they are neither objective or value free, nor exclusively “human”. Feminism implies that we recognise fully the inadequacy for us, the distortion, of male centred ideologies and that we proceed to think and act out of the recognition (Rich 1980a, p 20).

Thus, integral to the feminist project, according to Rich, is the production of knowledge and ideologies that are situated within women’s lives and experiences. Since the late 19th century, feminists have done so by working to understand the origin and nature of female oppression in a patriarchal society and to highlight women’s individual and collective experiences (Dupont *et al* 2019).

I also draw upon feminist scholarship on choice and decision-making and the counter-discourse it provides to neoliberal definitions and biomedical parameters. Specifically, feminist definitions of choice, which encompass notions of autonomy and access, provide the framework for critique for this study. Asserting claims to physical integrity, or autonomy, has been a central theme of contemporary feminist movements (Murphy-Lawless 1998). However, the issues surrounding choice and autonomy faced by women generally are exacerbated for birthing women because of their vulnerable position within a medical model of birth, where obstetric definitions of safety and the positioning of the mother-foetus dyad as separate entities can override maternal autonomy and physical integrity. Discussing childbirth, Murphy-Lawless (1998, p 21) writes:

But the validity of physical integrity takes on specific meaning in a situation where a woman has no way to guarantee that she will not be subjected to painful and disruptive medical techniques, whether she wishes them or not, whether they are necessary or not.

Feminist conceptualisations of choice will be explored further in Chapter 3, in which my theoretical framework is outlined.

1.6.2 Qualitative Feminist Research

A qualitative approach to an inquiry enables the researcher to thoroughly investigate an issue from the point of view of the study participants. Creswell (2013) suggests that a robust qualitative study highlights the voices of the

participants and provides for a complex description and interpretation of an issue. Within maternity care research, quantitative research into the safety and outcomes of varying birth models is useful in determining the shape of service provision – and is also used by women to determine the model that is most appropriate for them. However, Edwards (2005) suggests that using quantitative data and statistics still omits the substantive issues that women have in accessing homebirth and, furthermore, fails to develop a full understanding of women's concerns and experiences. This study therefore adopts a qualitative approach in the hope of developing a more thorough understanding of women's experiences of access to alternative birth models.

Feminist research posits that women's experiences play a crucial role in the generation of knowledge (Byrne and Lentin 2000, Hesse-Biber 2014), particularly in relation to women's experiences in general, and to those that are uniquely female, such as birth (Reinharz 1992). As a mechanism for producing this knowledge, feminist scholars place emphasis on the talk and experience of women as a key source of meaning and information (DeVault 1999). Furthermore, Hesse-Biber (2014, p 3) suggests that feminist researchers share a common lens through which they view and interpret the world, writing, "Research is considered 'feminist' when it is grounded in the set of theoretical traditions that privilege women's issues, voices and lived experiences." Another key tenet of feminist research includes the re-imagining of traditional participant-researcher relationship in analysis and the creation of knowledge (Oakley 1981). Feminist research critiques traditional knowledge claims, suggesting that researchers cannot be objective, and that they always bring their biases, but also experience and knowledge, to the research.

Furthermore, Kennedy (2002, pp 9-10) suggests that the duty of feminist research is threefold: "First, it must criticise existing social structures and ways of perceiving them. Secondly, it must introduce corrective mechanisms by providing an alternative viewpoint and data to substantiate it. Thirdly, it must start to lay groundwork for a transformation of social science and society." Through the adoption of a qualitative feminist approach to this inquiry, by turning to women's experiences as a missing source of knowledge regarding attempted access to models of care and by suggesting service provision solutions based on these experiences, I hope to fulfil this duty in some small measure.

1.6.3 Reflexivity in feminist research

Recognising that objectivity is not only unattainable but also the product of a patriarchal insistence on so-called objective facts as the only legitimate source of knowledge (Davis-Floyd 2018, Oakley 1981), the feminist researcher both declares her biases and experiences and sees them as a potential resource as she works to understand the experiences of her participants (Hesse-Biber 2014, Reinharz 1992). In Chapter 5, Section 5.4.7, I will discuss the transformation of the relationship between myself and the research participants from one that followed traditional top-down researcher-subject relationships to one that was dynamic and better aligned with the feminist principles of equality and a multiplicity of knowledges that underpin this study. For now, I will situate myself within this research and outline the experiences that have helped me develop an understanding of the issues under investigation.

I am a feminist, a homebirth mother, a journalist and a former birth partner (doula), and I bring these experiences and knowledge to this study. I have identified as a feminist since I was 13 years old (the same year I decided I would conduct a PhD “when I grew up”). Because of this early identification with feminism and interest in gender politics, I have remained *au fait* with contemporary discourses within this area over the past three decades, through reading, talking, debating and participating in social and political activism. This included meetings and protests in the run-up to the referendum on the Eighth Amendment. As a mother, I bring embodied and experiential knowledge of pregnancy, birth and motherhood to both my discussions of these topics and to my fieldwork. During our interactions, each study participant worked to quickly establish whether I myself had children. My affirmative answer signalled to them that I had experiential knowledge of the topics they were discussing and could relate to and understand their experiences. As a doula who has supported female relations and friends during the births of their children, I bring the knowledge that each woman and each birth is unique, and that birth experienced from the standpoint of the person not labouring contrasts significantly with the experiences of the birthing woman. If I had not given birth myself, I feel I would not truly appreciate the significance of the role that pregnancy and birth play in a woman’s emotional, physical, mental and social life. As a journalist, I bring my knowledge of the Irish healthcare services and legal system that I have gained over the past two decades covering these issues, including the referendum on the Eighth Amendment. I also bring my ability to interview, actively

listen and extract information from people to my research, as well as my ability to write, a key component of hermeneutic phenomenological research (van Manen 2016).

1.7 Choosing a hermeneutic phenomenological methodology

Within the multitude of qualitative research approaches, the specific methodological approach I have employed is hermeneutic phenomenology. This methodology enables me to explore and understand the lived experiences of childbearing women in their attempts to access alternative birth models within contemporary Ireland, while recognising the integral role that social factors play in shaping those shared experiences and the interpretations of them.

Phenomenology is rooted in lived experiences (van Manen 2016/2017a). Hermeneutics is particularly useful in attempting to understand the meaning individuals assign to experiences, and how their experiences and constructions of meaning are situated within a larger social context (Dowling 2004, McCudden 2015, van Manen 2016). This methodological approach has gained traction in recent years within nursing and midwifery research, as a means of furthering understanding of the lives and experiences of both pregnant women and midwives (Thomson and Downe 2008/2010, Ohaja *et al* 2017). Furthermore, hermeneutic phenomenology aligns with the emphasis within feminist research on the formation of knowledge, providing as it does a framework in which the researcher recognises that she will bring her experiences to her studies, and interpret the data based on these – and that all this can be used to enhance the quality of the research and the insights the research provides (van Manen 2016). Thus, hermeneutic phenomenology was deemed most appropriate to address my research question because of this study's emphasis on women's lived experiences of a particular phenomenon, that is, access to alternative birth options. This methodology will be discussed in detail in Chapter 4.

1.8 Notes on Language

Language is particularly important to feminist theory and scholarship, and feminist discourses have long sought to include a variety of voices, including those from within the LGBTQI+ community (though whether inclusion has been achieved is still debated). I therefore feel that as a feminist researcher, I must clarify and support several terms I use throughout this inquiry.

First, I will define and justify my use of the term “woman”. For the purposes of this study, I use the term “woman” to mean a biological woman who identifies as such, and within my participant criteria I only included those who are or have been pregnant. I have not included transmen who chose to give birth. This is because I wanted to focus on the experiences of biological women who are perceived by society and the maternity services as women, and investigate the gendered power dynamics that have shaped a maternal healthcare system that has been designed around the idea that women are the service users. While the roots of the oppression of women and transmen lie within the same patriarchal framework, pregnant transmen, as well as other cohorts within the LGBTQI+ community, face a number of additional barriers and challenges that lie outside the scope of this particular project (Alencar Albuquerque *et al* 2016, Melo *et al* 2011).

I will also make a note of the pronouns I employ when referring to women. Most often, books, articles and other literature that discusses women refer to women as “they”, “them” or “themselves”. This is true even if the author is a woman. At first, I did this to align myself with scholastic tradition and for ease and fluidity of language. This also made sense because I cannot begin, as an individual with one set of experiences and biases, to fathom the experiences of all women. However, I found this usage of “they”, “them” or “themselves” only served to push women further to the periphery of discourses regarding birth and maternity care, and to designate women as “the other”, perpetuating a process of m/othering ingrained within obstetric practice (van der Waal *et al* 2021) when women should, in fact, be at the centre of the maternity services (DoH 2016). Any story of gendered power structures is my story too, and the experiences the participants share are part of a larger female experience of structural inequalities inherent in healthcare provision and other aspects of life. I therefore often employ the language of “we”, “us” and “ourselves” to refer to women in order to include women in discourses and to emphasise the shared experiences of women.

Finally, I shall make one more caveat regarding language. This is in regard to the word “participant” to denote an individual who participated in this qualitative research, who was interviewed for this study and whose experiences and words constitute my data. I hesitate to use the word “participant” as this can carry with it the gendered power dynamics and misogyny inherent in much of traditional qualitative research (Oakley 1981). However, I have struggled to find a suitable replacement for this word, as so much of phenomenology and other methodologies

– with the notable exception of participatory action research – use it. I therefore have chosen to refer to the participants in my study “the women” as often as possible. When I do use “participant”, I hope the reader notes that I am using the phrase as a shorthand, conscious of the potential problems embedded within its use. The people who spoke with me for this research are, of course, much more complex than the demarcation of “participant” or even “woman” might suggest, and our relationships much more dynamic than those traditionally assigned to the researcher and (his) participants.

1.9 On midwives, doctors and other healthcare professionals

For this study, I was fortunate to have my research situated within contemporary midwifery discourses, as I have conducted this study with the advice and support of my two supervisors, who are both midwives, and I have done so within a School of Nursing and Midwifery. This has provided me with practical knowledge about maternity services and provided a complementary discourse to the service user experiences shared by my study participants.

It is important to note that throughout this study my aim is to critique systems and structures rather than individuals. Although healthcare professionals are responsible for their actions, it is important to remember the culture in which they operate. The medical profession has a powerful system of socialisation, demanding conformity as the price of participation (Martin 1989, p 13). Within this context, obstetric training is an initiatory process into which newly qualified obstetricians become professionals in the medicalisation of childbirth (Davis-Floyd 1987). It is also an “initiation into a misogynistic, heteronormative, colonial and racialised institution, and thus ... an initiation into practices of reproductive injustice through obstetric violence” (van der Waal *et al* 2021). Likewise, midwifery education requires students to collude with obstetric violence and perpetuate the engulfment of the maternal body as a rite of passage into the profession (van der Waal *et al* 2021). Furthermore, medicine is a powerful cultural system whose authority pervades society, to the extent that every individual to some extent upholds and perpetuates its values (Martin 1989).

Midwives, whose professional philosophy values woman-centred, relational care focused on the physiology of birth (van der Waal *et al* 2021), face additional challenges to supporting birthing women within the dominant medical paradigm (Kirkham 2018). In their working lives, they must operate within the dominant

paradigm and obstetric risk discourses, becoming conversant in the language of risk and use of medical technology. Their work is often hampered by the pervading philosophy of the workplace/hospital which is often overwhelmingly medically focused (Catling and Rossiter 2020). Additionally, as midwifery has worked towards professionalisation and strengthening its position within academic research, the profession has largely accepted and adopted the medical belief that scientific, positivistic knowledge is superior to other forms of knowledge (Henley-Einion 2009). OBoyle (2009) also supports this, suggesting that the scientific rationality of medicine now informs midwifery thinking. Likewise, in his study of independent midwifery in Ireland, midwives suggested that being “with woman” during pregnancy and childbirth proved difficult within the context of professionalisation (OBoyle 2009). Thus, midwives face continuous challenges as they attempt to provide woman-centred care within a medical paradigm.

Many of the findings within my study are based on negative experiences that women have had and are critical of contemporary Irish maternity services. However, the participants shared their experiences and stories with me in the hope that I might share them with others, so that similar adverse events and experiences will not occur again. I think that the improvement of services and patient satisfaction is something we can all share as a common goal, as we work together to achieve a maternity service that is truly woman-centred and evidence-based.

1.10 Structure of the thesis

Above I have outlined the social and historical context in which this study is situated, the theoretical underpinnings of this project and the methodological approach I have taken. These will be explored further in the following chapters, as will my methods, the findings from my study and actionable recommendations based on my findings. The details of each chapter are outlined below.

Chapter 2 presents a review of the literature related to hierarchies of knowledge and the production of authoritative knowledge. This review then examines scientific knowledge and, within this, obstetric knowledge and its position of authority over birth. This contrasts with the experiential, embodied and intuitive knowledge of childbearing women and the authority we place in a multiplicity of knowledge sources.

Chapter 3 presents my epistemological and theoretical framework for this inquiry. I discuss my epistemological stance of social constructionism, which underpins the study. I also discuss the issues of women's autonomy and access that underscore feminist discourses on choice and explore medical conceptualisations of the female body and the process that constructs women as other.

Chapter 4 details my choice of hermeneutic phenomenology as a methodology for this study. I describe the intersection of social science and feminist interests in the "excavation of meaning". Following this, I discuss Heideggerian hermeneutic phenomenology as it contrasts with Husserl's descriptive phenomenology, and van Manen's development of this as a methodology. Furthermore, I address feminist concerns regarding phenomenology.

Chapter 5 describes the methods I employed to conduct this study. As part of this, I outline van Manen's methods for conducting research and describe how I followed them in the sampling and recruitment of participants, data collection and analysis. I also discuss the steps I followed to ensure the trustworthiness and rigour of this study.

Chapter 6 presents findings in relation to the issue of information. Spanning participants' early pregnancies, the chapter details the ways in which information about alternative birth models were presented to women and how they went about gathering information on alternative birth models. It also explores findings in relation to their experiences with GPs and the dismissal of their birth choices by healthcare professionals.

Chapter 7 presents the findings in relation to the participants' experiences of attempted access to alternative birth models in the later stages of pregnancy and birth. I detail the ways in which the authority invested in the obstetric, medical model of birth determines the length of pregnancy and labour, suppresses women's embodied knowledge and negatively impacts on women's continued access to alternative birth models even later in pregnancy.

Chapter 8 critically discusses the findings, situating them within a feminist theoretical framework and the relevant literature.

Chapter 9, the conclusion of this thesis, outlines the implications of the findings and makes recommendations for policy, service provision education and research.

Chapter 2: Authoritative knowledge in maternity care: Concepts and praxis

2.1 Introduction

The aim of this study is to understand women's lived experiences of attempted access to alternative birth models in contemporary Ireland. These experiences, like all human experiences, are shaped by the social context in which they take place (Berger and Luckmann 1991). Therefore, before I examine women's lived experiences of attempted access, it is necessary to discuss the notion of authoritative knowledge and the role it plays in developing the social structures that privilege and perpetuate obstetric authority and power over childbirth. In practice, obstetric authority has had tangible implications for women in relation to maternity policy, practice and service provision. These in turn have played an integral role in women's negotiations of birth options. In Ireland, obstetric authority over pregnancy and birth has been supported by a deeply conservative and patriarchal society and by the Catholic church, which has also held significant authority over women's bodies and our access to reproductive healthcare. Therefore, in order to understand the context in which women are attempting to access alternative birth models, I will first discuss authoritative knowledge and the development of obstetric knowledge and power over birth in contemporary Ireland. I will then outline the ways in which this authority has impacted women, and the significant social, political and organisational developments that have produced the current maternity services, including policies regarding midwifery-led care and its availability to childbearing women. I then situate access to healthcare, describing the gender-based barriers, presented by society and the Church, that women in Ireland have faced within the last century, particularly in regard to reproductive and maternity care. Within the final section of this chapter, I discuss the counter-knowledge claims that women who opt for alternative birth models make in response to obstetric claims, and their lived experiences of putting these knowledge claims into practice.

2.2 Authoritative Knowledge and Power

2.2.1 The creation of authoritative knowledge

In order to understand women's experiences of attempted access to alternative birth options, it is useful to first look beneath the models of care, or birth paradigms,

to understand the knowledge claims that underpin them, and to the creation of authoritative knowledge itself. In this section I will discuss definitions of authoritative knowledge and its construction, as well as biomedical and obstetric knowledge systems. As Foucault (1980) notes, a critique of scientific knowledge is not to deny the need for the production of such knowledge, but instead highlights the requirement for the production of other types of knowledge.

In her cross-cultural analysis of birth practices around the world, Brigitte Jordan (1993/1997) provides the foundational work for understanding authoritative knowledge and its implications for birthing women. Her work describes how the legitimation and ascendance of the biomedical model as the authoritative knowledge system in relation to childbirth has resulted in the devaluation and dismissal of alternative knowledge systems as backward and naive (Craven 2005). Jordan concludes that birth choices are constructed through local belief systems, which are based on authoritative knowledge claims, and that within any society, several knowledge systems exist but some come to carry more weight or authority than others. Which specific system becomes dominant and gains authority is determined either by efficacy, that is, it does the best job at explaining the state of the world for a given society, or by structural superiority, that is, because it is associated with a stronger power, or both. Jordan (1997, p 57) writes that authoritative knowledge is persuasive because it seems natural, reasonable and consensually constructed. The group associated with the dominant knowledge system has the power to determine what knowledge is valued, and what knowledge thus becomes authoritative. Whether the knowledge of the dominant group is accurate or reflective of the other members of the society or group is not necessarily relevant. Instead, “the power of authoritative knowledge is not that it is correct but that it counts” (Jordan 1997, p 58). Such authoritative knowledge can be expressed at any level of a social system and is often so well established that it tends to be taken for granted as the truth (Downe and McCourt 2019, p 70).

According to Jordan, dominant groups maintain their power by emphasising the authority and importance of their own knowledge while discrediting those who value other knowledge sources. Hierarchical knowledge systems are generated and perpetuated through the mechanism of devaluing non-authoritative knowledge structures – and the subordination or derision of those who espouse alternative systems. In this scenario, those who place authority in alternative sources of knowledge are marked as “backward, ignorant and naive, or worse, simply as

troublemakers” (Jordan 1997, p 56). Authoritative knowledge claims and the ways they are upheld and perpetuated within the context of health and specifically within birth will be discussed below.

2.2.2 The expansion and parameters of medical and obstetric authority

In *The Birth of the Clinic* (1973), Michel Foucault examines the expansion of medical authority in Europe. As part of this, he discusses the shift that took place in France (and across Europe) during the 18th century, when medicine expanded its remit from being simply a “sorry analysis of infirmaries” concerned with diagnosing and alleviating disease to playing an authoritative role in determining health and normality (Foucault 1973, p 39). By becoming embedded within the governance of people and their health, and overseeing the maintenance of a healthy population, medics expanded the profession’s authority, becoming important to national governments and influencing healthcare policies and systems. The effect, still felt today, was that doctors have authority not only over the elimination of pathologies but also over aspects of the healthy body, including diet, smoking and alcohol consumption (Foucault 1973). Edwards (2005) refers to this expanded remit as the medical profession’s attempt to “collapse” the boundary between those who are healthy and those who are unhealthy, with the claim that everyone is at risk of disease. If this boundary is collapsed, and both disease and health fall within the remit of medicine, then the profession can exhort everyone to avoid those things that are considered to contribute to ill health and adhere to the requirements considered essential to good health (Edwards 2005, p 80).

Medicine’s expanding authority over the healthy populace in the 18th century occurred as the profession aligned itself with scientific knowledge and inquiry, as part of the Enlightenment movement. As the scientific quarter gained purchase as the new source of legitimate knowledge, or became the authoritative knowledge system, it became equated with truth (Newnham *et al* 2018, p 33). As scientific knowledge became equated with truth, scientific inquiry initiated a focus on certainty, which continues today. This focus on certainty also incorporated developing social constructions of time and linear progression (McCourt and Dykes 2010, Downe and Dykes 2010) (see Chapter 3, Section 3.4). Contemporary medicine, which remains situated within the sciences, continues to dominate healthcare practices by producing knowledge that reflects a narrow research agenda (Newnham *et al* 2018, p 49). This research agenda focuses on clinical interventions, quantifiable outcomes and professional practice or, as Downe and

McCourt (2019, p 71) suggest, “ever more advanced technical solutions to human problems”. It is based on the belief that certainty can be gained through research based on the study of specific elements of a system, which include enough individuals that the results can be generalised to whole populations (Downe and McCourt 2019). This is exemplified in the commitment on the part of many researchers to Randomised Controlled Trials (RCTs), and beyond that, systematic reviews, which currently dominate medical research and which appear to carry the promise of definitive answers. Within the context of healthcare, however, the demand for maximum certainty and the privileging of certain forms of scientific knowledge have led to the creation of practices and protocols that are not applicable to all members of the population (Downe and McCourt 2019, p 73) and do not necessarily reflect the needs, beliefs or expectations of service users (Downe *et al* 2015).

2.2.3 Obstetric knowledge and the colonisation of safety

Situated within the field of medicine, obstetrics organises itself as a rational practice (Murphy-Lawless 1998). Like medicine, the remit of obstetrics has expanded from the 17th and 18th centuries, when it only dealt with emergencies in birth, to include both healthy and unhealthy pregnancies. This expanded authority is reflected in contemporary birth practices and maternity services that are situated within a biomedical framework. Just as scientific and biomedical knowledge is privileged within healthcare provision and practice, obstetrics determines which knowledge is valid within the context of childbirth and maternity care. It does so by emphasising medical knowledge as the only legitimate source of knowledge (Murphy-Lawless 1998, Wagner 2008), to the exclusion of other knowledge claims. Reflecting biomedical research parameters, obstetric knowledge production focuses on certainty, quantifiable outcomes and technological interventions, rejecting the importance of women’s experiences, non-technological practices or protecting birth from unnecessary interventions (Newnham *et al* 2018). However, Murphy-Lawless (1998, p 8) writes that obstetric knowledge claims regarding childbearing women were not grounded in the myriad experiences of living, labouring women but upon “the supine, non-dynamic female body – dead or alive”. Globally, further obstetric knowledge of and power over the female body was gained during colonial rule and slavery (van der Waal *et al* 2021). However, because obstetric claims are based upon birth that is circumscribed by hospital

and medical practices, the knowledge it produces regarding women's embodied experiences of birth remains limited (Beckett 2005, Rothman 1982).

Situated within obstetric knowledge claims are specific concepts regarding risk and safety, as discussed in Chapter 1. These centre around the obstetric focus on pathology and the prevention of maternal and infant mortality and morbidity (Coxon *et al* 2014, Edwards 2011, Newnham and Kirkham 2019). This emphasis on physical pathology is underpinned by both a desire to control uncertainty and the primacy of risk within the medical paradigm (Downe and McCourt 2019). Thus, within obstetrics, definitions of risk are limited to physical risks, and what is "risky" and what is "safe" for mother and baby is calculated in relation to mortality and morbidity (Plested and Kirkham 2016). These concerns have led to the obstetric claim that birth is only really safe if it takes place in hospital, overseen by medical professionals (Yuill *et al* 2020).

Within contemporary birth discourses, "cornering the market on safety would seem to be a project in which obstetrics has successfully invested" (O'Connor 1998, p 62). However, Murphy-Lawless (1998) writes that obstetric claims regarding the ability to prevent mortality and morbidity are false because birth outcomes are never guaranteed, a reality that most women recognise. She says obstetric claims to safety have robbed women of our authority over birth, writing:

What a peculiar position it is that death is considered an abnormality, a deviation. Unexpected, unsought, a source of profound grief but a deviation from the human condition? It is pure hubris to reach such a conclusion. And yet as childbearers we accept, far more than we recognise, that obstetrics seeks to rationalise its practices on the basis that it can control exposure to death. It cannot, as it happens, but we have gone along with those beliefs, and they have gradually divested us of our experiential knowledge and skill in giving birth (Murphy-Lawless 1998, p 15).

Embedded in the obstetric claim that hospital is the safest environment in which to give birth is the implication that women who give birth outside of hospital are privileging their birth experiences over the physical safety of their babies (Newnham *et al* 2018), inaccurately assessing the risks associated with birth (Craven 2005) and violating the parameters of good motherhood (Cheyney 2008). Medico-obstetric suspicions regarding women's ability to make "good" decisions and protect the foetuses growing inside us is explored further in Chapter 3. Below,

however, I will explore the impact that obstetric knowledge and authority has for birthing women.

2.2.4 Obstetric knowledge/authority and its implications for birth

The implications of obstetric authority over birth for both obstetricians and birthing women can be seen in Jordan's anthropological critique of a high-tech medical environment (Jordan 1997). Describing one of the labours that she observed for her study, Jordan suggests that the obstetricians' knowledge carries authority in childbirth, while the birthing mother's knowledge and experience is devalued (and the attending nurse is caught up in perpetuating the institution's valuation of the doctor's knowledge). In a situation where a woman claims to be about to give birth, her knowledge is not given credence. Instead, staff wait until the doctor, whose knowledge is authoritative, says she is ready. Jordan writes:

What the woman knows and displays, by virtue of her bodily experience, has no status in this setting. Within the official scheme of things, she has nothing to say that matters in the actual management of her birth. Worse, her knowledge is nothing but a problem for her and the staff. What she knows emerges not as a contribution to the store of data relevant for making decisions but as something to be cognitively suppressed and behaviourally managed. In the labour room authoritative knowledge is privileged, the prerogative of the physician, without whose official certification of the woman's state the birth cannot proceed (Jordan 1997, p 64).

Obstetric technology plays a significant role in upholding and perpetuating obstetric authority over childbirth. Davis-Floyd and Davis (2018) write that this is due to the fact that within an obstetric/medical model of birth, authoritative knowledge is placed in technological birth machinery – and thus those with knowledge of these machines and jurisdiction over their use become the authorities on birth. They write: "Under this model, authoritative knowledge ... is vested in these machines and in those who know how to manipulate and interpret them" (Davis-Floyd and Davis 2018, p 190). With authoritative knowledge invested in obstetrics through the use of technology, decisions made by those within the profession are held as legitimate (Jordan 1997). Meanwhile, Kitzinger (1997) writes that as authority and expertise are invested in machines and those with the permission to use them, human touch in childbirth loses its authority. When touch,

used by midwives and mothers as an important tool for pain relief, information gathering and emotional support, loses its authority over birth, authority and power are taken away from those who employ it. Rich (1980b, p 638) also discusses the link between control and technology, suggesting that birth technology is used as a tool to enforce authority over women and our bodies. She writes:

It is increasingly clear that medical technology has ... become a means of alienating women from the act of giving birth, hence from their own bodies, their own creative powers, and of keeping birth itself so far as possible in male control.

Emily Martin (1989) discusses birth technology within the context of a mechanised view of the female body in her cultural analysis of reproduction, while Iris Marion Young (2005) provides insight into the implications of birth technology on women's embodied experiences during childbirth. Both Martin's and Young's ideas will be discussed in Chapter 3, within the context of the theoretical underpinnings of my study.

In conclusion, societies privilege certain knowledge systems over others, with one knowledge system becoming authoritative over another. In Western countries, scientific knowledge has been equated with certainty and truth. As medicine and obstetrics has aligned themselves with science, knowledge produced within these fields is also considered to be authoritative. This privileging of obstetric knowledge in birth means that knowledge and practices surrounding childbirth remain situated within an obstetric, biomedical framework that focuses on technology, certainty and risk while rejecting women's knowledge and experiences. In the following section I will explore the implications that medical and obstetric authority has had for women in contemporary Ireland.

2.3 Health and maternity care provision in contemporary Ireland

The authority of medicine over health and obstetrics over birth can be seen throughout the development of the healthcare services and specifically the maternity services in Ireland since the foundation of the State in 1922. Since that time, inconsistent access to services for the general population have been a persistent feature of healthcare provision in Ireland (Wren and Connolly 2019), and women have faced additional barriers when attempting to access reproductive services specifically (Conroy 2015, McAvoy 2015). While I have discussed

significant moments in Irish maternity care in Ireland in Chapter 1, I will now outline other developments within the Irish healthcare system that have impacted service provision and access to healthcare in general. I will then review, in greater detail, significant developments in the provision of maternity care specifically that have shaped women's experiences of attempted access to alternative birth models.

2.3.1 Irish healthcare service: An overview

Unlike many European countries, Ireland does not provide universal healthcare coverage to its inhabitants (Wren and Connolly 2019). Instead, there exists what Burke (2009, p 14) describes as a "fragmented system", with services provided by a mix of public, private and voluntary bodies. This has led to what is often referred to as Ireland's "two-tier" system, indicating the situation in which people who have private health insurance, or have the ability to pay out-of-pocket, can access diagnostics and treatments more quickly than public patients (Burke *et al* 2016). Within this context, individuals access care through a multiplicity of pathways. This complex system of access is one of the Irish system's "most distinctive traits" (Burke 2009, p 23), and has remained *in situ* despite repeated attempts at reform (Wren and Connolly 2019).

Embedded within the two-tier system of access to public and private care is the development of a hospital-centric service, which has resulted in seriously under-developed primary and community care services (Ruane 2010, Thomson *et al* 2012). This hospital-centric approach came about in part through a government focus on reducing financial barriers to hospital care, while also failing to address barriers to accessing primary and community care (Wren and Conolly 2019). In the late 1960s, the government began a process of examining how best to organise hospital care throughout the country. This culminated in the 1970 Health Act (see Chapter 1, Section 1.2.3) which established eight regional health boards. In 1971, responsibility for local public hospitals fell within the remit of the respective health boards. The regional health boards remained in place until January 2005, when, following the Health Act 2004, they were dissolved and the provision of all public healthcare services across the country came under the remit of the Health Service Executive (Burke 2009). It was hoped that the formation of one national body would lead to high-quality, standardised services throughout the country.

Within the last decade, there have been efforts on the part of the Irish government to reform the healthcare system so that it is more closely aligned with the social

models in place in other European countries, as well as international definitions, which are based on standardised services and providing access according to need and not ability to pay. The World Health Organisation (WHO) defines universal coverage as “a situation where all people who need health services (prevention promotion, treatment, rehabilitation and palliative) receive them, without undue financial hardship” (WHO 2013). In 2011, proposals to develop a universal healthcare system, funded by Universal Health Insurance (UHI), was announced by the Irish government, under the title of the 2011-2016 Programme for Government (Department of the Taoiseach 2011). Wren and Connolly (2019) argue that “it is hard to overstate the historic nature” of these proposals, with Burke et al (2016) noting that this was the first time a government committed to ending Ireland’s two-tier system of access to healthcare. However, by 2014 proposals for UHI were largely abandoned, due to concerns over cost implications, a lack of clarity regarding policy and implementation (Burke *et al* 2016) and opposition from stakeholders including health insurers and those with private healthcare insurance (Wren and Connolly 2019). Instead, in July 2015, the government introduced free primary care (through GP visit cards) for children under the age of six and for adults over the age of 70. In May 2017, the government announced its commitment to implementing Sláintecare, a ten-year roadmap aimed at introducing a single-tier universal healthcare service (Burke *et al* 2018). As of writing, the introduction of this programme is flagging, with recent senior resignations on the basis of lack of political will (Burke 2021). Burke et al (2016) note that due to a lack of implementation or abandonment of proposed reforms, Ireland has yet to provide its inhabitants with a universal health coverage system as defined by the WHO, and inequality of access, demarcated along public and private lines, continues.

2.3.2 Maternity services in contemporary Ireland

Contemporary maternity services in Ireland have developed within the context of fragmented healthcare reforms and a State focus on hospital-based care. In this section, I will specifically look at contemporary maternity care services in Ireland, building on from the discussion in Chapter 1, Section 1.2, and exploring further the policy developments that upheld and supported a medicalised, consultant-led, hospital-based model of birth and, later, policy shifts that promoted greater choice. I will also outline the alternative birth models currently available to women in contemporary Ireland.

The foundation of contemporary Irish maternity services can be traced to the late 1940s and early 1950s, with the historic debate regarding then health minister Noel Browne and the ultimate introduction of the Maternity and Infant Care Scheme (MICS), which was included in the 1953 Health Act (Kennedy 1998/2002/2012) (see Chapter 1, Section 1.2.2). Debates regarding this legislation and Dr Browne's proposals can be viewed as significant for three reasons: first, the scheme introduced free maternity care for pregnant women up to six weeks postpartum; second, the process demonstrated the influence and authority that medicine and the Church had over governmental healthcare policy; and third, it served to cement the central role that doctors and hospitals had in birth (Kennedy 2002). Medical authority over birth was facilitated by the MICS, which stipulated that free antenatal care would only be offered through GPs and hospital-based obstetricians who, since the introduction of the legislation, have provided "combined care" to mothers during the maternity period. Throughout the following two decades, Irish government policy further supported medicalised, hospital-based birth, particularly following the 1968 Fitzgerald report and the 1976 Discussion Document from *Comhairle na nOspidéal* (see Chapter 1, Section 1.2.3). The closure of smaller maternity units, which followed on from these reports, meant that larger maternity hospitals, such as those in Dublin and Cork, became busier and attending midwives had less time to be "with woman" (Kennedy 1998).

2.3.3 Piecemeal policy shifts towards greater choice for childbearing women

In Ireland, changes in policy proved to be piecemeal and services continued to lag greatly behind other countries in relation to access to midwifery-led models of care (Begley *et al* 2009) (see Chapter 1, Section 1.2.4). However, even within this context, several Irish government-sanctioned reports and policy documents produced in the last three decades recommended changes within the maternity services and urged the provision of woman-centred care, which would include offering women a range of options for birth (Begley *et al* 2009).

For example, following demands from women, several pilot schemes to support homebirths were funded by the now-defunct local health boards in the late 1990s: one in Galway, one in Cork, and one in Dublin's National Maternity Hospital (NMH). The short-lived homebirth scheme in Galway was initially supported by a group of hospital-based midwives, while the one in Cork was coordinated by a HSE employee and operated by self-employed midwives. The pilot in the NMH was a combined homebirth and Domino (Domiciliary Care In and Out of hospital)

scheme. Through this, women could receive antenatal care in a local clinic, postnatal care at home and have the option to give birth either at home or in hospital.

The Domino and homebirth service at the NMH remains in place and continues to be available to women living within its catchment area in south Dublin. The Cork scheme in its initial format was discontinued following its pilot phase, although homebirth services continue to be offered to women through a partnership between Self-Employed Community Midwives and Cork University Maternity Hospital. The Galway service only continued for a limited time following the initial pilot phase; there was opposition to it from senior obstetricians and funding was reallocated to provide for a neonatologist. The suspension of these homebirth services occurred despite their popularity amongst women and positive evaluation by the relevant health boards. A decade later, the HSE established a National Home Birth Service (NHBS), which will be discussed below in Section 2.3.5.

In 1998, the North Eastern Health Board (NEHB), now under the remit of the Health Service Executive – North Eastern Area (HSE-NE), convened a Maternity Services Review Group. This group was tasked with reviewing international midwifery practices and investigating future care options for the North East region. Known as the Condon Group, its resultant report, published in 2000, supported the medical model currently in place, recommending the provision of a “high quality consultant delivered service” (Condon 2000, p v). This included a recommendation for the closure of two maternity units in this region, one in the Monaghan Hospital and one in the Louth County Hospital, Dundalk. The NEHB was forced to close these two units at the end of February 2001, after the Irish Public Bodies Mutual Insurance, the insurers for the health board, withdrew coverage for them (Burke 2009).⁷

However, the Condon Report was rejected by the board of the former NEHB as it was not considered enough of a departure from current policy, and movement towards a policy shift began again in 2001, when the CEO of the former NEHB appointed a new committee to the Maternity Services Review Group (Begley *et al* 2009). Known as the Kinder Group, the remit of the new committee was once again to investigate options in relation to the future development of the maternity services

⁷ The continued role insurance companies have played in the provision of maternity services is discussed in sections 2.3.5 and 2.4

in the North East region, particularly in light of the closures in Monaghan and Dundalk. The Kinder Report (2001) produced by the review group highlighted the need for evidenced-based care and practice and, significantly, stated that “mothers in the low-risk category should be able to choose if they wish to deliver in a more accessible midwife-led unit” (Kinder 2001, p. 33). As part of this, it recommended that Midwifery-Led Units be established in Cavan and Drogheda, both situated in the North East region, in order to fill the gap in maternity services left by the closures of the units in Monaghan and Dundalk. Thus, not only did the Kinder report recommend that this lacuna in service provision be filled – the report also “represented a critical break with the dominant model of medical-led care in the Republic of Ireland” (Begley *et al* 2009, p 46). Its legacy has been a model of organisation which should involve all stakeholders (Kinder 2010), but this has not been taken up, as is evident from the National Maternity Strategy (NMS), wherein there is an ongoing agenda about keeping decision-making in the hands of the obstetric authority (Wood 2017). The NMS will be discussed further in Section 2.3.4.

But despite the Kinder report’s strong recommendations for an expansion of midwifery-led services, State support for choice in maternity care, when that choice included out-of-hospital births, remained uneven. In November 2003, a unanimous ruling from the Supreme Court meant that women did not have an automatic right to homebirth. In this case, O’Brien vs SWHB (South Western Health Board 2003), the court ruled that the health boards did not have a statutory obligation to provide homebirth services, despite the fact that Section 62 of the 1970 Health Act requires health boards to provide appropriate medical, surgical and midwifery services. However, the court ruled that the health board could fully comply with that obligation by providing hospital-based services (Carolan 2003).

Despite this ruling, further recommendations for greater choice and the expansion of midwifery-led care came in 2007-2008. At that time, an independent review of the maternity and gynaecology services in the Greater Dublin Area was conducted by KPMG consultants on behalf of the HSE. The review recommended that the maternity services offer women the choice of different models of childbirth in a wider range of settings, as well as the expansion of midwifery-led and community-based services, arguing that obstetric care is only required for high-risk women (Begley *et al* 2009, KPMG 2008).

A study, known as the MidU Study, was instigated by the HSE as part of the set-up of the units in 2004, and prospectively compared the midwifery-led care provided by the MLUs with the consultant-led care provided in the attached hospitals. Begley et al (2009, p 47) suggest that the MLUs represented “a significant development in the provision of maternity care in Ireland”. The MidU study found that midwifery-led care, as practised in the two MLUs, was as safe as consultant-led care and used fewer interventions during pregnancy and childbirth (Begley *et al* 2009). The number of babies needing resuscitation at birth, or admission to the special care baby unit, was the same for those born in the MLU and those born in the consultant-led unit. Following this positive feedback, the MLUs remained in Cavan and Drogheda on a permanent basis and continue to offer services to low-risk women.

2.3.4 Ireland’s first National Maternity Strategy

Despite the powerful findings of the MidU study, no other MLUs were established, and it was not for another fifteen years after the Kinder report, in January 2016, that further policy recommendations regarding midwifery-led models of care were published. These came in the form of Ireland’s first National Maternity Strategy – Developing a Better Future Together 2016-2026 (NMS). The strategy was developed as a response to several infant and maternal deaths, including that of baby Mark, the son of Róisín and Mark Molloy, at the Midlands Regional Hospital in Portlaoise in January 2012 and that of expectant mother Savita Halappanavar in October 2012 at University Hospital Galway. It provided a policy and strategic framework for the future development and delivery of maternity services in Ireland. Though the strategy is still in its ten-year implementation phase, it highlights choice as a key priority, arguing that low-risk mothers should be offered choice regarding their preferred pathways of care, in line with their clinical needs and best practice (DoH 2016). As discussed in Chapter 1, Section 1.2.5, this was an important moment in maternity care in Ireland, both because it was the country’s first ever national maternity strategy and because it represents the first time the government clearly advocated for choice and access to midwifery-led models for at least one cohort, namely, low-risk women.

The NMS outlines three care pathways for pregnant women (DoH 2016, p 88). This includes the Supported Care Pathway for low-risk or what the Strategy refers to as “normal risk” women and babies, who can choose to give birth at home, in an Alongside Birth Centre (as yet to be established) or in a hospital (the

development of the Alongside Births Centres will be discussed later in this section). The strategy envisions that care for women following the Supported Care Pathway is coordinated by a Clinical Midwife Manager and delivered by the community midwifery team, with most care being provided in the community and home settings. For medium-risk women and babies, as well as low-risk women who wish to avail of consultant-led care, the strategy suggests the Assisted Care Pathway. Women within this care pathway require a higher level of oversight, according to the strategy, should give birth in hospital and a named obstetrician/consultant is responsible for her care. The third option outlined in the strategy is the Specialised Care Pathway, for women who require a more intense level of care, either throughout or at a particular stage of pregnancy and birth. Mirroring the Assisted Care Pathway, birth takes place in hospital and a named consultant is responsible for the woman's care. However, despite an emphasis within the strategy on supporting women through different pathways, women's choices about care pathways must be mandated by an obstetrician (Wood 2017).

Despite the initial fanfare from political quarters and the Health Service Executive, implementation of the changes outlined in the NMS remain slow to date. Progress on the part of the National Women and Infants Health Programme (NWIHP), established to implement the strategy, has been hampered by a significant decrease in government funding. At the launch of the NMS in January 2016, then minister for health Leo Varadkar promised that funding would be ringfenced for the strategy for the following ten years, but this has not been fully realised. In 2018, the NWIHP received €4.55million from the Government for implementation of the strategy (Dunne 2018). In 2019, the programme received €4.1million. Furthermore, as experienced across all sections of the healthcare services, the Covid-19 pandemic impacted the work of the NWIHP, with staff diverted to establish and run the HSE's contact tracing service (NWIHP 2021).

One of the significant changes recommended in the NMS was the placement of a Director of Midwifery within each of the 19 maternity units, and this has been achieved, giving voice to midwifery service provision. As part of NWIHP work in 2020, the post of Advanced Midwife Practitioner (AMP) within each of the 19 maternity units has been developed⁸. The primary purpose of these AMP posts is to lead the ongoing development of the Supported Care Pathway for low-risk women, which includes the integration and development of homebirth services

⁸ These posts were developed and brought in two decades ago within the British NHS.

“where appropriate”⁹, enhance continuity of care to women and provide support for greater cooperation between the Supported and the Assisted Care Pathway (NWIHP 2021).

However, another significant recommendation within the strategy was the establishment of an Alongside Birthing Centre (ABC) (similar to the Midwifery-Led Units in Cavan and Drogheda), to facilitate low-risk mothers in giving birth outside a hospital setting. As of writing, not one of these units has been established. The strategy envisions the establishment of six maternity networks throughout the country, which would oversee maternity services within a designated geographical area. No new ABCs have as yet been developed and the only two MLUs were built before the NMS was launched. Instead of developing the ABCs, nine (of the 19) maternity units have developed home-away-from-home rooms, “providing a non-medical birthing experience” (NWIHP 2021, p 15). A further three maternity units are developing such rooms. Moreover, ABCs were not discussed in the 2020 report from the National Maternity Strategy. The significance of this, if any, remains unclear.

2.3.4.1 Women’s experiences and the NMS

Another key recommendation of the NMS was that research be conducted into the experiences of women of the maternity services as a whole. To this end, the first National Maternity Experience Survey (NMES) was conducted in 2020, with results published in October of that year. The survey was conducted by the National Care Experience Programme, which is a joint initiative between the HSE, the Health Information and Quality Authority (HIQA) and the Department of Health. Participants included women who had given birth in one of the 19 maternity units or through the HSE’s National Homebirth Services in October or November 2019. A total of 52% of the 3,204 participants said their experience of the maternity services was “very good”, while 33% said their experience was good. Some 15% rated their experiences as fair to poor (NMES 2020).

Sixty percent of the research participants reported that during the antenatal period, they were offered a choice in relation to the type of maternity care they would receive. However, crucially, for many of these women, the “choices” presented to

⁹ The medical language and caveats that surround discussions of homebirth and the Supported Care Pathway in the National Maternity Strategy will be discussed later in this section and in Chapter 8.

them by healthcare professionals were all hospital-based options, and the “choice” focused on whether they wanted private care, semi-private care or public care¹⁰. Homebirth, Domino and midwifery-led care were not commonly presented as choices or options, even for low-risk women (NMES 2020). This echoes remarks from Begley et al (2009), who write: “The medicalisation of birth has become normalised, with the focus on women’s decision making often limited to individual decisions, such as whether a woman opts for public or private healthcare during pregnancy and birth.” (Begley *et al* 2009, pp 29-30). Thus, the survey indicates that despite the ongoing implementation of the NMS, women continue to face challenges regarding choice, as they did a decade before, when the MidU study was conducted.

While the concept of choice will be explored further in Chapter 3, it is important to note here that while the NMS represents a significant moment in the advancement of maternity care and some of its key recommendations have been implemented, many of its claims surrounding women’s choices remain unmet. The commentary within the strategy acknowledges that women’s birth choices in Ireland have been historically limited and partially commits to rectifying this by creating a maternity service that offers and emphasises choice. However, within the strategy, discourses on choice are always couched within caveats regarding physical safety, reflecting the obstetric claim that safety and women’s preferences are at odds with each other. This issue is discussed further in Chapter 8, within the context of my findings.

Above, I have outlined the historical developments that have led to an Irish maternity service that, despite movements towards change, remains hospital-based and consultant-led (DoH 2016). I will now outline the specific options available to women who wish to access alternative birth models.

2.3.5 Homebirth Services and Midwifery-Led Units available to women

One alternative birth model is provided by the two MLUs in Cavan and Drogheda. These MLU services are available to women who live in the North East region of the country and within proximity of the units, who have healthy, low-risk pregnancies and who do not have a significant gynaecological or medical history

¹⁰ Women purchase private or semi-private care through their insurance. Through doing so, they can meet with a consultant during their antenatal visits, they can have semi-continuity of carer in the form of a consultant or group of consultants and they can share a room with a limited number of other new mothers, following the birth.

(HSE 2018). Women who do not reside in the catchment areas and/or do not meet the eligibility criteria are not able to access the MLU services.

Current maternity policy and practice offers three options for women wishing to give birth at home. The first is through the HSE's National Home Birth Service (NHBS), which was established in 2008. The establishment of this programme arose out of a dispute regarding insurance policies for homebirth midwives, when insurers for the Irish Nurses and Midwives Organisation union removed homebirth practice from their members' cover. OBoyle (2016) suggests that the NHBS was primarily established not to facilitate greater choice for women, but instead to secure a mechanism through which SECMs could avail of State-based indemnification. Through this programme, the HSE offers free homebirth services to women who have low-risk pregnancies. This service is provided by a very small cohort of independent midwives, known as Self-Employed Community Midwives (SECMs), many of whom work part-time and who are not spread evenly through the country, leaving large areas, particularly in the north and west, unserved. According to the HSE, there are 20 SECMs providing these services throughout the country (Meaney *et al* 2018/2020).

The most recent Planned Home Birth Annual Report from the HSE (Meaney *et al* 2020) provides the demographics of the women attempting to access the HSE's homebirth scheme, and the reasons why some women did not give birth at home but transferred to hospital. These figures provide insight into the context in which my study participants attempted to give birth at home. In 2017, 183 women across Ireland intended to give birth at home through the HSE homebirth scheme (Meaney *et al* 2020). This number represents a 4.7% reduction from 2016, when 192 women planned to give birth at home. Seventy per cent of mothers who attempted to access homebirths were multiparous. They had an older age profile compared with the average age of women who gave birth in the country, with 86% of those planning a homebirth with the HSE aged 30-39 years, compared with 64% in this age group for all women giving birth. The majority of women were of White Irish descent (150, or 82.2%), while 26 (14.4%) were of other White backgrounds and five (2.8%) were of Black or Asian ethnicity.

While 183 women intended to give birth at home through the HSE scheme in 2017, only 131 infants were born at home, with 31 women transferring during the antenatal period and 21 during labour. Nulliparous women were more likely to transfer to a maternity hospital during the antenatal period compared to

multiparous women (25% versus 18%). Induction of labour was one of the significant reasons for transfer of care during the antenatal period, with 19% of women transferring for this reason. Meanwhile, nulliparous women were five times more likely to transfer to hospital during labour as multiparous women (34% versus 7%). Failure to progress in labour (33%), as well as maternal request for analgesia (33%), were the primary reasons for hospital transfers during the intrapartum period. These figures are highlighted here as policies and practices regarding induction of labour for post-maturation and augmentation of labour played a significant role in accessing midwifery-led models of care for my study participants.

Outside of the HSE's SECM-delivered homebirth scheme, the National Maternity Hospital (NMH) also provides a public homebirth service through their Domino scheme to low-risk mothers who are based within the designated catchment area, which includes only areas of South East Dublin within 30 minutes travel time to hospital. Approximately 50 mothers give birth at home through this scheme annually, out of the 8,000 women who give birth annually under the care of the NMH (NMH 2019). Meanwhile, Waterford and Wexford hospitals offer very limited access to publicly funded homebirths, within the number of women giving birth through this scheme limited to single figures.

A third option is for women to give birth at home privately, facilitated by out-of-pocket payments and/or private health insurance policies. At the moment, private homebirth services are provided by Private Midwives, a company that is governed and insured in the UK but provides services in Ireland through Irish-registered midwives. As my research examines publicly funded options for midwifery-led care, figures for this company fall outside the remit of my study.

A fourth option is also available to women, one that has been present for millennia: professionally unassisted birth. This option, considered and chosen by some, is also called freebirth, but has been difficult to document or quantify in Ireland and abroad (Kenny and OBoyle 2015). This option also falls outside the remit of this study.

2.4 Access and outside influences

Although attempts at reforming the Irish health services have been made in recent years, contemporary maternity care remains situated within the larger context of a patriarchal society that has long been deeply conservative and religious (Murphy-

Lawless 2011). Thus, historically and contemporaneously, members of the public, and women specifically, have faced a number of barriers to accessing healthcare. These include restrictions put in place through the ongoing collaboration between the Catholic Church and the medical profession, as well as laws restricting women's access to reproductive care and through insurance company policies. I will discuss each of these three factors in turn.

2.4.1 Authority of medicine and the Catholic Church in the Irish context

General healthcare provision in Ireland has been significantly affected by the public-private mix and its hospital-centric organisation, as outlined above in Section 2.3. However, both general services and maternity care specifically have also been greatly shaped by historical collaborations between the Catholic Church and the medical profession. This has allowed priests and doctors to exert extensive control over healthcare provision in Ireland (Conroy 2015, Kennedy 2002, McAvoy 2015).

Collaboration between members of the medical profession and the Catholic clergy in Ireland regarding healthcare policy can be seen in 1911, prior to Irish independence (Wren and Connolly 2019). At this time, with the support of the Irish representatives in Westminster, members of these two powerful sectors were able to successfully oppose the provision of free GP care and medications in Ireland, even as this was introduced throughout the rest of the United Kingdom as a precursor to the NHS (Wren 2003).

After partition in 1922, the ensuing Civil War and a weak political structure meant that politicians held limited power compared with members of the Church, and the State lacked financial resources to deliver services (Wren and Connolly 2019). The Church stepped in to provide services, particularly healthcare and education, that in other countries were developed and administered by the State. Following the Second World War, other European countries developed State healthcare and welfare services based on a social model, and the Catholic Church as an organisation supported this. However, the Catholic Church in Ireland did not take this position, and Ireland continued not to provide universal health coverage, making the country an outlier within Europe. Collaboration between organised medicine and the Church, and the ability on the part of these two groups to block reforms and access to healthcare, can also be seen in the Mother and Infant Care Scheme debate, discussed in Chapter 1. The scheme was opposed by both the

Irish Medical Association and Catholic Church (Kennedy 1998/2002). The Church, concerned about the use of contraceptive methods and losing influence over families, argued that the right to determine healthcare decisions for children belonged to parents and not to the State (Wren and Connolly 2019). The medical profession, concerned about the loss of private fee income and the idea of becoming State employees (Browne 1986), supported Church opposition to the scheme. The resulting Maternity and Infant Care Scheme had immediate and long-term consequences for children and women, as discussed in Chapter 1, Section 1.2.2 and above in Section 2.3.2, both in terms of financial access to services and a perpetuation of the medical model of birth.

The relationship between the medical profession and the Church within Irish healthcare continues to be evident in the 21st Century in the context of hospital ownership, as a number of major hospitals continue to be run by religious charities or orders. One such hospital is St Vincent's in South Dublin, which is the proposed site of the New National Maternity Hospital. Concerns regarding religious control of a maternity hospital have been raised repeatedly by members of the public, prominent medical professionals and politicians (Boylan 2019). These centre around the concern that women might be denied services, such as contraception and abortion care, that are not in line with Catholic teachings. Negotiations regarding ownership of the hospital and the site on which it is to be built remain ongoing (Burns 2022).

Thus, the dual authority and collaboration between members of the medical profession and the clergy can be seen in the development and provision of healthcare and, specifically, maternity services. The teachings of the Church have also held significant sway over politicians and the formation of legislation regarding the dissemination of reproductive information and service provision. Examples of this will be outlined below.

2.4.2 Women's restricted access to healthcare in Ireland

Women's restricted access to reproductive healthcare has historically been enacted and upheld by the State through national legislation (Conroy 2015, McAvoy 2015). The decades between the 1920s and 1980s, in particular, saw a number of laws restricting women's access to healthcare services (Conroy 2015). Coupled with this was other legislation, including the 1937 Constitution, which

narrowly defined women's roles within Irish society and restricted women's full participation in public life (Kennedy 2002)¹¹.

Two pieces of legislation that dealt specifically with access to reproductive services included the Censorship of Publications Bill 1928 and the Criminal Law Amendment Bill 1934. The Censorship of Publications Bill, enacted in 1929, banned the publication of any information regarding contraception and abortion, and the procurement of either. Meanwhile, the Criminal Law Amendment Bill 1934, which came into effect in February 1935, included prohibitions on contraception, with Section 17 criminalising the importation, sale and distribution of contraceptives.

Following these decades of restrictions, a number of pivotal social movements and events took place throughout the 1960s and 1970s, which positively impacted women's roles and ability to access reproductive services. In 1961, oral contraceptives were marketed in the UK, and then in Ireland. They could not be banned because it was argued that they had other medicinal purposes, including the regulation of menstrual cycles (Murphy-Lawless 1987). In the UK, the Abortion Act 1967, which came into effect in April 1968, hugely expanded the grounds on which abortion was permitted for women, including for those travelling from Ireland. In 1973, the Supreme Court in Ireland made a landmark ruling regarding birth control (*McGee v Ireland*, 1973) which, six years later, in 1979, was converted into legislation allowing married women to access birth control. It was 16 years later, in 1994, that contraception was made available to all women regardless of marital status.

Following the 1973 McGee judgement, anti-abortion campaigners became worried that the courts might soon allow for abortion care to become officially available (Conroy 2015). As part of the political response to these concerns, a referendum on abortion was held in 1983. The referendum was carried by a large majority and Article 40.3.3, known as the Eighth Amendment, was inserted into the Constitution. Conroy (2015, p 46) writes: "The termination of pregnancy in Ireland has now been constitutionalised and internationalised, forcing what might have been a private and tragic moment in a woman's life into an act of exile and evasion."

¹¹ Constitutional reforms are expected to take place after the Citizens' Assembly on Gender Equality recommended that Article 41.2, which indicates that women should not work outside the home, be removed from the Constitution (Citizens Assembly 2021).

In 2008, three women who were forced to travel abroad because they could not access terminations in Ireland took their case to the European Court of Human Rights (ECHR). This case became known as *A, B, and C v Ireland*, and became a landmark case in the battle for women's access to reproductive healthcare. In 2010, the ECHR strongly criticised Ireland, and ruled that the country must provide "effective and accessible procedures" through which women can access their European constitutional right to an abortion (ECHR judgement 2010, paras 263-4).

The Eighth Amendment, although designed to prevent and control abortion, also affected the maternity care that healthcare professionals were able to provide to women who initially chose to remain pregnant. A stark example of this can be seen in the case of dentist and mother-to-be Savita Halappanavar, who attended Galway University Hospital in October 2012, but was unable to obtain a termination, and subsequently died of mismanaged sepsis (Holland 2018, Lentin 2015). Savita's case shocked the nation and was a major catalyst for public demand of a referendum on abortion. The impact of the Eighth Amendment was also seen in maternity cases where women wanted to decline recommended care but were told they could not because the consultant had to look after the interest of the foetus under the Eighth Amendment, and believed the mother was not doing so (Farsaci 2018).

On 25 May 2018, the Irish public voted in a referendum to repeal the Eighth Amendment, paving the way for existing barriers to accessing abortion to be removed. The full impact of the subsequent legislation on access to healthcare services remains to be seen, but many women are now able to access abortion care within a safe and legal framework (ARC 2020).

2.4.3 Role of insurance in access to alternative birth models

As the Church and State have shaped access to reproductive care, so too has the role of private insurance companies proved significant. This can be seen most acutely in relation to out-of-hospital births and, specifically, in debates regarding professional indemnity insurance for homebirth midwives, outlined in Section 2.3.3.

Furthermore, insurance companies uphold the medical model of birth by exerting influence over the provision of antenatal care to women planning to give birth at

home. OBoyle (2009) notes that during his ethnographic research into independent midwifery in Ireland, conducted in the late 2000s, a number of GPs told independent midwives and mothers considering homebirth that their insurers had advised them to “avoid being involved with homebirth” (OBoyle 2009, p 20). The HSE recommends to newly pregnant mothers who wish to avail of the HSE homebirth services that they register for the scheme through a GP. However, in some instances, GPs are citing lack of insurance coverage. According to the HSE, there were 30 recorded incidences (15.6% of homebirths) where GPs refused to provide shared care to mothers intending to give birth at home through the HSE’s homebirth scheme in 2016 (Meaney *et al* 2018). In November 2019, an online petition was created by birth activists, including mothers and midwives, requesting then Health Minister Simon Harris to ensure that all women were able to access GP care under the MICS, regardless of their intended place of birth (see Appendix 1, p 236). This suggests that insurance policies, and financial risks versus clinical risks, continue to affect the experiences and attempts to access care by women who are planning homebirths.

However, despite the restrictions that women in Ireland have faced in relation to accessing reproductive and maternity care, particularly out-of-hospital maternity care, childbearing women continue to seek access to care that respects their autonomy and their decisions. They have done so within the context of a conservative, patriarchal society and a healthcare system that situates birth within a medical model that upholds obstetric authority over birth. The ways in which childbearing women have sought out alternative birth models, our counterarguments to obstetric knowledge and our experiences when we are successful in our attempts to access alternative, midwifery-led care are discussed below.

2.5 Women’s knowledge and experiences: Counterarguments to obstetric knowledge and praxis

Initially in this chapter, I discussed Jordan’s concept of authoritative knowledge, the authority that biomedicine holds over healthcare and, within that, the authority that obstetrics holds over birth. I examined the ways in which the medico-obstetric hegemony has influenced the development of the healthcare services in contemporary Ireland, with particular regard to reproductive and maternity care provision. This hegemony, coupled with the powerful institution of the Catholic Church and Ireland’s peculiarly patriarchal legislative framework, has meant that

women's access to reproductive care and alternative birth models has been severely restricted. In the final section of this chapter, I will examine the authoritative knowledge claims made by women who wish to have access to alternative birth models, which are put forward as counterarguments to obstetric knowledge claims and the medical model of birth. Finally, I will also look at women's experiences of homebirth, which serve as embodied experiences of the alternative knowledge systems in which these women situate themselves.

2.5.1 Women's authoritative knowledge claims

Women seeking alternative birth models, such as homebirth, challenge the dominant obstetric model of birth by questioning its authority or "expert" knowledge and its views of childbirth (Cheyney 2008). Instead, many women interested in midwifery models of care ascribe authority to multiple sources of knowledge in relation to pregnancy and birth (Chadwick and Foster 2014, Davis-Floyd and Davis 2018, Davis-Floyd and Sargent 1997). These sources include biomedical knowledge, such as information provided by clinical diagnostics and birth technology, as well as research situated within a medical framework (Viisainen 2001)¹². However, women also ascribe authority to embodied knowledge or intuition, which homebirth mothers define as knowledge that was not intellectual but physical (Cheyney 2008, p 258). Many also place authority on experiential knowledge of childbirth, particularly their own (Yuill *et al* 2020) and that of other women, including midwives. This experiential knowledge is passed down from women who had already given birth, such as mothers and friends, to women who had not given birth, as part of a "feminine, woman-to-woman legacy" (Kay *et al* 2017, p 2). Finally, within this alternative framework, relational knowledge of oneself and others, particularly one's midwife, is another important source of authoritative information as women negotiate childbirth. This relational knowledge is formed through discussions between mothers and midwives in which information is shared, trust is built, and informed consent is fostered (Cheyney 2008).

Feminism also has a long tradition of emphasising multiple sources of knowledge systems as legitimate (Squire 2009), including women's experiences as a valid (and essential) source of knowledge when attempting to understand women's lives and how oppression is experienced (Edwards 2005, Stanley and Wise 1993).

¹² Research comparing maternal and neonatal outcomes for birthing in and out of hospital will be discussed in Section 2.5.2

Many women who are interested in homebirth in Ireland situate themselves within a feminist framework (O'Connor 2006), and thus also within a framework that privileges a multiplicity of knowledges and questions established patriarchal structures and practices. Producing an alternative body of knowledge that derives from women's experiences of homebirth enables researchers, practitioners and activists to critically assess current knowledge situated within hospital-based experiences and to broaden the dialogue and understanding around birth. Feminist discourses on knowledge and knowledge production will be explored further in Chapters 3 and 4.

2.5.2 Safety: Claims and critiques

Childbearing women share with the obstetric profession the view that the physical safety of their baby, as well as their own safety, is paramount (Plested and Kirkham 2016) and expect positive well-being for themselves and their newborns to be the main outcome of pregnancy (Downe *et al* 2015). As indicated in Section 2.5.1, women who adhere to the social model of birth draw upon multiple knowledge sources when making birth choices, and they often cite international scientific or academic research as one source of authoritative knowledge, when advocating for access to alternative birth models.

One study comparing birth outcomes and place of birth is a systematic review and meta-analyses that examined perinatal and neonatal mortality among women who intended to give birth at home at the onset of labour compared to low-risk women who intended to give birth in hospital (Hutton *et al* 2019). The authors also examined maternal outcomes and birth interventions among the same two cohorts (Reitsma *et al* 2020). The results indicate that the risk of perinatal or neonatal mortality was not different when birth was intended at home or in hospital (Hutton *et al* 2019). In other words, among low-risk women who intended to give birth at home at the commencement of labour, there was no increase in perinatal and neonatal mortality or morbidity compared with low-risk women who intended to give birth in hospital. This was true regardless of parity. Furthermore, there were no differences between the two cohorts in relation to other neonatal outcomes including admission to a Neonatal Intensive Care Unit (NICU), Apgar scores or the need for resuscitation. Meanwhile, low-risk women intending to give birth at home at the onset of labour experienced fewer obstetric birth interventions and adverse maternal outcomes, compared with low-risk women who intend to give birth in hospital (Reitsma *et al* 2020). Specifically,

women who planned to give birth at home were more than 40% less likely to give birth by caesarean section than those who planned to give birth in hospital, more than 50% less likely to have an instrumental vaginal birth, 70% less likely to use epidural analgesia and 55% less likely to have an episiotomy. Adverse maternal outcomes were also less frequent among women planning to give birth at home, with more than 75% fewer reporting maternal infection and more than 30% fewer reporting postpartum haemorrhage. There were no maternal deaths in either group among the nearly 50,000 women included in the studies that explicitly reported this outcome.

Prior to this research, the UK Birthplace study (Brocklehurst *et al* 2011) was another significant study examining outcomes and place of birth. The Birthplace study compared maternal and perinatal mortality and morbidity amongst low-risk women having planned births at home, in midwifery-led units (standalone and alongside birth centres) and in hospital-based obstetric-led units. It found that overall, there was no significant difference in mortality and morbidity rates between the midwifery-led units and obstetric units. The study indicated that for primigravida women, the risk of infant death was slightly higher at home compared with obstetric units, but this did not hold true when comparing outcomes with midwifery-led units. For multiparous women, the study found there was no greater risk of adverse outcomes for births at home or in midwifery-led units, compared with hospital births (Brocklehurst *et al* 2011).

The Birthplace study also found that the use of medical interventions during labour were significantly lower in homebirths and midwifery-led units, compared with obstetric units. While the study found that 58% of women in obstetric units had a physiological or “normal” birth, this number increased to 88% for planned homebirths. These findings influenced the 2014 NICE guidelines for intrapartum care for healthy women and babies. Although previous NICE guidelines (2007) had indicated that women who birthed in midwifery-led units had a lower risk of interventions, the new guidelines stated that mothers should be informed what they have a higher risk of medical intervention – with no improvement of outcomes – if they give birth in an obstetric-led unit (Brocklehurst *et al* 2011, NICE 2014). Furthermore, the Birthplace study found that women who had planned homebirths or at freestanding midwifery-led units were significantly more likely to breastfeed their babies at least once compared with planned obstetric-led births.

Other international studies also indicate the advantages of utilising alternative birth models such as homebirth and births centres for low-risk women. For example, Janssen *et al* 2002 and Janssen *et al* 2009 also found that planned homebirths attended by a midwife were just as safe, if not safer, in relation to perinatal death, than planned, attended hospitals births. In their comparison of perinatal mortality and morbidity between planned homebirths and planned hospital births among low-risk women in The Netherlands, de Jonge *et al* (2009) found there was no significant difference between home and hospital in terms of intrapartum and neonatal deaths. In other words, having a planned birth at home was just as safe as having a planned birth in hospital, provided, the authors write, that the maternity services facilitate homebirth through the provision of trained midwives and good referral and transportation systems. De Jonge *et al* (2013) found overall adverse outcomes to be less common amongst women with planned homebirths compared with those with planned hospital births. Amongst multiparous women, in particular, the difference was statistically significant, with the overall rate of adverse maternity outcomes at 1.0 per 1,000 births for planned homebirths, in contrast to the rate of 2.3 per 1,000 births for planned hospital births. This included a rate of postpartum haemorrhage of 19.6 for homebirth mothers versus a rate of 37.6 for mothers who gave birth in hospital (de Jonge *et al* 2013).

Other research has investigated the economic benefits in midwifery-led models. For example, a review of planned homebirths in the United States found that homebirth was associated with reduced healthcare costs (Cheyney *et al* 2014). Research by Stine *et al* (2012) and Toohill *et al* (2012) points to the reduced healthcare costs of midwifery-led models. In Ireland, Begley *et al* 2009 found care at the two MLUs in Cavan and Drogheda to cost 10% less than care provided in the corresponding consultant-led units (CLU), with the average cost of a physiological birth at an MLU equalling €574.30, compared with €631.64 in the CLU. Conversely, midwives participating in this study cited lack of resources as a reason for the active management of birth, which they believed did not actually meet the needs of low-risk women.

Although many of these studies have focused on low-risk women, advantages of midwifery models of care – whether at home, birth centres or in hospital – for women in all risk categories have also been found. For example, reviews of the Albany Midwifery Practice in South-East London, which provided midwifery-led

care to socially disadvantaged women from 1997-2009, found that a midwifery model of care can still offer advantages to mothers and babies, whether she gives birth at home or in hospital (Leap et al 2010, Sandall *et al* 2001). A review by Homer et al (2017) showed that mothers working with Albany clinic midwives experienced a higher vaginal birth rate, a lower induction rate and positive experiences of women compared with other group practices in the area, for both mothers who gave birth at home and in hospital. For these women, continuity of care and carer supported positive outcomes, even in a hospital setting.

Thus, studies indicate that planned, attended homebirth is most often just as safe or safer than birth in hospital for women and babies. OOH birth can often have a number of other health and financial benefits, including a decrease in interventions and an increase in physiological birth, as well as a reduction in costs.

However, within the alternative framework of knowledge espoused by women who give birth outside the hospital setting lie other conceptualisations of safety that are in contrast to those situated within obstetrics. For mothers, well-being encompasses a positive labour and birth experience and transition into motherhood (Downe *et al* 2015), alongside physical health indicators discussed in the research cited above.

In particular, women who adhere to alternative knowledge claims situate birth within a larger social and personal context (Andrews 2004a/2004b, Edwards 2005), contesting established obstetric narratives claiming that hospital is a safe birth environment (Cheyney 2008). For these women, the definition of safety encompasses a multiplicity of factors. It not only includes the physical health of mother and baby, but also values the birth experience as an outcome in itself, set within a tapestry of multiple outcomes that required consideration (O'Connor 1998). For example, women interested in alternative models of birth often believe that home is a safer birth setting for both their babies and themselves, not only because research, such as the studies cited above, suggests this to be the case but also because they believe a familiar environment with people they trust fosters autonomy and is conducive to birth without interventions (Edwards 2005, Holten *et al* 2016). For many women, relationships are crucial to a feeling of safety, which in turn supports the release of hormones conducive to physiological labour. For multiparous women, the knowledge that their older children were safe at home with

them also meant the option of home felt safer than hospital (Andrews 2004a, 2004b).

New research and guidelines have begun to reflect women's complex definitions of safety and recognise that health and well-being in birth encompasses other factors outside of mortality. For example, in their international cross-sectional study, Bohren et al (2019) highlight the negative impact that physical and emotional mistreatment during labour have on the safety and well-being of mothers, even when maternal or infant mortality do not occur. They suggest that maternal health indicators should account for women's experiences of care particularly in relation to safety and respect. Based on their systematic review of processes and outcomes that are important to birthing women, Downe et al (2015) recommend that antenatal care should incorporate social, cultural, emotional and psychological – as well as physical – support throughout pregnancy. Meanwhile, the World Health Organisation has updated its international guidelines (WHO 2018a) to include recognition of the importance not only of the physical safety of the mother and baby, but also the emotional and mental well-being of the mother.

Women's concepts of safety encompass complexity and recognise that the possibility of danger and even death is an inherent and, in fact, normal part of life. Murphy-Lawless (1998, p 15) speaks of "the heroism of the woman who on becoming pregnant must engage immediately with the possibility of profound loss, because there can never be guaranteed outcomes". She then asks: "Do women have a different position in relation to death, compared with doctors? I think this is very probable." However, obstetricians struggle to understand women's complex or nuanced value systems around birth and safety, believing that women who decline recommended care are interested in pursuing a particular birth experience "at all costs" (Jenkinson *et al* 2017). Medical dismissal of women's decisions will be discussed in Chapters 6 and 8.

2.5.3 Alternative knowledge in praxis: Birthing outside hospital

For birthing women who place authority in alternative knowledge systems, homebirth forms a praxis that challenges the obstetric hegemony over birth and undermines the unequal power relations between obstetricians and the reproducing woman as patient (Cheyney 2008, p 260). Situated within this alternative system, homebirth mothers share similar interests and priorities. These include the desire to give birth physiologically, without pharmaceutical or

technological interventions, to maintain autonomy, to exercise choice and control and to birth in a calm, familiar environment (Andrews 2004a, 2004b, Coxon *et al* 2014, Edwards 2005, Holten *et al* 2016, Jouhki 2012). They also share a rejection of the medical model of birth in favour of a social model. In her qualitative study of women's experiences of homebirth in Scotland, Edwards (2005) found that mothers wanted safety and protection for themselves and their babies and felt that homebirth offered this, while in another qualitative study of women's experiences of homebirth in England, mothers also reported being influenced by their previous birth experiences and concerns over older children (Andrews 2004b). Borrelli *et al* (2017) also found similar motivations for women giving birth both at home and in a Freestanding Midwifery Unit (FMU). Women believed that their planned place of birth was the safest option for themselves and their babies (Borrelli *et al* 2017, Plested and Kirkham 2016). Intermixed amongst these motivations are the myriad influences at play for all women as they decide upon a place of birth, including but not limited to socio-economic status, access to care and cultural, religious or ethnic backgrounds (Coxon *et al* 2014).

Women who successfully accessed alternative birth models experienced birth as an empowering, fulfilling event, one in which their knowledge and choices were respected (Andrews 2004b, Jouhki 2012). These mothers found that homebirth facilitated feelings of calm and relaxation and the ability to birth naturally (Andrews 2004b). Homebirth mothers also experienced a feeling of control and autonomy. Andrews (2004b, p 553) writes:

A sense of having control of oneself and over the birth was an important feature of the [homebirth] experience. Control had several dimensions involving control of the environment, control of self and involvement in care given. Some women spoke of a change in the balance of control they felt compared to hospital and the confidence this gave them.

Along with this welcome sense of being in control, women who had previously traumatic births in hospital and then birthed at home experienced healing and restored confidence, finding homebirth to be a transformative, "highly positive" and "fulfilling" experience (Dahlen *et al* 2011, pp 150 & 151).

2.6 Conclusion

Hierarchies of knowledge and obstetric authority over birth have shaped the development and provision of healthcare services and particularly reproductive and maternity care in contemporary Ireland. These in turn form the social context in which women's lived experiences of access to alternative birth models have taken place. In this chapter, I first outlined the nature of authoritative knowledge and discussed how obstetric knowledge claims have become authoritative within the context of birth. Obstetric dominance over birth has affected the choices and levels of access that women have to alternative birth models. Furthermore, influence from the Catholic Church and the medical profession has significantly affected the provision of both healthcare in general and reproductive care specifically. Despite barriers, there have been reforms that provide greater access to healthcare and more choices for childbearing women. These reforms themselves have faced challenges in implementation. However, in the midst of restrictions and biomedical hegemony, women continue to value alternative knowledge sources and seek to put their values into practice when giving birth. In the following chapter, I will move on to discuss the theoretical lens through which this research has been conducted.

Chapter 3: Philosophical and theoretical framework

3.1 Introduction

In Chapter 1, I introduced this study and situated access to alternative birth models in contemporary Ireland within a socio-historical context. In Chapter 2, I discussed the creation of authoritative knowledge, the ways in which medico-obstetric authority, as well as religious and political power, have constrained women's access to reproductive care. Furthermore, I also discussed women's counterarguments to obstetric knowledge claims. In this chapter, I will set out the philosophical and theoretical positions that frame this study. I first outline my ontological stance of critical realism and its connection to an epistemology of social constructionism. I then discuss the theoretical framework of feminism that underpins my study. In particular, I focus on feminist efforts to reconstruct knowledge about women's experiences and provide counterarguments to the social structures and conceptualisations that constrain women's lives. These include patriarchal and scientific concepts of the female body, the obstetric process of m/othering that attempts to transform the birthing woman into an alienated subject, and obstetric attempts to dismiss women's decisions when they fall outside acceptable parameters. From there, I discuss concepts surrounding the notion of choice in relation to feminism, as well as women's experiences of choice within reproductive healthcare settings. These ideas underpin my methodology and methods, which will be discussed in Chapters 4 and 5, as well as my findings, which are included in the subsequent chapters.

3.2 Ontological and epistemological foundation

My initial task in developing the philosophical framework for my research was to examine my ontological position. Ontology is the study of the nature of being, while epistemology is the study of the nature of knowledge and its production. One's understanding of the nature of being underpins an understanding of the nature of knowledge, its formation and what constitutes valid or acceptable knowledge (Bryman 2016). Thus, ontological and epistemological issues often both emerge and merge together (Crotty 2015).

The ontological paradigm in which my study is situated is critical realism. Realism asserts that there are realities that exist and operate outside of our minds, independently of our knowledge of it (Crotty 2015). This signifies that there exist

social realities that produce events and facts that shape our experiences. However, critical realists would also assert that reality is multidimensional, with our knowledge of reality socially, historically and culturally situated (Bhaskar 1997). Across and within societies, this knowledge of reality is articulated from different viewpoints, according to various interests and influences and is created by social interactions and human activity. Thus, critical realism as an ontology argues that scientific empiricism or positivism do not wholly explain reality, but neither do pure hermeneutic examinations or interpretivism. Instead, it suggests that drawing on both is crucial in any attempt to understand reality and human knowledge and experiences of that reality.

An ontology of critical realism impacts on my epistemology, that is, my understanding of how knowledge is produced and gathered and which knowledge is considered to be valid. If critical realism takes the view that all knowledge of reality is socially and historically situated, social constructionism as an epistemological framework takes the view that there is no objective truth waiting to be discovered (Crotty 2015). Instead, our knowledge of the world is constructed through our engagement and interactions with it. Knowledge is formed through a dialectic between the individual and phenomena that, while they exist objectively, can only be understood through human experience and our relationship with them. The epistemological paradigm of social constructionism asserts that knowledge of social phenomena is not formed in a vacuum but is negotiated historically and socially (Creswell 2013). Knowledge is constructed by individuals and communities through social interactions with the phenomena in question and also with each other (Andrews 2012). This implies that much knowledge, or what are deemed as “facts”, are socially created constructs, and will be different for different people (Crotty 2015). This does not imply that knowledge is not “real” – instead, it means that multiple knowledges are valid.

3.2.1 Social constructionism

The origins of social constructionism can be traced to the publication of *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* by Berger and Luckmann in 1966. In this, the authors assert that reality is socially constructed, and that individuals cannot be adequately understood outside of the particular social context in which they are shaped (Berger and Luckmann 1991). Our reality, and the everyday knowledge about our reality that we take for granted, is determined by our social context. Humans are thus inextricably linked with society

in a dialectical relationship that creates and shapes reality for the individuals living in that society, and their knowledge of that reality. The choices that individuals make take place within the social context and the prevailing understanding of knowledge and reality in which they live (Hirschmann 2003).

Interested in the production of knowledge, Berger and Luckmann's conceptualisation of social constructionism was grounded in their interest in developing a sociology of knowledge. For them, a sociology of knowledge must contend not only with the variety of knowledges within different human societies but must also understand the processes by which any knowledge comes to be established as reality. In other words, "the sociology of knowledge is concerned with the analysis of the social construction of reality" (Berger and Luckmann 1991, p 15).

While multiple realities exist, there are elements of everyday reality that individuals within a shared socio-historical context take for granted. People understand this shared reality of everyday as an ordered reality that makes sense to them because they live within the specific social context that privileges this reality. While individual perspectives may not overlap entirely, people can still share a common sense about the reality of their shared lives and a shared sense of what is considered the status quo.

This notion of knowledge that is taken for granted and is considered to be normal shares commonalities with Brigitte Jordan's (1993/1997) work on authoritative knowledge (see Chapter 2, Section 2.2). Jordan argues that knowledge that is considered to be authoritative within a given socio-cultural context comes to be considered "common sense". The common-sense knowledge within a specific social context is not considered thus because it makes the most sense for the largest number of people. Instead, it is considered common sense because it is situated within and disseminated by a dominant group, whose knowledge is authoritative. Common sense knowledge is therefore used to sustain hegemonic ideology and interests. Within the context of birth and maternity care, biomedical/obstetric knowledge is considered to be authoritative (Rothman 1989), instead of women's experiential or relational knowledge. Because of this, obstetric approaches to birth, such as the Active Management of Labour, or obstetric solutions to issues, such as a pregnancy that goes beyond 40 weeks or an extended labour, appear to be common sense and are taken for granted.

Vivian Burr expanded on Berger and Luckmann's ideas in her book *Social Constructionism* (1995/2015), and in doing so made a significant contribution to the ongoing development of social constructionism as an epistemology. She proposed four key assumptions of social constructionism. These include, firstly, a critical stance towards taken-for-granted knowledge and secondly, that knowledge is culturally and historically specific. Thirdly, it includes the assumption that knowledge is sustained by social processes and, finally, that knowledge and action are intertwined.

For Burr (2015), a critical stance towards taken-for-granted knowledge is inevitable as social constructionism is based on the idea that there is not one reality "waiting" to be discovered. Instead, there are multiple realities, and knowledge of the world is constructed between individuals and within social structures. Because of this, social constructionism opposes the epistemological claims of positivism or objectivism, instead inviting us to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world. Burr (2015, p. 3) writes: "Social constructionism cautions us to be ever suspicious about how the world appears to be." This can be applied to many taken-for-granted assumptions, Burr notes, including those of gender and sex.

Burr suggests that the ways in which we understand the world, including the concepts and categories we use, are both historically and culturally specific. She writes:

All ways of understanding are historically and culturally relative. Not only are they specific to particular cultures and periods of history, they are products of that culture and history, dependent upon the particular social and economic arrangements prevailing in that culture at that time (Burr 2015, p 3).

This means that any particular forms of knowledge are artefacts of a culture and society, and thus an individual's or one community's way of understanding is not any closer to the truth than another's. Crotty (2015), discussing the epistemological foundations of social research, also writes that the construction of knowledge is culturally and historically specific. He asserts that as soon as individuals begin to make meaning of the world, we do so through the lens bestowed upon us by our culture and society (Crotty 2015). The specific cultural, social and historical milieu into which we are each born determines what we know of the world, and constructs

our thoughts, feelings and the meaning we give to experiences within a social context.

Burr's third assumption of social constructionism includes the notion that knowledge is sustained by social processes. People construct knowledge of the world between themselves, and it is fabricated through the daily interactions that make up our social lives. These different interactions can bring about a variety of possible social constructions of events across cross-cultural and historical eras.

Fourthly, Burr writes that within an epistemological stance of social constructionism, knowledge and action go together – and with this the power relations within a society are revealed and perpetuated. With the potential for myriad constructions comes the possibility of multiple actions that could be taken. However, culturally and historically specific constructions of the world mean that some patterns of social action are sustained, while others are excluded. Burr writes: “Our constructions of the world are also therefore bound up with power relations because they have implications for what is permissible for different people to do, and how they may legitimately treat others” (Burr 2015, p. 5). Crotty (2015) also writes that dominant social constructions emphasise particular sets of meanings that exist to serve hegemonic interests and support particular power structures, while resisting movement towards greater equity. These ideas can be observed within contemporary Irish maternity services. For example, birth was previously constructed as a social event that took place in the home, amongst family and close friends. However, within the current biomedical hegemony, birth is constructed as a medical event that best takes place in hospital. Thus, women who wish to birth outside of this accepted construction are seen to be accessing “alternative” models of care and must often obtain “permission” to do so from an obstetrician, even if their construction of birth differs from the dominant biomedical one.

Thus, grounded in an ontology of critical realism and an epistemology of social constructionism, this study connects women's personal experiences of attempting to access alternative birth options to the wider social context, and the socially constructed norms and realities that have shaped labour and birth, as well as the maternal healthcare system. This ontological and epistemological stance can provide a deeper understanding of the lived experiences of women, as my study's participants interact with social structures, institutions and pre-existing meanings in order to create meaning around their own experiences. Furthermore, social

constructionism offers insight into the power relations that can arise from social constructions, and the ways in which the knowledge and reality for the dominant group can become authoritative. One social construct that is of particular significance to my study of birth practices and maternity care is gender, and thus I have adopted the theoretical perspective of feminism for this study. I will discuss this in the following section.

3.3 Theoretical framework: Feminism

3.3.1 Social constructionism and feminism

Situated within my epistemology of social constructionism, the theoretical perspective I have chosen to adopt for my research is feminism. Like social constructionism, feminist theories embrace the notion that realities are socially constructed, and as such, different people experience different realities (Squire 2009). Since the late 19th Century, feminists have worked to understand the nature of female oppression within a patriarchal society and to highlight women's subjective and collective experiences. Within these discourses, a number of feminist theoretical approaches have been developed to explain gender inequity, which mirror the complexity and diversity of women's lives (Squire 2009). More recent feminist discourses have highlighted the multiplicity of knowledges and experiences that are lived by different women (Hesse-Biber 2014), and the intersection of other identifiers including race, economic class, education, sexual orientation and differing abilities with gender (Crenshaw 2017, Letherby 2015). Mirroring Burr's (2015) argument that social action is embedded within constructionism, feminist theories are also projects of social criticism, part of a feminist effort to provide the theoretical framework in which to identify and rectify injustices (Young 2005).

3.3.2 Feminism and the production of knowledge

The perpetuation of unequal power relations within knowledge production has been of significant interest to feminist researchers, particularly as they relate to what constitutes valid knowledge, who determines which knowledge is valid and who produces knowledge (Burns and Walker 2005, Oleson 2011). Thus, feminist research, grounded in the recognition that different individuals and groups experience different realities, works to counteract the dominant knowledge claims through the production of woman-centred knowledge. Historically, academic

research has been conducted by (white, able-bodied, heterosexual) men and focused on the experiences of (white, able-bodied, heterosexual) men (Letherby 2015). Because of this, produced knowledge has been overwhelmingly androcentric. Additionally, the adoption of a positivistic approach to research, which makes the dual claim that reality is something “out there” to be discovered and observed, and that objectivity on the part of the researcher is both possible and desirable, has been heavily critiqued in recent years (Letherby 2015, Oakley 1981). Thus, a key project for feminist researchers is to understand and highlight women’s experiences in an effort to produce knowledge by and about women. Furthermore, just as feminist knowledge production is grounded in women’s experiences of gendered social relations, it is also closely aligned with judgements about the justice of these relationships and social structures, as well as theories of power (Ramazanoglu and Holland 2002). Feminist researchers involved in knowledge production may not agree on the meaning and implications of women’s varied experiences, or the meaning of justice and power, but we can potentially negotiate common political and ethical positions based on collective knowledge production.

3.3.3 Gender as a defining social construct shaping women’s lives

A central goal of feminism is to reveal the systematic, gendered structures of oppression that affect all women (Fielding 2015). While disparate feminist theories focus on different structures and processes as the primary perpetrator of women’s oppression, they all take women’s experiences and knowledge as the starting point for their analyses (Hines 2015). And while feminist approaches to understanding the nature and origins of female oppression are varied – reflecting the multiplicity of women’s experiences throughout different cultures and societies – it is useful to draw upon a baseline definition of feminism, so that one can understand the starting point or assumptions on which this research is based. Delmar (1986) provides assistance in this matter, writing that fundamental to feminism is the belief that women experience discrimination based on their sex and that they have specific needs which remain unmet due to this discrimination. Furthermore, radical disruptions to current patriarchal social, economic, cultural and political structures are needed in order to redress these inequalities. Adding to this definition, Hesse-Biber (2014) asserts that feminism views gender as a defining factor (though not the only variable) that shapes women’s lives.

Other feminist theorists also suggest that there are commonalities shared by women throughout cross-sections of society that can serve as a basis for shared experience, understanding and theorising about gender-based oppression within a patriarchal society. Iris Marion Young (2005), for example, writes that, despite variations in each person's experiences and opportunities, the situation of individual women within a given sociohistorical circumstance has a unity that can be collectively described and understood. She writes:

Gender [is] a particular form of the social positioning of lived bodies in relation to one another within historically and socially specific institutions and processes ... what it means to say that individual persons are "gendered" is that we all *find ourselves* passively grouped according to these structural relations (Young 2005, p 22, italics original).

Feminists have explored the meaning and implications of gender as a social construct for both women and men (Fielding 2015, Squire 2009), and queer theorists have worked to disrupt the traditional binary of male/female and its inherent heteronormativity (Butler 1990). However, I would suggest that although women have diverse definitions and constructions of gender, those who identify or are perceived as women share common experiences in relation to our role within society. Martin (1989, p 4) writes:

All are defined as "women", one of two usually permanent gender categories to which everyone in our society must be assigned; all (some more than others, some more aware than others) occupy subordinate positions to men, if not in their jobs, then in their families, and if not in their families, then in general cultural imagery and language.

The implications of these gender constructs are felt by women across different sectors of society, and have significant implications for the female body and our lived experiences:

All [women] have female bodies and experience common bodily processes such as menstruation and childbirth... all are affected in one way or another by medical and scientific views of female bodily processes (Martin 1989, p 5).

With contemporary Western healthcare situated within a medico-scientific paradigm, women's experiences are shaped by the patriarchal conceptualisations

of the female body, with gender and social inequalities embedded within maternity services (Bohren *et al* 2019). Gender, then, as a form of social positioning and oppression, remains a social construct that is useful to recognise and analyse when attempting to study lived female experiences, particularly within healthcare and maternity settings.

In summary, both an epistemological stance of social constructionism and a theoretical framework of feminism acknowledges that experience and knowledge are socially constructed within a society. However, it is the experiences and knowledge of the dominant group that becomes authoritative. Within a patriarchal society, men remain the dominant group and sexist social structures and relations work to constrain women's lives. Furthermore, as discussed in Chapter 2, obstetric knowledge is considered authoritative and women's support for a multiplicity of knowledges is dismissed. Thus, in childbirth, women feel the dual effect of gendered oppression and an obstetric dismissal of their knowledge and experiences. The specific gendered and obstetric constructions that childbearing women must contend with, particularly in relation to our bodies and decisions, will be explored further in the following section.

3.4 The privileging of the male body and the mechanisation of the feminine

Throughout pregnancy, labour and birth, two conceptualisations that childbearing women must contend with include the mechanical view of nature and the human (female) body that dominates modern science and medicine, and the patriarchal privileging of the male body over that of the female. These two conceptual frameworks will be explored in the following sections.

3.4.1 The mechanisation of nature and the female body

The medico-obstetric view of the female body is embedded within the modern scientific paradigm. Contemporary Western science has its roots in the Enlightenment and the Scientific Revolution of the 16th and 17th centuries. Fundamental to the development of modern science, as exemplified in the work of Francis Bacon (1561-1626), was the belief that nature – associated since ancient times with the female – could be investigated, controlled and manipulated for the service of society and the good of humankind (Merchant 1989)¹³. Mechanism

¹³ Perhaps a more accurate phrase would be the good of mankind, as Bacon's work was thoroughly situated within the social norms of his day, which viewed women as inferior to men.

became the conceptual framework of science, and proponents used the analogy of the machine in their attempts to understand the natural world (Downe and McCourt 2019). By using this metaphor of mechanisation, those developing the scientific paradigm believed that complex phenomena could be best understood and explained by reducing them to basic parts. Isaac Newton, for example, hoped to develop a unifying explanation of a clockwork universe that was divisible into parts that could each be understood in turn. Meanwhile, René Descartes theorised a separation of the body and mind, viewing the body as a mechanical structure with discrete, divisible parts (Newnham *et al* 2018)¹⁴. Interwoven with this developing mechanistic worldview were new constructions of time based on chronology and predictability (Mccourt and Dykes 2010). Time could now be conceptualised linearly and measured through the use of the pendulum clock, which was developed in 1658. This stood in contrast to previous concepts of time based within the cyclical patterns of seasons and agriculture. The fact that this linear conceptualisation of time – and the commodification of time that came with industrialisation – was presented as part of modern scientific progress legitimised it and gave it authority, even though it was a concept that arose out of a socially and culturally specific historical period (Mccourt and Dykes 2010).

The mechanical method of scientific inquiry that evolved during the 17th and 18th centuries thus operated along linear lines of inquiry, breaking down a problem into its component parts, isolating it from its environment and solving each section separately (Merchant 1989, p 182). Key features of this experimental method included the constraint of nature in the laboratory, dissection of nature by the scientist's hand and mind and the penetration of nature's hidden secrets. Scientists believed that nature could best be investigated through the use of machines and mechanical devices¹⁵. Thus, by interrogating and subjugating nature through the use of mechanical devices, scientists could control it.

Modern medical ideology, situated within science, espouses this mechanical worldview (Rothman 1989), as does obstetrics as a branch within medicine. In the 17th century, the developing field of obstetrics began to position childbearing

Thus, his vision included the hope that male scientists could manipulate nature in order to improve life for the male, privileged, educated classes (Merchant 1989).

¹⁴ For a further discussion of the Scientific Revolution and the role it played in the production of knowledge about women and the female body, see Newnham *et al* 2018.

¹⁵ Merchant (1989) presents an interesting discussion on the ways in which Bacon and his concepts regarding the subjugation of nature/women were influenced by the witch trials that were contemporary in his day.

women, and uteruses in particular, as birthing “machines” (Murphy-Lawless 1998). As these ideas were fostered within teaching hospitals across Europe (Murphy-Lawless 1998), male surgeons in England were attempting to oust midwives as the primary birth attendants and exert control over the natural (feminine) birthing process through the use of a new mechanical technology, namely, the forceps (Merchant 1989)¹⁶. By the end of the 17th century, women’s remit over birth was irreparably impacted, as doctors replaced midwives as the primary birth attendants and female midwives’ hands were replaced by “male hands using tools” (Martin 1989, p 54). In contemporary maternity care, mechanistic conceptualisations still influence maternity care, where its embedded notions of technological certainty and linearity lead to the assumption that pregnancy and birth must progress within this framework (Downe and Dykes 2010). These notions lead to the expectation that pregnancy and labour will fall within narrow time bands, and demarcate those that fall outside this framework as abnormal or pathological. These concepts are also seen in obstetrics, with the profession continuing to fragment the female body into different parts and the widespread use of birth technology (van der Waal *et al* 2021). While birth technology was discussed in Chapter 2 (Section 2.2.4) within the context of authoritative knowledge, further implications of these concepts for the labouring woman will be discussed below.

3.4.2 The dismissal of the female body as a faulty machine

If the world and everything in it is viewed as a piece of machinery, then everything is conceptualised in terms of what it can make (Rothman 1989). This includes bodies, which are viewed as potential resources capable of producing something. As a result, the efficient use of resources becomes an overarching goal, and individuals are expected to be well-oiled machines, and their bodies to be productive, rational and controlled (Rothman 1989, p 53).

Within this mechanical paradigm, scientific accounts of reproductive biology construct the male body as an efficient machine (Martin 1989), thus supporting culturally constructed gendered stereotypes (Martin 1991). This male efficiently, science alleges, is exemplified in the pro-active, prolific production of sperm, as

¹⁶ Only licensed physicians were allowed to use forceps during a birth (Merchant 1989). The increased use of this technology meant that women were increasingly pushed out of the birthing sphere. It is interesting to note that such licensing requirements continue to affect hospital birth practices, while professional indemnity has played a significant role in the ability of community midwives to attend homebirths (OBoyle 2009).

well as the strong and efficiently powered sperm themselves (Martin 1991). Scientific language also applies mechanical metaphors to the female body but, in contrast to the male body, the female one is thought to be inefficient, faulty and unproductive (Downe and McCourt 2019). This inefficiency, science suggests, is exemplified in the physical processes that are unique to women, such as menstruation. The flow of menstrual blood indicates a breakdown of the female “machine” which, in “wasting” an egg, has failed to efficiently perform its reproductive function (Martin 1991), while the menopause indicates the permanent failure to fulfil this role (Martin 1989).

However, even when a woman has become pregnant, childbirth is also constructed as an inefficient process, and this view of female physicality can be seen in the metrics used to evaluate childbirth. Because the female body is seen as flawed, the birthing woman and her uterus are in need of technology that will subdue the natural process into order. Uterine contractions are labelled as “efficient” or “inefficient”, and “progress” is assumed to be made at a specified, uniform pace, with each woman’s labour subdivided into many stages (Martin 1989, p 59). If all labours are thought to be potentially inefficient, then these faults can best be contained by setting strict “quality control” rules within which the machine is thought to function optimally (Downe and McCourt 2019, p 72). The ubiquity of such procedures reflects a biomedical ideology that connotes certainty, rationality, linearity and control, and treats women’s bodies as the malfunctioning machine that must be orientated towards these goals (Beckett 2005, Rothman 1989). This approach to the labouring woman’s body is clearly evident in the Active Management of Labour: “It is the need to ensure that the uterus, represented as a machine and prone to failure, has enough power to drive the somewhat reluctant foetus through the often unaccommodating reproductive tract that seems to form the basis for the Active Management of Labour” (Downe and Dykes 2010, p 90). This inappropriately linear, temporally constrained and mechanical approach to labour (and pregnancy) will be shown in Chapters 6 and 7 to be a significant barrier for women attempting to access alternative birth models.

A mechanical view of the labouring female body also has implications for the status of both the mother and the foetus, and their relationship with each other. Within a medical framework, the uterus-machine becomes something that produces a baby (Martin 1989), rendering the woman a mere vessel for the foetus until such a time

that she (efficiently) produces the baby. Women can be dismissed, as care becomes “all about the baby” (Daly *et al* 2021, p 4), leading to a situation in which “a woman can feel that she is merely a container for a foetus ... [and] that if she were not around the pregnancy could progress with more efficiency” (Kitzinger 1978, p 74). This focus on performing an efficient labour in order to produce the baby-product (Martin 1989) can again be seen in the Active Management of Labour, and in the assertion that women should be grateful if they give birth to a healthy baby, even if they themselves have had a traumatic experience (Kennedy 1998). When a person is treated as a machine that can be fixed by mechanical manipulations, it ignores other aspects of the self, such as emotions and relationships with other human beings (Martin 1989).

While a medical worldview conceptualises the body in mechanical terms and obstetrics views the female body as a potentially faulty machine, women’s experiences of maternity care – including attempts to access alternative birth models – are influenced by the patriarchal privileging of the male over the female body. This will be explored below.

3.4.3 The privileging of the male over the female

Patriarchy privileges the male over the female, with the consequence that while women make up over half the world’s population, women’s realities and worldviews are dismissed (Rothman 1989). The male body is epistemologically and socially privileged over the female (Annandale and Clark 1996, Rothman 1989), and valued over that of the female (Woodward 2015). The male body is viewed as the standard while the female body is seen as substandard or a deviation (Martin 1989).

McGregor (2020) and Jackson (2021) also suggest that medicine privileges the (white) male as normative, diagnosing and treating women as though we are simply men who lack male reproductive organs. Illustrating this point, Jackson (2021, p 12) writes: “In medicine, man is the default human being. Any deviation is atypical, abnormal, deficient”. Within this context, medical students are trained to look for male patterns of disease, trauma and pain, with women’s symptoms often described as “atypical” or “unusual” (McGregor 2020). Modern medical systems thus largely ignore, marginalise and minimise women, with the consequence that many women remain under- or undiagnosed and uncared for (Jackson 2021).

The ways in which the male body is used as a barometer against which to measure normality can be also seen in other aspects of contemporary health models. The dominant medical model assumes that the normal, healthy body is unchanging (Young 2005). However, it is only in adult males, prior to old age, that this can be the case and even then, the human mammal experiences regular changes related to daily circadian rhythms. Periodic body changes, including menstruation, pregnancy and menopause, are part of the normal embodied processes that healthy adult women experience. However, situated within a patriarchal worldview, medicine encourages women (and others) to think of pregnancy as a deviation from normal health. This is exemplified in the obstetric belief that birth is pathological and only normal – or “healthy” – in retrospect. Thus, pregnancy is in itself considered a deviant condition (Young 2005) – but tolerated because it produces the socially valued baby-product. The notion of the female body as an abnormal deviation from male bodies has meant that along with pregnancy, many uniquely female body processes, and thus female bodies in general, have come to be defined as pathological (Martin 1989, Young 2005). Further constructions of the female body, which inform women’s experiences of maternity care, will be discussed below.

3.4.4 The female body: a passive, alienated subject

Patriarchal and medico-obstetric conceptualisations have further implications for women beyond the mechanisation and subordination of female bodies. Both construct the (white, European) male as a dominant, active subject (Irigaray 1993) and the female as a passive object of lower status (van der Waal *et al* 2021). Young (2005, p 44) suggests that this is because patriarchal society defines and regards women as objects, as mere bodies, and not active, whole beings. Like the mechanical worldview, patriarchy partitions women into disparate parts, separating women’s selves from our bodies and enabling female processes such as menstruation or giving birth to be viewed as something that happens to us (Martin 1989). Meanwhile, modern obstetric-scientific discourses have also given rise to the onto-epistemological configuration of the active subject and the subaltern object (van der Waal *et al* 2021). Within this configuration, women are conceived as the object, rather than an autonomous subject, and so autonomy and subjectivity became mutually exclusive with having a uterus (Villamea 2020, Owens 2018). However, the position of the subject is dependent on the object, on the process of othering the object. Thus, the male, scientific subject must

appropriate everything else (including women) in order to define itself (Silva 2007, van der Waal *et al* 2021). Within birthing practices, the relationship between the obstetric subject and the birthing object remains defined by this appropriation. The existence of the obstetric subject is dependent on othering the labouring woman, and thus “the obstetric subject still constitutes itself through the violent engulfment of the maternal body, as the autonomous, self-determining agent of birth that delivers the ... (m)other of her child” (van der Waal *et al* 2021, p 41).

Patriarchal and scientific configurations of the female as an object have practical implications for women’s embodied experiences and the ways in which female bodies are treated. Women live with “the ever-present possibility that one will be gazed upon as a mere body, as shape and flesh that presents itself as the potential object of another subject’s intentions and manipulations, rather than as a living manifestation of action and intention” (Young 2005, p 44). Within the context of pregnancy and childbirth, women experience these “intentions and manipulations” in the form of medico-technological interventions, which provide a mechanism through which the birthing woman/object, or m(other), can be objectified (Young 2005, van der Waal *et al* 2021) and birth becomes something that is done to us (Martin 1989). These interventions can be violent, and unwanted on the part of the labouring woman (Bohren *et al* 2019). Women who experience obstetric violence during birth can feel alienated from their bodies, internalising objectification within the trauma process and referring to their bodies as a “lump of meat” or a “slab on a table” (Thomson and Downe 2008, p 271).

Being constructed as the other, however, does not merely have implications for the subjugation of women’s embodied or physical experiences. Modern scientific and obstetric discourses have also dismissed women’s ability to make decisions and, in particular, dismissed our choices in relation to birth and the unborn child. These issues will be discussed in the section below.

3.4.5 Dismissal of women’s choices: Unable to make “good” decisions

Just as post-Enlightenment scientific discourses have constructed the male body as normative, so too have they constructed the (white, European) male subject as the one endowed with universal reason (Silva 2007). In contrast, women have been constructed as inherently irrational, subject to uncontrollable emotions (Jackson 2021). As Newnham *et al* (2018, p 35) explain: “What science ‘discovered’ ... was that women were weaker and less intelligent than men”. Thus,

within Western societies, medicine from the 19th century onward viewed women as weak and psychologically unstable, with the womb considered to be the cause of a number of diseases and disorders (Young 2005), while today female hormones are blamed as the culprit of hysterical outpourings (Jackson 2021). Men have come to be viewed as active and intelligent, while women are conceived as having weaker minds and bodies. One 19th century biologist, Patrick Geddes, describes the alleged differences between men and women: “The more active males, with a consequently wider range of experiences, may have bigger brains and more intelligence; but the females, especially as mothers, have indubitably a larger and more habitual share of the altruistic emotions” (Geddes 1890, p 271, quoted in Martin 1989). These alleged physical weaknesses solidified the dominant idea that women were also poor decision makers, lacking control and reason.

Within obstetrics, which aligned itself with science, the (male) obstetrician was seen as the one endowed with universal reason, while having a uterus indicated a casual exclusion from reason (Villamea 2020). In particular, women have been especially considered to be poor decision makers in relation to the fetuses growing inside us. Since the late 19th century, medicine has recognised the importance of the physical (bodily) environment to the growing foetus and provided antenatal care in some form (Rothman 1989). However, the medical profession stopped short of viewing the pregnant woman and her foetus as one symbiotic whole, or the foetus as essentially part of its mother’s body. Instead, doctors maintained “the essentially patriarchal view that fetuses are seeds growing up, entirely separate beings ‘planted’ in the mother” (Rothman 1989, p 92).

Through the separation of the mother-baby dyad, as well as the use of medical technology such as the ultrasound, through which the foetus could be seen, the unborn child was constructed as a patient in its own right, with its own care needs separate from the mother (Duden 1993). This classification of fetuses as neonatal patients has meant that mothers are viewed solely as caretakers of the unborn. Pregnancy is therefore a process to be managed as the expected child is constructed into a “life”, something for which everyone is asked to take public responsibility as life (for the foetus) is transformed into a supreme value (Duden 1993, pp 2 and 4).

The separation of mother and child and the construction of the foetus as a patient, coupled with the dismissal of women as decision makers, has meant that women

could not be trusted to protect the babies growing inside us, and that, in fact, the greatest threat to foetal health comes from the maternal environment (Rothman 1989). Because women are often not trusted to be good caretakers or ecosystems for the neonatal patients growing inside us, doctors can effectively disregard the wishes of the mother, under the guise of working in the (foetal) patient's interest (Arney 1982, O'Connor 1998). Within medical birth settings, healthcare professionals have justified using physical and verbal abuse against women in order to ensure good outcomes for the baby (Balde *et al* 2017, Bohren *et al* 2016). The decisions of women who choose to give birth outside of biomedical parameters, and their ability to rationally weigh up risks and benefits in order to make "good" decisions, are viewed with particular suspicion (Craven 2005).

3.4.6 Race and poverty as social constraints

Although my study focuses on gender as it constructs women's experiences of access to healthcare, it is essential to note that race, socio-economic status and other signifiers constrain the experiences of women of colour, those living in poverty and those from other disadvantaged demographics. This can be seen in the higher mortality rates for non-White and economically disadvantaged mothers. In the UK, for example, Black women are four times more likely than White women to die in pregnancy or childbirth (Knight *et al* 2020, Limb 2021). Women from Asian ethnic backgrounds face a twofold risk, while women living in economically deprived areas are almost three times more likely to die than those from the most affluent areas. The impact of racism and classism can also be seen in the racialised dismissal experienced by women of colour in relation to decision-making. Rickie Solinger (2005), in her history of reproductive politics in America, writes that White women in America are not trusted to make "good" decisions in relation to their bodies and their babies – but women of colour face even further distrust and suspicion from the medical establishment and healthcare services. Bohren *et al* (2019), too, writes about the experiences of women of colour in their cross-sectional study of obstetric violence, in which women of colour experienced racial and ethnic discrimination during labour, with younger women of colour most often experiencing this form of abuse. Furthermore, McCabe (2016) suggests that neoliberal discourses on choice and empowerment are classed and racialised, and attempts to responsabilise individuals for their health ignore the barriers to information, care and resources faced by women of colour and/or those living in poverty. Meanwhile, van der Waal *et al* (2021), in their study of obstetric violence

and student rites of passage, suggest that obstetric training can be understood as an initiation into a misogynistic and racialised institution that engulfs the mother of colour through a negation, instead of an affirmation, of life (van der Waal *et al* 2021, p 38). Their research participants reported that colluding with institutional racism and racialising mothers appeared to be an entry requirement into the obstetric profession. Writing within an Irish context, Ronit Lentin (2015), following the death of Savita Halappanavar in 2012, writes about the intersection of racism and sexism that women of colour, particularly migrant women of colour, have experienced within the Irish maternity services. Pregnant and birthing women of colour are confronted with both an inadequate maternity service that has policed, controlled and abused mothers, as well as a racialised political narrative that engulfs pregnant migrant mothers in a process of othering and casts their birthing practices as a threat to the integrity of Irish identity (Lentin 2015, p 180).

In summary, medico-obstetric conceptualisations of women and the female body and mind are embedded within patriarchal and scientific paradigms. These dominant ideologies privilege the male body and construct the female body as a faulty machine and passive object, while women's knowledge and decisions are suppressed and dismissed. This misogyny is compounded for women of colour, combined as it is with racism, as well as other intersectionalities, including class or sexuality. The ways in which these concepts affect the choices that childbearing women have available to them will be discussed in the following sections.

3.5 Choice and Information

Contemporary society, and the maternity services situated within this social milieu, are organised around the concept of choice, and women are routinely confronted with the belief that we can and should be making choices as consumers. However, gendered and medical constructs also position women as poor decision-makers. Thus, women's position in relation to choice, particularly in the context of healthcare, remains problematic. The ways in which contemporary notions of choice are constructed by society in general, healthcare services and feminists – and the implications for women seeking access to alternative birth models – are discussed below.

3.5.1 Constructing notions of choice for women

Choice is a central concept of advanced capitalist societies, such as those in Western Europe, which view economic growth as both desirable and necessary (Symon 2006). Married with the idea that the individual is paramount, contemporary Western society upholds the notion that individuals should be able to choose products and services that best suit their needs. Within this, the concept of choice implies having a level of information and understanding, and the assumption that individuals have access to the information needed to make sound decisions (Symon 2006). Once an individual has all the relevant information, she can weigh up all the available choices using a rational process (Bekker *et al* 1999) and choose the optimal option (Beach and Lipshitz 2015).

Choice has also become an increasingly fundamental aspect of public health policy and practice in Western countries since the late 20th century, with informed choice considered one of the fundamental ethical principles guiding patient-centred care (Symon 2006, Yuill *et al* 2020). Reflecting general conceptualisations of choice, informed choice within the context of healthcare is seen as one that an individual makes about their care based on access to relevant and balanced information (Yuill *et al* 2020). Within maternity care, informed choice is the hallmark clinical principle of contemporary midwifery (MacDonald 2018) and forms a pillar of respectful maternity care under WHO intrapartum care guidelines (WHO 2018a).

Feminists have been able to use contemporary conceptualisations of choice and develop them in order to advocate for improvements for women in relation to healthcare and reproduction. For example, Second Wave feminism, which emerged in the 1960s and 1970s alongside other civil rights movements, articulated theories on autonomy and choice, as many feminists and other groups advocating for social change defined choice within a rights-based framework (Solinger 2005). The women's health movement in North America specifically developed and used feminist conceptualisations of choice in order to advocate for greater access and autonomy in reproductive and sexual healthcare (MacDonald 2018). Thus, feminists were able to use this rights-based concept of choice in relation to reproductive healthcare and argue in favour of a woman's "right to choose" in relation to such reproductive issues as birth control and abortion (Solinger 2005). By situating women's reproductive choices within a rights-based

framework, feminists were able to align themselves with the larger Civil Rights movement that was working to improve the lives of marginalised sectors of society.

Situating choice within a rights-based framework also meant that a woman's "right to choose" was not aligned simply to satisfaction as a consumer – it was linked to personal autonomy, and a recognition that women are the experts in relation to knowledge of our bodies. Acknowledging and validating our embodied experiences as an important source of knowledge and information can provide the possibility of control over our own bodies and selves within political and social contexts (Woodward 2015). *Our Bodies, Ourselves* (1973), the iconic publication of the women's health movement in North America, from the Boston Women's Health Book Collective, introduced the idea that with access to information and a sense of responsibility about one's own wellbeing comes personal autonomy and strength (MacDonald 2018, p 280). Tracy and Page (2019, p 140) build on this, writing: "Choice points to the personal autonomy that is fundamental to the rights and wellbeing of women. This right to choose is linked closely to being in control of your own body." Drawing inspiration from the women's health and civil rights movements, as well as the natural birth movement, Second Wave feminists advocated for midwifery-led, alternative birth models, in order to regain autonomy and choice for birthing women (Beckett 2005). For these birth activists, a woman's right to choose where and with whom she gave birth was an important dimension of reproductive autonomy (Beckett 2005). Thus, for many women, choice and one's ability to access reproductive care options was inextricable from personal autonomy and physical self-determination. However, as the women's health movement articulated, one cannot choose or access an option without knowing about it. Thus, information is a crucial element in a woman's negotiations of choices in maternity care.

3.5.2 Informed choice and consent in health and maternity care

Within the context of healthcare, the pathways for acquiring information are complex and myriad (Symon 2006). However, while many service users conduct independent information gathering, much of the information and knowledge regarding services, procedures and products is still held and disseminated by healthcare professionals. Within the context of maternity care, informed choice denotes a woman's ability to make decisions and access care that is aligned with her birth philosophy, the aspects of which have been balanced against those of other options (Yuill *et al* 2020). Furthermore, within midwifery care, informed

choice encompasses a decision-making process that relies on a full exchange of information in a cooperative, non-authoritarian and non-urgent setting (MacDonald 2018).

Informed consent is a concept and practice that shares common ground with informed choice, in that both concern the ethical duty of healthcare providers to disclose information in a way that is understandable to patients and which protects patient autonomy (Beauchamp 2011). Definitions of what constitutes informed consent, including what information is provided and how it is presented to women, are actively debated within healthcare and the legal profession. However, there is some agreement regarding definitions, particularly in medical circles. Providing and obtaining informed consent is not a once-off step, but a process of ongoing communication (DoH 2016), particularly within an ever-changing, varied event such as birth (Hewson 2004). Informed consent is underpinned by the notion of autonomy, that is, the right of the individual to decide upon the integrity of their own body or the right to self-determination (D O'Boyle 2006). Requiring informed consent within the context of care is an expression of respect for a person's autonomy and right to bodily integrity (DoH 2016). This right is a fundamental medical ethics principle. Also enshrined in law in European countries, the right to autonomy means that in order to give consent, an individual must have sufficient information and understanding of the procedure or treatment and must be able to make their decision free from external pressure (D O'Boyle 2006). Furthermore, the doctrine of informed consent recognises the right of individuals to weigh up risks and benefits for themselves (DoH 2016).

In her discussion of informed choice and informed consent within maternity care, MacDonald (2018, p 287-288) illuminates important traits that are useful in developing an understanding of both concepts, which are related but distinct. She writes that informed consent, as the authors above suggest, is an ethical-legal principle that is situated within clinical medicine and biomedical research. On the other hand, informed choice initially developed within midwifery as a fundamentally new way of approaching care, outside medical circles, although it has been since been adopted by mainstream policy and practice (or co-opted by them (McCabe 2016), an issue that will be discussed in Section 3.5.3). Within midwifery care, informed choice draws upon a multiplicity of knowledges and positions the birthing woman as an expert on her body and not just a health consumer (MacDonald 2018).

However, despite the fact that informed decision-making and consent are fundamental to contemporary healthcare in general and midwifery care in particular, the notion of choice within health and maternity care remains problematic for women, as many remain unable to actualise or exercise their decisions. These constraints and limitations will be discussed below.

3.5.3 Informed choice and consent as problematic

Choice is a socially constructed phenomenon, with gender, race and class all acting as constraints on women's abilities to choose and access healthcare options (Edwards 2005). In Chapter 2, I discussed the political and historical factors that shaped the social context in which women's reproductive choices in contemporary Ireland are situated. This context has in turn formed a maternity service that privileges obstetric-led, hospital-based birth practices, with the result that women's options for midwifery-led, out-of-hospital births have been constrained. Below, I will discuss the ways in which informed choice, as well as consent, have been further constrained by biomedical authority over birth, and compromised by the presence of the Eighth Amendment, thus disrupting or problematising conceptualisations of choice for women attempting to access alternative birth models.

3.5.3.1 When information is biased

During the antenatal period, a woman requires information regarding pregnancy, care and her various birthing options. However, despite the extensive information gathering process that pregnant women engage in, accessing unbiased information can remain challenging (Beckett 2005). This can be particularly true for the many women who rely on their GP/obstetrician for information regarding birth practices, as doctors and hospitals have their own set of interests – including resource management, liability reduction and staffing issues – that shape the way this information is presented to women (Armstrong 2000). When information regarding birth choices is controlled and restricted by the health service or a medical professional, women cannot exercise informed choice (Henley-Einion 2009).

The biomedical authority over birth information means that choice remains constrained for childbearing women hoping to access alternative birth models (Beckett 2005). For example, when information is presented from a biomedical

perspective, alternative, midwifery-led options are not explained as fully as medical options (Edwards 2005). This means that women are not necessarily presented with all the information regarding their birth options. For example, Edwards (2000, 2005) found that information regarding homebirth was not forthcoming, with participants finding it difficult to obtain information that might support their own needs and beliefs but might also lead to them challenging hegemonic policy and practice. Medical authority over birth also means that information regarding the risks of medical technology and pharmaceutical pain relief is biased, with doctors shaping and withholding relevant medical information when communicating with service users (Beckett 2005, Wagner 2000). For example, Newnham *et al* (2015/2017/2018) found that the way in which information was presented to women influenced their decisions. Specifically, Newnham found that using water for pain relief, which lies outside obstetric practice, was presented by the maternity services as “risky”. At the same time, information regarding the risks associated with epidurals were acknowledged but downplayed in patient handouts, while potentially negative effects on the infant were ignored (Newnham *et al* 2015). This meant that while labouring women, in theory, had the choice of using water for pain relief, their access was influenced by the biased presentation of the information provided to them.

3.5.3.2 When information is coercive

Choice and informed consent are not only problematic, however, when information regarding care pathways and options is presented from within a hegemonic framework. They also become problematic when the information that is presented is used in a coercive manner or when pregnant women face pressure from healthcare professionals to choose an obstetric solution to an issue. From a legal standpoint, consent can be rendered invalid if given under duress or undue pressure is placed upon the service user (Hewson 2004). However, women experience pressure when our ability to make “good” choices or act as “responsible mothers” is called into question if we step outside the obstetric model and seek alternative information (Jordan 1997, Yuill *et al* 2020).

One specific form of obstetric discourse that can be used coercively to obtain consent is the “dead baby threat”. This specific tactic, also referred to as “shroud waving”, is discussed by Reed *et al* (2017) in their international mixed methods study of childbirth trauma. Researchers found that women were coerced into agreeing to unnecessary interventions through the employment by hospital staff of

the “dead baby threat”. Participants felt the claimed risk to their baby was vague or exaggerated in order to pressure them into compliance. Bohren *et al* in their cross-sectional qualitative (2016) and mixed-method (2019) studies of the treatment of women during childbirth also found that care providers threatened women regarding the safety of their baby in order to ensure they complied during labour, as did Balde *et al* (2017) in their qualitative study of attitudes towards mistreatment during birth. In their phenomenological study of women’s lived experiences of birthing without a midwife, Plested and Kirkham (2016, p 30), also found their participants experienced the “dead baby threat”, writing:

A specific style of risk discourse took the form of “shroud waving” where the professional articulated that the baby or the mother might die if the woman did not follow advice or a particular course of action.

Thus, gaining access to unbiased information regarding choices that lie outside what is acceptable within the biomedical model of birth, and the manner in which information is presented to women, can mean that the information/choice equation remains problematic for childbearing women, and this imbalance has far-reaching consequences for them and their babies.

3.5.3.3 When consent is compromised

Consent, and thus choice and access to care, has been a particularly complex issue for childbearing women in Ireland as a result of the Eighth Amendment which, from 1983 to 2018, equated the right to life of the foetus to that of the mother. The presence of the amendment in the Constitution meant that if a pregnant woman wished to refuse treatment recommended by her healthcare provider, she might not always be supported to do so. For example, the National Maternity Strategy (DoH 2016) states that in situations where an informed refusal of treatment would not threaten the life of the baby, the woman’s choice of informed refusal should be facilitated. However, where a woman’s informed refusal was deemed by healthcare professionals to have negative implications for the foetus, the Strategy advised that providers seek legal advice (DoH 2016, p 78).

However, despite biomedical and legal restrictions on choice and consent, childbearing women have continued to gather alternative information and redefine the concepts of choice and consent in ways that are aligned with their birth philosophies and practices.

3.5.4 Childbearing women's definitions of choice and information gathering

Feminists, as outlined in Section 3.5.1, have redefined consumer-based definitions of choice. Likewise, childbearing women also redefined choice in relation to birth to form a concept that is rooted within a social, holistic, relational model (Davis-Floyd 1992, Edwards 2004, Murphy-Lawless 1998). Kennedy writes: "Choice involves freedom, opportunity to participate, to decide to disclaim, repudiate, accept, all options often denied women in labour" (Kennedy 2002, p 27). This notion of choice goes far beyond the predetermined shopping list of options touted by capitalistic, consumer societies and aligns it instead with autonomy and relationships based on equality and respect (Edwards 2004). It also signifies that the decision-making process around choices and access is complex and far from straightforward.

Childbearing women consider sources of information and knowledge that are outside of the obstetric paradigm to be authoritative because this knowledge is mirrored in their experiences or is aligned with their own birth philosophies and general worldview. As discussed in Section 3.3, this valuation of non-dominant knowledges is often aligned with feminism, which has a long tradition of emphasising multiple sources of knowledge systems as legitimate (Squire 2009), including women's experiences as a valid (and essential) source of knowledge (Edwards 2005, Stanley and Wise 1993). As the homebirth movement in Ireland (and abroad) is grounded in feminism, many homebirth mothers place importance on multiple sources of knowledge and consider multiple sources of knowledge to be authoritative (Chadwick and Foster 2014, Davis-Floyd and Davis 2018, Davis-Floyd and Sargent 1997).

Childbearing women counteract obstetric dominance over birthing information by seeking out information from sources outside their GP or hospital-based healthcare providers. Cheyney (2008) speaks about the process of gathering information from alternative sources, such as friends, midwives and studies on homebirth, as well as online sources, as a mechanism of resistance to the dominant medical paradigm. Women turn to these alternative sources particularly when they are looking for more detailed information or information that is aligned with their birth philosophy (Yuill *et al* 2020). Mothers seek new information and narratives about birth as part of a process of "unlearning and relearning" old and new information and knowledge (Cheyney 2008, p 258). Thus, choices regarding

the negotiation of pregnancy and birth are made within this tapestry of information and knowledge sources.

3.6 Conclusion

In this chapter I have presented the philosophical and theoretical underpinnings that form the framework for my study. My ontological stance of critical realism underpins my epistemology of social constructionism. This epistemology allows me to connect women's personal experiences of attempted access to alternative birth options to the wider social context, and the socially constructed norms and realities that have shaped labour and birth, as well as maternity service provision. Social constructionism also serves to provide a deeper understanding of the lived experiences my study's participants as they interact with social structures, institutions and pre-existing meanings in order to create meaning around their own experiences. Furthermore, social constructionism as an epistemology offers insight into the power relations that can arise from social constructions, and aligns well with my theoretical perspective of feminism, which also examines the social structures surrounding gender and female experiences, and ways in which women can experience these as oppressive. Patriarchal and scientific notions of women conceptualise the female body as mechanical, inefficient and potentially pathological, and women's choices as suspicious when they fall outside accepted parameters of good woman/motherhood. I also examined feminist definitions of choice as well as the concepts of informed choice and consent in modern healthcare. Furthermore, I outlined the ways in which the biomedical hegemony in contemporary Ireland and obstetric discourses on risk have constrained information and women's choices in relation to birth. In the following chapter I will discuss how these philosophical and theoretical underpinnings have influenced the methodology I employed in this study.

Chapter 4: Methodology

4.1 Introduction

Within the context of social constructionism and feminist theory, a hermeneutic phenomenological approach was adopted for this research, as this methodology emphasises the human experiences of understanding and interpretation (Thomson and Downe 2010), as they happen within a social context. The phenomenological element enabled women's lived experiences to be explored, while the hermeneutic element enabled the meaning they assigned to their experiences to be included and recognised as an integral part of their experiences (van Manen 2016). Both the experiences and interpretations of the participants, as well as the experiences and interpretations that I bring to this project, were situated within the social and historical context of contemporary Irish society and modern maternity care provision.

Within this chapter, I first outline feminist methodological discourses regarding the lived experiences of women and then discuss overlaps between feminism and phenomenology. I explore definitions of phenomenology and then outline the main tenets of phenomenological thought, which are associated within Edmund Husserl (1970), Martin Heidegger (1962) and Hans-Georg Gadamer (1975). Following this, I outline the tenets of what is considered "new" phenomenology and the ways in which contemporary researchers, particularly those in nursing and midwifery, utilise phenomenology as a methodological approach. I also summarise and address critiques of these contemporary approaches. Finally, I discuss the work of Max van Manen, which has most significantly informed my research methodology and methods, and the ways in which his work brings together phenomenological theory and practice. The methods I employed for this inquiry, which are based on van Manen's six steps for conducting hermeneutic phenomenological research, are detailed in Chapter 5.

4.2 In search of a feminist methodology

Feminist scholarship is rooted in women's experiences, emphasising unrecognised, suppressed or distorted aspects of women's work and lives (DeVault 1999). Feminist researchers, therefore, attempt to highlight the experiences of women in an effort to "correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position" (Lather

1991, p 71). However, while many feminist researchers choose a qualitative approach to their studies, there is no one methodology that is considered “feminist” (Reinharz 1992). It is, instead, the theoretical underpinnings and vantage point that places any study within the larger feminist project. Thus, a quantitative study structured around participant surveys can highlight the breadth of an issue a cohort of women are experiencing, just as a qualitative study based on interviews can highlight the depth of a phenomenon, and its impact on women. The particular challenge for the feminist scholar, then, is to find a methodology that not only highlights women’s experiences but also best fits with her research question. Marjorie DeVault (1999) suggests there is a wealth of meaning to be “excavated” from “woman-talk” and, indeed, feminist researchers should place emphasis on the talk and experiences of women as key sources of meaning and information. She writes that the dismissal of women’s talk as gossip or hearsay – perhaps one could say as “old (mid)wives’ tales” – is a tool used by the pervading patriarchal social structure to trivialise women’s experiences, thoughts and opinions. I therefore chose a qualitative approach that involved interviewing women in order to “excavate” the meaning of their lived experiences of accessing alternative birth models.

However, feminist research is also a project of social change (Young 2005, Hesse-Biber 2014). Therefore, feminist researchers face an additional challenge, articulated by DeVault (1999, p 59): “The dilemma for the feminist scholar, always, is to find ways of working within some disciplinary tradition while aiming at an intellectual revolution that will transform that tradition.” It was with these concerns in mind that I began to investigate hermeneutic phenomenology as a potential methodology for this project and ultimately chose it as the one most aligned with and appropriate for this study.

4.2.1 Feminism and hermeneutic phenomenology

Feminism and hermeneutic phenomenology share a number of important epistemological and ontological themes (Code 2003). Both movements aim to ground knowledge within lived human experience, and both share a desire to critique scientific knowledge claims regarding knowledge and objectivity. The importance of highlighting women’s experiences as an authoritative source of knowledge to the feminist movement was discussed in Chapters 2 and 3. A major part of the feminist scholastic project since the 1960s has been to question the validity and objectivity of the scientific paradigm, and to challenge the biased,

patriarchal power dynamics inherent in research methods and modes of knowledge production that are situated within it (Hines 2015). Like feminism, phenomenology also turns to experiences as sources of knowledge (Moran 2000), rather than representing them in abstract theory or imposing binaries such as thinking and feeling, or reflection and action (van Manen 2016, xvii). In other words, for both hermeneutics and feminism, knowledge is situational and grounded in experience (Code 2003). Specifically, phenomenological inquiry is grounded in first person perspectives of events as they are experienced by individuals in the world (Luft and Overgaard 2014). It does not aim to give a so-called objective account of a phenomenon, as empirical science does, but instead aims for an account that captures the phenomenon as experienced by an individual or group of individuals. Like feminism, hermeneutic phenomenology is critical of the rationalist and reductionist models of human experience found in empirical science, and instead calls attention to the aspects of experience neglected by empiricism, particularly the underlying assumptions that shape our lives and understanding (Moran 2000, p 13).

In grounding knowledge in lived experience, phenomenology is employed to bring to light that which lies hidden or has been obscured (Heidegger 1962). In this, it shares commonality with feminism, for which a primary goal is to reveal invisible yet systematic structures of oppression (Fielding 2014). Similarly, phenomenology works to reveal our everyday understanding of the structures that shape who we are, the endeavours we undertake and what we believe is possible. Thus, both feminism and phenomenology “attempt to go to the roots, to show up the foundations that underlie the questions we ask” (Fielding 2014, p 518).

This interest in revealing systematic yet invisible social structures speaks to another shared belief between feminism and hermeneutic phenomenology: the idea that our lives are experienced within the social context in which we are situated. For feminists, the focus remains on the ways in which women experience personal, economic and racial oppression as a result of gendered social and political structures. Likewise, hermeneutic phenomenology asserts that human experience is situational and relational, and always related to something in the world (Luft and Overgaard 2014). This particular assertion of hermeneutic phenomenology, and its divergence with Husserlian claims regarding experience, will be discussed in Sections 4.3 and 4.4.

Furthermore, as will be discussed in Section 4.3, both feminism and hermeneutic phenomenology share a commitment to social action based on the knowledge constructed from lived experiences (van Manen 2016). This has also led to my choice of phenomenology as the most appropriate methodological approach within which to investigate women's lived experiences of attempted access to alternative birth models.

Although feminists have drawn upon phenomenology in order to highlight the systematic oppression of women, the fit between the two paradigms has not always been easy (Fielding 2014). Specific critiques will be addressed in Section 4.4. alongside my general discussion of phenomenology's founders and their ideas.

In summary, the shared epistemological assertions and aims outlined above have led me to conclude that hermeneutic phenomenology is the most appropriate approach to take in this study of women's experiences of attempted access to alternative birth models. In particular, I have relied on the methodology and methods of Max van Manen, and my reasons for this are outlined below. However, before I do so, I will discuss definitions of phenomenology as posited by those who founded and developed the movement. I will then briefly outline the origins of phenomenology and the theorists who developed it in order to provide the context in which van Manen's work is situated.

4.3 Definitions of phenomenology and hermeneutic phenomenology

For the contemporary researcher, finding a succinct definition of phenomenology can be challenging as philosophers and others identified with the practice of phenomenology have diverse interests and apply their interpretations in various ways (Moran 2000). Further confusion can arise when the philosophy is used as a methodology, as I do, with varied approaches claiming to be situated within phenomenology. However, despite these difficulties, there are definite distinctions between Edmund Husserl's transcendental phenomenology and Martin Heidegger's hermeneutic phenomenology, which have implications for the methodology employed within a study (Koch 1995). Thus, it is useful to understand what phenomenology has meant to some of those who have developed it as a philosophy and a research approach and explore the definitions with which my inquiry is most closely aligned.

Some help in the formation of a working definition of phenomenology can be gained from looking to the Greek root of the word “phenomenon”, which means “to show itself” (Heidegger 1962, p 51). Both Heidegger and Husserl, considered to be the founders of phenomenology, maintain that the study of human phenomena must begin by turning “to the things themselves” or *Zu den Sachen selbst* (Husserl 1970, Heidegger 1962). Thus, phenomenology means “to let that which shows itself be seen from itself in the very way in which it shows itself from itself” (Heidegger 1962, p 58). This, however, writes Heidegger, is simply the formal expression of the maxim, “To the things themselves” (Heidegger 1962, p 58).

Turning to human phenomena, or experiences, is therefore the task of phenomenological research (van Manen 2016), and discovering the meanings of these experiences is the primary focus of the phenomenological inquirer:

In phenomenological research the emphasis is always on the meaning of lived experience. The point of phenomenological research is to “borrow” other people’s experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience (Van Manen 2016, p 62).

Therefore, phenomenological research is always grounded in lived experiences (Code 2003, Moran 2000), the events and occurrences that take place as we go about our lives (van Manen 2016).

Furthermore, van Manen (2016) suggests that phenomenological research is a call to action, a demand from an issue or problem, or perhaps a demand from those traditionally referred to as research participants, to fully understand their lived, felt, embodied experiences – the starting point of research for many feminist scholars (Reinharz 1992). Van Manen (2016 p 32) writes: “Phenomenological research requires of the researcher that he or she stands in the fullness of life, in the midst of the world of living relations and shared situations.” Moran (2000, p 4) concurs, writing that phenomenology is a practice rather than a system, aimed at getting “to the truth of matters”. Thus, action is integral to the definition and practice of phenomenology and its application as a methodological approach.

The aim of phenomenological inquiry, therefore, is to gain an understanding of a particular experience for those who lived through it (Williamson 2005). Within this,

hermeneutics offers a person-centred approach to the explorations of the meanings and lived experiences of a phenomenon (Thomson and Downe 2008).

4.4 Origins of phenomenology

4.4.1 Edmund Husserl

Although phenomenology has developed into a methodological approach, it first arose as a philosophical endeavour prior to World War I and has since occupied a prominent position in modern philosophy (Dowling 2007). Understanding its origins and the intellectual concerns of its original thinkers is therefore important if a researcher is to remain grounded within phenomenology and maintain rigour in her research (Giorgi 2000).

Phenomenology as a philosophy was founded by German mathematician Edmund Husserl (1859-1938), and then further developed by Husserl's student, Martin Heidegger (1889-1976). In his search for the foundations of knowledge, Husserl was concerned with epistemology, that is, how we know what we know (Koch 1995). He was worried that, at the turn of the 20th Century, philosophy was not taking the human subjective experience as its starting point but was instead aligning itself with the scientific paradigm, which sought empirical verification (Williamson 2005). However, despite his concerns that the subjective experience was being ignored as a means of understanding the world, his concepts remained situated within a positivistic worldview, and were based on the Cartesian duality that assumes a mind-body split (Dowling 2007, Koch 1995). Husserl therefore set out on a philosophical project to describe human phenomena in their most essential form (Cohen 1987).

Husserl wanted to get to the essence of a phenomenon and was concerned with getting "to the things themselves" (Husserl 1970). He argued that the lifeworld (*lebenswelt*), a notion that he posited in his largely posthumous book *The Crisis of European Sciences and Transcendental Phenomenology* (1970), is that which individuals experience pre-reflectively, before resorting to interpretations (Dowling 2007). For him, this idea referred to the world of immediate experience, the world as experienced in its natural, primordial state (Husserl 1970). In other words, lived experience involved the immediate, pre-reflective consciousness of life (Dowling 2007). It was therefore important to Husserl to understand the essential features

of phenomena free from the social context, and to not impose explanations before phenomena have been understood from within (Moran 2000).

Husserl asserted that phenomenology should work to understand these essential features, or essences, that constitute the consciousness and perception of the human world (Koch 1995). It is through Husserl's search for essences that the Cartesian mind-body split is evident, with his assertion that phenomenological inquiry means presenting a systematic view of mental content which is organised and situated as separate to the body and the larger world (Koch 1995). According to Husserl, a person's understanding of the world originates in the mind, and therefore a study of these basic understandings or essences must be the project of phenomenology.

The two notions of the lifeworld and essences led to the development of Husserl's idea of phenomenological reduction. Used as an important epistemological strategy, the concept of phenomenological reduction refers to the understanding of a phenomenon in its pre-reflective, uninterpreted state, free of cultural and social influences (Moran 2000). Thus, argued Husserl, in order to truly understand a phenomenon, a human experience, one must consider it outside of its cultural or social context. In order to do so, one must set aside or "bracket" this outer reality, as well as one's preconceived beliefs and biases, in order to truly get to its essence (Koch 1995).

It is Husserl's idea of bracketing that represents one of his most problematic arguments for those more closely aligned with the interpretive phenomenology of Heidegger. Likewise, feminists working to highlight the social structures and cultural assumptions that are integral to women's experiences of oppression would assert that nothing happens outside of such a context. Furthermore, examining the social construction of gender has been an important project of Second and Third Wave feminism (Young 2005), as discussed in Chapter 3. This has been a response to essentialist arguments that women's biological differences to men infer specific (often subordinate) roles (Fielding 2014). Thus, feminist and queer scholars remain uncomfortable with Husserl's insistence on essences. For example, queer theorist Judith Butler criticised the Husserlian notion of a subject that precedes construction, challenging essentialist arguments in relation to gender (Butler 1990, Fielding 2014).

4.4.2 Martin Heidegger

In contrast to Husserl's thinking, Heidegger developed what is known as interpretive, or hermeneutic, phenomenology. This philosophy focuses both on lived experiences and the interpretations individuals give to those experiences, with proponents suggesting these two cannot be separated (van Manen 2016). Researchers, likewise, within this approach, suggest that they can never be completely severed from their own views and experiences whilst conducting an inquiry (Koch 1995).

Heidegger built upon Husserl's idea of the lifeworld, giving it a "more worldly, existential thrust" by suggesting that phenomenology was the study of our ways of being in the world (van Manen 2016, p 183). It is thus through Heidegger that phenomenology begins to recognise the social context in which human experiences take place. Heidegger proposed that the understanding of human experiences is rooted in a relationship between the personal and the social, the individual experience as it happens within the larger context (van Manen 2016). Thus, "hermeneutic phenomenology is a philosophy of the personal, the individual, which we pursue against the backdrop of an understanding of the evasive character of the *logos* of *other*, the *whole*, the *communal*, or the *social*" (van Manen 2016, p 7, emphases original).

Heidegger's concerns focused on the nature of being, or how we are in the world. He begins his seminal work *Being and Time* (1962) by asking the question, what does it mean "to be"? From this, he develops his concept of "*dasein*", which translates into "being there" or "being-in-the-world" (Heidegger 1962). For Heidegger, this *dasein*, this being-in-the-world "stands for a unitary phenomenon" (Heidegger 1962, p 78). It signifies that our being, our experiences, cannot be isolated from the world, from the social and historical context in which our "being" is situated. Being-in-the-world "has always submitted itself already to a world which it encounters and this submission belongs essentially to its being" (Heidegger 1962, p 121). This encapsulates Heidegger's notion that human existence and experiences are inextricable from the world, or the environment in which they take place. Likewise, our understanding and interpretations of our experiences are also situated within "the world", and do not originate from an inner sphere or realm of consciousness, as Husserl asserted. Tradition, those ideas that present themselves as self-evident, shape our interpretations and play such a central role to our existence, that *dasein*, our being-in-the-world, cannot separate itself from

tradition. Because of this, being-in-the-world cannot encompass objectivity, as it/we cannot separate ourselves from the ideas in which we live (Heidegger 1962).

Thus, our existence, which includes both experiences and understanding, cannot be extricated from the world (Koch 1995). Therefore, in contrast to Husserl's attempts to access pre-reflective experiences, one cannot, nor should not, attempt to distinguish between a pre-reflective experience and the reflection of it because one cannot happen without the other (Heidegger 1962). Consciousness cannot be divorced from the world of human existence, and thus the mind-body split supported by Husserl cannot adequately capture the human experience. Thus, any individual's lifeworld must take into account the context that shapes their "being-in-the-world", and their interpretations of it. Therefore, the phenomenologist must recognise that all experiences and interpretations exist and are created within a social and historical context and cannot be divorced from them (Heidegger 1962).

In scholarship, hermeneutics originally signified a philosophical approach traditionally employed when interpreting biblical or other ancient texts, but has since come to encompass a focus on interpretation and meaning. Heidegger first posited the concept of hermeneutics within phenomenology, arguing that the understanding of a phenomenon must go beyond mere description and be developed through hermeneutics, or interpretation (Heidegger 1962). It is only through the interpretation of phenomena that a researcher can uncover its hidden meanings. Thus, Heidegger proposed the concept of the hermeneutic circle to illustrate the notion that an individual's understanding of being-in-the-world is a reciprocal activity (Koch 1995). This concept was developed by Heidegger's student Hans-Georg Gadamer and will be discussed in further detail below in Section 4.4.3. Within modern hermeneutic phenomenology, there is a focus not only on a phenomenon, but also on the meaning and interpretation that research participants assign to the "texts" of their lives (Manning 2012, Ohaja *et al* 2020). This approach allows a researcher to explore a phenomenon by attempting to "read" human practices, experiences and circumstances in ways that create understanding (Kay *et al* 2017). Adopting a hermeneutic phenomenological approach enables the researcher to shed light on a phenomenon by examining it in the "world" or social context in which it is situated.

Like those whose experiences cannot be bracketed from their world, the hermeneutic researcher cannot nor should not "bracket" her background or beliefs because doing so is not possible (Koch 1995). Instead, we should recognise that

the state of being inevitably means being-in-the-world, and researchers are situated in and inseparable from our particular context. This idea is closely aligned with feminist research, which values the experiences and knowledge of a researcher and views them as a resource when attempting to understand an issue. Van Manen's views on bracketing will be outlined in Section 4.5.3, while the concept of the researcher's knowledge as an asset will be discussed in Chapter 5, Sections 5.4.6 and 5.5.3.

4.4.3 Hans-Georg Gadamer

Heidegger's student, Hans-Georg Gadamer (1900-2002), built upon his mentor's belief that all existence is hermeneutic by developing the idea that understanding always takes place through the lens of tradition and language (Williamson 2005). Gadamer proposed that hermeneutic research is dialectical, and interpretation permeates every activity, with the researcher considering social, cultural and gender implications of the phenomenon under investigation (Koch 1996). Here I will limit my discussion to his ideas around the hermeneutic circle and the fusion of horizons, as well as his principle of genuine listening, as these are of most relevance to my study.

The concept of "fusion of horizons", which Gadamer outlines in his seminal work, *Truth and Method* (1975), encompasses the idea that while people have their original prejudices – or horizon – this horizon can be fused or expanded as one examines new information. Gadamer views the horizon as the point in a situation or worldview that "limits the possibility of vision" (Gadamer 1975, p 302). In the case of phenomenological inquiries, a researcher can see a new, broader horizon after speaking with participants, and developing a better understanding of their experiences. Original and new horizons can fuse together to give a person a deeper understanding of a phenomenon.

The concept of the fusion of horizons is closely linked to Gadamer's conception of the hermeneutic circle. As horizons are fused together and the participant and researcher begin to influence and inform one another's experiences and interpretations, the hermeneutic process becomes cyclical or, as Dowling (2004, p 36) says, it becomes "a dialogical method whereby the horizon of the interpreter and the thing being studied are combined". This circular process is dynamic, with no beginning, end or subject-object dichotomies (Williamson 2005). This has echoes with feminist scholarship, which reimagines the researcher-participant

relationship as collaborative, with each influencing the other and creating a new, dialogic knowledge (Hesse-Biber 2014). The hermeneutic circle is thus a metaphor used to describe the experience of moving dialectically between the part and the whole (Koch 1996). This hermeneutic process does not happen in a vacuum but within the social, cultural, historical context in which an individual lives (Williamson 2005). Neither can the meaning an individual assigns to an experience be given outside of context. Williamson (2005, p 49) writes: "So, within the hermeneutic circle, the whole can be understood by the study of the particular, and the particular, with reference to the whole." Within research, it is not merely the participants who are positioned within the hermeneutic circle, but also the researcher (Koch 1996). Thus, a researcher incorporating hermeneutics considers both the individual participant and the implications that the social and historical context have on her experiences and interpretations (Dowling 2007). The implications of these concepts for my research will be explored in later sections and in Chapter 5 on methods.

Both the fusion of horizons and the hermeneutic circle are part of the process of understanding that a researcher undertakes throughout a phenomenological investigation, and this is facilitated by Gadamer's principle of genuine listening. For Gadamer, the goal of any hermeneutic situation is to understand the other (Cubukcu 2012). In the case of research, the researcher attempts to understand the participant, although in this process the participant also comes to a better understanding of the researcher. This understanding can be accomplished through dialogue with the other. Genuine listening, for Gadamer, asks that researchers let the participant, our partner in dialogue, speak to us and possibly correct us (Cubukcu 2012).

Thus, Gadamer's thinking around the fusion of horizons, the hermeneutic circle and genuine listening assist the researcher in developing a deeper understanding of the phenomenon under investigation. Following Gadamer, phenomenology made stronger advances into the realm of research. These developments are discussed below.

4.4.4 Contemporary Phenomenology

While traditionally, phenomenology has been firmly situated in the field of philosophy, it has always been a working philosophy that provides a meaningful space for inquiry and research (Luft and Overgaard 2014). During the latter half of

the 20th century, a number of researchers, particularly within the fields of nursing and psychology, developed various phenomenological methodological approaches. In recent decades, it has become a popular approach to studies in the field of psychology and nursing (Koch 1995). These projects have largely stemmed from North American universities and have been influenced by the work of psychologists Amedeo Giorgi, P.F Colaizzi and Adrian van Kaam, from the Duquesne school at Pittsburgh University in Pennsylvania. While these inquiries take “inspiration” from the philosophical underpinnings of phenomenology (Giorgi 2000), its proponents also see its value as a research methodology, particularly when the experiences of a specific cohort are under investigation. Giorgi, Colaizzi and van Kaam, influenced by Husserl’s phenomenology, developed research methods involving description, reduction and the search for essential structures (Dowling 2007).

However, many healthcare researchers within this “new school” have been influenced by Heidegger’s concepts of “being-in-the-world” and the hermeneutic circle, and have placed greater emphasis on the importance of describing study participants’ lived experiences within the context of culture (Caelli 2000, Dowling 2007). Midwifery researchers have employed hermeneutic phenomenology to great effect when studying the lived experiences of childbearing women and midwives. This methodological approach is ideally suited to childbirth, with its focus on context, lived experiences and the meaning assigned by individuals to those experiences (Crowther *et al* 2014, p 158). Furthermore, Ohaja *et al* (2019) write that phenomenology is closely aligned with the practice and profession of midwifery, as midwives employ a holistic and reflexive approach to providing care, focusing on the individual experiences and interpretations of women while simultaneously acknowledging the social context in which these are taking place. For example, Thomson and Downe (2008/2010) have taken this approach in their exploration of women’s experiences of childbirth trauma, while Kay *et al* (2017) utilised it in their study of women’s experiences of engaging with birth stories during pregnancy. Meanwhile, Ohaja *et al* (2017) employed this approach in their investigation into the experiences of birth attendants in Nigeria. However, the development of phenomenology from a philosophy to a methodology has not taken place without debate, nor without criticism of the researchers who utilise it. These critiques, and their counterarguments, will be explored below.

4.5 Critiques and Responses

4.5.1 Critiques of the new phenomenology

Researchers within the new school of phenomenology have been criticised for a lack of scientific rigour and lack of clarity regarding the distinctions between Husserlian descriptive phenomenology and Heideggerian interpretive phenomenology (Koch 1995). For example, following a review of 30 nursing research papers that adopted phenomenology as a methodology, Crotty (1996) criticised the new phenomenological studies for not seeking out pre-reflective experiences or employing phenomenological reduction, and instead only including interpretations in data collection and analysis. He was concerned that nurse researchers adopting a phenomenological approach were more focused on experiences rather than on seeking the essence of the phenomenon under investigation, which he saw as the original intention of phenomenology. In doing so, he suggested that this body of research was not phenomenology according to the European tradition but was instead a North American hybrid. Furthermore, he suggested that phenomenological reduction, often not employed by new phenomenologists who emphasise the importance of social context, is essential if such essences are to emerge and be understood. Therefore, he argued, these researchers were remiss in situating their inquiries within the phenomenological tradition.

More recently, van Manen, who has played an important role in developing phenomenology as a research methodology, has also criticised the pervasiveness of the term “phenomenology”. He has expressed concern that contemporary researchers have strayed too far from the intellectual depth and rigour that phenomenology demands (van Manen 2017b). In particular, he has urged researchers to remain grounded in phenomenology when conducting data analysis and warned phenomenological researchers against using the quantifying or coding techniques often employed in data analysis in other forms of qualitative inquiry (van Manen 2017a). These particular concerns regarding data analysis will be addressed in Chapter 5, Section 5.5.

4.5.2 Responses to critiques of phenomenology as a methodology

Responding to Crotty’s criticisms of new phenomenology, Dowling (2007) suggests that many healthcare researchers within the new school of

phenomenology are not seeking to investigate the pre-reflective experiences that are characteristic of Husserl's phenomenological reductionism. Instead, researchers working within the framework acknowledge the influence that social and cultural constraints have on the experiences and interpretations of the research participants. Furthermore, a hermeneutic approach is necessary in order to fully understand patient/service user experiences as they are lived within a social and historical context (Dowling 2007). This approach aligns well within a healthcare and social scientific framework, she suggests, because it seeks to understand the reality of an individual's experience as they engage with the phenomenon under investigation. Additionally, the hermeneutic approach adopted by many nurse researchers emphasises reflexivity and the role it plays in conducting rigorous research and in connecting theory and practice:

In a clinical discipline such as nursing, phenomenological reduction is often accompanied by practical and even ethical issues in attempts at divorcing nurse and researcher identities. The adoption of a hermeneutic approach which emphasises reflexivity is perhaps essential in addressing this dilemma. ... Reflexivity therefore assumes a key role in discussions of interpretive phenomenological methods. This would seem an appropriate development as it embraces a human science perspective of intersubjectivity methodologically as well as philosophically (Dowling 2007, p 137).

Thus, Dowling suggests that adopting a hermeneutic phenomenological approach to methodology does not, as Crotty writes, lead to a lack of rigour. Instead, with its emphasis on experiences as they are socially and historically contextualised, and its emphasis on reflexivity, adapting phenomenology as a methodology can lead to a greater understanding of the phenomenon under investigation.

Moreover, Giorgi (2000) suggests that critics should not be overly critical of those who employ phenomenology in some form in order to gain better insight into human experiences, and should distinguish between researchers who are strictly following phenomenology as it was originally conceptualised and those who are inspired by it. He writes: "Often, to be inspired means that one is attracted by someone's thought, even though one is aware that he or she has to modify what was said in order to make it meaningful in the context where the one inspired wants to use it" (Giorgi 2000, p 10).

The work of Van Manen, with his experience as a Canadian-Dutch scholar, serves as a bridge between the older European side of phenomenology and the newer North American developments. His ideas and methods present a framework for using hermeneutic phenomenology as a rigorous methodological approach while remaining cognisant of its philosophical underpinnings (Dowling 2007).

4.5.3 Max van Manen

The work of Max van Manen (b. 1942), which is situated within the hermeneutic phenomenology tradition and has greatly informed my study, will be discussed throughout this section and in Chapter 5.

Like Heidegger and Gadamer, van Manen asserts that experience cannot be divorced from interpretation, and that the lived experiences of human beings provide the necessary starting point for both understanding and phenomenological research. Van Manen also dismisses bracketing as unrealistic, suggesting that a researcher's experiences, if consciously recognised, can help deepen her understanding of a phenomenon.

Building on Heidegger's assertion that phenomenologists must study the "everyday being-in-the-world" (Heidegger 1962, p 94), van Manen writes that "lived experiences" refer to the ordinary, everyday experiences as we live through them (van Manen 2017a). Lived experience, he suggests, "names the ordinary and extraordinary, the quotidian and the exotic, the routine and the surprising, the dull and the ecstatic moments and aspects of everyday experience as we live through them in our daily human existence" (van Manen 2017a, p 813). These lived experiences, as we live through them, are raw – and it is upon reflection of these lived moments that individuals assign meaning to them. It is therefore the task of the phenomenologist to examine lived experiences and ask, "What was this experience like?" (van Manen 2017a, p 812). In doing so, the researcher can bring the lived experience into focus and orientate or connect it to the meaning assigned by those living through it, and to the larger social context. Through reflection on the meaning of a phenomenon, on a lived experience, the phenomenological researcher can come to acknowledge and understand the "unusualness of the usual" (van Manen 2017a, p 816). Van Manen explains: "It is not the unusualness but the usualness of everyday common experience that is unusual and that brings us to wonder and the desire to understand the meanings of our lived experiences" (van Manen 2017a, p 816).

The point of using phenomenology as a qualitative research methodology is to arrive at phenomenal understandings and meaningful insights (van Manen 2017a). The researcher gains, or comes to, these meaningful insights through a process of “wondering” about or reflecting on the significance of the ordinary meaning of an experiential phenomenon.

Also of great significance to phenomenological research, suggests van Manen, is the process of writing, and an essential task for researchers situated within this methodological approach is to write a phenomenological text (van Manen 2016). Thus, writing is not simply one of the final steps in a research project but it is an integral part of the research. Writing and re-writing is an essential part of the process of phenomenological reflection and wondering, and the researcher can only come to “meaningful insights” regarding the phenomenon under inquiry through multiple written drafts (van Manen 2016/2017a):

Phenomenological research is ultimately a practice of authoring an insightful text on a phenomenological topic. Researchers need to realise that the outcome of phenomenological research is inseparable from phenomenological reading, writing and rewriting. The more profound phenomenological insights may only come in the process of wrestling with writing and reflective rewriting (van Manen 2017a, p 823).

Thus, through his understanding of the concepts and applications of both traditional and new phenomenology, his explorations of the meaning of lived experiences and his positioning of writing as an integral part of phenomenological research, van Manen provides the framework for a sound methodological approach to research.

4.6 Conclusion

In this chapter I have outlined the decisions faced by feminist researchers when choosing a methodology and discussed the shared concerns of both feminism and hermeneutic phenomenology, the methodology most appropriate in answering my research question. I then discussed definitions of phenomenology, as well as a summary of its founders and their contributions to the field. Phenomenology both as a philosophy and more recently as a methodology is a rich and complex movement. At its heart, however, is a focus on lived experiences and, with hermeneutic phenomenology, we find both a desire to focus “on the things

themselves” and an acknowledgement that experiences and the meanings that individuals give to them happen within a socio-historical context and cannot be divorced from that. A number of contemporary researchers, including Max van Manen, have modernised phenomenology and adapted it into a research methodology as much as a philosophy. Van Manen outlines six steps that researchers can follow in conducting hermeneutic phenomenological research, and these will be discussed in detail in the following chapter on methods.

Chapter 5: Methods

5.1 Introduction

In this chapter, I present the operationalisation of my study based on the philosophical and theoretical framework presented in Chapter 3, and the methodology outlined in Chapter 4. Hermeneutic phenomenology, as the methodology employed for this research, has informed the specific methods I have utilised to carry out this investigation. In particular, these methods were conducted within the framework of van Manen's six steps to conducting phenomenological research, which has helped maintain rigour and transparency within this study, and an orientation to the lived experiences of the research participants. Van Manen suggests that while these six steps are somewhat linear, a researcher will inevitably traverse back and forth amongst them, in a journey that resembles the hermeneutic circle. Below, I present my approach to identifying the population sample, and accessing and recruiting participants. I also discuss my methods for data collection and data analysis, and how I addressed issues of quality and rigour.

5.2 The six steps of van Manen

The six steps for conducting phenomenological research, as outlined by van Manen (2016), are:

1. Turning to the nature of the lived experience
2. Investigating experience as we live it
3. Hermeneutic phenomenological reflection
4. Hermeneutic phenomenological writing
5. Maintaining a strong and oriented relation to the phenomenon
6. Balancing the research context by considering the parts and the whole

These six steps encompass the research process, from the development of the research question to the completion of a written thesis. Van Manen's definitions of them, and the practicalities involved in following them as I conducted my research, are discussed below.

5.3 Step 1: Turning to the nature of the lived experience

Van Manen's first step, Turning to the Nature of the Lived Experience, involves the initial contemplation of a phenomenon and what it might mean to those who have experienced or lived it. Within academic discourse and practice, this step involves the formulation of a research question, aims and objectives. In the case of my own project, I began contemplating women's experiences of the maternity services in contemporary Ireland and the desire to access alternative models of care and non-medicalised birth experiences. This included the contemplation of the context in which these experiences occurred, such as available services as well as the gendered restrictions to reproductive care that have defined much of the healthcare provision in Ireland throughout the last century. After a review of the literature, I formulated my research question, namely, "What are women's lived experiences of attempted access to alternative birth models in contemporary Ireland?", as well as my aims and objectives (see Chapter 1, Section 1.5.2).

Once I turned to the nature of the lived experience and articulated my research question, aims and objectives based on that, I was then able to move on to van Manen's second step in the process of conducting phenomenological research.

5.4 Step 2: Investigating experience as we live it: Data collection

In order to practice van Manen's second step, Investigating Experience as We Live It, one must use lived experiences as the starting point for one's research. With this in mind, a researcher gathers or collects the stories of individuals' lived experiences. In traditional academic terminology, this would include population identification and participant recruitment, as well as data collection. Within van Manen's phenomenological approach, data collection is conducted through semi-structured or unstructured interviews with a cohort of individuals who have experienced a particular phenomenon. Thus, in order to investigate the lived experiences of childbearing women attempting to access alternative birth models, I developed a sample strategy, inclusion and exclusion criteria, recruited participants and then collected data through semi-structured interviews.

5.4.1 Sampling and recruitment

The population for this study was childbearing women over the age of 18 living in the North East region of Ireland who were attempting or had attempted to give birth at home or at one of the country's two Midwifery-Led Units (MLUs) within the past

five years. The sample was drawn from local homebirth and breastfeeding groups in the greater Dublin area, as well as Cavan and Drogheda, where the two MLUs are located.

Participants in this study included primipara and multipara women who fell into one of two cohorts. The first included postnatal mothers who, during their most recent pregnancy, had planned to give birth at home or at one of the two MLUs but were ultimately unable to do so. The second group included pregnant mothers who were currently planning to birth at home or in one of the MLUs. Initially, I planned to only include those who fell into the first demographic but as my thinking around phenomenological methodology developed, I decided to include the pregnant women, in order to more fully and tangibly understand the phenomenon of attempted access to alternative birth options as it was taking place. For the purposes of this study, I have only included those who were considered low risk or have been deemed eligible to give birth at home or an MLU by a healthcare professional¹⁷.

Essential to this study is the capturing of the experiences of women who theoretically have the greatest access to publicly funded alternative birth choices in Ireland, in order to ascertain the levels of access in this privileged catchment area, and whether these experiences “on the ground” mirrored policy recommendations. This, therefore, was the justification for the inclusion of women

¹⁷ For the eligibility criteria for the HSE homebirth scheme, see <https://www.hse.ie/eng/services/list/3/maternity/hb003-policy-to-support-the-secm-to-assess-the-eligibility-suitability-of-women-for-home-birth.pdf>. High risk women who have medical conditions outlined in Tables 1 and 2 of this document are not eligible for HSE homebirths. These medical conditions can also be viewed in Meaney et al (2020), Appendix B, p 36. For a full list of medical conditions that designates a woman as medium risk and requires referral to a consultant for a final assessment before she is deemed eligible for a homebirth, see Tables 3 and 4 in the above document, or Meaney et al (2020), Appendix C, p 38. These factors include age (women over 40), abnormal blood pressure readings and specific previous pregnancy complications. Women with none of these conditions are considered low risk and are automatically eligible for the homebirth scheme. Given the significance that length of pregnancy and labour had for my participants, it is interesting to note that under HSE guidelines, reasons for intrapartum transfer to hospital include a spontaneous rupture of the membranes greater than 18 hours or a diagnosis of “prolonged” labour (Meaney *et al* 2020, Appendix D, p 40). Appendix E (p 41) in the same report outlines guidance for prolonged labour, based on NICE 2014 guidelines. SECMs are advised to transfer women to hospital and into obstetric care if the second stage of labour lasts longer than three hours for nulliparous women or two hours for multiparous women. For nulliparous women, an SECM is advised to diagnose delayed labour and prepare for a transfer of care after two hours if birth is not imminent; for multiparous women, delay should be diagnosed after one hour (Meaney *et al* 2020). Meanwhile, a total of 19% of women who transferred to hospital during the antenatal period were transferred for induction of labour (Meaney *et al* 2020).

living within Dublin and the greater North East region of the country, where Self-Employed Community Midwives provide homebirth services through the HSE scheme (Meaney *et al* 2020), and one of the primary maternity hospitals (the National Maternity Hospital) provides a well-established homebirth service and where the country's two MLUs are located.

The focus of this inquiry is on whether low-risk women can access alternative birth models and which barriers might prevent them from doing so. Because of this, I excluded women who successfully gave birth at home or in one of the MLUs and/or had not been denied access for any birth, as they would be less able to provide insight regarding potential barriers to access than those with experiential knowledge of them.

5.4.2 Sample strategy

I employed two primary strategies in identifying suitable candidates for this study, including purposeful sampling and snowball sampling. Purposeful sampling (Palinkas *et al* 2015) is a popular strategy used in qualitative research for the selection of information-rich cases, and involves the identification of individuals who are experienced with, or particularly knowledgeable about, the phenomenon under investigation (Cresswell and Plano Clark 2011). This strategy is aligned with my methodology, as phenomenological research is based upon the experiences of individuals who have experienced the phenomenon under study. Criterion sampling is a specific technique within purposeful sampling, which allows for all individuals who meet the predetermined criteria to be eligible for selection (Palinkas *et al* 2015). I employed this technique in order to capture a sufficient breadth of experiences of attempted access, which includes the process of seeking access to alternative birth models, so that I might adequately understand and capture experiences common to all participants. Meanwhile, snowball sampling (Patton 2002), which involves word-of-mouth information about the research project that is passed on from one participant to another, was another technique I employed. Patton (2002) compares this type of sampling with a snowball as it goes down a hill – one key participant will suggest another, who will in turn add important details or experiences to the growing corpus of information or data. In the case of my study, one key participant, who was crucial in highlighting the experiences of women attempting to access the MLUs, recommended to other women that they also participate in the research. These women in turn contacted me and I screened them in order to determine whether they fit the inclusion criteria,

in line with my purposeful criterion sampling. If they met the criteria, I then interviewed them. Below is the inclusion and exclusion criteria I employed, as well as my justification for them.

Inclusion Criteria:

Participants eligible for criteria in this study included women who were:

- Low risk/approved for the HSE homebirth scheme or MLU and therefore not excluded from participating in alternative birth models due to clinical reasons
- Living in Dublin or the greater North East region at the time of pregnancy and birth
- Wished to give birth at home or in the Cavan or Drogheda MLU, and had attempted or hoped to access one of these options
- Gave birth within the last five years
- Over 18 years of age

Exclusion Criteria:

- Women who have successfully accessed birth at home or in one of the MLUs and/or who have not been denied access for any birth during the past five years

5.4.3 Recruitment

Once I formulated the participant criteria for my study, I contacted key gatekeepers to request that they pass on information about my study, along with my contact details, to potential participants. Primary gatekeepers I contacted included the Homebirth Association of Ireland, the Doula Association of Ireland and Self-Employed Community Midwives working as part of the HSE homebirth scheme in the Dublin region. As part of this engagement process, I sent the gatekeepers information about the project as well as my contact details, which they were free to pass on to potential participants. Women interested in participating in the study then contacted me. One SECM was particularly supportive of this study, and three of her clients got in touch with me after she passed my information onto them. As potential participants may use online forums as a significant source of information

and networking, I contacted the gatekeeper, or administrator, of one Facebook group, Homebirth Hopefuls, to ask whether I might post information about my research and my contact details in the forum. Once I received an affirmative answer, I did this, and several participants contacted me after reading my message. As mentioned above, one participant, who had hoped to attend one of the MLUs, recruited other participants by encouraging other women whom she knew from her local breastfeeding group to contact me.

When contacting me, potential participants often outlined details of their experiences without any prompts from myself. This enabled me to determine whether they fit the inclusion criteria. I then sent all potential participants a recruitment pack, via email, as this was the primary mode with which they communicated to me. The recruitment pack included a Participant Information Leaflet and an Informed Consent form, both of which had been approved by the School of Nursing and Midwifery Research Ethics Committee (see Appendixes 2 and 3). Those who wished to participate then returned a signed Consent form. All eligible participants who volunteered were included in this study. Many said they were motivated to speak with me because they hoped that my research could be disseminated to other childbearing women, and they hoped that their contribution could help other women have positive birthing experiences and greater access to alternative birth models.

5.4.4 Sample size and participants

I originally hoped to include 15-30 participants in this study as other studies of women's experiences of childbirth and the maternity services, which informed my own, included a similar number of participants. For example, Thomson and Downe's interpretive phenomenological study of childbirth trauma included 14 participants (Thomson and Downe 2008). Kay et al (2017) interviewed 20 participants for their hermeneutic phenomenological study of women's experiences of engaging with birth stories across two generations. Meanwhile, Nadine Pilley Edward's study of women's experiences of homebirth in Scotland included 30 participants (Edwards 2005). Ultimately, 28 pregnant and postnatal women participated in my study (see Appendix 4 for participant demographics). The number of participants and the breadth and depth of their experiences allowed me to capture and understand the phenomena of attempted access to alternative birth options throughout the North East region.

All 28 of the participants in my study lived within the North East region of Ireland, including areas throughout the city and county of Dublin, as well as Co Kildare, Cavan and Drogheda. They ranged in age from 25 to 44 at the time of our interviews.

A total of 10 participants were pregnant at the time of our interview and 18 were postnatal participants. Seventeen were attempting to or had attempted to access a homebirth, while 13 had attempted to access an MLU – this included one who wanted to give birth either at home or at an MLU. Twenty-six were multiparous, while the other two were pregnant with their first child at the time of the interview. This mirrors the parity of women who intend to give birth through the HSE homebirth scheme, 70% of whom are multiparous (Meaney *et al* 2020). Four participants also disclosed previous miscarriages or terminations to me. Two had negative hospital experiences during their miscarriage/termination care, and this was a contributing factor that led both these participants to seek out non-hospital-based births for their subsequent pregnancies.

The participants were mostly from white, middle class and educated backgrounds, mirroring the demographics of those interested in alternative birth models in other countries (McCabe 2016, O'Connor 1993). All were Caucasian, with 24 from a native Irish background, while four were originally from other European countries. This reflects ethnicity trends for those who intended to give birth through the HSE homebirth scheme (see Chapter 1, Section 2.3.5)¹⁸. As a cohort, my participants were more highly educated than the general population. One had obtained a PhD and one was a PhD candidate at the time of our interview, while nine held Masters degrees. Eleven held third-level degrees. Three held advanced certs and three did not disclose their education level to me. Many worked in the science, social care, healthcare or education sectors. Furthermore, all participants were in heterosexual relationships at the time of our interviews, often with the father of their child(ren), although one participant identified as bisexual.

In line with ethical issues regarding privacy, I have anonymised the participants through the use pseudonyms (see Appendices 2 and 3). I myself chose the pseudonyms for each participant. Further ethical issues will be outlined below.

¹⁸ A total of 2.8% of those who gave birth through the HSE homebirth scheme in 2017 belonged to Asian or Black ethnicities. However, no one from these ethnic backgrounds contacted me about participating in this study. This issue will be discussed further within Chapter 9, Section 9.6, in which I address the limitations of this study.

5.4.5 Ethical issues and General Data Protection Regulation (GDPR)

Ethical issues were an integral part of the sampling, recruitment and data collection processes. Ethical approval was obtained from the School of Nursing and Midwifery Research Ethics Committee at Trinity College Dublin in July 2017, prior to the commencement of the recruitment process. As a researcher, it was essential that I engaged with participants in an ethical and respectful manner, and in a manner that did not breach their privacy under data protection laws, including the General Data Protection Regulation (GDPR), which was introduced during the time in which I was undertaking my research. Each participant gave of her time and shared confidential and intimate details with me, which I listened to with care and respect, expressing this through my body language and words. Many also wanted to hear of my experiences and opinions and so I shared some of this with participants in order to build trust (this reciprocity will be discussed in greater detail in Section 5.4.7). As part of the ethical approval process, I developed a list of counselling referral services, which also included a list of regulatory bodies, in the event that the participants wished to contact any of these organisations arising from issues raised during our discussions. None expressed a need or desire to avail of these resources. Several participants disclosed that they had received counselling for traumatic birth experiences, but no longer required this service. With one participant, I felt compelled to tell her about the Irish Medical Council's mechanism for patient complaints. She said she had already considered this option but did not wish to pursue it. I also discussed this interview with my supervisors, and, respecting the participant's autonomy and privacy, we decided that no further action was required.

The GDPR legislation was introduced across Europe in May 2018, while individual states could also bring in country-specific legislation. Ireland did so, in the form of Health Research Regulations. After attending a GDPR and HRR training course hosted by Trinity's School of Medicine, and consulting with the Data Protection Officer for the School of Nursing and Midwifery, it was determined that the initial steps I had taken to protect the privacy and personal data of my study participants and obtain their consent remained in line with the new regulations.

5.4.6 Data Collection

In line with van Manen's framework for data collection, I obtained primary data for this study through semi-structured interviews with the participants. As outlined in

Chapter 4, Section 4.2, DeVault (1999) suggests feminist researchers should view female conversations and experiences as key sources of meaning and information. Interviews in particular offer a researcher access into people's thoughts and memories in their own words, an asset that is particularly important when studying women's experiences "because in this way learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women" (Reinharz 1992, p 19). Furthermore, the use of semi-structured interviews facilitates the explication of a variety of experiences and understandings, promotes freedom of expression for the participants and allows the uniqueness of each individual to stand out (Ohaja 2015, p 140). Thus, I chose semi-structured interviews with female participants as my primary source of data, which is both in line with my feminist theoretical framework and my hermeneutic phenomenological methodology.

The experiential knowledge of interviewing gained during my work as a journalist allowed me to develop an interview guide while discussions with my supervisors allowed me to refine this so as to be appropriate within the context of academic research (See Appendix 6 for interview guide). Although the guide served as a general framework for the interviews, it was not always followed sequentially as the discussions were led by the women, and what they felt was important for me to know in order to understand their experiences. Follow-up questions were based on information provided by the participants, and I used open-ended questions, such as "So tell me about this pregnancy", to ascertain the participants' views, while I employed probing questions, such as "Could you explain that more?" or "In what way specifically?" to obtain deeper and meaningful answers and to clarify issues raised by the participants.

Although each participant had read the Participant Information Leaflet and I explained the purpose of my research via email before we met, I began each interview by outlining my research again, and the purpose of the interview within the larger project. I also sought additional verbal consent from each participant to record the interview with an audio recorder, although they had already given written consent through the Informed Consent Form. I also took written notes throughout the interviews, to support the audio recordings. Following the interviews, I transcribed the audio recordings myself, noting physical gestures, emotions expressed through words or tone of voice and external factors, such as babies feeding or interruptions from children, in order to develop the context in

which the interviews took place. I also compared the transcripts to my written notes to confirm the accuracy of the recording and transcription.

Because the interviews were participant-led, I asked whether they would like to begin by discussing their most recent pregnancies, during which they attempted to access birth at home or in an MLU, or whether they would like to begin their reflection somewhere else. Most of them began by sharing experiences of their first births with me, or previous pregnancies that ended in termination or miscarriage, indicating that these formed the context in which their attempts to access alternative birth models were situated. One spoke of the birth of a sibling, which she had attended. As they spoke, I conveyed through body language, including eye contact and nodding my head, as well as supportive non-verbal sounds such as “mmm”, that I was listening to what they said. Often participants would ask me “you know what I mean?” in order to confirm that I understood a specific point or the meaning of the experience they were trying to convey to me. Through responding to them with verbal and physical cues, I employed Gadamer’s principle of genuine listening (See Section 4.4.3). Once they shared these experiences, some participants began to discuss their most recent pregnancies unprompted, while for others I used directed questions set out within the interview guide to move the interview onto the topic of their most recent pregnancy. New issues or aspects of access raised by the participants during interviews I then brought up in subsequent interviews. The participants thus played an ongoing role in the direction of the interview process.

All interviews were conducted at a venue chosen by the participants. For some, this was their home, for others it was their place of work, for one it was a café. For the women living in Cavan and Drogheda, most of the interviews were conducted over the phone, as they all had young children and this was most convenient for them. I interviewed each participant once, as I was able to reach data saturation with one interview per participant. Furthermore, participants indicated to me that they had shared everything about their experiences they wished to share. I gave them an opportunity at the end of each interview to share more, by asking whether there was anything else they would like to say. I also told each participant that they could contact me via email or telephone if they wished to add anything further. One pregnant participant, who had previously given birth at home, emailed me as a follow-up to say she would be interested in speaking with student midwives or expectant mothers about her experiences, with a view to broadening their

knowledge about natural birth. However, she did not share anything further about her experiences for my study. I also chose to conduct just one interview per participant out of respect for the participants themselves. All of them were busy mothers who were pregnant and/or had small children and working both inside and outside the home. Four participants were due to give birth within a few weeks of our interviews, and I felt it disrespectful to take up any more of their time for my own research, after I had reached data saturation, and they were busy preparing to give birth. Furthermore, including a broad range of pregnant and postnatal participants in my cohort provided me with a breadth of experiences sufficient to make more than one interview with individual participants unnecessary.

As a feminist researcher conducting a study situated within an epistemological framework of social constructionism, I recognise that I cannot bracket out the experiences and opinions that I myself bring to the table when conducting my research. However, also as a feminist researcher, I view my own knowledge and experiences as a resource rather than a barrier in helping me to understand the participants' experiences. Thus, my professional background as a journalist enabled me to formulate questions that would help participants reflect upon their experiences, quickly build rapport with them and actively listen to them during data collection. Reflexivity is also an integral component of feminist research (Hesse-Biber 2014), and this means that while my prior experiences and knowledge are a resource that can help me better understand the phenomena under investigation, it also means that I must foster a strong self-awareness in relation to the emotions and thoughts I have while conducting research. In order to foster this self-awareness, I kept a journal in which I recorded my thoughts and feelings following interviews. I also discussed these with my supervisors. Further issues, which changed the way in which I thought about interviews and ultimately helped me grow as a feminist researcher, arose while conducting the interviews. These will be discussed in further detail in Section 5.4.7.

Secondary contextual data regarding the maternity services and healthcare policy was collected from a review of national policy documents and reports, including the National Maternity Strategy (DoH, 2016), the National Standards for Safer, Better Maternity Services (HIQA 2016), the Mid-U study (2009) and the HSE homebirth reports (Meaney et al 2018/2020), as well as data from the Central Statistics Office. A third level of data was garnered from attending informal meetings with midwives and others working within the areas of maternity and

policy, attendance at reproductive rights meetings and public demonstrations in the run-up to the abortion referendum in May 2018, and my ongoing work as a journalist covering healthcare stories. This added depth to my experiential knowledge of the maternity services in Ireland.

5.4.7 Interviewing Women: Data collection as system-challenging praxis

Issues regarding gender and power arose during the data collection phase of this study. When I began my data collection in September 2017, I was confronted with unexpected scenarios in the field, namely, a desire on the part of participants that our relationships be reciprocal, expressed by participants in the form of questions about my opinions or personal experiences. This challenged both my notions about the relationship between researcher and participant and about objectivity. This conflict led to further reading on feminist scholarship and praxis which, in turn, informed and strengthened my theoretical framework and epistemological foundations regarding the production of knowledge as I completed my data collection.

Traditionally prescribed behaviour for the qualitative research interviewer would be to take on an active role, directing the interview and eliciting information/data, while remaining objective and detached but friendly (Selltiz 1965). In contrast, interviewees would be expected to remain passive, responding to interviewer's questions with useful information, and not posing questions of their own to the researcher. As interview techniques in the field of sociology developed throughout the 20th century, some sociologists such as Sjoberg and Nett (1968) and Galtung (1967) gave advice on specific interview techniques designed to help researchers maintain objectivity in relation to their participants. This involved suggesting that researchers use non-committal phrases in order to deflect requests from interviewees for information or support.

However, a number of feminist researchers, such as American sociologist Marjorie DeVault (1999) and British sociologist Ann Oakley (1980), began to find traditional interview models inadequate when interviewing women, particularly about intimate subjects such as childbirth, hysterectomies or sexual assault. Oakley (1981), whose longitudinal study *Transition Into Motherhood* (1974-1979) established a new paradigm in feminist research, offers a compelling critique of traditional interview methods. She suggests they are the product of a masculine paradigm,

and thus prove inadequate when researchers – particularly those who are interested in redressing patriarchal power dynamics – are interviewing women:

The entire paradigmatic representation of “proper” interviews in the methodology textbooks owe a great deal more to a masculine social and sociological vantage point than to a feminine one. For example, the paradigm of the “proper” interview appeals to such values as objectivity, detachment, hierarchy and “science” as an important cultural activity which takes priority over people’s more individualised concerns. Thus, the errors of poor interviewing comprise subjectivity, involvement, the “fiction” of equality and an undue concern with the ways in which people are not statistically comparable (Oakley 1981, p 38).

These beliefs surrounding the conduct of “proper” interviews are not only intertwined with gendered notions of objectivity and subjectivity (an ongoing issue within maternity care, See Chapter 3, Section 3.4.4); they are also linked with broader gendered stereotypes and reflect the values of the dominant masculine group, such as objectivity (however false that might be) and privileging intellect over emotion (however unrealistic that is). Because of this, what passes for “objective” in many studies is actually the position of privileged white males (Hubbard 1979, p 31).

Some feminist researchers choose to work within traditional research frameworks or value systems, in order to have their research recognised as valid, and thus reach the widest possible audience (Reinharz 1992). Initially, I adopted this strategy for my study, and I began fieldwork with an underdeveloped concept of scientific objectivity, especially regarding the power dynamics between the researcher and the researched. I had not yet spent time unpacking that idea, but I (naively) believed that objectivity was something I could and must maintain in order for my data collection – and myself as an academic – to be legitimised. But like Oakley, I found my notions of scientific objectivity and techniques for diverting interviewee requests for information or reciprocity quickly becoming untenable in the field. I, too, found that the interviewees asked a number of questions. I also found that the inevitable relationship that is formed between two mothers while conducting interviews on the intensely personal experiences of pregnancy and birth meant that establishing reciprocity between myself and the participants ultimately facilitated interviews rather than hindered them.

Oakley (1981, p 43) movingly describes a request for information from one frightened mother/participant who asked, "Is it right that the baby doesn't come out of the same hole you pass water out of?". Oakley foreshadowed my own experiences when she wrote: "It would be the understatement of all time to say that I found it very difficult to avoid answering these questions as honestly and fully as I could" (1981, p 43). She identified that she was asking a great deal of the women, not only in terms of time but also in terms of asking them to discuss intimate, emotional and even taboo topics. Because of this, she felt a responsibility to establish a reciprocal relationship between herself and the participants.

Social scientist Christine Webb (1984) also experienced a similar incongruity between theory and praxis when she interviewed women about their experiences of hysterectomies:

To respond to these women with "uh huh" or "that's interesting" ... would have been somewhat awkward to say the least and would not have contributed to encouraging them to speak openly about their experiences. ... But neither did I feel it appropriate to collude in criticising the hospital or doctors in the context of a research interview (Webb 1984, p 253).

Conducting interviews with the first few research participants, I experienced situations that were perhaps not so stark as those experienced by Oakley and Webb, but none-the-less involved interviewees seeking information from me. I felt I needed to give them something of myself – something that went outside my self-imposed rules of "objectivity" or the traditional interviewer/interviewee power dynamic – in order for the interview to continue, and in order for the interviewee to continue to divulge information/data. The first interview was conducted with a woman who worked as a scientist, and we followed a traditional participant-researcher format. This began to prove inadequate by the second interview. During this interview, the woman described the birth of her daughter in very intimate detail, revealing sensitive, potentially embarrassing information about her body. She then asked my opinion on something about the maternity services. I paused, hesitant to express an opinion, but realising that in that situation, it would be insensitive not to share something of myself, and potentially damaging to our fledgling relationship, after she had shared such intimate information with me. A similar situation developed with the third participant, when she asked me my opinion on why the medical model of birth is perpetuated in contemporary Ireland. She had also just shared intimate details of her birth stories, and a number of her

own opinions, with me. I gave her an indefinite answer, hoping we could return to her reflections, but this approach did not answer what this participant needed (and clearly had not had access to during her care), and she asked for my opinion again. Through her words and facial expressions, it became evident that she would not reveal more information without first receiving some from me, in the form of my opinion on the medical model of birth. These experiences in the field taught me that I had to approach my relationship with the participants in a different way. I read the discussions by other feminist scholars, which helped me to amend and develop my approach to field work and data collection. As my approach became more nuanced, I offered more information about myself when the participants made inquiries, focusing on building a more reciprocal relationship with the participants and more equitably distributing power. This in turn prompted the participants to deepen their hermeneutic exploration of their experiences and expand our shared horizons, adding phenomenological breadth and depth to this study.

In this section I have detailed my data collection phase, which is in line the second step in van Manen's methods for conducting phenomenological research. I will now turn to his third step.

5.5 Step 3: Hermeneutic phenomenological reflection: Data analysis

Once I completed the collection of life stories and experiences, I progressed to van Manen's third step, Hermeneutic Phenomenological Reflection. This step denotes an iterative, circular analysis of the data, and involves movement from the particular, out to the general and back to the particular. This continuous analytical process ensures that the particular experiences and understanding of the participants are highlighted, while the broader social structures that shape those experiences are also examined (Ohaja 2015). It is in thus within the analysis of the data that Heidegger's notion of being-in-the-world, as well as the concept of the hermeneutic circle and the Gadamerian fusion of horizons is incorporated (See Table 1). In particular, a circular analysis involves the contemplation of themes, which are used as tools to understand the meaning of an experience. The themes disclose or reveal meanings and provide the "structures of experience" (van Manen 2016, p 790).

5.5.1 Data analysis

In order to uncover themes, or structures of experience, from within the data, I employed van Manen's three approaches, including the wholistic approach, the selective or highlighting approach, and the detailed or line by line approach. The wholistic approach examines the text, which in the case of my study were the interview transcripts, and asks what the fundamental meaning of the interviews as a whole would be. By employing the selective approach, a researcher engages with the text, highlighting reoccurring themes or issues that capture the experience of the participant. Finally, the line-by-line approach examines each sentence in order to discern which segments best reveal or provide insight into the experience. I will return to these three specific approaches and the application of them to my analysis further on in this section.

Polit and Hungler (1999) suggest that the search for themes begins the moment data collection commences. Thus, even as I conducted the interviews, I began thinking about possible themes emerging from the participants' experiences. Following each interview, I wrote in my research journal about each participant's main points and the potential themes that had arisen. I also noted any strong emotional reactions I had to the stories the participants told me. I often felt angry about the way in which participants had been treated by hospital staff or family members. While these feelings were an inevitable part of my interpretation of their experiences, I did not want to analyse the data solely through the prism of frustration, but within my broader personal and the larger social context.

I traversed between van Manen's three approaches throughout data analysis, in order to ensure that I adequately understood and captured women's experience of accessing alternative birth models in contemporary Ireland. In order to familiarise myself with the data, I transcribed the audio recordings of the interviews myself and then listened back to them, comparing the text with the audio recording, to ensure accuracy and to develop further understanding of the text. This phase of analysis was highly iterative, as I repeatedly re-read the transcripts (Thomson and Downe 2008). In line with van Manen's wholistic approach, I read each transcript, examining each one as a whole and then analysing all 28 transcripts, and their relationship with each other, as a whole to gain a holistic understanding of the phenomenon of access to alternative birth models. As I did so, I considered what the fundamental meaning of each transcript was, as well as the meanings and themes of the full set of transcripts. During this process, I selected words, phrases

or statements that were shared by multiple participants, or seemed to be of significance to all of the participants' experiences. These formed the beginnings of themes that gave meaning to the phenomena under investigation.

In order to develop these themes further, and ensure they were grounded in the data, I printed out and re-read the texts of the transcripts, following van Manen's selective approach to data analysis. I then manually coded themes and sub-themes, narrowing down the ones that were of most significance based on their recurrence within the texts and between participants. I then followed van Manen's line-by-line approach, examining each sentence in order to discern which ones best reveal or provide the most insight into the experience. Following this, I used NVivo qualitative data analysis software to facilitate better organisation and storage of the data, and for transparency.

I also created mind maps, which visually helped to clarify the themes and subthemes that were of most significance. An example of the initial mind map I created regarding information and choice is below.

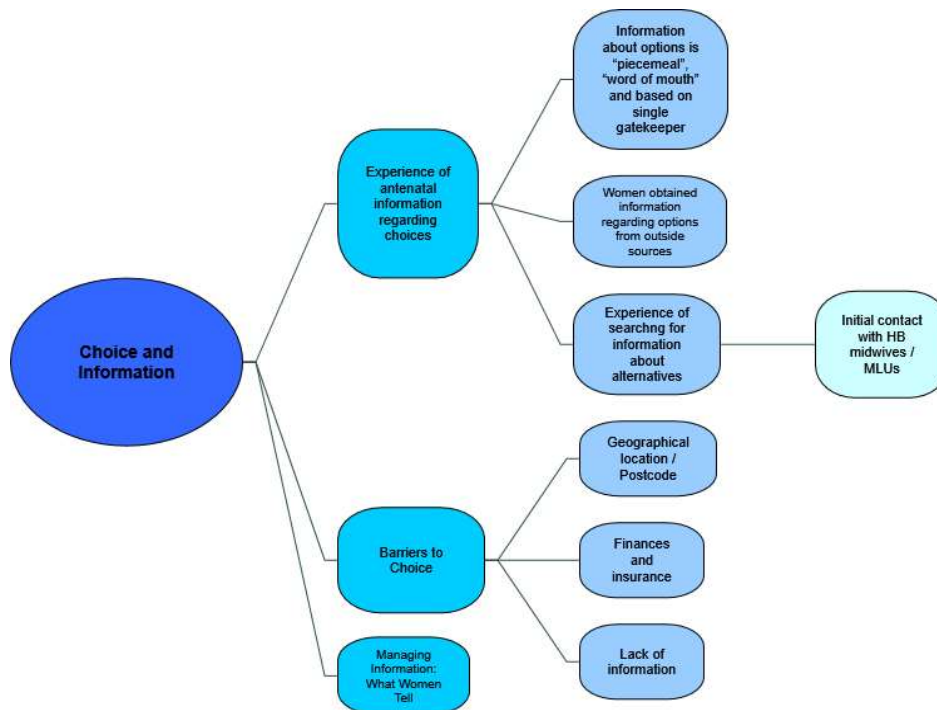


Figure 1: Initial mind map for the theme of Choice and Information and emerging sub themes (see Appendix 7 for an enlarged image)

An example of the initial mind map I created regarding authoritative knowledge, policy and candidacy (eligibility) is shown here:

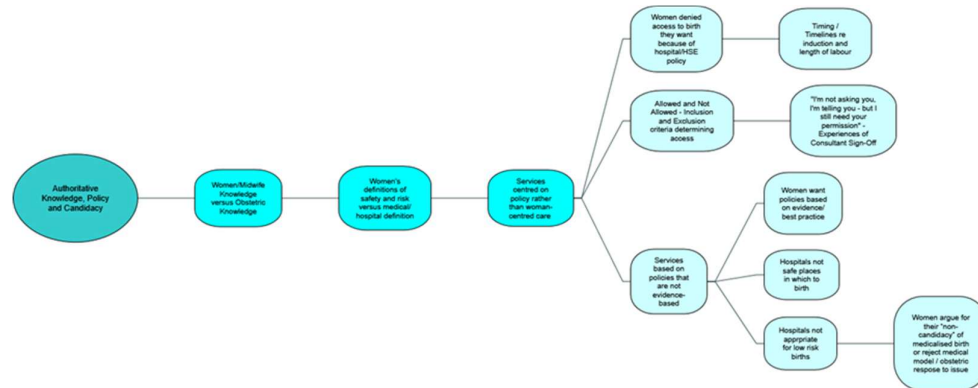


Figure 2: Initial mind map for the theme of authoritative knowledge, policy and candidacy and emerging sub themes (see Appendix 7 for an enlarged image)

The themes within these mind maps were later refined as I discussed them with my supervisors and returned to the data. For example, through these steps, the issue of gathering information regarding options emerged as a dominant theme shared by all participants, while it became clear that the initial theme of managing information was only important to a limited number of participants and thus did not capture the collective experience of access to alternative birth models shared by my participants. These and other themes were also refined as I began writing my findings chapters based on my data analysis. As will be discussed in Section 5.6, van Manen argues that the writing process itself is an essential step in uncovering the meaning, and the significant themes, within a phenomenological inquiry. It was thus through writing multiple drafts of my findings chapters, as I refined the themes and sub-themes, that I was able to focus on those that would most clearly explain the meaning of the phenomenon.

Heidegger's concept of being-in-the-world, the concept of the hermeneutic circle that both he and Gadamer developed, and the latter's notion of the fusion of horizons, informed my analysis of the data, as has my feminist framework. As discussed in Section 4.4.2, the concept of being-in-the-world signifies the idea that our existence and experiences, cannot be isolated from the social and historical

context in which we are situated. Likewise, our understanding and interpretations of our experiences are also situated within “the world”. This is aligned with feminist theory, which embraces the notion that realities are socially constructed and that gendered social structures shape women’s personal experiences (See Section 3.3). The concept of “fusion of horizons” encompasses the idea that while people have their original prejudices – or horizon – this horizon can be fused or expanded as one examines new information (Section 4.4.3). As horizons are fused together, the participant and researcher begin to influence and inform one another’s experiences and interpretations, forming the hermeneutic circle. The practical implications that these concepts have had during the data analysis phase are outlined in Table 1:

Table 1: Data analysis framework

Hermeneutic phenomenological principles	Application	Feminist principles	Application
Being-in-the-world	I acknowledge that the experiences of the participants are situated within the context of the Irish maternity services and shaped by the social and historical specificity of contemporary Ireland. Prior to analysis, I developed an understanding of the context in which they were attempting to access alternative birth models and analysed their personal experiences through this lens.	Realities and experiences are socially constructed, and women’s lived experiences, particularly of oppression, are situated within and determined by the social, cultural and historical context in which they live.	I acknowledged and examined gendered structures of oppression in which the participants’ experiences took place and connected their personal experiences to the broader social context. Likewise, I acknowledge that the differences in each woman’s lived experience were subjective, diverse, fluid and relative.
Hermeneutic Circle	I developed an understanding of	The production of knowledge is co-	As I analysed the transcripts, I

	<p>the participants' experiences through this iterative process, which involved moving back and forth between parts of the transcripts (the parts) to each transcript as a whole (the whole). This allowed me to understand the themes which formed the meaning of access to alternative birth models.</p>	<p>constructed through interactions between individuals and through interactions between individuals and their wider community/ social context.</p>	<p>acknowledged the expertise and knowledge that the participants hold in relation to the subject under investigation. My knowledge and expertise were informed by theirs. During data collection, my relationship with the participants was collaborative, and their experiences informed the questions that I posed to subsequent participants, thus making them co-creators in the process of knowledge collection and production (See Section 5.4.6 and 5.4.7).</p>
<p>Fusion of horizons</p>	<p>My understanding of the participants' experiences of access to alternative birth models was broadened as I read and re-read the transcripts. This deeper understanding allowed my original horizons, or limits of understanding, to be fused with new horizons, or points of understanding, as I produced themes from the data.</p>	<p>Acknowledgement of multiple subjectivities</p>	<p>The varied viewpoints of each of the participants and their embedded prejudices, as well as my own, were considered in the overall meaning and interpretation of the phenomenon of access to alternative birth models.</p>

Genuine listening	Through transcribing the audio recordings of the interviews and multiple readings of the transcripts, I allowed the words and texts (transcripts) of the participants to speak to me so that I could accurately understand common themes. In instances where my assumptions were inaccurate, I allowed the experiences of the participants to correct my understanding.	Woman-to-woman talk	Analysing the interviews of the participants, which were based on dialoguing with them, allowed me to utilise the experiences and conversations of women as my primary source of meaning and information.
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(Cubukcu 2012, DeVault 1999, Gadamer 1975, Hesse-Biber 2014, Heidegger 1962, Ohaja 2015, Squire 2009)

5.5.2 The problem of data analysis in phenomenological research

As outlined in Section 5.5.1, van Manen proposes three steps for analysing a phenomenon in depth to create themes, which he defines as meaningful insights that help the researcher and the reader understand what a phenomenon is like for those who have lived it (van Manen 2016). However, in his later work, van Manen warns that phenomenological data cannot be analysed and codified through present day qualitative methods that employ the language of data collection, capturing, coding and analysis (van Manen 2017a). In fact, he argues that the words “data” and “analysis” in the sense of collection and coding are not appropriate for a phenomenological inquiry, identifying: “It is actually somewhat bizarre to use the objectifying term ‘data’ for phenomenological inquiry as phenomenology is concerned with meaning and meaningfulness rather than ‘informational’ content” (van Manen 2017a, p 814).

This is because methodologically, phenomenology relies on data as phenomenological examples, rather than data as objectified or coded units, he asserts. Examples in a phenomenological inquiry serve to examine and express

aspects of meaning of the phenomenon. Within the context of phenomenological inquiry, a researcher should not be concerned with informational units of data that can “objectively” demonstrate something. Instead, the focus of a phenomenological inquiry is to get to the understanding of a phenomenon and to convey this meaning to readers through examples that illuminate and illustrate what the phenomenon was like for those who lived through it (van Manen 2016/2017a).

However, as a novice researcher, a PhD candidate must also be able to demonstrate both that she understands qualitative research methods and demonstrate trustworthiness and rigour. In order to reconcile these disparate concerns, I have used phenomenological examples, individually experienced, and brought together into themes, in order to convey the meaning of the phenomenon of attempted access to alternative birth models. These themes are included and discussed within my two findings chapters. However, in order to demonstrate my familiarity with general qualitative methods and my decision trail, I have, as seen above, employed the language of data collection and analysis used within other qualitative methods. I am using this language cognisant of the fact that when I employ a word such as “themes”, I am using it in the sense of a phenomenological theme or example. When I employ “coding”, I use it not because I am strictly speaking dealing with informational units, but because organising themes from collections of hermeneutically interrogated exemplars in such a way assists me in the process of understanding and presenting the phenomenon under investigation.

5.5.3 The self as a resource in data analysis

In research that is underpinned by hermeneutic phenomenology, such as this study, a researcher recognises that experiences take place within “the world” (Heidegger 1962), that is, within a social context (van Manen 2016). This signifies that the way in which participants experience a phenomenon and the meanings they assign to these experiences are mediated through the social and historical context in which the participants are situated (Koch 1996). The researcher also brings her own interpretations to the participant interviews, and thus the data analysis consists of a double hermeneutic – the participants’ interpretations of her experiences and the researcher’s interpretations of the participants’ experiences, all of which are socially and culturally specific. Within the context of feminist research, this double hermeneutic facilitates the co-production of knowledge.

It is this fusion of the participants' experiences with the researcher's own interpretations that is the strength of hermeneutic phenomenology, as it leads to greater understanding (Koch 1994). A researcher's own historicity and values do not constitute an obstacle to the research process but instead make research meaningful (Koch 1994). Furthermore, Heideggerian phenomenologists challenge the notion that theory can be generated from the standpoint of a researcher who stands outside of a situation (Koch 1995). This takes us to the heart of hermeneutic phenomenology, which is based on the assertion that knowledge begins with lived experiences (van Manen 2016).

Experiential knowledge proved to be an asset for both myself and the participants. When conducting interviews, my knowledge of birth as a multiparous woman (and former doula) informed my questions and helped me understand the issues discussed by the participants. From the point of view of the participants, knowing that I had experiential knowledge of pregnancy and childbirth was very important, as they were then confident that I understood what they were talking about.

It is thus my interpretation of the participants' experiences – my co-construction of meaning with them – and my ability to understand them that helps me to reveal and express a greater understanding of their experiences, in this case, of accessing alternative birth models. Bracketing my experiences – if that were possible – would only diminish or obscure the double hermeneutic underpinning my understanding of the participants' experiences and the co-construction of meaning.

5.6 Step Four: Hermeneutic phenomenological writing

Integral to van Manen's definition of phenomenological research is the process of writing about a phenomenon, and thus he defines Hermeneutic Phenomenological Writing as a crucial fourth step in the conducting of a phenomenological study. Good phenomenological writing, he argues, reawakens a basic experience of a phenomenon, so that the reader can come to a better understanding of it, as lived by those who experienced it (van Manen 2016). Through the writing process, it is my task as researcher to make visible the experiences of the women who attempted to access alternative birth options.

Writing thus formed an integral part of the data analysis phase. As part of this work, I wrote multiple drafts of my findings chapters, refining the themes exemplified in

Figures 1 and 2 (See Section 5.5.1) as the experiences of my participants became more visible through each draft. This work of rewriting and reworking to reveal the dialectic between experience and context then enabled me to return to my findings chapters with an even clearer understanding of the context in which my participants' experiences were situated. For example, as seen in Figure 1, I initially conceptualised "choice" as a theme. However, through writing about it within this initial assignment, I realised that the concept of "choice" was better aligned and understood if positioned within my theoretical framework rather than as a theme. Likewise, through writing about the notion of authoritative knowledge, seen in Figure 2, I realised an early discussion of it as a foundational concept underpinning healthcare and the maternity services was more appropriate than a later discussion of it as a theme.

Thus, van Manen's initial four steps cover the lifespan of a research project, from developing an initial understanding of the topic and a research question, to collecting and analysing data to writing up one's findings. However, throughout all these steps, a researcher must establish rigour and trustworthiness. It is these issues that van Manen incorporates into his fifth step.

5.7 Step Five: Maintaining a strong and oriented relation to the phenomenon: Establishing rigour and connecting theory with practice

Van Manen's fifth step is concerned with rigour and reminds the researcher to remain focused on the fundamental question and concepts of her inquiry. Furthermore, he argues that a researcher must connect theory with practice and use it as a springboard for action. This concern with rigour or trustworthiness can be seen throughout research, and is something all researchers strive for, not just those working within the framework of phenomenology. Likewise, feminist researchers are committed to making visible the process of knowledge production (Ohaja 2015, p 154). For those conducting quantitative research, set within a positivistic paradigm, establishing rigour is achieved by demonstrating replicability and objectivity (Koch 1994). However, this is neither possible nor desirable within the context of feminist qualitative research that is situated within a hermeneutic framework. Therefore, the question becomes, how does one establish rigour or trustworthiness within such a study?

Guba and Lincoln (1989) suggest that instead of appealing to criteria of replicability and objectivity, qualitative researchers can strive for credibility, transferability and

dependability (Guba and Lincoln 1989). A researcher's self-awareness is essential in order to establish credibility, which is enhanced when the researcher describes her experiences and interpretations as a researcher. Keeping a research journal, a practice I have followed, increases self-awareness (see Section 5.5.1). Following on from this, dependability refers to the notion that a study can be "dependable". A study is dependable if it can be audited, that is, if readers can clearly follow the decision trail made by the researcher (Guba and Lincoln 1985, 1989). Furthermore, a study can be considered dependable when, given transparency in the report, another researcher could arrive at similar or comparable conclusions, but not contradictory ones (Sandelowski 1986). Transferability – also referred to as "fittingness" by Guba and Lincoln (1989) – denotes the suggestion that researchers should adequately describe the social context of the study so that readers can see how the participants experiences "fit" into the context. It refers to the notion that one's findings could be transferable to another situation, and that people from a different country or healthcare system could relate to them. In order to accomplish transferability, a researcher should provide sufficient contextual information so that it is possible for others to make similar judgements or come to similar conclusions (Reinharz 1983).

Koch (2006) expands on the ideas of Guba and Lincoln, writing that a researcher employing hermeneutic phenomenology can establish rigour by providing a detailed description of the "decision trail". This involves an explanation of the decisions the researcher made throughout the study, particularly in relation to the themes or experiential exemplars that are decided upon during data analysis. Through a description of this decision process, a reader will come to understand why the researcher made her decisions, even if the reader might have made different ones. Koch writes:

The themes emerging from the text are not always the same for researchers and readers because perfect agreement when analysing the same material would not be expected. Readers may not share the authors' interpretation but they should be able to follow the way in which the author came to it (Koch, 2006, p 92).

With this in mind, I have described the context in which my study participants lived their experiences in Chapters 2 and 3 in order to establish transferability (Guba and Lincoln 1989). In order to establish my decision trail (Koch 2006), I have detailed the methods I have employed as I conducted this study, including my

decisions and actions regarding data collection and analysis. Furthermore, in the presentation of my findings (see Chapters 6 and 7), I have primarily used direct quotes from the participants. It is hoped that this will assist the reader in judging that my interpretation is an accurate representation of the participants' accounts of their experiences.

Along with addressing rigour within a research project, maintaining a strong and oriented relation with a phenomenon means that research must have a strong connection to real life, that theory and praxis should not be separated. For van Manen, this means that research that is truly phenomenological must also be a call to action. He writes:

Hermeneutic phenomenological reflection deepens thought and therefore radicalises thinking and the acting that flows from it. All serious and original thinking is ultimately revolutionary ... and so to become more thoughtfully or attentively aware of aspects of human life which hitherto were merely glossed over or taken for granted will more likely bring us to the edge of speaking up, speaking out or decisively acting in social situations that ask for such action (van Manen 2016, p 154).

The phenomenon under investigation for this study is women's lived experiences of attempted access to alternative birth models in contemporary Ireland. These experiences are situated within the context of the Irish maternity services, and the country's chequered history of access to reproductive care for women. As such, I am called upon as the researcher to "speak up" in regard to any implications their experiences have for service provision and policy implementation (see Chapter 9). Considering my feminist theoretical framework, feminist research is also inextricably linked to action (Kennedy 2002, Young 2005). Therefore, as a feminist researcher conducting a hermeneutic phenomenological study, it is necessary to think about the implications my research may have for the maternity services and any changes that might be proposed. These will be explored in my final chapter.

5.8 Step Six: Balancing the research context by considering the parts and the whole

Step six reminds the researcher to continuously measure the parts of the research, such as the stories from participants, within the larger context of the study as a whole and within the broader social context. As discussed in Section 5.5, I

considered the parts (one participant's experiences) in relation to the whole (the experiences of the other participants) and the collective experiences of the participants in relation to the social and historical context during the data analysis phase. In the following two findings chapters, I will present the participants' experiences, while in Chapter 8, my discussion chapter, I consider their lived experiences and the phenomenon of attempted access to alternative birth models within the larger social context.

5.9 Conclusion

In the operationalisation of this study, I have relied upon van Manen's methods, or six steps, for conducting a hermeneutic phenomenological inquiry. Working within this framework, I chose a population sample, recruited participants, collected data, primarily through semi-structured interviews, analysed the data, and wrote and rewrote the findings. Through the data analysis, the lived experiences of this inquiry's participants came to light. These experiences have been structured in the form of themes, and it is these themes that are presented in the following two findings chapters.

Chapter 6: Information and the dismissal of women's birth choices

6.1 Introduction

Informed choice is a hallmark clinical principle in contemporary midwifery (MacDonald 2018) and forms a pillar of respectful maternity care under WHO intrapartum care guidelines (WHO 2018a) (see Chapter 3, Section 3.5). The notion of informed choice implies a level of information and understanding and requires that individuals have access to the information needed to make their decisions (Symon 2006). Once an individual has all the relevant information, she can weigh up the available choices and choose the option that best suits her and her baby. However, even after a woman makes her decision regarding birth options, her choices are often dismissed, particularly if they are situated outside the parameters of the medical model of birth and obstetric calculations of risk. Dismissed as troublemakers (Jordan 1997), women who decide to birth within alternative settings are often accused of inaccurately assessing the risks inherent in birth and failing to protect their baby (Craven 2005). By accusing women of bad choices in relation to their children, obstetrics contends that doctors are better equipped to make "good" decisions regarding childbirth than the women they deem to be delinquent. Healthcare professionals, such as GPs, can employ a specific risk discourse referred to as "shroud waving" or the "dead baby threat" in order to challenge or dismiss women's choices (Plested and Kirkham 2016).

The findings from analysis presented in this chapter illuminate the participants' lived experiences of gathering information regarding alternative birth models, where and how they received this information and how this information (or lack thereof) affected their access to birth models. For many participants, the initial interaction with GPs and hospital-based midwives was significant in determining whether they received information regarding access to alternative birth models from healthcare providers, or whether they did so from alternative sources such as websites, female friends or directly from Self-Employed Community Midwives (SECMs), who provide homebirth services through the HSE scheme. GPs and midwives who conducted the booking visits with the participants thus played a crucial gatekeeping role in the experiences of the participants. Overall, the data from the participants showed that information given to pregnant women is neither standardised nor adequate, in that not all options, particularly midwifery-led

options, are presented, even to those with low-risk pregnancies who live in the catchment area in which alternative models are available. Furthermore, a number of participants indicated that information regarding midwifery/homebirth models was primarily gathered through informal channels, such as friends or online forums, rather than within the context of their initial booking visit.

I also present findings in relation to the experiences of some participants in which their decisions regarding birth options were challenged or dismissed, as they sought to gather information and, later on in their pregnancy, as they attempted to discuss their choices with healthcare providers. Some of the participants had their decision or desire to give birth at home questioned or criticised by their GPs. Birth choices made by other participants were also dismissed by healthcare professionals using the mechanism of the Eighth Amendment as a tool with which to exert power and control over the participants.

Following this chapter, I will present my second set of findings in Chapter 7, which covers the theme of permission and timing, and then discuss the findings in their entirety, as they relate to my theoretical framework and the relevant literature, in Chapter 8.

6.2 Gathering information

6.2.1 Gathering information – from healthcare professionals

The lived experiences of the participants regarding the information they received and gathered about birth options varied greatly and depended largely on the initial healthcare professional with whom they met during their booking visit. For example, two participants were told about the HSE homebirth scheme by a hospital staff member, while those attending the National Maternity Hospital were told about the hospital's homebirth scheme. Five of the 12 participants in Cavan and Drogheda initially found out about the MLUs during their booking or early antenatal visits. Those who were told about the full range of options, including homebirth and the MLUs for those living in Cavan or Drogheda, considered themselves lucky to have met with the healthcare professional they did, and yet they still often felt they had "happened upon" the information.

The participants who were told about either homebirth options or the MLUs by healthcare professionals felt this information was given to them by chance and depended on the GP/midwife with whom they met on the day. Participants used

different language to describe this experience, including the phrase “word of mouth” to indicate the non-standard, almost accidental dissemination of information regarding alternative birth models.

Sara, for example, was one of the participants who was told about the HSE’s homebirth scheme by a midwife during her hospital booking visit. Sara was pregnant with her third child when we conducted our interview and had given birth to her first child at a birth centre in Sydney, Australia. She then returned to Dublin and was living in the catchment area for the National Maternity Hospital’s (NMH) homebirth scheme and gave birth to her second child at home through that. She then moved to the northside of Dublin. She knew that she was outside the catchment area for the NMH, and therefore thought her only option was to give birth at another maternity hospital (which does not have a homebirth scheme). She said:

I was talking to a midwife there and she said, oh is this your first baby in [this hospital] or if you’ve been here before? And I said, no, my first daughter was, or my daughter was born in Australia and my son was born as a homebirth through Domino [at the NMH].

And she said, oh, are you having a homebirth again? And I said, oh, I thought I couldn’t have one. And she said, oh no, ye can, you can. You just need to, em, she said you just need to find your own midwife and you need to be signed off. ... So, but she actually was kind of saying, look into it. Have a look into it now.

Em, and then I, so I did. And then I saw that you can have em, a HSE midwife [SECM] and, you know, they’ll liaise with the hospital and it’s this fantastic service that only seems to be word of mouth. I didn’t see it anywhere. It was only because she said that.

Sara, p 2, L 18-27

Sara reiterated her belief that the fact that she had been provided with information regarding the HSE homebirth scheme was due to her chance encounter with a particular midwife, who acted as gatekeeper to the information. She said:

Yeah, so it seems to be quite behind here [in Ireland] ... like the fact that I only found out about this [the HSE scheme] through word of mouth. That,

that midwife – like, if I'd had a different midwife that day, I might not have found out about it at all.

Sara, p 13, L 17-20

While attending a local midwifery clinic run by the same hospital she attended, Sara discovered that the midwives there did not know about the HSE homebirth scheme. This experience reinforced for Sara the idea that the information regarding the HSE homebirth scheme had only been provided to her because of the specific midwife on duty during her booking visit. She said:

And even when I went to, em, I went to see the community midwives and they've got the clinic up there, and I said about what I was doing, and they said they'd never heard of it. The midwives themselves had never heard of it.

Sara, p 3, L 3-6

Another participant, Fiona, spoke of her experience with information regarding the homebirth scheme at the National Maternity Hospital. Like Sara, she found out about the scheme from a healthcare professional at the hospital during the course of her booking visit. Echoing Sara's language, she used the phrase "word of mouth" to describe the non-standardised or circumstantial way in which information was shared.

Fiona, who works for a health insurance company, said the birth options that women know about often relate to the type of health insurance they have or don't have, with women thinking about birth options only in so far as they include private, semi-private or public care¹⁹. However, she said, most women, including herself initially, aren't aware of options regarding the full range of birth models. Fiona, who was originally planning to opt for semi-private care, said:

So I just, I actually said to the consultant, I've been reading up about active birth and I said, you know what, I'd be interested in an active birth. And she

¹⁹ Under the MICS, all pregnant women are entitled to free maternity care. If a woman has insurance or the financial means to pay out of pocket, she can pay for private or semi-private care. With private or semi-private care, women can meet with a consultant during their visits, they can have semi-continuity of carer in the form of a consultant or group of consultants and they can share a room with a limited number of other new mothers, following the birth.

said, well, there's absolutely no point in going semi-private. Why didn't you sign up to the Domino midwives? Which is a scheme available out here...

I think there's a very low, a very low awareness of that. And so people think their options are public, private or semi-private but they don't necessarily know about the community midwife option in public, which is absolutely amazing. And it's very much word of mouth.

Fiona, p 1, L 28-p 2, L 9

Later during the interview, Fiona reiterated her belief that information regarding the NMH's homebirth scheme is disseminated in a piecemeal manner, even though information is available on the hospital's website. She said:

I don't know how you hear about it. Like it's advertised on the website but I think most people are [made aware of it by] word of mouth.

Fiona, p 14, L 12-13

Fiona then spoke about the information shared among mothers about birth, suggesting that women need support and information about physiological birth early during the antenatal period. She said:

I think you hear more negative stories than positive stories actually about birth and when you're at these postnatal groups it's like you're sharing a badge of honour almost and how horrible, not how horrible was yours, but people look at you when you say, no I did it naturally and I had no intervention and I had no painkillers and I had no – they kind of look at you going, wow, like.

So I don't think there's enough support, you know. And I think more women could do it but there needs to be much earlier support.

Fiona, p 15, L 11-18

For Deirdre, a pregnant participant, the information pathway was straightforward. She also heard about the HSE scheme through several hospital-based midwives during one of her antenatal visits. They told her about the HSE homebirth scheme

and the link to the website with the contact details. Deirdre, who was over 20 weeks pregnant at the time she rang the SECMs²⁰, said:

They [the hospital-based midwives] told me about the HSE, um, scheme. ...Um, so they told me about the link for the midwives [SECMs]. And I contacted [my SECM] through that – I contacted about four or five of them but [my SECM] was the one who got back to me, because she had a cancellation in November [due date].

Deirdre, p 2, L 22-27

Another participant, Eva, also received information about her options during her initial antenatal visits from midwives working in the local community clinics, who were attached to a Dublin maternity hospital. However, Eva suggested that obtaining information about all of one's options remains challenging, even if a woman is meeting with midwives experienced in supporting natural birth. She said:

It's just like, if you choose to find the information, you can. So I don't think people in, I don't think the general thing is that you are given the information. I think you have to look for it. And even then, you won't know where to look for it unless, you won't even know it exists, I suppose, if you're not within circles of people that are into it, or you're not in a community midwives' scheme - that knowledge and information just isn't there.

Eva, p 28, L 15-21

In contrast to those who received or gathered information regarding homebirth schemes, most participants interested in giving birth in the MLUs in Cavan or Drogheda areas had previously heard about the units, although this information was also garnered largely through informal channels, including friends or relations. One participant, Anna, who was hoping to give birth to her first child in the MLU in Drogheda, said the service is not well advertised but that she found out about it from two sources – from being “quite known” in the local area and her GP. She said:

Well, I think, so I'm, I'm from Drogheda, so the MLU is quite known in the Drogheda area. Em, and you know - and not that it's well advertised

²⁰ As there are so few SECMs, individual SECMs might not have the capacity for women hoping to book with the HSE scheme after the first trimester.

because I don't think it is advertised as well as it should be - but em, I think it was probably my GP had said, oh, there is the MLU, if you want to go down that road²¹.

Anna, p 1, L 3-6

Another participant, Cassie, found out about the MLU in Cavan through an information leaflet that her GP gave her. She said:

Cassie: I got a flyer from my doctor which was [entitled] Your Options.

Researcher: So you had the consultant led care and the public care, and the MLU.

Cassie: Yeah, that's how I found out about it, actually, was the flyer and I saw the MLU and I went, that's the way I want to go.

Cassie, p 1, L 14-17

Once Cassie made her decision, she rang the MLU directly and was booked in for an initial appointment.

Another participant, Agnes, was also told about the MLU by a healthcare professional during her booking visit. However, echoing the experiences of Sara and Fiona, Agnes also felt the fact that she was told about the MLU was dependent on the individual provider, who acted as gatekeeper and, in this instance, supported the MLU. Agnes, who refers to the midwife as “the nurse”, said:

I think it was actually the nurse who told me about the MLU. She was booking me into the hospital and she's a really nice nurse ... she just seemed to be a kind of rebellious sort of a nurse. I don't know, that's kind of what I got from her. She was kind of like saying, yeah, the consultants don't like, you know, they're trying to keep you over to this side of the ward [the CLU] but you're, she was saying, you're totally the demographic [for the MLU]. You're the exact sort of person that would love the MLU, so if you're interested I can just, I can send you up there afterwards.

Agnes, p 2, L 1-7

²¹ The reactions some participants received from their GPs when they attempted to discuss their decisions to birth in an MLU or at home will be presented in Section 6.3.

Anna, mentioned above, was told about the MLU through her GP during her first pregnancy. She then had her booking visit with the MLU and was signed up for it. However, she had to ask about the MLU during her booking visit for her second child. She said:

On our second baby, I had to ask to go into the MLU, and I don't know why that was. When I went into the booking appointment, they didn't, you know, automatically, em, put the sticker on my file and, em, I said to them, I was like, well, can I do the MLU? And she was kind of surprised, and she was, and I said, and she was like, Oh! Sure, that's no problem.

Anna, p 1, L 7-10 and p 2, L 4-7

Through these excerpts, it can be seen that the antenatal visits, and particularly the initial booking visit, are significant moments in the gathering of information regarding alternative birth models. Another participant, Caoimhe, attempted to get information from the local maternity hospitals about her birth options. Caoimhe had been living in the UK for the first three months of her pregnancy and when she returned to Ireland began to search for information regarding her birth options. Experiencing significant stress, she asked her partner to contact hospitals. She said:

[My partner] was trying to go out to the corridor on his lunchbreak and breaks and quiet times at work and make calls, which was a disaster because he could never get through to them. There wasn't, there didn't even appear to be a clear number that you could call, if you wanted to know your options for giving birth and all that sort of thing.

He was ringing the hospitals, but he was only getting through to like the front, secretary ... and they were like always confused by what he wanted, because he was like, I want to ask some questions about my partner's options for giving birth, and they were like, well, everyone's busy right now.

Caoimhe, p 14, L 36-40 and p 15, L 3-9

Thus, these findings illuminate the experiences of participants who were provided with information about alternative birth options from healthcare professionals during their early antenatal appointments. Together, the experiences suggest that information provision can be non-standardised and dependent on healthcare

professionals who act as gatekeepers to information and thus choice, as healthcare staff often have their own set of interests and concerns that shape the way information regarding options is presented to women (Armstrong 2000). These experiences mirror those from Daly et al (2021), who found the type and quality of information regarding pregnancy and birth varied between individual GPs. However, pathways for acquiring information are complex and myriad (Symon 2006), and women often turn to alternative sources as part of efforts to seek detailed information or information that is aligned with their birth philosophy (Yuill *et al* 2020), or as a mechanism of resistance to medical conceptualisations of birth (Cheney 2008) (see Chapter 3, Section 3.5.4). Thus, for some participants, like Caoimhe, who did not receive information regarding alternative birth models during their early antenatal visits, accessing information became a multi-step and complex process and many turned to sources outside their hospital or GP antenatal visits for information. These experiences are presented below.

6.2.2 Gathering information – from alternative sources

For the participants who turned to alternative sources of information outside of routine antenatal care, their independent research overwhelmingly involved speaking with other women, in person or via online groups on social media platforms. For multiparous women, this included networks of mothers whom they had met following the birth of their first child, again, in person or via Facebook groups. It also involved deliberate and focused research, primarily on the internet (e.g., conducting an internet search using terms such as “homebirth” and “Ireland”). These participants then made contact with the homebirth midwives or the MLUs themselves, returning to the setting of their booking visit with this new information in order to discuss their options with their healthcare providers.

For Ruby, the process of gathering information about alternative birth models included multiple steps. Ruby had had a traumatic experience during the birth of her first child in hospital. Because of this, she decided to seek out an alternative for the birth of her second child. She spoke with a friend, who had given birth at home with Private Midwives²², but Ruby could not afford the €4,000 fee, so she continued her search for information about whether another, more affordable, mechanism for giving birth at home was available. After searching online, she

²² Private Midwives, formerly Neighbourhood Midwives, is a private company offering homebirth services across Ireland. Women can pay for the services via insurance, if they have it, or out of pocket.

found out about the HSE homebirth scheme, but she was unclear about the specific steps she needed to take to sign up to the scheme. She describes what she did after that:

Ruby: Em, so I'd rang up two of the local health centres and they hadn't a clue. They were like, what? A homebirth? Uh, no, no, I don't know.

Researcher: Is this where you took [daughter] for her –

Ruby: The public health checks, yeah. So yeah, they hadn't a clue so I was like, right, okay then, surely that's something they should know, but... So I was googling away, anyway, and then found how to get in touch with them. And I got in touch with the main lady over it [the Designated Midwifery Officer] and she said I'd have to ring around a few of the midwives to see who'd be available around my due date.

Researcher: How many weeks were you at this point?

Ruby: I think I was about 20. So a few of them had said no, and ... then [laughs], then I got onto [SECM], and she said, yeah, I'm free, so I was like, oh my god, wow. This is happening. I couldn't believe it.

Ruby, p 9, L 21-33

Echoing the experiences of other homebirth participants such as Sara and Fiona, Ruby described the provision of information regarding birth options as “pot luck”, describing how she had to “jump through hoops” to find out about how she could access the HSE homebirth scheme. She said:

I think it was just pot luck.... Em, so yeah, definitely, like the fact that I'd never heard of it, the health centres hadn't heard of it, em, I had to go ringing around all these midwives to see if their availability. I did have to jump through hoops to make it happen.

Ruby, p 20, L 2-6

However, Ruby said that once she found out about the DMO through her internet-based research and spoke with her, and then liaised with the SECM, information about the HSE homebirth scheme was forthcoming:

Once I got in touch [with the DMO], the information was very readily available. When I got through to [the DMO], she spent ages on the phone

talking me through everything. Em, and then [SECM] was really thorough, spent hours here talking to us so, it's like, once you got in touch, they were great for answering questions and being supportive and stuff. It was more just beforehand that – it's like this secretive thing.

Ruby, p 20, L 22-26

Another participant, Mary, turned to an older woman as a source of information on homebirth. After a traumatic, hospital-based experience for the birth of her first child, Mary decided that she would give birth to any subsequent children at home. When she began to consider having another child, she went and spoke with Bridgette, the mother of a friend. Mary told me:

I told Bridgette that I was probably going to, we were going to try for a child very soon after we got married, did she know anything about homebirths? Because I thought, if anyone's going to know, Bridgette's going to know. And she said, well, I had the three of them at home. And I didn't know that. And she said, but it could be very, very different from when I had them, she said, but I'm sure if you look up stuff there'll be groups and things like that. So she just kind of told me to go look it up. ...

Em, but I went and I literally just looked up homebirth in Ireland. And the HSE website ... came up and I read about it ... And so then I just went down and I looked at the, the thing, and I saw [midwife's] name, and she lives just round the corner. So that was literally, I just sent her an email.

Mary, p 9, L 24-30, p 12 L 12-15

Once Mary became pregnant, she arranged with the SECM to provide care. Mary then attended an antenatal visit with her GP with the information about homebirth and her plans for it already obtained from outside sources²³.

Another participant, Keelin, had been interested in homebirth for several years before she decided to conceive. When she did so, she contacted a woman she knew through a Facebook group of women interested in homebirth. This woman gave Keelin the contact number of an SECM working with the HSE. Keelin said:

²³ Mary's experiences with her GP will be discussed in Section 6.3.1

So I rang [the SECM] straight away and, em, I told her I was pregnant and she was like, how long are you gone? And I was like god, probably two weeks if anything. And she was like, it's fine, she goes, no, you have me booked in, she said, and she gave me the details or whatever, told me to go to the doctor and all that. Em, and that was the start of it.

Keelin, p 2, L 33-37

Keelin then went to her GP and told her of her plans to have a homebirth, and they filled out the relevant forms.

Molly conducted independent research about homebirth during the initial weeks of her first pregnancy, and then got in touch with an SECM through a friend. It was through this that she accessed further information about the HSE's homebirth scheme. She said:

On my first pregnancy I checked out all the options. I read the literature on best births, I read all the books I could find and I met a number of the professionals involved. And, but I was swayed towards a community midwife because my friend had been to her and as soon as I met her it was, she was just fabulous, so that's how I chose, that's how I accessed that service.

Molly, p 3, L: 8-12

Meanwhile, women interested in giving birth in one of the MLUs in Cavan or Drogheda also, in some cases, found out about the MLU from female friends and relations.

Em, from word of mouth and then, I suppose, em, just from different friends that have had, you know, my husband's cousin's wife had her baby with the MLU.

Siobhán, p 12, L 23-24

These experiences also speak to the considerable effort the women themselves made to inform themselves about their choices, and the time, energy and effort they spent researching their options. Taken as a whole, my participants' experiences of information provision mirror those of Daly et al (2021), who also found that access to information about pregnancy and birth varied greatly between

individual women. Some of their participants described very good access to information while others disclosed inconsistent degrees of information quality, which encompassed an ignorance of options amongst those one might expect to know about them or a lack of resources such as websites and leaflets. The efforts made on the part of my participants to inform themselves appear necessary even though the MLUs were established more than 15 years ago, and the HSE homebirth scheme, in its current form, has existed for over a decade. Despite this, the participants' experiences suggest that this information is not always easily accessible. However, as presented in Chapter 3, Section 3.5, information is crucial to facilitating choice. These ideas will be discussed further in Chapter 8.

6.3 Dismissing women's decisions about birth

The previous sections have discussed participants' experiences of gathering and accessing information and the steps they took in order to learn about their options regarding birth models. This section will focus on the moments in their information-gathering journey when some of the participants were confronted with criticism or dismissal from healthcare professionals regarding their decisions in relation to birth. These reactions came from GPs who questioned or challenged the participants' decisions to give birth at home or at an MLU, often through medical discourse regarding safety and risk. Women's decisions were also dismissed when healthcare professionals used the now-repealed Eighth Amendment as a rhetorical tool for undermining women's decisions. These experiences fit into broader issues regarding the obstetric dismissal of women's decisions to birth outside the hospital setting and assertion that the maternal environment constitutes the greatest threat to the foetus (Rothman 1989) (see Chapter 3, Section 3.4.5). These issues will be explored further in Chapter 8, Section 8.3.

6.3.1 Reactions from GPs

The GP plays a central role within the Irish healthcare system in general and maternity care specifically. Women must confirm their pregnancy with a healthcare professional in order to avail of free care under the MICS (see Chapter 1, Section 1.2.2), and most women attend their GP to do so. Thus, a woman's relationship with her GP often plays a significant role in her experience of care.

Some participants spoke about their experiences of discussing their decision to give birth at home or an MLU with their GP, during early antenatal visits. Some of them experienced the reactions from their GPs as strongly negative, with the GPs

criticising the decisions being made by participants or, in one instance, exerting control by withdrawing from the relationship with that participant.

Mary, a pregnant participant, had been attending the same GP, an older man, since she was a girl. She said her GP was a significant source of support to her during her first pregnancy, as the father of the baby left her while she was pregnant, and she felt her GP “looked after” her during that time and had become a father figure to her. Hoping to continue this supportive patient-provider relationship during her second pregnancy, she told him she was planning a homebirth through the HSE scheme. However, reflecting obstetric discourse around safety, he suggested that birth outside of hospital was not safe. She said:

Mary: Then I went to my GP. And that was awful. ... I mentioned homebirth, and he just started telling me story upon story and it, look –

Researcher: What type of stories?

Mary: That there's cases out there where, you know, the babies, there's loads of things wrong with them, and – he said, which I perfectly, and I completely understand, he said, look, the thing that I've learned about babies is, that when things go wrong, they go wrong really, really fast. And when they go wrong, you want to be in a hospital.

And those words really stuck with me. So after that, I came out, I told [my husband]. He got terrified, because he was like, whoa, if the GP doesn't think it's okay, then maybe it's not okay. He got so scared. And then I got scared and I was just like, oh no. And the GP told me that, because I had had a fast labour, I had a higher chance of haemorrhaging. So, I just went from being delighted about having a homebirth to being absolutely petrified about having a homebirth.

Mary, p 12, L 1-17

After this reaction from her GP, Mary spoke with her SECM and the DMO for her area and they addressed her concerns. Mary also thought again about how much she did not want to repeat her traumatic hospital experience. She then decided to continue with her plans to give birth at home and was still planning to do so at the time of our interview, which took place when she was 36 weeks pregnant.

However, the GP's strongly negative reaction caused so much upset that she did not return to him for another antenatal visit.

Another participant, Anne-Marie, also experienced a very negative reaction from her GP when she told her she was planning a homebirth. During our interview, she compared the experience to breaking up with a friend:

When I did get pregnant, and I went to my GP of 15 years or so, she pretty much pushed me out the door, and said, bye bye, which was devastating. ... I said I was interested in it [homebirth], and she nearly, like, took a step back and was like, Oh no, I can't have anything to do with you. Em, I can't do with homebirths. She said it was because I, that she could only do, only be the GP for patients in a very particular area. And I didn't understand why this was the case because I already knew that, like, the GPs don't attend you during the birth. It's only for during the, you know, the antenatal period²⁴.

So I knew that didn't make sense but I was totally taken aback, and when I mentioned fear of hospitals, she started like shoving papers at me for, em, counselling and CBT. So I was very like, what is going on here? But yeah, pretty much like hand on the back, see ya now, send us a picture of the baby. And I just burst into tears outside because, like that, I'd been with her for years and had, you know, she'd been kind of with me through various struggles and what have you. Em, and she was delighted that I finally got pregnant and all of that. But then it was just like being ditched by a friend, you know, for even mentioning it.

Anne-Marie, p 3, L 31-34–p 4, L 14

Meanwhile, Deirdre was also planning a homebirth, but nearly decided not to after her GP employed obstetric risk discourse to challenge Deirdre's decision to birth at home. Deirdre told me:

So I didn't have a good experience with the GP. I told her that I was having a homebirth and she ... spoke about the things that could go wrong in a

²⁴ Insurance company Medisec does not cover indemnification to GPs if they provide antenatal combined care to women intending to give birth at home (See [Important Notice Mother And Infant And Home Births - Medisec Ireland](#)). In 2016, there were 30 recorded incidences (15.6% of homebirths) in which GPs refused to provide shared care to mothers intending to give birth at home through the HSE's homebirth scheme (Meaney *et al* 2018).

homebirth and she asked me did I know about the cord around the neck and, you know, obviously I've done my research and you know I've spoken to my midwife about all that, so I am aware of it. But yeah, I definitely got the feeling that she was not into it, and twice she told me that she'd follow up [with her insurance], because I had to go to her for my vaccinations, and she hasn't gotten back to me on either occasion. ...

But I did get incredibly upset after, em, after I met with the doctor because it made me question kind of a lot of things, like was I doing the right thing? And I think she planted a few negative seeds in my head about it.

Deirdre, p 3, L 26-28–p 4, L 1-19

As with Mary, Deirdre, who was 33 weeks pregnant at the time of our interview, also spent a period of time questioning her birth choices after her choices were undermined by her GP, although she also continued to plan for a homebirth, after speaking with her partner. Like Anne-Marie, Deirdre experienced a withdrawal of the patient-provider relationship in the form of her GP not following up with her regarding aspects of care.

Aileen, who was planning to give birth in an MLU, also experienced a negative reaction from her GP, though she was not as upset about it as the participants mentioned above. She said:

So I suppose then, em, my GP expressed slight hesitation maybe when I was about, I think she passed a comment along the lines when I was about six months, oh the MLU got their hands on you? [laughs]. I said, yeah. And I said, would you be concerned? I said I'm low risk. And she said, no, you are, but you know, she said, I just, you know, would just be a bit concerned. But she kind of didn't, didn't elaborate on that and didn't go into anything more. So I was quite happy still to continue with em, like, there was no cause, no cause for concerns.

Aileen, p 2, L 18-23

Through these excerpts, the participants have shared experiences in which their GP undermined, disapproved or dismissed their decisions regarding place of birth. This included a signalling of the end of their professional relationship and responsibility as a result of the woman's choice. The choices made by other participants were also questioned through another mechanism, namely, the legal

framework of the Eighth Amendment, which was still in place at the time the participants whose experiences are included below were giving birth.

6.3.2 Undermining women's birth choices – coercion under the Eighth Amendment

As discussed in Chapters 1 and 2, the Eighth Amendment gave a foetus's right to life equal status to that of the mother. While the amendment rendered obtaining an abortion illegal, it had implications for all pregnant women. For some of the participants in my study, their decision to choose alternative birth models was undermined by healthcare professionals, who employed the Eighth Amendment as a mechanism with which to dismiss their choices.

One of the participants, Aoife, suggested that the Eighth Amendment created a culture in which a woman's choices and autonomy could be ignored or dismissed. She said:

There's no emphasis on consent in Ireland, because of the Eighth Amendment, so you just have stuff done to you. And I just find that so sad.... And for as much as the Eighth Amendment isn't wielded as the big monster for the vast majority of pregnancies, it can still be used as leverage to make women do what doctors want.

Aoife, p 11, L 22-23 & p 12, L 5-7

While Aoife spoke in general terms, another participant, Noelle, told me of her personal experiences in relation to the Eighth Amendment. Having had a caesarean section for the birth of her first child, she wanted to have a VBAC for her second baby. The consultant told her she would have to be continuously monitored during her labour, once she came into hospital. She said that she did not want this, as she believed, based on her research, that intermittent monitoring would be just as safe, and would enable her to remain mobile during her labour, thus increasing her chances of a VBAC. She told me:

I argued with him [the consultant] about my informed consent and my right to bodily autonomy. And in the end, I kept on saying, but do I have the right to make an informed decision? ... An informed decision, or an informed refusal for a CTG if I did go into labour? And in the end, he said he'd have to contact the hospital lawyers because the foetus has equal rights to the

mother because of the Eighth Amendment. And therefore, he'd have to look out for the rights of the foetus and protect the foetus.

Noelle, p 7, L 21-23 & p 8, L 1-4

Noelle's experience highlights the ways in which healthcare professionals could disregard women's choices and preferences using the Eighth Amendment. She also highlights an aspect of access discussed in Chapter 1, Section 1.5.4, that is, the right to refuse access to medicalised birth options.

Another postnatal participant, Keelin, who had planned to give birth at home, spoke of the role the Eighth Amendment played in her pregnancy, specifically in relation to induction. As Keelin approached the 42nd week of her pregnancy, she became concerned about the authority that the amendment placed in the hands of medical staff, and the authority hospital doctors held over her pregnant body. She therefore sought advice from birth activists and midwives, including the pioneering homebirth midwife Philomena Canning (now deceased). Keelin said:

So I was so afraid I was going to go over. And I started ringing around people, and em I asked people what my rights would be if I went over by 14 days, like as in, could they force me to be induced? And em, I got in contact with, oh god, I can't remember a lot of the names or organisations because, again, people would have just said, look, here's a number to ring and here's a number to email. But, em, they were amazing and they all got back to me. Em one of them was that, you know the midwife, Philomena... She got in contact with me and she said to me that, essentially, they could force me to em, have a, to be induced, because of the Eighth Amendment.²⁵

Keelin, p 7, L 4-12

²⁵ A healthcare professional/hospital could seek legal advice in the event they believed a woman's informed refusal would constitute a threat to the life of the foetus, and could then request a court order seeking legal permission to override the woman's decision. The NMS, written before the repeal of the Eighth Amendment, states that in situations where a pregnant woman refuses or wishes to discontinue a recommended treatment, the healthcare professional should have an in-depth discussion with her about the treatment, potential risks and possible alternatives. The NMS then states: "Where an assessment is made that the informed refusal would not threaten the life of or have a deleterious effect on the baby, then the woman's choice of informed refusal should stand. However, where there are implications for the health or life of the baby, as defined by her team of healthcare professionals, then the HSE's National Consent Policy recommends that legal advice should be sought" (DoH 2016, p 78).

From this, Keelin understood that the Eighth Amendment meant a woman's right to consent or decline recommended care was contested. She said:

She [Philomena] said, because of the Eighth Amendment that, basically, hospitals could argue that I was putting the baby's life in danger by letting it go over too much. So, basically, they could – and I'd read a story, actually, where someone I think was forced to have a section or was going to have, there was going to be a court injunction or something to make her have a section – and that, like, was a huge fear.

Em, and like I said, those last couple of weeks, I just, I, I, it just really ruined it for me, it really did. Em, but, yeah, I don't know, they just, yeah, they just said, she said to me and, and a few of the other em, associations said to me that, yeah, essentially they could, they could em, bring me to court and make me have, make me be induced or have a section or whatever it was, em, and say that it was the safety, for the safety of the baby.

Keelin, p 13, L 11-20

Thus, in Keelin's story, we can see that she was told that the Eighth Amendment could be used to undermine her choices, and decisions in relation to her body, and she experienced significant anxiety and fear in the final weeks of her pregnancy as a result of this.

6.3.3 Other experiences of dismissal

As seen in section 6.3.1 and 6.3.2, the decisions made by participants regarding birth options were challenged or dismissed during the antenatal period. Other participants found their decisions and autonomy dismissed during the intrapartum period for their previous children. These experiences form part of context in which participants attempted to access alternative birth models.

Anna began labouring in one of the MLUs but was transferred to the Consultant-Led Unit (CLU) as a trace showed that the baby's heartrate was increasing during contractions. Like the experiences of Mary and Deirdre, Anna felt her wishes were dismissed by healthcare professionals using the threat of potential harm or risk to the baby, and the power this threat held for her while giving birth.

They kind of played what I call the dead baby card. ... They moved me then into the [CLU], and em, they wanted to put me back on a continuous trace,

and I didn't want to go back on continuous trace. And, till the day I die, I will remember the midwife telling me to get up on the bed because I was putting my baby's life at risk....

I will never forget her saying to me, you know, you are putting your baby at risk, you know what I mean. And I think that when somebody says that to you, you're immediately compliant. Do you know what I mean? You're like, oh my god, you know, of course I'm going to do absolutely anything that's going to make sure that my baby is okay at the end of it all.

Anna p 3, L 2, p 3, L 12-15 and p 5, L 15-18

Anna spoke further of how she felt dismissed and was assigned the role of vessel for her baby. She said:

And that was it. You were on that bed and stay on that bed and I felt that if I said anything em, I didn't know, do you know what I mean. It was, I was dismissed kind of as, I was no longer, em, the way I would put it is - I no longer had a voice. I was just a vessel to deliver this baby....

From the minute I got up onto that bed after she told me em, to get up onto it that I was, em, I was purely a vessel to get that – I was no longer [Anna]. I don't know what I was but I wasn't me. You know what I mean. Or, I wasn't seen to be a person.

Anna, p 4, L 27-30 and p 5, L 35-36–p 6, L 1

Thus, Anna's experiences of dismissal, although it took place during the intrapartum period, echoed the experiences of others who had their decisions questioned and dismissed by healthcare providers through the use of obstetric discourses regarding safety and risk.

Molly also experienced dismissal of her choices and autonomy through the use of the "dead baby" discourse. For the birth of her fourth child, hospital staff recommended an induction. Molly said:

They kept on looking at me with those eyes, "do you want your baby to die?" eyes, and I was just like – and my husband fell for it because he hasn't read, I've read everything. ... But I know I don't, I'm not an expert in

any of this, but I did feel very confident that I could give birth naturally. So anyway, I felt, em, I felt coerced into taking the induction drugs.

Molly, p 6, L 2-7

These individual experiences of dismissal are reflected in the larger discourse on risk and choice. As presented in Chapter 1, Section 1.4, obstetric risk management strategies are focused on infant mortality and morbidity and based on singular incidents with very poor outcomes. This leads to the problematic situation in which routine maternity care for all is based upon the outcomes of a small number of exceptional cases (Scamell *et al* 2019). These strategies impact the provision of information and access to care and influence the choices available to women (Bryers and van Teijlingen 2010). The implications of these discourses on women's choices and access to alternative birth models, also explored in Chapter 3, Section 3.5, will be discussed further in Chapter 8.

6.4 Conclusion

This chapter has focused on my findings as they relate to the participants' experiences of gathering and obtaining information regarding alternative birth models. As their lived experiences illuminate, the initial antenatal visits, and the individual healthcare providers with whom participants met, proved significant in determining the source of their information. Those who did receive information regarding alternative birth models during their initial antenatal visits then sought out information elsewhere, through online forums, social networks or alternative healthcare professionals such as SECMs. Other participants began their search for information by seeking alternative sources and then spoke with healthcare professionals. The inconsistent and complex pathways in which information regarding alternative birth models was available and provided led participants to describe the provision of information as "pot luck" and "word of mouth". Many expressed the desire for there to be information that was consistent, evidence-based and easily accessible. These experiences fit within the framework of choice and how neoliberal and medical definitions of choice often prove problematic for women, particularly when accessing reproductive care (see Chapter 3, Section 3.5). These findings will be situated within my theoretical framework and the relevant literature in Chapter 8.

Within this chapter, I have also presented findings in relation to experiences of participants who had their decisions regarding birth undermined, as they traversed

along their information-gathering journey. This doubt or counter-discourse to alternative pathways came in the form of service providers, specifically GPs, challenging participants' choices and decisions regarding place of birth. As the participants continued on in their pregnancies, others also had their choices and decisions criticised or dismissed using the mechanism of the Eighth Amendment. These experiences fit within a framework that dismisses women's choices and constructs the male doctor as the active, reasonable subject, and the birthing female as the passive, unreasonable subject (van der Waal et al 2021, Young 2005) who engages in risky behaviour (Craven 2005) (see Chapter 3, Section 3.4.4).

As participants had their choices regarding birth disregarded so too did they have the ability of their bodies to give birth challenged. My findings in relation to the latter notion will be presented in the following chapter. Then, in Chapter 8, I will discuss both sets of findings within the context of my theoretical framework, the relevant literature and current national maternity policy.

Chapter 7: Permission and timing

7.1 Introduction

In the previous chapter, I presented the first of my findings, which centred around the lived experiences of women as they gathered information and made decisions regarding alternative birth models. My second set of findings is presented in this chapter. These illuminate the participants' experiences of negotiating medical definitions of health and obstetric metrics regarding the definition of "low-risk" in relation to pregnancy and birth. For some participants, this experience was grounded in seeking permission from a consultant to give birth at home, a requirement for some women wanting to give birth through the HSE homebirth scheme. This proved to be a crucial step in determining access to homebirth for them. Other participants were confronted with policies regarding length of pregnancy and length of labour as they attempted to access alternative birth models. Furthermore, many participants spoke of the negative consequences that medical metrics and interventions have for women, asserting that their experiences of them are often dismissed as irrelevant within obstetric discourses on neonatal mortality and morbidity.

The requirement for a consultant sign-off for some women, as well as the time limits for gestation and labour, suggest that notions of choice can be problematic for women attempting to access alternative birth models within the context of a maternity system that is shaped by obstetric-led policy. These policies regarding maternal health and risk are situated within the larger patriarchal and medical processes that fragment women's bodies (see Chapter 3, Section 3.4) and suppress women's embodied knowledge regarding health (see Chapter 2, Section 2.2). As in Chapter 6, I will present this set of findings below. Then in Chapter 8, I will discuss the findings presented in Chapter 6 and this chapter and situate them within the literature and my theoretical framework of feminism and choice.

7.2 Seeking permission – the consultant sign-off

One HSE policy that played a significant role for my participants in their experiences of attempted access to alternative birth models, and specifically homebirth, was the requirement for some to be signed off by a consultant. If a woman is interested in the HSE homebirth scheme, she has an initial appointment with an SECM (see Chapter 6, Section 6.2 for women's experiences of gathering information about the scheme). During this meeting, the woman and the SECM

discuss the criteria for homebirths and agree on the woman's eligibility for the service. Application and consent forms are then signed by the woman and the SECM, which are then forwarded to the Designated Midwifery Officer (DMO) to confirm eligibility.²⁶ Some women, such as those who have experienced one factor within the medium-risk category, may require an individual assessment by a consultant obstetrician (Meaney *et al* 2020) before they are accepted onto (or denied access to) the scheme²⁷. The participants in my study who required a consultant sign-off felt themselves to be healthy and believed that homebirth was the most appropriate model of care for themselves and their babies. Thus, in order to negotiate the HSE eligibility criteria and the consultant sign-off, they took varied approaches.

Lorraine, for example, negotiated the requirement by requesting a specific consultant because she had heard through friends that the consultant was "homebirth friendly". Upon her request, Lorraine was assigned to this consultant during her booking visit. This "homebirth friendly" consultant signed Lorraine off as she had hoped, so Lorraine described her experience of consultant-sign off as positive. However, she still described the requirement as an "obstacle" to be overcome in order to access the birth of her choice (namely, homebirth) and said she was "grateful" that the consultant signed her off. She said:

So I requested with my booking form in the hospital, I requested [specific consultant]. And hoped for the best. And then I had my booking appointment, where you don't see your consultant. And then I saw, on my booking appointment, that they had put me with [specific consultant], so I was super happy about that. That was the first obstacle. ... I'm super grateful that, that she signed off on that.

Lorraine, p 8, L: 9-10; L 11-18; p 10, L: 10-11

²⁶ The Designated Midwifery Officers (DMOs) monitor the provision of the homebirth service as per the HSE Home Birth Service agreement. Women hoping to book a homebirth can initially contact one of the DMOs, or the SECMs directly, to obtain information about the scheme.

²⁷ For the eligibility criteria for the HSE homebirth scheme, see <https://www.hse.ie/eng/services/list/3/maternity/hb003-policy-to-support-the-secm-to-assess-the-eligibility-suitability-of-women-for-home-birth.pdf>. For a full list of medical conditions that designates a woman as medium risk and requires referral to a consultant for a final assessment before she is deemed eligible for a homebirth, see Tables 3 and 4 in the above document, or Meaney *et al* (2020), Appendix C, p 38. These factors include age (women over 40), abnormal blood pressure readings, previous gynaecological surgery and specific previous pregnancy complications.

Another participant, Deirdre, was also planning a homebirth through the HSE scheme and was attending the hospital for her antenatal care during the first half of her pregnancy. Echoing Lorraine's feelings of gratitude, Deirdre described herself as "lucky" to be assigned the same "homebirth friendly" consultant with whom Lorraine met. Deirdre said:

I had to get my obstetrician to sign off that it was okay to have a homebirth ... And luckily I had [specific consultant] who, I don't want to say she advocates homebirth but she, she's open to alternatives, and so she signed off on that.

Deirdre, p 2, L: 9; L: 14-15

Both Lorraine and Deirdre recognised the power that consultants had in determining whether they could access the alternative model of their choice. They also feared – or perhaps recognised – that not all consultants support homebirth. Thus, they felt "grateful" or considered themselves "lucky" when they were "given permission" to give birth at home. Another participant, Molly, took a different approach to obtaining her consultant sign-off. She recognised that she needed it if she was to access the HSE homebirth scheme, which she wanted to do. However, she also attempted to assert her own autonomy with the consultant who was signing her off by telling him she did not need his permission. She said:

So then I had to go in and speak to an obstetrician, and he said he would sign me off. And I said, I didn't ask you to sign me off, I'm just telling you I'm having a homebirth.... But anyway, eh, because I was signed off by the man who I didn't ask to sign me off ... I was "allowed" – in quotation marks – to have a homebirth.

Molly, p 2, L: 1-3; L: 12-13; L: 13-14

In her use of the language "in quotation marks" in relation to "allowed" Molly recognises the problematic nature of the consultant sign-off requirement for women who hold their own embodied and experiential knowledge as authoritative.

For another participant, Mary, her experiences of consultant sign-off was fraught with confusion and frustration. Mary found herself in the position of arguing with hospital staff for access to a consultant, so that she could follow the proper channels that would allow her to be signed off and access a homebirth. During our

interview, she described her exchange with staff at a maternity hospital, which took place during her second trimester:

Mary: So then, I went out to make my next appointment, I got booked into the midwife clinic, and when I came back for that appointment, they said the midwife clinic wasn't on and I had to go into the normal waiting area. So I went, I was only there probably about 15 minutes, and they refused to see me because I was having a homebirth. And they said, are you with the Domino scheme? I said, no. I'm with an independent midwife [SECM]. We can't see you. I said, I know you can't see me, but I need to get my bloods and my urine done here. No, we won't do that either. And I was like, no, I have to.

Researcher: This is the midwives in the regular clinic saying this to you?

Mary: Yep. So then I was like, I said, I don't even see my GP. I do my combined care between the hospital and my midwife. And they said, you don't need, you don't come to us at all, you only see your midwife. I said, no, 'cause – I was going by what I'd read off – and I was like, no, I have to come here, I was like, one of you, I was like, a consultant has to sign me off so I'm even allowed to have a homebirth.

Mary, p 15, L: 26-p 16, L: 5

Mary thus highlights the power that a consultant has in determining whether she would be “allowed” to have a homebirth, as well as the confusion and frustration she experienced in attempting to get signed off.

A postnatal participant, Anne-Marie, who had hoped to give birth at home, suggested that the notion that women are “allowed” or “not allowed” to access the type of care they wish for is so pervasive within the maternity services that many childbearing women have internalised this. Echoing the experiences of other participants who also had their decisions around birth challenged through obstetric discourse on risk (see Chapter 6, Section 6.3), she said:

The language amongst the majority of people in [my online mum's group] is, I won't be “let” go past 40 weeks. I won't be “let” have this, I won't be “let” have that, they're bringing me in to induce me. Why? Ah, they just have to. They're like, no. Why? Why? You know, ask for a reason. But the vast majority of them would just go along with this and would barely even

question it. There would be only a few in that group, like myself, who would kind of go, do you know what? Can you give me some evidence-based reasons why you think whatever-it-is is necessary. Em, and just, just kind of like shaking the bogeyman stick of, you know your baby will die, kind of, is not good enough. You need to tell me why.

Anne-Marie, p 11, L 11-20

Thus, for women hoping to give birth within the alternative model of homebirth, the requirement for some to receive a consultant sign-off was a crucial step in determining their ability to access birth at home. Participants had to negotiate this complex situation and “play along” even if they disagreed with the idea that they should have to get permission from a consultant or believed the HSE’s criteria for low-risk pregnancies did not reflect their state of well-being. Thus, women’s ability to access the alternative birth model of their choice was bounded by obstetric power and authority over birth and over the pregnant female body. In the following section, I will discuss women’s experiences of attempted access to alternative birth models in relation to the timing of pregnancy and birth, which was a common point at which the participants experienced challenges to access to their preferred choice. This use of time limits demonstrates continued expression of obstetric power over and fragmentation of the female body, and suppression of birthing women’s knowledge.

7.3 On the clock - experiences of obstetric timing in relation to length of pregnancy

The findings discussed in this section emerged out of the experiences of participants who were unable to give birth within an alternative model because of hospital policies in relation to time. Specifically, these timelines related to length of pregnancy or gestation, which can lead to pharmacological induction of labour (and other unwanted interventions) or, separately, to length of labour, which lead to medical interventions, such as syntocinon augmentation, instrumental birth or episiotomies, designed to progress labour or precipitate birth artificially. Both the induction and augmentation of labour move women into a high-risk category, thus excluding them from low-risk birth settings such as home or an MLU. Initially, I will discuss timing in relation to duration of pregnancy and the ways in which guidelines regarding induction impacted the ability of some participants to access alternative birth models. These policies regarding length of pregnancy are situated within the scientific paradigm that uses mechanical metaphors to understand the human

body and privileges certainty (Downe and McCourt 2019, Newnham *et al* 2018). Aligned with this are obstetric notions that place labour within a linear framework (Mccourt and Dykes 2010, Downe and Dykes 2010) and conceptualise the female body as an inefficient machine with disparate parts, best controlled by the doctor/mechanic (Martin 1989, Rothman 1989).

According to NICE and WHO guidelines, a normal pregnancy is between 37-42 weeks in length (NICE 2014, WHO 2018b). Based on these guidelines, one might expect that policies regarding the length of pregnancy shouldn't vary. However, according to participants, they do differ slightly between Irish maternity hospitals, with significant repercussions for mothers. For example, at one maternity hospital in Dublin, routine policy on induction of labour is "Term plus 14". At hospitals located outside Dublin, routine practice is "Term plus 10"²⁸, though for participants attending one of the MLUs the policy was "Term plus 12". It is important to note that in this context, "term" indicates 40 weeks, so "Term plus 14" is 40 weeks plus 14 days, or 42 weeks.

Several of the participants who signed up for one of the MLUs, and who maintained healthy pregnancies, remained pregnant longer than the local guidelines permitted. Because they went beyond the timeframe, induction of labour was advised and they had to transfer to a consultant-led unit (CLU). Thus, at the final moment of pregnancy, they were ultimately unable to access birth in an MLU, as they had hoped to do.

For example, Siobhán signed up with one of the MLUs but was induced at 40 weeks, 11 days. She refers to the idea that she was induced a day earlier than the guidelines permit because it was close to the weekend, when there are fewer staff on. She describes how upset she was about the hospital policy regarding length of pregnancy, which did not mirror her embodied knowledge regarding the state of her and her baby's health and which denied her the opportunity to give birth at the MLU.

Siobhán: So at term plus 11, so on the Thursday night, I had to present myself to the maternity ward to get the first gel. Em, and I was in floods of tears. I really didn't want to do it. I was just so desperate.

²⁸ Often hospitals book induction a few days before 42 weeks as a safeguard in case an emergency arises and they have to reschedule the induction appointment, or to ensure that labour has commenced by the 42-week mark.

Researcher: And then why was the induction happening?

Siobhán: Because I was term plus 11.

Researcher: Okay.

Siobhán: So MLU due date is term plus 12 so I had to go in on the Thursday night because, you know, the weekend was coming kind of thing. Em, so that was the deadline.

Siobhán, p 3, L: 32-34; p 4, L: 7-11

Another postnatal participant, Caitriona, who had been planning to birth in an MLU, was also induced, even though this did not reflect her beliefs and knowledge regarding the health of her baby.

Caitriona: And then, em, I went to 12 days overdue. So, I still, I suppose, felt that I was in the low-risk, em, category, but because you go 12 days over, em, I had to be transferred [to the CLU] to be induced.

Researcher: Twelve days was the limit in the MLU?

Caitriona: Yeah. Now, I think at the moment, from talking to other, like, more recently, they won't let you go ten – ten is the max that I have heard of them. It was 12 at that time, six years ago.

Caitriona, p 2, L 18-24

Meanwhile, when Caoimhe attended a Dublin hospital for a routine appointment at 41 weeks and four days (Term plus 11), a consultant recommended that she be induced. Caoimhe, who was induced the following day, said:

So, I ended up being induced because I went over – so I was, what was it? A week and five days overdue. There was a doctor who saw me, who was like, oh you need to be induced now. And I was like, hold up, well I hadn't really planned for this. Can't I just wait until I'm two weeks overdue? And she was like, no, we don't do that here.

And I was pretty upset, and not really making eye contact with her, you know, tears forming in my eye, and I was really upset about the idea that I wouldn't be allowed to just naturally go into labour. So, she went through

everything, and told me there was a much higher risk of the baby suddenly dying, even though it was perfectly healthy, and I was perfectly healthy.

Caoimhe, p 2, L: 9-17

Here, Caoimhe struggles with both policy and practices regarding length of pregnancy and induction of labour²⁹. She describes the discordance between hospital policy, as presented to her by the consultant, and her embodied knowledge regarding the health and wellbeing between herself and her baby.

Meanwhile, Keelin was another participant who went past her due date during her first pregnancy. She was planning to give birth at home and had signed up to the HSE homebirth scheme, whose guidelines stipulate that women transfer to hospital care if their pregnancy goes beyond 42 weeks. Although Keelin went into spontaneous labour at 41 weeks and five days, she experienced significant levels of stress in the last days of her pregnancy because she was so worried that she would not be able to give birth at home. During our interview, she expressed the fear and frustration she felt as she approached the 42-week mark:

That last two weeks were really horrible for me, and I'd had the best pregnancy, I had such a nice time, and I didn't have any, nothing bad, I didn't have any morning sickness, I didn't have any heartburn, nothing. And then those last two weeks I remember thinking, I was going to go 14 – if you go over 14 days you have to go into hospital. I kept saying to [SECM], what if I paid you as a private? And she's like no, we're just not insured, like you cannot. You'll go into the hospital and that'd be it...³⁰

I was so upset, I was like, I can't believe my homebirth's going to be taken away from me! Em, but yeah, and like I had, I remember just thinking, oh, this is just really unfair. ... and it's put a lot of stress on women at a time when you're already, like, stressed.

Keelin, p 6, L: 1-6; L: 24-26; L: 30

Thus, while Keelin's pregnancy did not go beyond the 42-week mark, she felt the presence of this policy negatively impacted her experience of access to the alternative birth model of her choice. Furthermore, she experienced her embodied knowledge of herself and her baby as being at odds with policy regarding length

²⁹ Evidence on induction of labour will be discussed in Chapter 8, Section 8.5.2.

³⁰ For a discussion of insurance and SECMs, see Chapter 2, Section 2.3.5.

of pregnancy, and these policies as a mechanism that could override her autonomy and access to her birth preferences, as well as something that brought anxiety to her last weeks of pregnancy.³¹

7.4 On the clock – Experiences of obstetric timing in relation to length of labour

While obstetric demarcations regarding the normal length of pregnancy impacted women's experiences of access to alternative birth models, obstetric metrics regarding length of labour also played a significant role. Like policies and practices concerning induction, guidelines regarding the length of labour are also situated within a framework that conceptualises women's bodies as inefficient machines (Martin 1989, Rothman 1989) that are prone to error (Downe and Dykes 2010), utilising medical technology to fragment and control the birthing female (Davis-Floyd and Davis 1997, Rich 1986) and alienate us from our bodies (Thomson and Downe 2008, Young 2005). Furthermore, the guidelines are also situated within obstetric definitions of health and risk and can perpetuate the suppression of women's knowledge regarding health. For those giving birth at home through the HSE scheme, a woman must transfer to hospital if she has not given birth 18 hours after spontaneous rupture of the membranes (the rule was previously 24 hours but was revised in 2016)³². Those giving birth in one of the MLUs must do so within 12 hours of established labour. Thus, in relation to the timing of pregnancy and birth, my participants were once again confronted with obstetric metrics regarding health and risk and conceptualisations regarding the capacity of the birthing female body.

One participant, Aileen, who received her antenatal care at one of the MLUs, went into spontaneous labour and laboured in the MLU. However, after 12 hours, one of the attending midwives said Aileen was not progressing quickly enough, per hospital guidelines, and suggested she transfer to the CLU. Aileen did so, and her

³¹ Daly et al (2021) use the expression "induced anxiety" to describe interactions with healthcare providers that instigate or increase anxiety for pregnant and birthing women.

³² Under HSE guidelines, reasons for intrapartum transfer to hospital include a spontaneous rupture of the membranes greater than 18 hours or a diagnosis of "prolonged" labour (Meaney *et al* 2020, Appendix D, p 40). Appendix E (p 41) in the same report outlines guidance for prolonged labour, based on NICE 2014 guidelines. SECMs are advised to transfer women to hospital and into obstetric care if the second stage of labour lasts longer than three hours for nulliparous women or two hours for multiparous women. For nulliparous women, an SECM is advised to diagnose delayed labour and prepare for a transfer of care after two hours if birth is not imminent; for multiparous women, delay should be diagnosed after one hour (Meaney *et al* 2020).

daughter was born seven minutes later, in the CLU. Within that time, an episiotomy and a vacuum extraction had been performed. Referring to the CLU as the “maternity ward”, Aileen said:

I remember her [the midwife] saying, we're going to transfer you over to the maternity ward, which is just across the hall. And I remember she said, we'll get a wheelchair. I said, what? For god's sake. Wheelchair? You know, like, this was like, I, at this stage I still felt quite empowered, I was very strong, I was just dancing, em, and I was definitely in the zone because I had very little clothes on. So I was definitely in the zone, I remember, I definitely still felt strong at that point, so that was at half past one they transferred me over. And then there was a series of interventions quite quickly. Em, I was given syntocinon I think, em, and then there was an episiotomy and one attempt at a vacuum, and my daughter was born at 1.37.

Aileen, p 4, L: 15-19; L: 22-25

In this, Aileen describes how she was initially able to access the alternative birth model of her choice during labour, and experienced feelings of strength and empowerment. However, at the final moment, she was unable to give birth in the MLU and access the birth of her choice because of the hospital policy regarding length of labour. The dissonance of these policies with the empowering labour and the embodied knowledge that Aileen had experienced up until her transfer to the consultant-led unit was represented for her by the unnecessary wheelchair.

Women who give birth at home through the HSE scheme must also, according to their scheme's guidelines, do so within a specific timeframe before they must transfer to hospital. Keelin, whose concerns regarding HSE policy on length of pregnancy were discussed above, was unable to fully access an alternative birth model and give birth at home. She said:

I finally went into labour on the twelfth day. I was so fucking, I couldn't believe it, I was so happy I started feeling contractions ... [But] in the end, I was completely exhausted, and [SECM] said to me, like she was trying loads of different things, and she said to me, I'm going to try one more thing, and if that doesn't work, how do you feel about going into the hospital? And at that stage, I was like, I don't care. Just bring me into the hospital, I can't do any more. I was like, completely exhausted. And I never

thought that'd I'd be okay with going into the hospital, but I was. Although, I was really upset too, like I was crying. You know, and I didn't, I did feel like a bit of a failure. I remember thinking, I'm a total failure.

Keelin, p 6, L: 36-37' p 7, L: 1-7

Another participant, Niamh, also had to transfer to hospital for the birth of her first child, as she had not given birth 24 hours after spontaneous rupture of the membranes. Borrowing the language of the attending midwife, she described the experience of having that 24-hour timeframe as being “on the clock”. She said:

Researcher: So the guideline is 24 hours after your water breaks?

Niamh: Yeah, and it was one of the things she [SECM] said, like here are the reasons you text me straight away, like if there was blood, if there was, em, the meconium, if your waters break and you haven't – when your waters break – she's like, even if you're not in labour, you have to text me, because then we're on the clock.

Niamh, p 14, L 18-22

By the time Niamh gave birth to her second child, the HSE guidelines had changed to stipulate that women birthing at home must transfer to hospital if birth isn't imminent 18 hours after spontaneous rupture of the membranes. She asked a hospital-based doctor the reason for the change in guidelines. She said:

I asked in [the hospital] when I was in there why it [the guideline] had changed, eh, and they said that, eh, they went with the national average. No – they went for the, the 24 hours was the national average, the 18 hours was the lowest of any hospital [they] asked ... And I said, and what's the science behind it? And he shrugged.

Niamh, p 2, L 6-11

While the above excerpts capture the experiences of participants interviewed postnatally, hospital guidelines regarding length of labour also played a role in the access journey for pregnant participants. For example, Jenny said one reason she was planning to give birth at home was because she queried the timeframe for labour imposed on women birthing in hospital (which she understood to be ten hours). Suggesting that the timeframe was based on the needs of the hospital rather than the labouring women, she said:

If somebody tells me, you know like, you've got ten hours to go from zero to ten centimetres then my question would be like, okay why? Like, that's cool but why, like? And then if it doesn't make sense in my head, like if it feels more like em, something that's done from an efficiency or just policy or practice point of view then I don't really, eh - not that I won't go with that but I'll question it to make sure that it's definitely something that I agree with, as opposed to em, you know, just rolling with it.

Jenny, p 6, L 6-12

Another participant who was planning to birth at home decided to transfer to hospital during labour because she was exhausted and wished to have an epidural. Notwithstanding that decision, like the participants above, she spoke of how her knowledge of her health and body were dismissed in favour of routine practice, which in her case was experienced in the standard dose of syntocinon given to augment labour.

I said, "look, I'm really sensitive to hormones." [Staff said]: "Yeah, yeah, yeah, yeah, yeah." And then you're put on the drip and then, oh look, foetal distress. [I thought] "No kidding. I told you I'm very sensitive to hormones." [They said] "Oh, we're going to have to dial that right back." [I said] "Mmm, yeah, sure what would I know – it's only my body."

Anne-Marie, p 9, L 1-4

Anne-Marie also said she felt as though she was "on the clock" during labour, indicating that this time pressure situated within the medical model of birth in which hospitals operate. She said:

There is a certain attitude as well, of get them in, get them out. You know, and that goes with the whole medicalised thing of, you know, on the clock of like, oh, you know, you've been here an hour and you've only dilated by this much.

Anne-Marie, p 10, L 38-41

Thus, the experiences of the participants suggest that maternity policies regarding length of pregnancy and labour, as well as obstetric definitions of health, have a negative impact on some women and, at the eleventh hour, deny women access

to alternative birth models. These findings will be discussed further in relation to my theoretical framework in Chapter 8.

7.5 Medical interventions and women's experiences of birth

Above, I have presented specific instances in which participants were confronted with medical metrics regarding healthy pregnancies, length of gestation and length of labour. Many of the participants whose pregnancies and births went outside the parameters of medical norms were the recipients of medical interventions. Medical interventions to induce or augment labour have physical implications for women and infants and, as seen in the above excerpts, these policies and interventions also affected the ability of some of the participants to access the birth of their choice. However, medical interventions also have emotional consequences for women. One participant, Fiona, whose experiences of receiving information were presented in Section 6.3.1, said:

Fiona: I think once you have one negative experience or one medical intervention experience I think it's gonna be very hard for you to trust that your body can do it a second time around.

Researcher: Hmm. Why's that?

Fiona: Em, I don't know, I just think, you know, the panic would set in, the fear would set in, the experience that you had you know and that will then eventually prohibit you.

Fiona, p 14, L 38-40–p 15, L 2

However, Agnes said that while a negative birth experience has significant consequences, women's experiences and wishes are dismissed within the medical focus on foetal mortality. She also suggests that obstetrics views women's bodies as incapable of giving birth:

I think that people say, you shouldn't complain if your baby's safe. If your baby is healthy and safe, then you shouldn't expect more. And I think that's the problem. Because whenever I told my experience to people afterwards, I told it to loads of people, I says, you know, this happened and then I got sewn up and I had to be transferred and then this doctor said that. And like, like people nearly without fail said, ah sure look, you've baby's safe, your baby's out. You know, what's the problem, basically ... [but] that's not the

whole story. What about the mother's experience and what about bonding and what about empowerment and feeling empowered as a mother instead of just having your power taken away by these consultants who say, no, you can't actually do it on your own. I better help you. Go lie on your back, like.

Agnes, p 19, L 12-23

Like Agnes, Lorraine suggested that women's experiences are suppressed within the obstetric focus on neonatal mortality:

[People think] the fact that the baby's alive means everything's good. And that's not the only thing that's important. Of course, it's the main thing, but you know, you can't leave out how a mother experiences that thing because you're never, you're never going to forget the way you were made to feel in labour.

Lorraine, p 3, L 6-8

This also echoes with Ciara's suggestion that women's experiences of birth are dismissed:

But there definitely is a kind of a put up and shut up attitude of, your, ah sure, you know, haven't women been doing it for years? Em, and so-and-so had six kids and they were fine, you know, what are you whinging about?

Ciara, p 12, L 35-36-p 13, L 1-2

Another participant, Anna, queried the idea that women need medical interventions in order to give birth. She said:

You know, like women have been having babies since forever, so I don't know when it suddenly became that we were questioning our ability to have them. You know, we don't question, can we grow this baby? But all of a sudden it gets to the end and we're like, oh Jesus, I can't give birth to this baby.

Anna, p 1, L 21-23-p 2, L 1

Meanwhile, Caoimhe stressed the importance of trusting women's bodies during labour and minimising interventions. However, she suggested that this was not within the scope of the medical model of birth:

I have always been very opposed to the medicalisation of birth. I have always thought that trusting women in their capacities to do what their – it's not even trusting women; it's trusting women's bodies because so much of it is not within our own consciousness, but it's like the hormonal, just the way things kind of work and everything falls into place. It's like our bodies are designed to do things a certain way, so if you can trust the body to do that and provide a woman with the tools and the knowledge to not be afraid of that [that would be good].

Caoimhe p 11, L 3-8

Caoimhe said medical notions of female bodies and birth did not tally with hers and feared the authority hospital staff can wield over women's bodies during birth. She also offered a vision of birth that celebrated women's bodies:

[My] idea of being healthy and of being well, does not sync up with being in a space where those things are like monitoring you – and they have the power to say whether you're well or not well. That felt so arbitrary and cruel and cold and clinical and medical, and I didn't want to have any part of that because that didn't tally up with my idea of birth, which is like rosy flesh, and secretions of various kinds and of opening up and just bodies being bodies, just the body, bodily-ness of it, seemed in such opposition to this, like, the chrome and the plastic and all of those things that are in a hospital.

Caoimhe p 13, L 40-44-p 14, L 2

In these excerpts we see participants suggesting that medical interventions such as those used to induce and augment labour can lead to negative birth experiences, including a loss of power and choice, for women. These disempowering experiences are in turn situated within the fragmentation of women's bodies and the alienation and engulfment of the birthing m/other (van der Waal *et al* 2021). However, participants also assert that women's experiences should not be dismissed and offer an alternative lens with which to view birth that focuses on the capabilities of the birthing female body.

Along with offering an alternative, empowering view of the female body, participants also offered an alternative vision for their preferred birth environment, one in which they felt safe and empowered, with birth attendants whom they knew and trusted.

Molly and Niamh, for example, spoke of their experiences with the homebirth midwives with whom they were planning to give birth, and the importance of feeling safe and having a relationship with them based on trust and respect.

Molly said:

I was swayed towards a community midwife because my friend had been to her and as soon as I met her it was, she was just fabulous. She was very good and she would have protected me from a lot of the health service stuff. ...

For all four births, there was a huge emphasis on building my confidence to give birth with the homebirth midwives, and I didn't even realise until I gave birth that that's what had been going on, the first time. I was being told I could do this, I was built for this and fear was never a thing.

Molly p 3, L 10-13; L 24-27

Niamh also praised her homebirth midwife, saying:

In terms of going into labour, it was great to have that kind of [care]. ... She [SECM] told us all the time, so this will happen in this, and that just made me feel so confident. Then when it did it was oh, here's the thing that she said.

Niamh, p 10, L 36-38

Along with trusting one's midwife, participants also spoke of the hospital as an environment that was not conducive to birth, and offered home as an alternative in which they felt safe and comfortable. Echoing the words of Caoimhe, above, Molly said:

So my experience when I went in there [hospital], I mean, it's just not conducive to labour. It's noisy, you can't get sleep. It made me anxious because I wanted to rest before I had to do labour. ...

Women need basic things like food and rest when they're labouring and they don't get those [in hospital], and as a result, it's a crisis. That's my experience, that was my experience of it.

Molly, p 5, L 6-7; p 6, L 13-15

Laura, meanwhile, spoke of feeling safe and comfortable in her home environment. These positive feelings were, in part, due to the fact that she knew she would not have obstetric interventions at home:

What interested me [about giving birth at home] was around the, well, if I was at home, I'd be more relaxed, I wouldn't have the interventions and, honestly, I was only saying to [husband] last night, I said the thoughts of having the baby here, being able to get into my own shower afterwards, being able to have a cup of tea from my own cup, and then getting into my own bed is just, the thoughts of that was amazing. Not having to be in a hospital bed that's uncomfortable and too small and you know, like, being able to, being in your own house. Just the thoughts of that. And particularly with a toddler as well. I mean, you know, thinking about, well, if I had to go into hospital, like, who's going to mind her? I've never been away from her for a night.

Laura p 13, L 6-13

Thus, in these excerpts we can see participants offering an alternative to the obstetric interventions and mistrust of the female body many of them experienced in hospital, in favour of a birth environment in which they felt safe and birth attendants who empowered and respected them and their ability to give birth confidently.

7.6 Conclusion

These findings indicate that national and local hospital policies play a significant role in women's experiences of access to alternative birth models, limiting women's choices and ability to access the birth of their choice. These policies are a reflection of the authority that obstetrics maintains over birth, as pregnant and labouring women, as well as midwives, must continue to fit within obstetric metrics, while women's embodied knowledge of the health and wellbeing of their bodies and babies are dismissed. The obstetric colonisation of birth (O'Connor, 1998) has meant that hospital policies and clinical assessments regarding pregnancy and birth are routinely given authority and weight (Reed *et al* 2017), with Browner and Press (1997) noting that the advice of doctors "carries the force of command", such is the privileged position that scientific knowledge occupies. Thus, within contemporary Irish maternity services, women's embodied knowledge, as well as women's beliefs regarding safety and risk, are often dismissed or discredited in

favour of the medical knowledge espoused by hospital/health service policies and practices.

As discussed in Section 7.2, one policy that plays a significant role in women's experiences of attempted access – and demonstrates continued medical authority over birth – is the requirement for some women to obtain a consultant sign-off. The HSE requirement that a woman must fit within the category of “low risk” and that only consultants can adjudicate on borderline cases, indicates continued obstetric authority over birth. Furthermore, locally variable maternity service policy regarding length of pregnancy impacted significantly on my participants' experiences of access to alternative birth models. Siobhán, Caoimhe and Keelin, for example, felt healthy even as their pregnancies went beyond 40 weeks. The variation in the application of limits of policies and practices regarding length of labour also played a significant, and often negative, role in women's experiences of access to alternative birth models, and suggests it is less the quality of the scientific evidence than the authority of the local (obstetric-led) policy that perpetuates such practices. Participants such as Niamh and Keelin, who were giving birth at home, had to do so within 24 hours, while those giving birth in an MLU, such as Aileen, were required to do so within 12 hours.

In the previous chapter, I presented my findings in relation to how information-giving and a dismissal women's decisions around place of birth represent key moments in their gaining, or not, of access to alternative birth options. In this chapter, the findings have encompassed policies that once again dismiss female knowledge, but in particular disregard natural variations in the female body and physiology, undermining women's ability to give birth where they wish. Furthermore, women report how medical risk management negates the negative impact that unwanted interventions can have on a woman's birthing experience. Unnecessary intervention is listed as a key motivator to alternative birth place decision-making and is revealed as a common part of their “eleventh hour” experience even where access initially seemed successful. In the following chapter, these two sets of findings will be discussed and situated within my theoretical framework and the relevant literature.

Chapter 8: Discussion

8.1 Introduction

This chapter discusses my findings in relation to women's lived experiences of attempted access to alternative birth models in contemporary Ireland, in light of the relevant literature on authoritative knowledge and in the context of my feminist theoretical framework regarding the female body and choice. Initially, I suggest that the phenomenon of attempted access is one of inconsistency and constraint. Examples of this are seen in my findings, which I will summarise in order to illuminate the phenomenon and foster an understanding of the significance that it held for those who lived it (van Manen 2016). In Section 8.3, I situate my findings in relation to the provision of information within an obstetric maternity system, while Section 8.4 discusses the findings in relation to women's decisions and challenges from healthcare professionals within the context of feminist discourses on women's birth choices. Section 8.5 examines the participants' experiences of obstetric metrics relating to the pregnant and birthing female body, including official timeframes for the length of pregnancy and labour. Section 8.6 will discuss the ways in which women's experiences are dismissed in favour of a "healthy baby" and how this focus on neonatal mortality masks obstetric efforts to circumscribe women's autonomy, while Section 8.7 will examine the requirement for some homebirth women to obtain a consultant sign-off. I will then discuss the implications of these findings in relation to the National Maternity Strategy, women's choices and access to alternative birth models in contemporary Ireland. Finally, I conclude by offering the alternative vision for choice and access proposed by my participants and other women who are reframing birth and supporting alternative models.

8.2 The phenomenon of attempted access to alternative birth models

In phenomenological inquiries, the "horizon" indicates the point at which one's understanding of an experience or phenomenon comes to an end (Gadamer 1975). A "fusion of horizons" occurs when a researcher comes to see a new, broader horizon after speaking with participants and developing a better understanding of their experiences. Original and new horizons can fuse together to give the researcher a deeper understanding of a phenomenon, which is then expressed through her findings.

As set out in Chapters 6 and 7, my findings indicate that the participants' choices and autonomy were inconsistently supported across the maternity system when their choices fell outside the obstetric framework and medical model of birth. Participants' knowledge, decisions and birth choices, and well as their physical capabilities and autonomy as pregnant and labouring corporeal beings, were often suppressed or disregarded as they attempted to access alternative birth models. Taken as a whole, these findings indicate that the phenomenon of women's lived experiences of attempted access to alternative birth models is one of inconsistency, constraint and denial.

This constraint, experienced collectively and individually by participants, was due to a lack of standardised provision of information and the ongoing use of obstetric metrics when determining risk factors in pregnancy and birth as a basis for eligibility for alternative birth options. Viewed as a whole, the participants' experience of attempted access indicates continued obstetric authority over birth, even within a framework of service provision that espouses choice for childbearing women and appears to support the promotion of physiological childbirth.

Throughout their entire journeys of attempted access to alternative birth models, from previous hospital-based births that motivated them to seek out alternatives (Chapter 6, Section 6.3.3), to gathering and discussing information during the antenatal period (Chapter 6, Sections 6.2 and 6.3.1), to seeking a consultant sign-off (Chapter 7, Section 7.2) and through experiences of post-maturity and labour (Chapter 7, Sections 7.3 and 7.4), participants experienced dismissal of their birth choices and their reproductive bodies. Once the baby was born, some participants also experienced a dismissal of themselves and their experiences, situated within a focus on the "live baby" or "healthy baby" (see Chapter 7, Section 7.5), or within postnatal care that was "all about the baby" (Daly *et al* 2021).

The inconsistencies and constraints that formed the phenomenon of attempted access for the participants in my study were experienced at different points throughout their antenatal and intrapartum journeys. For example, gathering or receiving information about alternative birth models was the first – and therefore a significant – step in accessing these models. As presented in Chapter 6, their experiences regarding information about birth options were complex and varied. Some obtained this information during their initial antenatal appointments, when healthcare professionals informed them of either the hospital's homebirth scheme, the HSE homebirth scheme or the relevant MLU. However, the participants who

were told about alternative models during their booking visits felt that it was down to chance that they heard about such schemes, and the fact they did so was dependent on the chance support of a particular professional or, in the case of one participant, the fact that she had previously given birth at home. Meanwhile, other participants gathered information from sources outside the antenatal appointment setting, such as other women, the internet, social media groups, books or the local primary care centre, with one participant describing the availability of information from official sources as “pot luck”. The fact that the provision of information about the full breadth of birth options was not standard for these low-risk participants in a region where all options are theoretically available suggests that information regarding alternative birth models is not accessible to service users as a whole. This lack of a standardised or universal approach to information provision means that alternative, midwifery-led options for place of birth are not always discussed or explained as fully as medical options. Thus, participants’ experiences indicate that information regarding alternative birth models is constrained or suppressed within standard antenatal care provision. This finding is significant as it indicates that despite the availability of alternative birth models in policy and theory for those who are eligible, information regarding birth options largely fails to promote real choice for women.

As presented in Chapter 6, Section 6.3, the decision made by my participants to give birth within an alternative setting was at times dismissed or disregarded by healthcare professionals during the antenatal period. For some, their antenatal visits became the sites in which they were confronted with both gendered stereotypes of the irrational female and medico-obstetric beliefs regarding the appropriate setting for birth and women’s ability to protect the baby. This confrontation was experienced when the choice to give birth at home or in an MLU was challenged by their GPs, many of whom used obstetric risk discourses to dismiss the woman’s decisions. Other GPs withdrew their care, and another suggested a mental health services referral, all exerting power and control over the relationships with participants. As a result of these unsupportive or dismissive reactions from GPs, participants experienced both self-doubt and what Daly et al (2021) describe as “induced anxiety”, which refers to interactions with healthcare providers that instigate or increase anxiety for pregnant and birthing women. Other healthcare professionals used the Eighth Amendment as an argument to undermine women’s agency and dictate women’s birth choices.

As presented in Chapter 7, Sections 7.3 and 7.4, obstetric power over women and the female birthing body, expressed through management regimes, can be seen in my participants' experiences of maternity service/hospital policies regarding rigidly demarcated timeframes for the length of pregnancy and labour. For both the homebirth and MLU cohorts, biomedical and patriarchal conceptualisations of the female body are embedded within the experiences of many of my participants as they negotiated the later stages of their pregnancies. Those who were induced experienced hospital policy regarding length of gestation as being unresponsive to and at odds with their experiential reality and their embodied knowledge about the health of themselves and their babies. Because of this dissonance, they felt anger and frustration as these hospital policies proved to be insurmountable barriers in their attempts to access alternative birth models. Those whose labour was artificially augmented also experienced rigid hospital policies that denied or suppressed their knowledge and abilities. As women giving birth, they were "living manifestations of action and intention" (Young 2005, p 44). However, their bodily autonomy and knowledge of themselves and their babies was suppressed by hospital policy and professionals who viewed them "objects" for "manipulation" (Young 2005, p 44).

Finally, some of the participants who wished to give birth through the HSE homebirth scheme had to obtain a consultant sign-off. This was a requirement for participants who, according to guidelines, experienced a health/risk issue (such as age) that could exclude them from homebirth services. However, the participants conceptualised themselves as healthy and homebirth as a safe model for themselves and their babies. Despite this, they were required to seek permission from a consultant before being allowed (or forbidden) to have a homebirth. This permission seeking, even when granted, clearly signalled to them the extent and penetration of obstetric power into normal pregnancy and birth.

Having reviewed the experiences that capture the phenomenon of attempted access to alternative birth models, I will now situate these experiences within my theoretical framework and the relevant literature.

8.3 Information provision within an obstetric maternity system

The experiences of gathering information about birth choices reflect those of other childbearing women in contemporary Ireland. In their qualitative study of the maternal health-related issues that matter most to first-time mothers in Ireland,

Daly et al (2021) also found that access to information about pregnancy, birth and the postnatal period varied greatly between women and also within an individual perinatal experience. Some described very good access to information while others disclosed poorer levels of access. Also echoing participant experiences in my study, Daly et al (2021) found that women often relied on their GP to provide information but the type and quality of the information varied significantly according to the individual GP.

Accessing information is an essential component of making an informed choice about one's healthcare and, within the context of this study, the birth model most appropriate for oneself and one's baby. However, as discussed in Chapter 2, Section 2.2, the dominant group within a healthcare service has the power to determine which knowledge carries authority and therefore which information is important to propagate (Jordan 1993/1997). In contemporary Ireland, the obstetric profession is the dominant group within maternity care. Obstetric language frames what is "known" about birth, which is then recognised and internalised as the "common sense" knowledge regarding birth (Newnham *et al* 2018, p 82). When information is presented from within and constrained by the obstetric paradigm, the ability to make fully informed decisions and genuine choices is undermined. Newnham et al (2018, p 172) express the bounded nature of contemporary childbirth, information and choice, writing: "In a society where intervention-free birth is presented as 'risky' and medicalised birth as 'safe', the process of information giving and receiving is so tainted that it is difficult to see how women have genuine choice to any significant degree."

The way in which information is presented by healthcare professionals to pregnant women influences their decision making (Stapleton *et al* 2002). This was especially relevant in relation to information regarding access to alternative birth models, as the information provided (or not) to women, or the way in which it is presented, has a significant impact on the choices they made. Choices that are available in theory but not actively supported by staff are rarely taken up by pregnant women (Stapleton *et al* 2002). Midwives might wish to discuss alternative options but are often concerned about recommending care that contradicts normative obstetric practice, and thus may not present such non-normative alternatives (Stapleton *et al* 2002).

As discussed in Chapter 3, Section 3.5, supporting service users to make informed choices is a stated pillar of modern healthcare (Symon 2006), and particularly

modern maternity care (MacDonald 2018, Tracy and Page 2019, WHO 2018a). The ability to make an informed choice assumes that service users have access to information regarding all their options, in a way that is easy to obtain and understand (Hewson 2004). Therefore, when the information given is restricted or limited, women cannot exercise informed choice (Henley-Einion 2009). In relation to my study, pregnant women indicated that access to alternative models is constrained by the lack of consistent, standardised information regarding the full range of birth options.

While some participants experienced constraints or inconsistencies in information, others experienced the dominance of medical authority during discussions with their GPs and other healthcare professionals regarding their birth choices. These issues will be discussed below.

8.4 Women's decisions – Reaction from GPs and the Eighth Amendment

Childbearing women must contend with both medical and gendered notions regarding their decisions around birth. In tandem with this, women must contend with the pressure from healthcare professionals to make “good” or “safe” choices in relation to the foetus growing inside them.

As discussed in Chapter 3, Section 3.4.5, Western medicine has traditionally viewed women as weak and hysterical and often poor decision-makers (Jackson 2021, Oakley 1980, Young 2005). Within the context of maternity care, the decisions made by women who attempt to access care that falls outside the accepted parameters of medicine or contradicts normative clinical practice are viewed with suspicion by healthcare professionals situated within an obstetric framework (Stapleton *et al* 2002). Women experience pressure to make choices in line within obstetric clinical practice, as otherwise their decisions are called into question (Hewson 2004, Jomeen 2010) and inconsistently supported by maternity care professionals (Kruske *et al* 2013). Both midwives and obstetricians tend only to support women when these decisions were in line with the healthcare provider's preferences. Doctors, as a professional group, believe themselves to be the most competent at making final decisions regarding a woman's pregnancy and birth (Kruske *et al* 2013). Daly *et al* (2021, p 5) made similar findings, suggesting that women are not adequately supported to feel confident in their own ability to make decisions as new mothers. Through this lack of support and respect for women's

decisions regarding their care, contemporary maternity services have deprived women of the right to self-determination (Houd and Oakley 1983).

Contemporary Western medicine also considers that women may make poor or risky decisions in relation to the fetuses growing inside us (Craven 2005, Rothman 1989, Solinger 2005). Since the latter half of the 20th century, medicine has constructed the mother-foetus as a conflicting dyad rather than an integral unit (Rothman 1982), and the foetus has been conceptualised as a patient with “scientifically” defined needs that must be addressed by medical professionals (Duden 1993, p 4). Based on this conceptual separation of the mother-baby unit, contemporary maternity services divide care and treatment for the woman and her newborn (Houd and Oakley 1983, Rothman 1989). Women who wish to give birth outside the dominant biomedical model are, in particular, constructed as “bad” mothers who fail to accurately assess the risks associated with childbirth (see Chapter 1, Section 1.4.1). Because of their (our) failure to align with obstetric risk assessments, these mothers are thought to take unnecessary and dangerous risks in relation to the fetuses inside them (Craven 2005, 195). By doubting women’s decisions in relation to their children, the obstetric profession contends that they are more competent than women in judging the best interests of the foetus. As a result, a woman’s agency is undermined, even denied, and decisions regarding her body and her baby are assigned to members of the medical, legal and political professions (Houd and Oakley 1983). Through the separation of the mother-foetus unit, medicine has also pitted a positive birth experience for the mother against the outcome of a healthy baby (Martin 1989). This alleged conflict is rooted in an obstetric focus on mortality and morbidity and in a dismissal of women’s capabilities to make good decisions and to mother effectively. Meanwhile, participants who experienced dismissal through healthcare professionals’ employment of the Eighth Amendment framework were also confronted with the obstetric separation of the mother-baby dyad and what Duden (1993) refers to as a privileging of the neonates “right to life” over that of the mother’s autonomy.

My findings in relation to women’s decisions about birth alternatives are thus significant as they mirror the experiences of women situated in differing social and historical contexts who experienced a similar dismissal or disregard for their decisions by healthcare professionals. My study adds unique insight into the experiences of women and their interactions with GPs, when attempting to discuss alternative birth models. In particular, my research highlights the obstetric risk discourses, medical authority and the threat of removal of care employed by GPs

in relation to women whose birth choices fell outside the limits of acceptable obstetric practice.

Furthermore, the experiences of my participants highlight the unique context of giving birth while the Eighth Amendment was *in situ*. Previous research has highlighted the negative impact that the Eighth Amendment had on women seeking access to abortion care (Murphy-Lawless and Oaks 2021, Quilty *et al* 2015). The experiences of my participants add nuance to this body of work by presenting the ways in which women who chose to remain pregnant experienced the Eighth Amendment as a barrier to consent (or informed refusal) and a barrier to accessing their birth choices.

8.5 Dismissal of the pregnant and labouring body as a faulty machine

Throughout pregnancy and birth, my participants were confronted with reactions that reflected gendered constructions of the female body and scientific-medical conceptualisations of the body as a machine. Embedded within this mechanical metaphor are obstetric notions regarding the alleged inefficiency of the female birthing body. These constructs and conceptualisations were manifested in participants' experiences of policies regarding induction and augmentation of labour. Their experiences can be usefully viewed through a lens of feminist critiques of the medico-scientific paradigm (see Chapter 3, Section 3.4).

With the medico-scientific paradigm that continues to view women as inefficient machines (Downe and McCourt 2019), as well as weak and hysterical (Jackson 2021), reproduction comes to be the legitimate subject matter of medicine (Oakley 1980). Obstetrics diagnoses and defines women as maternity cases and women's birth experiences take place within these narrow medical parameters. Furthermore, the timing of pregnancy – determined by biomedical technology such as ultrasonographic dating – becomes the measure and the arbiter of normality and abnormality (Downe and Dykes 2010), and women are viewed as inefficient birthing machines when they fall outside these obstetric demarcations. The women in this study demonstrate that childbearing women are expected to give up their autonomy, which is then “mastered by members of the dominant social group: the social, professional and gender elite of male dominated-medicine” (Oakley 1980, p 8). For my participants, obstetric metrics and power to determine the birthing process is seen particularly in their experiences of policies regarding length of labour and pregnancy.

8.5.1 Length of labour

The application of mechanical and industrial metaphors to the human body, coupled with the shift of birth from home to hospital, has meant the phases of labour have been equated with a factory production line (Martin 1989, Rothman 1989). Within this paradigm, labour, like other “functions” of the female body, is judged within a linear framework of space and time, and birth is only controllable by imposing strict time limits (Downe and Dykes 2010). Bounded by these notions of mechanisation, efficiency and linearity, there is little room left for women to labour without obstetric interventions. Instead, women, “grounded whether they like it or not in cyclical bodily experiences, live both the time of industrial society and another kind of time that is often incompatible with the first” (Martin 1989, p 198). Medical interventions in labour are deemed necessary in order to optimise hospital “throughput” and control the “natural unreliability of the female body in labour” (Murphy-Lawless 1998, p 42). For birthing women, these interventions and the rationale underpinning them serve to “continue the idea of mechanisation by viewing labour progress in isolation from the woman who is experiencing it, as well as applying rigid, extraneous and artificial timelines against which women must perform” (Newnham *et al* 2018, p 37).

Labour augmentation is grounded in Friedman’s curve, which suggests that labouring women will dilate at one centimetre per hour. However, the accuracy of Friedman’s estimations, which were based on the labours of women in a specific hospital setting, regarding the progression of labour have been refuted in recent years (see Oladapo *et al* 2017 and Oladapo *et al* 2018, discussed below). Moreover, the notion that all labours must make linear progress, at similar rates to other labours, does not take into account physiological variations (Downe and McCourt 2019) or the fact that “progress” is affected by social, emotional and environmental factors, as well as parity and previous birth history (Davis-Floyd and Davis 1997). A recent systematic review of observational studies found that cervical dilation patterns for low-risk women during labour are not linear and deviate considerably from Friedman’s curve and hospital policies that are based on its metrics (Oladapo *et al* 2017). Specifically, the review suggested the expectation that labouring women should dilate at a minimum of one centimetre per hour throughout the first stage does not reflect the experiences of most healthy women, regardless of parity. The authors assert that “a ‘failure of labour to progress’ – a poorly defined but generally accepted term – has become a leading indication for

oxytocin augmentation and primary caesarean section” (Oladapo *et al* 2017, p 945)³³. They also observe that this interventionist approach to childbirth, which includes the AML model, can interfere with physiological birth and has a negative impact on maternal health outcomes and birth experiences. In contrast to the established expectation that women should dilate at one centimetre per hour, Oladapo *et al* (2017) observed that the median time it took both nulliparous and multiparous women to dilate by one centimetre was longer than one hour until a dilatation of five centimetres was reached, with markedly rapid progress observed after six centimetres. Women admitted to hospital before reaching four centimetres dilation (traditionally considered the moment of active or established labour) tend to progress very slowly and can take up to 24 hours before achieving full dilatation. Despite dilation rates slower than one centimetre per hour, however, most women achieved full dilation of ten centimetres and gave birth vaginally (Oladapo *et al* 2017). Based on variations in cervical dilation and labour progression, interventions to expedite labour to conform to a cervical dilatation threshold of one cm/hour are inappropriate and the use of averaged labour curves in labour management should be de-emphasised (Oladapo *et al* 2018)³⁴. Meanwhile, in 2014, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine published revised recommendations regarding the assessment of labour progression (ACOG 2014). The professional bodies suggest that current obstetric timeframes for labour, based on Friedman’s curve, do not reflect women’s experiences of labour, and lead to unnecessary interventions.

My study is significant as the participants’ experiences of augmentation of labour suggest that hospital policies remain embedded within outdate medical conceptualisations of time and the female body, and the participants’ critiques of their treatment reflect international debates regarding the management of labour. However, my inquiry also adds to the body of existing midwifery and feminist research by demonstrating that adherence to the Active Management of Labour (AML) acted as a barrier to accessing alternative birth models for some of my participants, who were transferred to the hospital ward or “Consultant-Led Unit” after they did not give birth in the MLU within the specific 12-hour timeframe. Those

³³ Failure to progress, as well as maternal request for analgesia, are the primary reasons for intrapartum transfer to hospital by women planning to give birth at home through the HSE scheme (Meaney *et al* 2020). Participant experiences of this will be discussed later in this section.

³⁴ The World Health Organisation has updated its partograph recommendations based on this research. See the new WHO Labour Care Guide (2020).

giving birth under the HSE scheme also had to contend with a 24-hour timeframe (now 18 hours), with some transferring to hospital as a result. “Failure to progress” is a common reason for intrapartum transfer from home to hospital (33%) (Meaney *et al* 2020, O’Connor 2006), and for a number of my participants giving birth at home or in the MLU. Thus, my study adds to existing discourses by demonstrating that participants were ultimately unable to access alternative birth models due to service/hospital policies that attempt to regulate and manage these alleged inefficiencies of the female birthing body. Furthermore, this research demonstrates the ways in which labour augmentation policies negatively affect women’s experiences of access in contemporary Ireland.

8.5.2 Length of pregnancy

The medical paradigm that places labour within a linear framework and conceptualises the female body as a machine is also reflected in my participants’ experiences of Irish maternity hospital policy regarding length of pregnancy. As presented in Chapter 7, Section 7.3, maternity hospitals have policies in place regarding length of pregnancy and induction of labour for post-maturity, which are variably based on NICE guidelines (NICE 2014). However, those policies did not mirror the embodied knowledge of some of the participants in my study. Their experiences of dismissal of their choices and assertions of well-being demonstrate the ways in which hospital gestation policies act as barriers to accessing alternative birth models at the final stage of pregnancy.

As outlined in Chapter 7, Section 7.4, hospitals have strict policies regarding the length of pregnancy, after which induction is recommended and pharmacological interventions are used to induce labour. In 2020, 34.9%, or 19,450 of the 55,799 women who gave birth nationally had their labours induced, though the stage of gestation was not indicated (National Women and Infants Health Programme (NWIHP) 2021). Amongst the 19 maternity units in Ireland, induction rates varied from 25.3%-39.5%. According to the NWIHP, their report does not “explore reasons for variations, but explanations probably include clinical factors, sociodemographic trends, and organisational behaviour and practices” (NWIHP 2021, p 47). Lawrence-Beech (2021) suggests that the focus on a baby’s due date, which is based on a statistical average length of pregnancy, is the result of the medicalisation and standardisation of birth or, in the language I have used throughout this thesis, the result of obstetric authority over childbirth.

Recent research suggests that the 40-week due date can only provide an approximate timeframe in which the baby might be born. For example, in a retrospective study that included 18,708 women who gave birth to single neonates, Khambalia et al (2013) found that only 5% of births occurred on the estimated due date, regardless of the dating method. Furthermore, induction can present risks to healthy mothers and babies, particularly if it takes place before 42 weeks. Rydahl et al (2019) found there to be no improvement in neonatal outcomes if induction takes place before 42 weeks. Specifically, their retrospective register-based cohort study of 152,887 women indicated that inducing labour at “Term plus 10”, or 41 weeks 3 days, instead of waiting until 42 weeks, did not decrease the incidence of stillbirths, perinatal deaths or low Apgar scores. Furthermore, the authors also point out that a policy of induction at “Term plus 10” significantly increases the rate of induced labour. While this point may seem obvious, they remind readers that induction interferes with physiological birth and increases the likelihood of other medical interventions. If the number of women who are induced increases, so too does the number of women who receive medical interventions during the intrapartum period.

Obstetric metrics that place pregnant women outside the boundaries of normality when this contrasts with the women’s embodied knowledge of health, and policies that recommend induction for post-maturity when a woman does not wish to take this course of action, can be understood within the concept of the faulty female body. As discussed in Chapter 3, Section 3.4.4, patriarchal and scientific configurations of the female as an object have practical implications for women’s embodied experiences and the ways in which female bodies are treated. Within the context of pregnancy, women’s bodies, separated from the rest of our being, are viewed as incapable of birthing, and women’s embodied knowledge can be dismissed when it contrasts with obstetric-led policies. Within this framework, the use of medic-technological interventions to induce labour are thus justified. These interventions can often be unwanted on the part of the labouring woman (Bohren *et al* 2019), and can also cause harm, though harm to the woman is often not factored into the equation when the safety of the baby is prioritised. Women who experience unwanted interventions, such as induction of labour, can feel alienated from their bodies, internalising patriarchal and obstetric objectification within the trauma process.

The international debate on length of pregnancy, as well patriarchal and scientific conceptions of the female birthing body, are reflected in the experiences of my

participants. Specifically, they were confronted with policies and practices regarding the induction of labour that are situated within an obstetric framework, rather than in their own embodied knowledge and birth philosophy. For my participants, these policies and practices meant that, at the “eleventh hour”, access to alternative birth models was denied, as induction meant that they were moved to a high-risk category and no longer allowed to give birth in an alternative setting.

For my participants, being seen as “mere bodies” (Martin 1989) whose pregnancies and labours were in need of medical management led to a dismissal of their choices and their autonomy. These experiences of dismissal will be explored in the section below.

8.6 Birth experience, dismissal and the “invisible women”

Dismissal of the participants’ choices, bodies and selves was a common theme that emerged from the phenomenon of attempted access. The participants’ experiences of dismissal are significant as they mirror those of other childbearing women in contemporary Ireland. For example, Daly et al (2021, p 8) found that central to the experiences of many participants was a feeling of invisibility, even in the midst of the very services that were supposed to be focused on supporting them. Like the participants in my study, theirs also felt unseen, unheard and dismissed, and described themselves and their care needs as being secondary to those of their babies.

The focus on a “live baby” dismisses a woman’s experience and right to choose where she gives birth under the guise of protecting the unborn child. Klassen (2001, p 61), writing about the experiences of homebirth mothers, suggests:

Arguments against homebirth that belittle women’s experiences of birth ... and refuse to acknowledge women’s right and responsibility to choose their desired place to give birth, fit along a continuum with ... foetal rights arguments. They downplay a woman’s role and experience giving birth in place of emphasising the “outcome” of the baby.

Klassen goes on to suggest that this concern regarding the foetus does not extend to children as they grow older, thus suggesting that medical claims regarding the safety of the unborn have less to do with safeguarding and more to do with control over women’s autonomy. She writes:

In a society that proclaims passionate interest in healthy babies but then fails to find solutions to the problems of child poverty once those babies age, these are not so much positive arguments guarding the baby as they are negative arguments circumscribing the autonomy of the birthing woman (Klassen 2001, p 61).

Thus, a suppression of women's experiences, through a focus on the "outcome", that is, a live baby, can be viewed as an expression of medical or obstetric efforts to separate the symbiotic mother-baby unit and exert control over women's autonomy and birth choices.

The varied forms of dismissal that shaped the access journey for my participants were situated within the medical model of birth, which includes policies based upon obstetric metrics and conceptualisations of the female reproductive body. However, as discussed in Chapter 2, Section 2.5, many women who give birth within alternative models, including this study's participants, situate themselves within non-obstetric paradigms. In particular, they view their bodies and birth within a holistic and woman-centred framework. Many therefore would not support obstetric metrics regarding length of pregnancy and labour, where these metrics did not resonate with their embodied knowledge of health. Therefore, this set of findings indicate that a significant part of women's lived experiences of attempted access to alternative birth models includes a confrontation with policies that are rooted in an obstetric paradigm. This confrontation and the suppression of women's knowledge is also seen, perhaps even more explicitly, within the context of the consultant sign-off, discussed below.

8.7 Consultant sign-off

One HSE policy that played a significant role for my participants in their experiences of attempted access to alternative birth models, and specifically homebirth, was the requirement for some women to obtain a consultant sign-off (see Chapter 7, Section 7.2). The participants in my study conceptualised risk and health within a framework that was based on relational, experiential and embodied knowledge, while their eligibility to give birth outside of hospital was based on medical knowledge. Their conceptualisations of birth mirror those discussed in other research projects, which found childbearing woman interested in alternative birth pathways often utilise risk assessments that are contextual and embedded within their own lives and experiences (Andrews 2004a, Stahl and Hundley 2003).

Women's considerations of risk include emotional, cultural, psychological and relational concerns (Edwards 2005), along with concerns for the birthing female body and its treatment (Chadwick and Foster 2014, O'Connor 1998). Additional risk assessments for women include considerations regarding the quality of the birth experience, a woman's ability to exercise choice and autonomy and her ability to access support for her emotional and mental health (Bohren *et al* 2019) (see Chapter 1, Section 1.4.1).

However, the homebirth participants in my study, both the ones who required the consultant sign-off as well as those who did not, had to negotiate and be defined within an obstetric framework of risk if they were to be "allowed" to give birth at home through the HSE scheme. This was also true for those birthing in the MLU, who were also required to meet the eligibility criteria of low-risk, as set out within a medical framework. For members of both cohorts, participants' own definitions of health and risk were disregarded in favour of obstetric metrics and their birth options were determined by this. Nearly four decades ago, Houd and Oakley (1983) found that maternity services across Europe and North America utilised obstetric risk criteria to determine appropriate candidates for alternative birth models. This meant that eligibility for alternative birth models, such as giving birth at home or in a birth centre, were determined not by the pregnant women but by healthcare professionals determining eligibility through obstetric metrics. A woman might consider herself eligible for alternative models but the power to make such a determination lay in the hands of healthcare professionals, often the ones she met during her initial antenatal visit (Houd and Oakley 1983) (see Chapter 1, Section 1.4.2). The findings from my study suggest that women who wish to access alternative birth models continue to be defined and constrained by obstetric metrics and authority.

One of the participants, Molly, articulated the frustration and irony she felt with the consultant sign-off requirement, when she told him she wasn't asking for his permission but also knew that she needed it if she wanted to give birth at home through the HSE scheme (see Chapter 7, Section 7.2). The consultant sign-off is an example of the way in which access to alternative birth models is bounded by obstetric authority. The constraint placed on women's choices by obstetric metrics can also be seen within the NMS despite its pro-choice rhetoric (Wood 2017). The ways in which obstetric authority restricts choice and constrains access within the maternity services will be discussed in the following two sections.

8.8 Choice as a problematic concept and constraints on access

The experiences of my participants suggest that choice is a problematic concept in contemporary Irish maternity services due to the constraints with which patriarchal social structures, obstetric authority and legal frameworks such as the Eighth Amendment shaped their experiences of access. As discussed in Chapters 1 and 3, women at all stages of reproduction must contend with a tapestry of gendered social structures and expectations, and women's choices are often bounded by them. These constraints are further accentuated when a woman becomes pregnant. In her examination of motherhood within patriarchal society, Adrienne Rich writes:

As soon as a woman knows that a child is growing in her body, she falls under the power of theories, ideals, archetypes, descriptions of her new existence, almost none of which have come from other women (although other women may transmit them) and all of which have floated invisibly about her since she first perceived herself to be female and therefore potentially a mother (Rich 1986, p 62).

In my study, participants experienced these “theories, ideals and archetypes” in the form of gendered notions about their decisions regarding birth and their bodies. These notions of female-ness have formed the social context in which the participants attempted to access alternative birth models, and manifested themselves in the challenges and criticisms regarding choices during the participants' access journeys.

Meanwhile, obstetric notions regarding birth and the female body also form the context in which my participants' experiences of choice and access have occurred, and has meant that the parameters of women's decision-making and ability to exercise choice are bounded. Specifically, choices and pathways of care available to childbearing women remain situated within an obstetric model of birth (Scamell *et al* 2019) and remain predicated on obstetric definitions of safety and risk, despite the fact that modern maternity services use the rhetoric of choice and present themselves as systems receptive to patient preferences (McCabe 2016).

For a woman giving birth in contemporary Ireland, the antenatal booking visit is the initial moment in which she is defined within an obstetric framework and her body becomes the site on which obstetric definitions of risk are played out. I have focused my research on the experiences of those who were considered low-risk

during this initial clinical assessment (or later signed off by a consultant). However, as they continued in their attempts to access alternative birth models, their choices were still constrained by obstetric definitions of risk and continued authority over birth.

Like other maternity care professions and stakeholders, obstetrics uses the rhetoric of choice – but only insofar as women's choices fall within an obstetric definition of safety. Heath (2013, p 2) writes that maternity services in Western countries are developing “a culture of conformity which pays lip service to autonomy and choice but within which the individual is only really free to make the choice that is approved by the state.” This dissonance, between the “lip service” of choice and the reality that choices are bounded by obstetric policies, can be seen in the experiences of my study participants. Examples of this are expressed in the variable and inconsistent provision of information regarding birth options, in the consultant sign-off requirement for some women and then again in policies and practices regarding length of gestation and labour. Thus, while the Irish maternity services and the NMS in particular use the rhetoric of choice, the experiences of my participants suggest that women are only free to make choices sanctioned within an obstetric framework, which is upheld through national and local policy and practice. This means that beneath the woman-friendly packaging of choice rhetoric, medical dominance prevails (McCabe 2016) and access to alternative birth options remains problematic.

Along with obstetric authority, the Eighth Amendment also meant that for 35 years, birth and reproductive choices were uniquely constrained for pregnant women living in contemporary Ireland. As discussed in Chapter 6, Section 6.3.2 and Section 8.3, the presence of the Amendment in the Constitution meant that doctors had a legal mechanism through which they could impose certain interventions on women choosing to remain pregnant if they believed the foetus to be at risk. OBoyle (2009) writes:

The status of the unborn child in the Irish constitution also leaves the status of the pregnant woman in something of a contested position. Unlike men and non-pregnant women, the pregnant woman, by virtue of the “rights” of the child within her, has, at least potentially, to face the challenge of her rights, freedoms and choices being contested, constrained or even denied (2009, p 21).

Several of my participants highlighted this contested position of the relative rights of the foetus and the mother as a part of their access stories, suggesting that access to care was also problematised for women in Ireland who chose to remain pregnant, at least until the Eighth Amendment was repealed in 2018. This conflict can be seen in situations where a woman's preference for aspects of care such as intermittent monitoring (as in the case of Noelle), or the ability to decline care (as in the experience of Keelin), could potentially be overruled while the Amendment remained part of the Irish Constitution.

Within this context of patriarchy, obstetric authority and the Eighth Amendment, women's birth choices remain bounded within the biomedical paradigm of birth. The advent of the National Maternity Strategy (NMS), discussed in Chapter 1, Section 1.2.5), was developed with a view to offer service users greater choice and woman-centred maternity care (DoH 2016, p 4). However, the experiences of my participants, coupled with a closer examination of the NMS in Chapter 1 and below, indicates otherwise.

8.9 The National Maternity Strategy – promoting choice or perpetuating obstetric power?

According to the NMS, childbearing women in Ireland previously experienced a lack of choice. The strategy hoped to redress this, to ensure that women have “appropriate and informed choices and access to the right level of care and support” (DoH 2016, p 4). However, a close reading of the NMS would indicate that medical authority remains upheld within the maternity services, ultimately determining which choices are available to women. This medical authority over access to birth options can be seen in the fact that while the strategy ostensibly supports women's choices, it insists that those choices remain in line with obstetric risk assessments and pathways of care are mandated by a consultant (Wood 2017). This constraint on women's choices can be seen in the foreword to the Strategy, written by the chair of the Maternity Strategy Steering Group, which initially states: “Women should be offered choice regarding their preferred pathway of care” (DoH 2016, p 3). While the use of “choice” and, later, “normalisation” initially seems promising, these concepts are then tempered with the language of “in line with their clinical needs and best practice” and the phrase “*insofar as possible*, all care pathways should support the normalisation of pregnancy and birth” (DoH 2016, p 3, italics mine). Later in the strategy, the importance of providing choice is again emphasised – but is again couched within obstetric

notions of risk. The strategy states that the HSE, through the newly established National Women and Infants Health Programme, will ensure that “pregnant women are offered choice in the selection of an appropriate pathway of care, based on safety, risk profile and needs” (DoH 2016, p 114).

It is clear, based on the findings of my study, that obstetric definitions and metrics continue to influence and constrain women’s lived experiences of choice and can act as significant and real barriers to access to alternative birth models. A pillar of the strategy is determining whether a woman is low-risk (or what the strategy refers to as “normal risk”), medium-risk or high-risk. Tracy and Page (2019) write that obstetric risk scoring systems enable obstetrics to restrict midwifery services to only those women who are considered to be low-risk. These scoring systems ensure obstetric control over both birthing women and their predominantly female birth attendants/midwives (O’Connor 2006). Ultimately, this means that authority over birth does not belong to the childbearing woman, nor to midwives, but to obstetric consultants. For example, like the HSE’s homebirth scheme, the strategy says that low-risk women should have the option to give birth at home. However, it also states that this should only happen within a medical framework, if a woman has “permission” from an obstetrician (DoH 2016). This upholds the current HSE homebirth scheme requirement for some women to obtain a consultant sign-off. Thus, while the strategy ostensibly hails in a new era of choice for childbearing women, a pregnant woman’s health is still defined, and her choices are determined (and bounded), within an obstetric framework.

In these circumstances where the strategy perpetuates a biomedical paradigm of birth through the support of obstetric metrics and authority, the provision of services for women who are deemed low-risk within this framework not only remains geographically patchy and poorly advertised but the future of these services also remains unclear. When the strategy was launched, it was envisioned that Alongside Birth Centres (ABCs) would be built in all maternity networks across the country. Although these ABCs would not be freestanding, such as are available in the UK, they would be accessible to low-risk women who wished to give birth without medico-pharmacological interventions. When it was launched, the strategy charged maternity networks with developing plans for the provision of an ABC in their area. The strategy states that pending the development of the ABCs, or if a maternity unit is too small to “justify” a discrete unit, a space in which women can birth naturally should be created within the existing maternity unit. As yet, six years after the launch of the plan, no ABC has been developed. Labour and birth are

sensitive physiological processes substantially influenced by environmental factors and, in a hospital setting, institutional authority permeates the atmosphere within the birth environment, irrespective of the design of a room (Goldkuhl *et al* 2021). This authority leads to a power imbalance between institutional demands and women's individual needs. Providing a home-like environment within a hospital often means inflexible hospital policies and practices are followed and the presence of medical technology leads to unnecessary interventions (Houd and Oakley 1983). The NWIHP website reports specifically on supported care pathway initiatives and in 2021 reported on the development of "home-like" rooms (NWIHP 2021). However, "home-like" rooms within hospitals do not fully support the choices of women who wish to have a physiological birth and cannot be seen as a reasonable alternative to fully implemented ABCs. Furthermore, the HSE's commitment to supporting homebirth for low-risk women remains unclear as the strategy places a caveat for those women wishing to give birth at home. It states that low risk women "should, *where feasible*, have the option to give birth at home" (DoH 2016, p 94, italics mine). Whether this feasibility is based upon geographic location, availability of midwives or some other factor remains unclear. However, its presence within the strategy would seem to indicate that even low-risk women may not have access to homebirths.

Thus, while the concept of choice has been popularised within maternity care policy and provision within the last several decades in other Western countries (Tracy and Page 2019, Yuill *et al* 2020) and the last several years in Ireland (DoH 2016, O'Brien *et al* 2018), women's ability to choose their birth environments and attendants, and to access alternative options, remains severely constrained. Discussing access to abortion care under the Eighth Amendment, Sherlock asks: "Can an option to which there is no viable alternative truly count as a 'free' choice?" (Sherlock 2015, p 71). I would suggest that a similar idea applies to childbearing women attempting to access birth services. If the only birth option that is viable is birth in hospital, then women are not free to choose or access alternative birth models.

However, despite the weight of obstetric authority over birth and ongoing constraints on access, my study participants continued to support alternative knowledge systems and attempted to give birth outside the parameters of the medical model. This knowledge and action constitute a persistent form of resistance to obstetric claims over women's reproductive lives and will be discussed in the following section.

8.10 An alternative vision for choice

In the face of the biomedical hegemony and obstetric authority over birth, my study participants conceptualised birth within an alternative framework that valued the embodied and experiential knowledge held by themselves, other women and midwives, and that situated birth within a social context. Based on this framework, they attempted to access birth choices that were most in line with their knowledge systems and values.

Within the context of the maternity services, the notion of choice, for my participants and other childbearing women, is not simply an individual consumer matter, but a complex, relational one that includes concerns about their other children, partners and families. These efforts on the part of my participants mirror work by other women who collectively have defied patriarchal and neoliberal parameters and found ways to explain and understand female experiences such as childbirth (Martin 1989). Childbearing women have also reclaimed birth by developing alternative definitions of choice that are rooted within a social, holistic, relational model (Davis-Floyd 1992, Murphy-Lawless 1998, Edwards 2004). By emphasising the connectedness between woman and child, and woman and midwife, and de-emphasising the individual, women can disrupt neoliberal notions regarding birth (Newnham *et al* 2018). In seeking, accessing and engaging in alternative birth practices, women resist the dominant medical model of birth and promote an embodied alternative.

Many of my participants felt their personal autonomy and bodily integrity was dismissed by healthcare professionals during hospital-based births, and they attempted to redress this through giving birth within alternative settings. A concern for autonomy and its relationship with choice is reflected in feminist and alternative birth discourses (see Chapter 3, Sections 3.5.1 and 3.5.4). In the context of maternity care, choice is the ability to be in control of one's body and to access one's birth preferences. As Tracy and Page (2019, p 140) write: "Choice points to the personal autonomy that is fundamental to the rights and wellbeing of women. This right to choose is linked closely to being in control of your own body." However, official maternity systems throughout Europe have tended to deprive women of their right to self-determination and assigned authority over birth decisions to medical professionals, as well as governments or the courts (Houd and Oakley 1983, see Chapter 1, Section 1.3.2). Therefore, if a maternity service is to truly offer choice, then choice must not be constrained by obstetric metrics.

Instead, the maternity services must offer women the opportunity to discuss options, access the option of their choice and to decline services if they wish to do so. Alternative models of care must be geographically widespread with maximal eligibility – or, I would suggest, eligibility should perhaps be removed from the access equation if the maternity services are to be truly supportive of women’s choices and autonomy.

A desire for choice which acknowledges relationships and promotes genuine autonomy leads women to seek out information regarding alternative birth models. Cheyney (2008) has identified the process of gathering information from alternative sources, such as friends, midwives and studies (on homebirth), as a mechanism of resistance to the dominant medical paradigm. Mothers seek new information and narratives about birth as part of a process of “unlearning and relearning” old and new information and knowledge (Cheyney 2008, p 258). This search in turn creates new knowledge systems and supports alternative practices, such as birthing at home or a birth centre, that are based on these alternative paradigms.

Thus, although the Irish maternity services in general and the National Maternity Strategy in particular may espouse the notion of choice in childbirth, choices remain bounded within a medical model that perpetuates and supports obstetric authority and knowledge. However, women interested in alternative birth models seek and, in doing so, build a framework of alternative knowledge and practice that envisions choice as a more complex concept encompassing autonomy, personal relationships and a consideration of multiple forms of knowledge. In valuing a multiplicity of knowledges and attempting to give birth within a framework that empowers and respects themselves and their relationships, women resist neoliberal notions of choice, the biomedical hegemony and obstetric authority over birth. If contemporary Irish maternity services are to truly offer choices to childbearing women, the conceptualisations of choice currently espoused within the maternity services must reflect women’s own experiences and birth philosophies, and provide birth options that are truly alternative and readily accessible.

8.11 Conclusion

This chapter has taken the findings presented in the previous two chapters and contextualised them within feminist discussions on knowledge, choice and female

bodies. As reflected in studies from other countries, my participants' lived experiences of attempted access to alternative birth models remained complex and fraught with continued confrontations with the dominant obstetric model of birth. This meant that the phenomenon of access to alternative birth models is largely and, paradoxically, one of constraint, perpetuated by a maternity service that remains situated within a narrow, risk-adverse medical paradigm. However, for feminist scholars, knowledge and action are inextricably linked. As McGregor (2020, p 4) writes: "It's not enough for us to merely observe the scope of the problems women face in our modern medical system or even to voice our feelings of anger and betrayal at what we see; we need to always be asking, 'What can we do about this?'" Therefore, as a piece of feminist research, it is not enough for me to simply critique service provision and policies, through the experiences of my participants. I must also provide suggestions for action, for ways in which to improve services for women based on the knowledge of my findings. I will do this in the following chapter.

Chapter 9: Conclusion, implications and recommendations

9.1 Introduction

The final chapter of this thesis discusses the implications of my findings regarding the phenomenon of women's lived experiences of attempted access to alternative birth models in contemporary Ireland. Leading from this discussion, I present recommendations for policy, service provision, education and research. The study's new contributions to the knowledge base are then made explicit. The chapter concludes with a discussion of the limitations of the study.

9.2 Summary of findings

The findings of this study show that women's lived experiences of attempted access to alternative birth models remain constrained and complex, as discussed in Chapter 8. Viewed as a whole, the participants' experience of attempted access indicates continued obstetric authority over birth, even within a framework of service provision that espouses choice for childbearing women.

In relation to information, the study found that pregnant women often receive information regarding their birth options from a healthcare professional during their booking visit or from lay and online sources. For my participants, the initial clinical interaction was significant in determining whether they received information regarding access to alternative birth models from healthcare providers/gatekeepers, or whether they did so from alternative sources such as websites, friends or, for those planning homebirth, directly from Self-Employed Community Midwives (SECMs). Overall, my participants found that the information available to them regarding alternative birth models was not comprehensive or standardised across the maternity services, even within the North-East region of the country where all alternative options are theoretically available to this low-risk cohort. For all of the participants, and particularly those who did not receive information during their booking visits, information was gathered through informal channels, such as other mothers, friends or social media.

Within this process of gathering information during the antenatal period, some participants had their birth choices dismissed or disregarded by their GPs, signifying that these interactions acted as micro-barriers to women's access to alternative birth models. Others also had their decisions disregarded, with healthcare professionals sometimes using the legal framework of the Eighth

Amendment as a device with which to dismiss pregnant women's choices in relation to their fetuses and their bodies. It is through these experiences of disregard and dismissal of their choices that participants were confronted with patriarchal and obstetric suspicions that women are unable to accurately assess the risks inherent in childbirth and make "good" choices in relation to the fetuses growing inside them.

Just as women were confronted with notions regarding their ability to make good choices, so too did they find themselves at the intersection of patriarchal and medical conceptualisations regarding the faulty female body. This was manifest in the experiences of the participants whose ability to give birth naturally within an MLU or at home was constrained, often in the very last days and minutes, by obstetric-informed hospital eligibility policies regarding the appropriate management and control of the length of pregnancy and labour. These policies overrode and suppressed the embodied knowledge of my participants, who believed themselves and their babies to be healthy, and their bodies capable of successfully birthing their infant. Notions of the faulty female body were also evident in the experiences of those participants who required a consultant sign-off before becoming eligible for the HSE's homebirth scheme. Embedded within this requirement is the notion that a woman's pregnancy and health must always be judged within an obstetric framework. My findings in relation to this matter indicate that women's access to alternative birth models are constrained by the requirement for a consultant sign-off because, even if a woman is choosing a homebirth, her "choice" is bounded by whether or not a consultant decides that her body is capable of giving birth without obstetric support and technology. Obstetric metrics embedded within the consultant sign-off suggest that access to alternative birth models is problematic for women in a maternity system that is shaped by biomedical policies.

Therefore, in summary, women's lived experiences indicate that the phenomenon of attempted access to alternative birth models, including birth at home or in an MLU, are highly constrained and restricted, even for highly educated and assertive low-risk women in a geographical location where the full range of birth choices are, at least in theory, fully available.

9.3 Implications of the study

This is the first study in Ireland examining women's lived experiences of attempted access to alternative birth models. Adopting a hermeneutic phenomenological approach situates women at the heart of this study, by highlighting and analysing their experiences of attempted access to their preferred birth choices. This focus on women's experiences and voices mirrors the goal of Irish maternity policy, exemplified in the National Maternity Strategy, which aims to put women's voices and experiences at the heart of the maternity services. A hermeneutic approach also allows for a fuller understanding of women's experiences as it does not divorce the experiences from the social and historical context in which they take place. With this contextualisation in mind, situating access to alternative birth models in contemporary Ireland within the social, political and cultural context of women's access to reproductive healthcare deepens an understanding of the issues faced by birthing women, even as women gain greater access to other aspects of reproductive care. Situating this study within feminist discourses on reproduction and choice highlights the idea that where and with whom women give birth is an integral part of any feminist discussion on choice and reproductive justice.

Meanwhile, the theoretical framework of this study, encompassing feminist conceptualisations of choice and the female body, deepens and enriches the knowledge and understanding of women's experiences of attempted access to alternative birth models by shedding light on the ways in which women gather information about alternative birth options and attempt to access these options, while navigating a maternity system that remains situated within a medical model.

Furthermore, the findings of this study offer new insight and contribute to knowledge on this topic by situating women's access to care within the framework of authoritative knowledge as set out in Chapter 2. Having demonstrated that competing knowledge systems underpin the complex phenomenon of access, I have provided a more nuanced understanding of that complexity by separating out aspects of the access journey. These aspects include information gathering, eligibility negotiation, the ongoing and contingent nature of that eligibility, and the many uses of the mother/baby distinction, and highlight the failure of the Irish maternity service to support women's choices and facilitate access to alternative birth models.

The participants situate birth within a social model and draw from a tapestry of knowledge sources in order to form their choices and priorities regarding health, birth and their bodies. This tapestry includes biomedical and scientific knowledge, but also experiential, embodied and relational knowledge. However, as they attempt to access a birth that fits within their paradigms, they are confronted with a maternity service that remains embedded within a biomedical paradigm and shaped within an obstetric, risk averse framework. This means that the successful negotiation of access to alternative birth models remains challenging. This seems to be the case even for women such as my participants, who are considered to have low-risk pregnancies and live within a service-rich region. Furthermore, institutions that are embedded within gendered social structures, such as hospitals and healthcare services, view childbearing women through a gendered lens, suppressing women's views and experiences. Women are disempowered by the patriarchal institutions of the maternity care services and obstetrics.

The findings show that women are interested in knowing about all the options available to them in relation to where and with whom they give birth. Participants critiqued the lack of standardised, easily accessible information from official sources, often seeking instead alternatives and more social, relational models. They sought out information on their options and, when this was not readily available, they persisted in finding out information from sources outside of routine maternity care.

The participants also wished to give birth in an environment in which they felt safe, with birth attendants whom they knew and trusted. For some, this relational safety was at home while for others this was in a Midwifery-Led Unit. Because women articulate this desire to birth outside a hospital setting, these options need to continue to be available and steps must be taken to ensure they are accessible to women throughout the country. Specific actions that could assist the maternity services in moving towards the true provision of such options will be outlined in Section 9.4.

This study comes during the implementation of the National Maternity Strategy (NMS) – a significant national policy document. As discussed, the NMS was first launched in 2016 with the goal of full implementation within a ten-year timeframe. However, a lack of Government funding and political will, combined with the Covid-19 pandemic, the 2021 hack of the HSE IT system and a focus on other reproductive services such the introduction of abortion care, has meant that

implementation of the care pathways aspect of the strategy has been lost among other priorities. In particular, there has been little to no development of the Alongside Birth Centres, which were due to be rolled out nationally and would be available to low-risk mothers as part of the Supported Care Pathway outlined in the strategy. However, despite these setbacks, as well as the critiques discussed in Chapter 8, the strategy provides a framework for an improved maternity service and thus can offer an opportunity to create more choice and access for women.

9.3.1 Knowledge and action

Providing the knowledge with which to work towards women's emancipation from patriarchal oppression is integral to feminist research projects, while action is also a significant step in studies informed by a hermeneutic phenomenological approach and situated within an epistemological stance of social constructionism, such as my own. Hines (2015) states that feminists have long connected theory and action while Young (2005) also writes that feminist studies are projects in social criticism, part of a feminist effort to provide a framework in which to identify injustices and locate their sources in social relations and structures. Meanwhile, van Manen (2016) maintains that true phenomenological research is inherently a call to action. Likewise, social constructionism is concerned with historically and culturally specific constructions of gender and power. Thus, within an epistemological stance of social constructionism, knowledge and action go together – and with this the power relations within a society are revealed and addressed (Burr 2015).

Therefore, a feminist study such as this one must combine knowledge with action. The knowledge produced through examining and highlighting the experiences of women regarding their attempts to access alternative birth models must have implications for maternity service provision. These will be outlined below in the form of recommendations.

9.4 Recommendations for policy, service provision, education and research

9.4.1 Policy recommendations

The ongoing implementation of the National Maternity Strategy should incorporate the knowledge and experiences of childbearing women into the co-production of implementation actions. This can be achieved by collaborating with women through service user panels and engaging with advocacy organisations. The

Strategy has previously incorporated the views and experiences of women, as the Steering Group charged with the development of the National Maternity Strategy included service user representatives. This should continue to be replicated in the ongoing implementation of the strategy to ensure that services improvements and developments continue to reflect women's priorities and concerns.

Three areas in which women should be supported in their decisions include length of pregnancy, length of labour and the HSE's eligibility criteria for its homebirth scheme. In order to support women's choices, service providers should allow for negotiations regarding these policies and support a woman's decision should she disagree with a healthcare professional's risk assessment or should she choose to decline care or interventions that are based upon routine practice. As set out in Chapters 7 and 8, current policies in Irish hospitals recommend routine induction before 42 weeks' gestation and require women to give birth within 12 hours or, if a woman is giving birth at home, within 18 hours of spontaneous rupture of the membranes. While these may be appropriate as guiding practice documents, all women should be able to decline such recommendations should they wish to do so. As it stands, these policies present challenges for women who do not want to follow such guidance, compounded by the fact that the timeframes for routine induction are not consistent throughout Irish hospitals. However, as discussed in Chapter 8, Section 8.5, practices regarding augmentation of labour and induction before 42 weeks do not reflect international research (Oladapo *et al* 2017/2018, Rydahl *et al* 2019), nor are these timeframes reflective of participants' experiences of pregnancy and labour or their embodied knowledge regarding their health and wellbeing. Therefore, I would recommend that healthcare providers should facilitate discussions and negotiations regarding these policies, if women believe the guidelines do not reflect their embodied knowledge or their birth preferences.

Under current HSE policy, pregnant women who fall within a medium risk category (see Chapter 5, Section 5.4, Chapter 7, Section 7.2 and 7.4 and Chapter 8, Section 8.4) but who wish to give birth at home must consult with an obstetrician, who will determine eligibility for the homebirth scheme. However, some of my participants believed that certain health factors, including age, weight or gestational diabetes, should not indicate that they be considered medium risk, and thus require a consultant sign-off. I would thus recommend that all service providers support negotiations and discussions surrounding this criteria. Alongside this, I would recommend that the eligibility criteria be reviewed, with a view to revising

guidelines if necessary in order to ensure that they reflect international best practice and women's experiences.

9.4.2 Service provision recommendations

The development of the Alongside Birth Centres throughout the country should be a top priority in relation to maternity care service provision. As outlined in the NMS, these centres are integral to the provision of choice for women throughout all regions of the country. However, six years into the implementation of the strategy, none have been built or developed. In order to address this gap in choice and service provision, the NWIHP can support maternity networks to assess the feasibility of developing an ABC in their local area and assist in the generation of solutions, in instances where the development of such a centre initially appears to be unfeasible. The State should provide the NWIHP with adequate financial and human resources so that the programme can provide this support and help operationalise the development of the new birth centres.

Self-Employed Community Midwives (SECMs) play a crucial role in the provision of the HSE's homebirth service. However, only 20 SECMs operate throughout the country. If the homebirth service is to be a viable option in the North East and throughout the country, as outlined in the NMS, more midwives are needed to serve the Irish population, which consistently has one of the highest fertility rates in Europe (DoH 2016). In order to recruit more SECMs, a review of working conditions as well as an investigation exploring factors impacting homebirth service provision as a career choice for midwives are warranted. Additionally, more training opportunities for student midwives interested in attending homebirths are needed, and these will be set out in Section 9.4.3.

In the latest annual report on the HSE's homebirth scheme, the report's authors made two recommendations in relation to service provision, specifically in the area of intrapartum transfers to hospital (Meaney *et al* 2020, p 8). These recommendations include the identification of a liaison consultant in each maternity unit, to assist in the effective transfer of women from the homebirth service and the development of a structured notification system between individual maternity units and the relevant SECM following transfer to hospital, to improve communication between services. These recommendations are in line with research from de Jonge *et al* (2009), which suggest that homebirth does not increase perinatal mortality or morbidity, provided the maternity services offers

adequate referral and transfer plans for emergencies. In light of my findings regarding length of labour, and the ways in which obstetric timeframes impacted some of the participants' ability to give birth at home, I would concur that these recommendations as outlined by the HSE report, and international literature, would improve the quality of services and care options for women.

Quality care and access to preferred birth models has a highly positive impact on women. For example, Daly et al (2021, p 5) found that women who had access to quality, individualised maternity care felt increased confidence and overall wellbeing as they made the transition into motherhood. Women were able to experience this confidence "when they feel genuinely heard, their concerns are taken seriously, the healthcare practitioner has time to pay attention, communication is respectful and up-to-date information is given and genuine choice offered" (Daly *et al* 2021, p 5). Furthermore, women who birthed at home felt respected and listened to and thus described their birth experiences as positive and empowering (Andrews 2004b). Conversely, poor experiences of maternity care can negatively affect women and their future health-seeking behaviours (Bohren *et al* 2019). Thus, improvements to service provision which increase access, choice and quality of care for service users, such as those outlined in this section, could have a positive impact on perinatal women.

9.4.3 Education and training recommendations

The non-standardised information provided to my participants regarding birth options highlights a learning and development opportunity for healthcare professionals. This could be addressed in the form of a formal training module for all healthcare professionals who provide antenatal meetings with women, perhaps situated within CPD requirements set out by the Nursing and Midwifery Board of Ireland and the Irish Medical Council. The module could be co-designed with service users and could involve education regarding the full range of birth models on offer to low risk women, and the international evidence to support these models, as outlined in the National Maternity Strategy. The knowledge and experiences of service users could also be drawn upon as part of an educational component discussing women's motivations for choosing to give birth within an alternative framework.

In order to facilitate greater knowledge of physiological birth, it is recommended that third-level midwifery and medical students gain experience in attending births

that take place at home or within an MLU. Through attending these births (following consent from birthing women, which could be obtained during antenatal appointments), future healthcare professionals can develop an understanding and appreciation of the rhythms of non-medically managed births and learn how to work in partnership with women, respond to their individual needs and support them using non-pharmacological techniques. Previously, midwifery students were required to attend homebirths as part of their training, though this requirement was discontinued, with a lack of women giving birth at home cited as the reason. However, if midwives in Ireland were trained in supporting homebirths, more women could access such services, and thus both professional knowledge and individual experiences of homebirth would increase.

In order to educate and inform individual women about their birth options, it is recommended that a nationally standardised leaflet outlining the maternity service options available to low-risk women be developed by the National Women and Infants Health Programme (NWIHP) or another section of the HSE. The NWIHP has already developed an information pamphlet describing the three pathways of care, available to women of differing risk levels, as outlined in the NMS, with an emphasis on the Supported Care Pathway (NWIHP 2019). I recommend the development of an additional leaflet, outlining the options and evidence regarding outcomes for birth at home or hospital, or in an MLU where applicable, which should then be provided to women during their initial booking visit. This leaflet could be provided in a physical format or online as part of the National Maternity Service Directory project, a comprehensive online resource for maternity service users and providers currently being developed by the HSE (NWIHP 2021). Women should also be given the opportunity to discuss the options outlined in this new leaflet with healthcare professionals, as previous research into a similar intervention found that when such a leaflet was not highlighted or discussed by healthcare professionals, women did not understand its significance or implications for their pregnancies (Stapleton *et al* 2002). Daly *et al* (2021) also highlighted the need for a comprehensive guide to the Irish maternity services and models of care to be provided at the start of a woman's pregnancy. Thus, the development of a new, comprehensive leaflet would improve the quality and accessibility of information regarding alternative birth models, and women's knowledge of such options.

9.4.4 Research recommendations

Women's voices are critical to the maternal health research agenda because as service users they can identify aspects of care, service provision, and health and wellbeing that impact and matter most to them (Daly *et al* 2021, p 1). Thus, many of the recommendations outlined in this section take women's voices and experiences of maternity care as the starting point for further investigations.

Aligned with the view that research regarding the maternity services should be situated within women's experiences, my study has provided insight into the experiences of women attempting to access alternative birth models in the North East region of the country. Additional research into the experiences of women attempting to access alternative birth models in other areas of the country, where MLUs are not available, would capture a broader picture of women's experiences nationally. This research could stand alone or be conducted as a qualitative component of the ongoing National Maternity Experience Survey, which is overseen by Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health (DoH).

As a piece of qualitative research, my study offers an in-depth understanding of women's access journeys once they decide to give birth through an alternative care pathway. To complement this research, I recommend that a quantitative study on how many women express a desire or interest in giving birth at home or in an MLU and how many were unable to access these services be conducted. This study could be based on data gathered by the HSE's DMOs, who are the official first point of contact for women wishing to give birth at home through the HSE scheme. Alternatively, data could be collected by GPs, hospital-based midwives or SECMs during antenatal appointments. This research could provide HSE and government policy makers, as well as the NWIHP, with statistical data on service demand and the service's ability to meet that demand to use in the evaluation of the development of homebirth and Alongside Birth Centres, as outlined in the NMS's Supported Care Pathway, and in the planning for future maternity care.

While my study had focused on the experiences of normal-risk women in a service-rich area, the experiences of healthcare professionals would also offer invaluable insight into the issues surrounding delivery and accessibility of alternative birth models. Thus, it is recommended that research into how healthcare professionals offer information about birth options to women during antenatal appointments be

conducted. Specifically, this research could examine the experiences of healthcare professionals in providing information to women during the antenatal period and potential barriers that these healthcare professionals may face in doing so. This research could include discussions regarding time and staff pressures, hospital culture and potential opportunities for further partnership and dialogue between service users and providers. Stapleton et al (2002) found that some midwives wish to discuss alternative options but are often concerned about recommending care that contradicts normative obstetric practice. The reasons for this, and potential supports for midwives to discuss alternative birth models, could be included as part of this research. Meanwhile, an investigation into the experiences of midwives attending OOH births, and particularly their experiences of current policies in relation to timing and the length of pregnancy and labour, would provide further insight into potential opportunities for fostering greater access for women planning to give birth at home or in an MLU.

McCourt and Dykes (2010) suggest that while scientific concepts of time have influenced birthing women and their experiences of maternity care – as my study has demonstrated – hospital-based midwives and other healthcare professionals have also been impacted by these notions. Instead of managing caseloads based on the rhythms and needs of a small cohort of birthing women, midwives work within a shift system, often performing repetitive, fragmented tasks for multiple patients. Research into the ways in which the concepts of linear time and institutional demands influence midwives and the type of care they provide to women would shed light on ways in which policies that support women's choices could be developed.

Furthermore, the Steering Group that developed the NMS notes in the strategy that while freestanding birth centres (also called freestanding midwife-led units) are available in some jurisdictions, such as the UK, the group did not recommend the development of such units in the Republic of Ireland. Instead, the group recommended that the NWIHP monitor and evaluate the implementation of Alongside Birth Centres. I recommend that while the proposed ABCs remain in development, research be conducted into the feasibility of introducing freestanding birth centres.

Finally, I would recommend that research into the potential advantages of midwifery-led models of care for women who are considered to be high-risk should be conducted in Ireland. Concomitantly, an evaluation of the current models of

obstetric risk employed by the Irish maternity services, including the clinical criteria through which women are designated low-, medium- or high-risk would be useful in opening up a public dialogue around the possibility of broadening the eligibility criteria for birth at home or in an MLU. As indicated in Chapter 2, Section 2.5.2, reviews of the Albany Midwifery Practice in South-East London, which provided midwifery-led care to socially disadvantaged women from 1997-2009, found that a midwifery model of care can still offer advantages to women and babies, whether the mother gives birth at home or in hospital (Leap *et al* 2010, Sandall *et al* 2001). Meanwhile, Homer *et al* (2017) found that for women working with Albany clinic midwives, continuity of care and carer supported positive outcomes. Therefore, further investigations into ways in which midwifery models could be provided to a broader range of childbearing women in Ireland could prove useful in developing a maternity service that provides woman-centred care and higher levels of access to reproductive care for women.

9.5 Contribution to knowledge

The aim of this study was to explore the phenomenon of women's lived experiences of attempted access to alternative birth models in contemporary Ireland. Employing a phenomenological approach to women's experiences of access to this area of reproductive care within an Irish context constitutes a new contribution to national and international research on women's reproductive choices and access to alternative birth models. Epistemological concerns regarding the perpetuation of unequal power relations within knowledge production have been of significant interest to feminist researchers, particularly as they relate to notions of what constitutes valid knowledge, who determines which knowledge is valid and who produces knowledge (Burns and Walker 2005, Oleson 2011). Thus, feminist research, grounded in the recognition that different people experience different realities, works to counteract dominant knowledge claims through the production of woman-centred knowledge. By taking a woman-centred approach to research that is based upon women's experiences, I have contributed to the body of knowledge that offers an alternative framework to childbirth and healthcare access research that is often situated within biomedical and andro-centric paradigms. Furthermore, by producing knowledge on birth choices that is grounded in women's experiences, I have highlighted the issues that matter most to women in relation to maternity service provision and added women's voices to the existent body of maternal health research.

Furthermore, applying a feminist framework to birth knowledge, choice and access has offered new insights into the process of providing, gathering and receiving information and about options to service users, and the barriers to access to those options as experienced by women, which are experiences of patriarchal and medical conceptualisations of the female mind and body.

This study also makes a new contribution to the body of knowledge and contemporary discourses on choice in maternity care (see Chapter 1, Section 1.4 and Chapter 3, Section 3.5). It does so by highlighting the dichotomy inherent in government policy documents espousing choice in maternity care policy while simultaneously continuing to situate maternity care provision within an obstetric framework. This work also highlights the constraints on choice and access that arise from this conflict between choice and risk ideologies and the impact these conflicts, and obstetric authority, have on women's access to their preferred healthcare options (Chapter 8, Sections 8.7 and 8.8).

Furthermore, this study makes a unique contribution to the body of knowledge regarding the ways in which the Eighth Amendment (see Chapter 6, Section 6.3.2 and Chapter 8, Section 8.3) has impacted the reproductive lives of women in Ireland. In particular, this research has done so by exploring the ways in which the presence of the Eighth Amendment in the Irish constitution constrained access to healthcare options not only for women who sought abortions but also for those who chose to remain pregnant. Postnatal participants gave birth before the Eighth Amendment was repealed by referendum in May 2018 while some of the interviews with pregnant participants were conducted after this historic date. However, the Repeal agenda remained at the forefront for many within my study cohort, exemplified in their discourses on access to birthplace as a reproductive choice. Thus, my research provides a unique insight into the experiences of childbearing women as they negotiated bodily autonomy and alternative birth models during this significant transitional period in Irish reproductive history.

As set out in Chapter 1, a research project closely aligned with my own is Marie O'Connor's study into homebirth in Ireland, which she conducted in 1992. While the HSE conducts regular reviews of their homebirth service (see Meaney *et al* 2018 and 2020), my study remains the first since O'Connor's study to offer an in-depth, qualitative investigation into the issue of homebirth from the standpoint of women. My study also builds on the research of the MidU project (Begley *et al* 2009) (see Chapter 2, section 2.3.3) but contributes to a further understanding of

the MLUs by grounding new research in service users' experiences and highlighting women's experiences of attempted access to the MLUs.

9.6 Limitations of the study

While I have discussed the strengths and contribution of this study, some limitations have also been identified. Recognising the role that a researcher plays in both the data collection phase and the interpretation of the data is integral to the reflexivity required in feminist research. Thus, while the prior experiences and knowledge that I brought to participant interviews enabled me to build rapport with the participants and understand their experiences, my own personality and my presence as a researcher affected the ways in which they shared their experiences (see Chapter 5, Section 5.4.7). Furthermore, my interpretation of the data, while aided by my prior experiences of Irish healthcare services and knowledge as a homebirthing mother, was also influenced by these (see Chapter 5, Section 5.5.3). Feminist researchers contend that this explicit interpretive subjectivity is present in any research endeavour and that the positivist notion of objective research remains both unattainable and undesirable (Oakley 1981). Nonetheless, while the researcher will always influence the research, it is important to note that my own personal experiences and social and historical specificity influenced this research project and the findings.

Information sharing in maternity care often takes place within a dialogue, and this study has focused on women's experiences of discussions with healthcare professionals as the women attempt to access alternative birth models. While the experiences of healthcare professionals within these discussions is outside the remit of my study, it is important to note that these healthcare professionals also have their own unique knowledge and experiences regarding and affecting the provision of information. This piece is not included in this project.

Challenges to conducting this research were presented by my use of hermeneutic phenomenology as a methodological approach. While this approach is often used by health science researchers as a methodology, van Manen warns that researchers must maintain the intellectual rigour required of phenomenology and, specifically, that phenomenological data cannot be analysed and codified through contemporary qualitative methods that employ the language of data collection, capturing and coding and analysis (van Manen 2017a). I have addressed these concerns by maintaining a strong relationship with the phenomenon (see Chapter

5, Section 5.7) of women's lived experiences of attempted access, as suggested by van Manen. As part of efforts to address concerns regarding rigour, I have drawn from the data phenomenological examples, in the form of participant quotes, that provide insight into the phenomenon under investigation, helping the reader to know and understand what the phenomenon was like for those living through it (van Manen 2017b). Thus, while other methodological approaches would have highlighted different aspects of women's attempted access to alternative birth models, phenomenology was most useful in highlighting women's lived experiences of this phenomenon and the social context in which they took place.

Although only a small percentage of women who give birth in Ireland are from Asian, Black or mixed raced ethnicities (Meaney *et al* 2020), I had hoped to capture the experiences of some of these women within my study. However, only women from white Irish and white European ethnicities contacted me about participating in this study. Whether women of colour are giving birth at home through informal, non-HSE channels or whether they are not giving birth at home remains unclear and under-investigated. Thus, this study has not, unfortunately, captured the lived experiences of women of colour in accessing midwifery-led care.

9.7 Conclusion

In this chapter I have set out the implications of my findings regarding women's lived experiences of attempted access to alternative birth models in contemporary Ireland. Based on these implications, I have presented recommendations for action in the areas of policy, service provision, education and research. I have also discussed this study's new contributions to the body of knowledge on women's choice and access to midwifery-led services in contemporary Ireland and discussed the limitations of the study.

While the maternity services and the National Maternity Strategy espouse choice as a priority in the provision of maternity care, my findings indicate that a woman's ability to actualise her birth choices and access alternative models of care remain constrained within a maternity system situated within the medical model of birth and bounded within obstetric authority over childbirth. These constraints on women's access to alternative birth models in contemporary Ireland are further bounded by a society and legal framework that has consistently denied women access to reproductive choice and care. Addressing some of the recommendations outlined above, including the development of Alongside Birth Centres outlined in

the NMS, could prove useful in efforts to align service provision with a national policy that promotes choice and access in maternity care.

I will make one final note. I began this research bothered by the power imbalance within the maternity services and the fact that while contemporary policies espouse the notion of woman-centred care, birthing women often appeared to experience a loss of autonomy and choice within service provision. This project and its specific remit grew out of the frustration that power was being taken away from women right at the moment when we are at our most powerful. However, the women who participated in this study, who gave of their time and energy so that their experiences might in some small way improve the experiences of other women, have been truly inspirational. They have shown me that even when faced with challenges and obstacles, they continued to advocate for themselves and their babies, and fight for a service that provides empowering, out-of-hospital, midwifery-led care for all women. In doing so, they disrupt a medicocentric maternity service and patriarchal power structures, and help all women reclaim power over our births and our bodies.

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Appendices

Appendix 1: Participant Information Leaflet

Participant Information Leaflet

Title of study: Women's Experiences of Access to Alternative Birth Options Within the Context of the National Maternity Strategy [title modified during course of study]

Introduction

I would like to invite you to participate in a research study about contemporary birth norms in Ireland, and access to alternative birth options. I believe that a number of mothers are interested in birthing options outside the normative model of medicalised, pharmaceutical-assisted, hospital-based birth. While the new National Maternity Strategy, launched by then Health Minister Leo Varadkar in January 2016, aims to place women at the centre of our maternity services, there is very little research into the types of births that women living in Ireland today are truly interested in. I believe that by speaking with mothers such yourself, those who were interested in alternatives during pregnancy, we will discover both what mothers want in birth, and the current gaps in our maternity services. Information gathered during this research will hopefully, in some small way, inform maternal health service planners, national policy and maternity hospitals themselves. In-depth interviews with mothers like yourself will form the greater part of the data. This information sheet is designed to enable you to decide whether you would like to participate in this research.

Procedure

Data collection will involve at least one audio-recorded, semi-structured interview, in which you are invited to speak freely about your experiences during pregnancy in gathering information about birth options and attempting to access alternatives, and the conversations you had with friends, family and healthcare professionals about this. You are also invited to speak about the birth model you ultimately opted for, and to talk about the birth of your child during our postnatal interview. These interviews can take place in your home, or at a public place most convenient to you, and will mostly likely last 1-2 hours. I will give you a list of interview questions and topics before we conduct the interview, so that you can have time to reflect on your experiences and think about what you would like to say. Afterwards, you will be given access to the transcripts of your interviews.

Benefits

There are no immediately tangible benefits to your participating in this study. However, I believe that on a personal level, it might be satisfying for you to tell your story to someone, and I hope you can feel the validation that comes with someone truly listening to your stories, particularly ones about an event of such major importance as the birth of your child. On a social level, I hope you can feel some benefit from contributing to and shaping a study that could add to the body of research on what women want in birth, and inform hospital and national policy regarding birth options.

Risks

I do not anticipate any risks to you. The only potential upset that might occur is that you may feel some distress if you chose to disclose to me events that occurred during your pregnancy or birth that were upsetting to you. However, you are under no obligation to share anything distressing with me, and I will treat everything you chose to tell with me with the utmost respect and confidentiality.

If you should become distressed, I can provide information about support organisations, such as Women's Aid (on **1800 341 900**) or Nurture, which offers support for pregnancy and childbirth mental health issues (on 01 843 0930).

If you make a disclosure of a criminal act or of a child in danger of abuse or neglect it is my responsibility to break confidentiality and report this to An Garda Síochána. Similarly, if you disclose medical, nursing or midwifery malpractice I must also report this to the relevant regulatory body.

Any inconvenience for you will be kept to a minimum. The interview will take place in your home, or another place of convenience to you. Interviews will take approximately 1-2 hours, and you are welcome to have your baby with you if you wish.

Confidentiality

Your identity will remain anonymous and details about you confidential. Any identifying features will be removed before publication of research findings. Field notes and audio recordings taken during our interview will be stored in a secure place.

Compensation

You will receive no compensation or payment for participation in this study. Research data collection is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary participation

If you agree to participate in this study, you will be asked to sign a consent form indicating your willingness to do so. Your participation is entirely voluntary, and you are under no obligation to participate. You may withdraw from the study at any time without question.

Permission

Ethical approval from the University of Dublin, Trinity College has been granted.

Further information

Thank you for taking the time to read this information sheet. If you have any queries about this study, your rights as a participant or wish to clarify any aspects I am happy to meet with you to discuss them further.

Liz Farsaci 085 158 2862 farsacie@tcd.ie

Appendix 2: Participant Consent Form

TRINITY COLLEGE DUBLIN

INFORMED CONSENT FORM

LEAD RESEARCHERS:

Liz Farsaci, PhD candidate

Dr Colm OBoyle, Supervisor

[Dr Liz Newnham became adjunct supervisor, in addition to Dr OBoyle, in December 2018]

BACKGROUND OF RESEARCH:

Through exploring the ways in which normative birth models are perpetuated in Ireland today, I hope to gain insight into the types of birth options and experiences that mothers wish to have available to them, and their current levels of access to their preferences. Specifically, I want to investigate antenatal choices made by mothers about alternative birth models and the barriers that prevented them from ultimately accessing those models for the births of their children.

These issues are particularly pertinent at present, and correlate directly with discussions currently taking place on a number of political, social and service-wide levels. However, while the new National Maternity Strategy, launched by then Health Minister Leo Varadkar in January 2016, aims to place women at the centre of our maternity services, there is very little research into the types of births that women living in Ireland today are truly interested in. I believe that by speaking with mothers who were interested in alternatives during pregnancy, we will discover both what mothers truly want in birth, and the current gaps in our maternity services.

PROCEDURES OF THIS STUDY:

A significant element of data collection will involve at least one audio-recorded, semi-structured interview with each participant, in which they are invited to speak freely about their experiences during pregnancy in gathering information about birth options

and attempting to access alternatives, and the conversations they had with friends, family and healthcare professionals about this. Participating mothers are also invited to speak about the birth model they ultimately opted for, and to talk about the birth of their child. These interviews can take place in their home, or at another place of most convenience, and will last 1-2 hours.

I will give participants a list of interview questions and topics in advance of the interview, so that they can have time to reflect on their experiences prior to our meeting.

PUBLICATION:

This research will be presented before my supervisor and other senior colleagues at Trinity College Dublin, in Spring 2018 or Autumn 2018, and again in March 2021. Publications in which the research will be published will be determined at a later date.

Individual results may be aggregated anonymously and research reported on aggregate results.

Identifiable data or material may be retained in a secure file after the study is completed. However, this material will be stored securely, and will not be used in future unrelated studies without further specific permission being obtained.

DECLARATION:

- I am 18 years or older and am competent to provide consent.

- I have read, or had read to me, a document providing information about this research and this consent form. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction and understand the description of the research that is being provided to me.

- I agree that my data is used for scientific or academic purposes and I have no objection that my data is published in scientific or academic publications in a way that does not reveal my identity.

- I understand that if I make illicit activities known, these will be reported to appropriate authorities.

- I understand that I may stop electronic recordings at any time, and that I may at any time, even subsequent to my participation have such recordings destroyed (except in situations such as above).
- I understand that, subject to the constraints above, no recordings will be replayed in any public forum or made available to any audience other than the current researchers/research team.
- I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights.
- I understand that I may refuse to answer any question and that I may withdraw at any time without penalty.
- I understand that my participation is fully anonymous and that no personal details about me will be recorded.
- I have received a copy of this agreement.

PARTICIPANT'S NAME:

PARTICIPANT'S SIGNATURE:

DATE:

Statement of investigator's responsibility:

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

RESEARCHER'S CONTACT DETAILS:

Liz Farsaci

085 158 2862

farsacie@tcd.ie

INVESTIGATOR'S SIGNATURE:

DATE:

Appendix 3: Gatekeeper Information Letter

Dear Madam,

I am studying antenatal decisions regarding birth options at the School of Nursing and Midwifery at Trinity College Dublin, and I am hoping that you might be able to assist me with informing both antenatal and postnatal mothers about my study, in the hope that they might wish to participate in it.

Would it be possible to place information about my study, which I could provide to you, on [name of organisation] website, or in your member newsletter? I would also be happy speak about my research at any public meetings [organisation] might be hosting over the coming months.

Please find further information about my study below. I am happy to speak with you over the phone or in person if you would like to discuss anything further.

Thank you for your time and consideration in this matter. I look forward to hearing from you.

Kind regards,

Liz Farsaci

085 158 2862

[Participant Information Leaflet was attached to gatekeeper letter]

Appendix 4: Participant demographics

Profession removed and geographic area generalised to ensure anonymity. Educational attainment inserted and generalised to protect anonymity.

Pseudonym	Pregnant/ Postnatal	Birth location	Area (by county)	Education level	Number of children	Age
Aoife	Pregnant	Homebirth	Dublin	Postgraduate degree	2*	36
Caoimhe	Postnatal	Wanted homebirth	Dublin	Postgraduate degree	1**	28
Eva	Postnatal	Wanted homebirth or MLU	Louth	Third level non-degree	2	30
Niamh	Postnatal	Wanted homebirth	Dublin	Third level degree	2	36
Molly	Postnatal	Wanted homebirth	Dublin	Third level degree	4	44
Noelle	Postnatal	Wanted MLU	Cavan	Third level degree	2	34
Mary	Pregnant	Planning homebirth	Dublin	Third level non-degree	2*	25
Kate	Pregnant	Planning homebirth	Dublin	Undisclosed	2*	34
Laura	Pregnant	Planning homebirth	Kildare	Third level degree	2*/**	36
Jenny	Pregnant	Planning homebirth	Dublin	Postgraduate degree	2*	29

Edith	Pregnant	Planning homebirth	Dublin	Postgraduate degree	2*	35
Fiona	Postnatal	Wanted homebirth	Dublin	Postgraduate degree	2	37
Anne-Marie	Postnatal	Wanted homebirth	Meath	Third level degree	1	39
Lorraine	Pregnant	Planning homebirth	Dublin	Undisclosed	1*	40
Keelin	Postnatal	Wanted homebirth	Dublin	Third level degree	1	37
Ruby	Pregnant	Planning homebirth	Dublin	Third level degree	2*	25
Sara	Pregnant	Planning homebirth	Dublin	Third level degree	3*	38
Deirdre	Pregnant	Planning homebirth	Dublin	Postgraduate degree	1*	36
Margaret	Postnatal	Wanted MLU	Louth	Third level degree	1	28
Siobhán	Postnatal	Wanted MLU	Cavan	Postgraduate degree	2	36
Ciara	Postnatal	Wanted MLU	Louth	Third level non-degree		28
Cassie	Postnatal	Wanted MLU	Cavan	Postgraduate degree	1	27
Caitriona	Postnatal	Wanted MLU	Cavan	Postgraduate degree	3	37
Aileen	Postnatal	Wanted MLU	Cavan	Postgraduate degree	2*	36

Agnes	Postnatal	Wanted MLU	Cavan	Postgraduate degree	2*	31
Helena	Postnatal	Wanted MLU	Cavan	Third level degree	X**	43
Anna	Postnatal	Wanted MLU	Louth	Third level degree	2	33
Hazel	Postnatal	Wanted MLU	Cavan	Undisclosed	2	34

*Including one in utero

**Previous miscarriage

Appendix 5: Interview guide / Examples of interview prompts

Interview guide

Below is the initial interview guide designed prior to data collection. This guide was designed in order to facilitate the facilitate the semi-structured interviews with research participants. Initially, I planned to examine participants' motivations for accessing alternative birth options and messages regarding such options from outside influences. This prompted questioned regarding these matters. However, my understanding of the topic developed through research and fieldwork, I focused on access as a primary focus of this study.

Initial questions regarding birth options

If you have older children, tell me about their birth(s).

How did those experiences influence your initial thoughts and feelings about the birth of your youngest child?

When during the antenatal period did you begin thinking about alternative birth options?

What type of alternative birth options did you have in mind when you first began exploring them?

Where did you first come across the idea that there were (possible) alternative birth options?

Information and messages from healthcare professionals

Where and from whom did you first get information about the birth?

Which birth options were discussed at this time?

What option(s) were presented to you by the first healthcare professional with whom you discussed the birth?

Did you seek out information from your GP?

Did you seek out information from a midwife? Was she based in a hospital, clinic or elsewhere?

During your initial visit with your GP and/or your initial booking visit, what information did you receive about the birth? What type(s) of birth were discussed?

What messages about birth options and alternative birth options did you receive during an initial GP and / or booking visit?

Messages from family, friends and society

What types of conversations did you have with your partner about birth options?

What did your partner think of alternative birth options? Did they have a preference that differed from yours? If so, what was it and why?

What were the messages you received as a girl, and then as a woman, and then as a pregnant woman about birth from your mother, female relations and other family members?

From friends?

From the media (including news outlets, films, books, etc)?

Information about alternative birth options

Where and with whom did you first seek out information about alternative birth options?

What information did you find out about alternative birth options?

What were the sources of this information?

Which alternative birth option did you prefer, and how did you come to that decision/preference?

Were you comfortable seeking info on alternative birth options locally?

Did you have to go outside your locality to obtain information about alternative birth options?

Access to alternative birth options

What steps did you take to find out whether you could access alternative birth options and/or your preferred birth option?

Was your preferred alternative birth option accessible?

If your preferred birth option was not available, why not?

How did you find out or come to believe it was not available to you? Who told you and what did they say?

What were the barriers to access for you?

Why did you ultimately choose the birth option you opted for?

Did you feel you had a choice regarding birth options?

Interview prompts

During data collection, the interview guide was modified as participants and I engaged in a dialogic co-creation of knowledge regarding experiences of access. These modifications included the interview prompts below, and were designed to encourage participants to clarify or expand on their initial comments.

Interview with Laura (example of facilitating conversation to include most recent birth experience)

Laura decided to open interview by speaking about her professional background and decision to stay at home since she became pregnant with her first child. Following this discussion, we have the following interaction:

Researcher: So, how would you, do you want to start with this pregnancy or is her birth the context?

Laura: Yeah, her birth is probably the context, I'd say.

Researcher: Okay, let's talk about her birth.

Interview with Anna (example of asking participant to expand on their comment in order to illuminate the lived experience)

Anna: I think when I went down to the CLU em, there's this, to a certain degree, all em, I think consent went out the window. I think that em, it snowballed into an awful lot of interventions that I think I have avoided if I had been more vocal or if my partner had been more vocal. But, em, they kind of played what I call the dead baby card.

[Anna finishes her discussion of the birth]

Researcher: And what about, what about the experiences of the, as you said, the “dead baby card”?

Anna: Well, I mean, exactly. I mean, you know, it was you know, and, as I said, I will never forget her saying to me, you know, you are putting your baby at risk, you know what I mean. And I think that when somebody says that to you, you’re immediately compliant. Do you know what I mean? You’re like, oh my god, you know, of course I’m going to do absolutely anything that’s going to make sure that my baby is okay at the end of it all. So I did, I got straight up onto the bed like she told me to.

Interview with Agnes (example of asking participant to expand on their comment):

Agnes: My husband’s cousin there, she ended up with a C-Section there because her placenta was low so that was obviously going to happen either way. But she kind of said from early on, even early in the pregnancy, she said, she’s like, look, I don’t care as long as the baby’s safe. And that’s kind of – you hear that an awful lot.

Researcher: And do you think people think good birth experience and safe baby are opposed to each other? Is it an either/or kind of thing, do you think?

Agnes: I think that people say, you shouldn’t complain if your baby’s safe. If your baby is healthy and safe, then you shouldn’t expect more. And I think that’s the problem.

Appendix 6: Participant demographics questionnaire

During early participant interviews, I asked the questions below within the interview itself. However, participants conveyed discomfort in answering the questions in person through body language or tone of voice. In line with feminist methods and concepts of reflexivity, I modified my approach, sending them the questions via email, which I indicated they could respond to via email or during our interview. Participants chose to answer the questions via email, suggesting to me that this was the approach most favoured by them in relation to the collection of demographic information.

Participant Questionnaire

What is your name?

What is your age?

Where do you live?

Have you lived in other cities/countries, apart from your current location?

Do you have any children? If so, how many?

What are the birth dates of your child(ren)?

Where did you give birth to your child(ren), including your youngest child?

What is your profession?

What is your household income bracket (highlight in bold):

- €0-30,000

- €31,000-45,000

-€46,000-60,000

- €60,000-€80,000

- €80,000-plus

What is your education level?

What is your racial/ethnic background?

How do you identify in terms of your sexuality (straight, lesbian, gay, bisexual, transgender, questioning or other)?

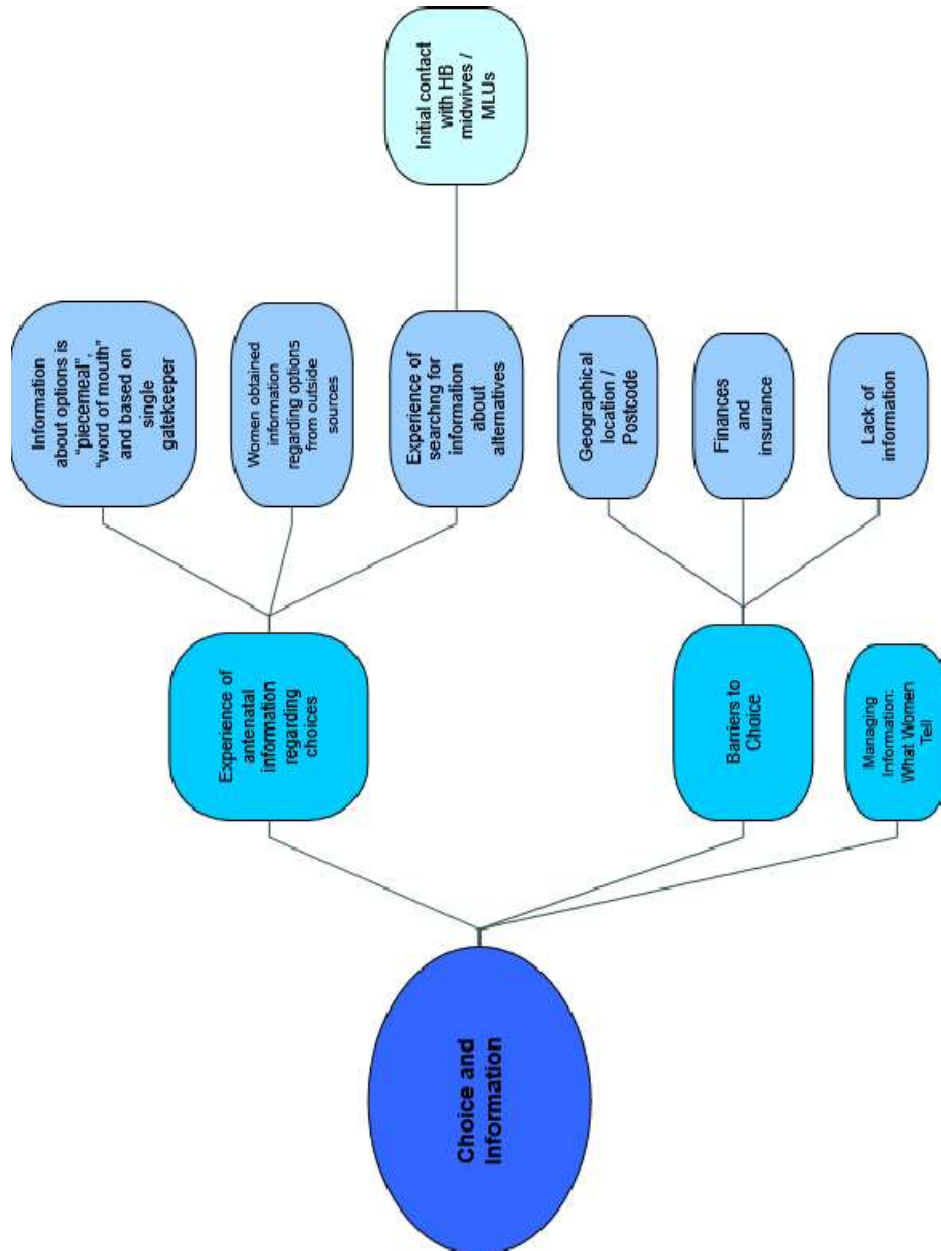
What is your current relationship status?

What was your relationship status at the time of your most recent pregnant and/or child's birth, if different to your current relationship status?

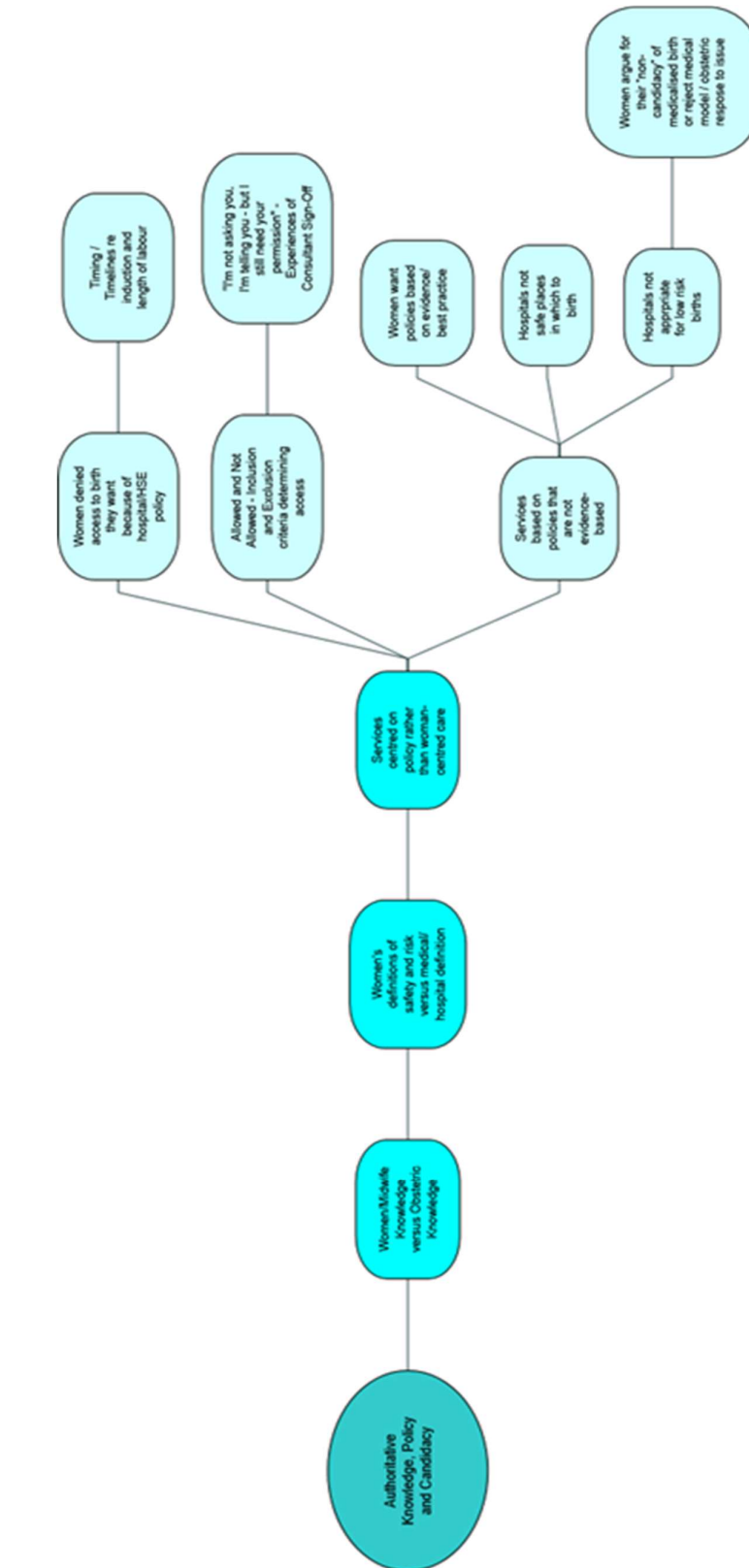
Appendix 7: Mind Maps

Below are enlarged images of the mind maps included in Chapter 5, Section 5.5.1

Mind Map 1, regarding initial themes of “choice” and “information”:



Mind Map 2, regarding initial themes of authoritative knowledge, policy and candidacy (eligibility):



Appendix 8: List of Abbreviations

AN – antenatal

AML – Active Management of Labour

DMO – Designated Midwifery Officer

DOMINO – Domiciliary Care In and Out of hospital

ECHR – European Court of Human Rights

HIQA – Health Information and Quality Authority

HSE – Health Service Executive

GP – General Practitioner (family doctor)

MICS – Maternity and Infant Care scheme

MLU – midwifery-led unit

NHBS – National Home Birth Service

NICE – National Institute for Health and Clinical Excellence

NMES – National Maternity Experience Survey

NMH – National Maternity Hospital

NMS – National Maternity Strategy

PN – postnatal

SECM – Self-Employed Community Midwife