

AN ABSTRACT OF THE THESIS OF

Leah S. Houtman for the degree of Master of Arts in Women Gender and Sexuality Studies presented on December 11, 2014.

Title: "It's not about *Place* it's about *Space*:" Place-of-birth Decision-making in Cork, Ireland

Abstract approved:

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Despite apparently supportive national policies, including nation-wide legalization of home birth and coverage by the national health care system of the costs associated with that option, these births account for less than 1% of all births in the Republic of Ireland. Using data collected during participant observation, both in person and by following the conversations of over 800 advocates of home birth on social media, as well as through open-ended interviews with 11 women who had planned home birth in the past two years, I sought to answer the questions: Why do some women choose to give birth at home despite cultural norms for hospital birth? For those who make this choice, is the process experienced as straightforward and supported, or are there barriers and challenges that undermine autonomous decision-making with regard to birth place? Data analysis based in emergent grounded theory revealed three themes common to the experiences of the participants: negotiating safety, educating and trusting oneself, and finding community. Although not all participants related to all of these themes, the

combination allowed women to create a counternarrative to the dominant understanding of home birth as “dangerous” and “risky.” Recommendations include education for general practitioners and obstetricians on the safety of home birth as well as in the processes and procedures to assist women in accessing that option, the provision of information on home birth to all newly pregnant women, and evidence-based insurance coverage to GPs and midwives that is relevant to their scope of practice.

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“It’s not about *Place* it’s about *Space*.” Place-of-birth Decision-making in Cork,
Ireland

by

Leah S. Houtman

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Leah S. Houtman, Author

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DEDICATION

This work is dedicated to my daughter, Darwin Hazel Houtman. May she come of age in a place and time where she can choose and access the care that is right for her.

CHAPTER 1: Introduction

At first glance, the United States and the Republic of Ireland differ substantially in their approaches to the provision of maternity care, and especially in their stances towards home birth. In the United States, maternity care is treated like any other health issue; the individual's insurance plan covers some or all of the cost, and the client pays the balance out of pocket. In some instances, state or federal aid helps cover the costs of health care for low-income individuals. Home birth, though, is a state-by-state legal issue. A pregnant woman may choose to give birth at home in any state, but the status of the midwife differs across state lines. Twenty-eight states recognize and regulate Certified Professional Midwives (CPMs), 9 states have no legal protections for CPMs, and 13 have active legislation blocking CPMs from practicing legally (Big Push for Midwives 2013). Women who choose home birth also often face increased scrutiny from friends, family, and mainstream health care providers based on the perception of increased risk associated with out of hospital birth (Coxon, Sandall & Fulop, 2014). When the legal restrictions on home birth and public opinion are coupled with the fact that most insurance plans will not cover the costs associated with CPMs, thus requiring women to pay out of pocket for their preferred care, it is unsurprising that the rate of planned home birth in the United States is extremely low at only 1.36% in 2012 (MacDorman et al 2014).

In the Republic of Ireland, on the other hand, home birth is legal in all areas of the country; indeed, in 2012 the Minister for Health, Dr. James Reilly, stated

publically that more women should be given the opportunity to birth at home (Gartland 2012). Further, the national health care system will cover the costs associated with home birth, provided the birthing woman and attending midwife both meet certain requirements. Those with sufficient financial resources may choose to opt out of public health services and pay to retain a private physician, but the government is the primary source of funding for health care for most people in Ireland (Armstrong 2010, 16). Maternity care is free to all women, and medical practitioners contract with the state to provide care to pregnant women and infants (Kennedy 2002 & 2012). Still, 40% of women in Ireland choose to pay extra for private or semi-private care with a consultant obstetrician, whether they hold private insurance or not (Millar et al 2008, 40). Additionally, some hospitals offer home birth services in their communities (HBA Ireland, 2014). Although Ireland offers these legal and structural supports, the rate of home birth in that country is less than 1% (Millar et al 2008; Kennedy 2010). This number represents a sharp decline from roughly 33% in 1950 (Kennedy 2008).

Because the policies and health care structures surrounding home birth are so different between the United States and Ireland, it is surprising that the rates of women choosing home birth are so similar. The purpose of this study was to identify and examine the factors that influence decision making around birth location for women in Ireland. Why do a small percentage of women choose to give birth at home despite cultural norms for hospital birth? For those who do make this choice, is the process experienced as straightforward and supported, or are there barriers and challenges that undermine autonomous decision-making with regard to birth

place? Using data collected via participant observation at gatherings and through following the stories and conversations of over 800 advocates of home birth on Facebook, as well as in-depth, semi-structured interviews with eleven women who had planned home births in Ireland, I found that the process is neither simple nor straightforward, and involves significant negotiation of needs, wants, and even a redefinition of what it means to have a “safe” birth. Further, I came to understand that the concept of “choice” is flawed, as it fails to account for the social, financial, and geographical pressures that come into play during the process of securing maternity care in Ireland. I explore these findings in more detail in Chapter 4.

Models of Birthing Care

Whether due to allegiance to a specific model of care or, more generally, as a result of fear and risk discourses surrounding talk of childbirth in Ireland, advocates of both home and hospital camps contribute to a heated debate over the “proper” place to give birth. In this section, I examine some of the ways Irish women and their providers construct what are often seen as opposing models of care. I also review the most recent research on the safety of home birth and midwifery-led care and briefly discuss the ways this body of literature is contested or supported within this polarizing debate.

Various approaches, models or what are sometimes called “philosophies of maternity care” differ in many ways, but perhaps nowhere more so than around the levels of technology and management that they apply. Cheyney (2011) differentiates between midwifery and medical models of care by explaining that medical models

characterize birth as “potentially dangerous, pathological, and in need of technological intervention and medical management” while midwifery models see women as healthy, as experts on their own bodies and babies, and as active participants in the birth process (Cheyney 2011, 13). Cheyney’s work builds on the earlier work of Barbara Katz Rothman (1982) and Robbie Davis-Floyd (1992).

Rothman notes that, despite the fact that all knowledge comes from somewhere—that is, it is not formed in a vacuum— and is informed by its social, historical, and political context, obstetrical knowledge has come to be seen as a single truth. This obstetric “truth” views pregnancy and birth through a technocratic and medicalized lens, in which “birthing women are thus objects upon whom certain procedures must be done” (Rothman 1982, 34). The birthing women themselves are objects rather than autonomous actors in the birth process.

On the other end of the spectrum from the obstetric model is the midwifery model of care, which center on “a woman’s perspective on birth, in which women are the subjects, the doers, the givers of birth” (Rothman 1982, 34). Further, the midwifery model sees labor and birth as a complicated, yet normal process that cannot be broken down into discrete parts to be categorized and pathologized as is common in the obstetric model. Davis-Floyd uses the term ‘holistic’ rather than Rothman’s ‘midwifery model.’ This then includes all practitioners who share a view of health as holistic and who “favor integrated clinical, social, and spiritual definitions of human health and illness” (Cheyney 2011, 15). This term may also be used differentiate between hospital-based midwives who are sometimes seen as relying on technocratic methods as opposed to home birth midwives who are more

closely (and somewhat problematically) associated with holistic models.

While the aim of this study was not to debate the relative merits of each of these approaches, nor to make claims regarding the safety of one mode or place of birth over another, I *have* approached this work from a particular read of the safety literature. That is, I began this work from the premise that home birth is a reasonably safe and acceptable option for low-risk women who have access to medical back-up. I also acknowledge that regardless of one's interpretation of the safety studies, home birth is already occurring. I simply hope to explain why and how a small percentage of women go about choosing home birth when it is not culturally normative.

Home Birth and the Safety Research

In 1985, the World Health Organization (WHO) issued a report stating that birth is “a natural and normal process” (436) and that midwives and traditional birth attendants should be the primary caregivers for women during normal pregnancy, birth, and postpartum periods. They also recommended avoiding the too-frequent use of technologies such as cesarean, routine electronic fetal monitoring, episiotomy, and administration of analgesics or anesthetics— all of which are ubiquitous in U.S. hospital births. In 1992, Beverly Chalmers, a consultant for the WHO, revisited these recommendations to review their validity. She examined the results of several randomized controlled trials to evaluate perinatal technologies, concluding that the WHO recommendations of 1985 were upheld by the results of those trials. She claims that the original WHO recommendations

constitute “sound guidance for those providing perinatal care” (Chalmers 1992, 710).

Since then, several studies have been done that look specifically at place of birth, primary birth attendant, or both and their relative impacts on maternal and infant health outcomes. In British Columbia, Canada, by Janssen and colleagues (2002) compared the outcomes of home births, hospital births attended by the same midwives who attended the home births, and hospital births attended by physicians. Participants were matched based on similar risk status between the home birth group and the physician-attended group. There were not enough participants who had midwife-attended hospital births to pair them with other groups, but their outcomes were included in the report. Findings showed that women who had home births had lower rates of interventions than the women who had hospital births, regardless of attendant. This included lower rates of epidural, labor induction, augmented labor, and episiotomy. Women who planned home births had half the number of cesareans as the midwife-attended hospital births, and one-third the number in the physician-attended hospital birth group, further demonstrating the difference in outcomes based not only on attendant, but also on birth setting (317). There was no increased risk demonstrated by the home birth group over the hospital birth groups, though the authors do indicate that the rates of some adverse outcomes were so low in all groups that they were unable to draw statistical comparisons (315). These findings are in accordance with other similar studies in Canada that also show decreased rates of intervention, lower morbidity for mother and baby and equivalent perinatal mortality (Janssen et al 2009, Hutton et al 2009).

Other studies indicating the safety of home birth include those by Ackermann-Liebrich and colleagues (1996) who found that home births in Zurich were associated with similar or slightly better outcomes as compared to hospital births while resulting in fewer interventions, Johnson and Daviss (2005) who conducted a study of planned home births in both the United States and Canada, and a study by Lindgren, Brink, and Klinberg-Allvin (2011) that specifically examined the decreased incidences of perineal tears in planned home births in Sweden as compared to hospital births. A recent Cochrane Review by Olsen and Clausen (2012) assessed available data on birth outcomes for home and hospital births. This analysis built on an earlier review (Olsen & Jewell 1998) and also included results from an additional observational study. Finding no convincing evidence of improved outcomes in the hospital births, the authors state that planned home births for low-risk women attended by trained midwives who have medical back-up are reasonably safe within systems with integrated medical care and, thus, should be made available to low-risk women (Olsen & Clausen 2012, 15).

Finally, Cheyney, Bovbjerg, Everson, Gordon, Hannibal, and Vedam (2014) reported outcomes for almost 17,000 planned, midwife-led home births in the United States occurring between 2004 and 2009. Specifically, low-risk women who planned home births, even if they transferred to the hospital at some point during or after labor (89.1% of the sample birthed at home), experienced “high rates of normal physiologic birth and very low rates of operative birth and interventions, with no concomitant increase in adverse events” (Cheyney et al 2014, 10). Further,

the cesarean rate in this sample was 5.2%, significantly lower than the U.S. national rate of roughly 33% in 2013 (Hamilton et al 2014, 2). These studies demonstrate not only the safety of home birth for many women, but in doing so also offer reasons for choosing that option in the form of statistically positive outcomes.

In the chapters that follow, I report findings from my research into the reasons women choose home birth in Ireland, and what challenges they face in accessing that option. In Chapter Two I move from a discussion of the home vs hospital debate, examined in Chapter 1, to an exploration of the specific circumstances of birth and maternity care in the Republic of Ireland. I include discussion of the dominant medical model, access to self-employed community midwives (SECMs), and the various “schemes” implemented by the Health Services Executives (HSE) to meet the needs of Ireland’s mothers. I also examine the tensions between the HSE and the home birth community and present some of the implications that these tensions have for maternity care in Ireland. In Chapter Three, I explain the methods I used in conducting my research on the motivations that lead women to seek out home birth as well as to explore what factors make that process more or less difficult. In Chapter Four, I present a thematic analysis of the results of that study, and in Chapter Five I discuss the implications of my findings and draw meaning from those results using theories of affective economies (Ahmed 2004). Finally, in Chapter Six I reflect on possibilities for moving forward, including ways to mitigate some of the difficulties in accessing a range of options in maternity care as described by participants in this study.

CHAPTER 2: BIRTH IN THE REPUBLIC OF IRELAND

This chapter explains broadly the ins and outs of maternity care in Ireland, including the dominant model of care, as well as the consolidation of maternity hospitals and the "crisis" of Irish maternity services. The sub-section entitled "Community midwifery, home birth, and the Memorandum of Understanding" elucidates the current state of home birth in Ireland along with the tensions between Health Services Executives—the overseers of Ireland's public health services—and the home birth community. In "What Women Want" I summarize the literature that has been published regarding the preferences of mothers and prospective mothers in Ireland. In "Responses to Home Birth" I describe the reactions and comments made by policy makers and hospital administrators regarding home birth as a possible option, and in "Implications" I discuss the possible outcomes of the dissonance between administrative attitudes and the wants and needs of a small percentage of Irish women who want the option of giving birth at home.

Care Options in the Irish Maternity System

In the case of Ireland, models of care can be generalized into three broad categories: 1) consultant-led care, associated with higher rates of intervention and technology use; 2) in-hospital, midwife-led care—often in Midwifery Led Units (MLUs)— which offers a sort of middle ground between holistic care and a technocratic birth culture; and 3) home birth, whether through hospital schemes or with self-employed community midwives (SECMs). These categories represent a

gradient from technocratic/medical models to holistic/midwifery models.

Consultant-led care represents the highest number of births in Ireland, though MLUs are gaining traction. Although accurate numbers are difficult to track given inconsistencies in methods of data collection, home births with SECMs accounted for only 0.2% of all births in 2012, and total rates of home birth, including those through hospital home birth schemes, are estimated at less than 1% of the 72,225 births that occurred in that year (National Perinatal Epidemiology Center 2013).

Maternity care has long been free in Ireland; it begins during pregnancy and ends 6 weeks after birth, and only covers maternity-related issues. Women may pay extra for a private consultant, and initially, under the 1954 Maternity and Infant Care Scheme, women were able to pay for a choice of hospital or maternity home. Kennedy argues that this caused home birth to be seen as ‘the poor woman’s option,’ as they were the ones who could not pay extra for the hospital or maternity home. Thus, home birth came to be seen as worth little in terms of cultural capital (Kennedy 2012, 380). This led to a strong reliance on and backing of the medical profession, including obstetric medicine in Ireland.

In 1970, the Health Act extended hospital maternity services to all women, and in that year, only 3% of women gave birth at home (down from 33.5% in 1955), a rate that dropped further to 0.3% by 1991 (Kennedy 2012, 381). While all Irish hospitals offer consultant led care—that is, care led and overseen by a consultant obstetrician— only some offer midwifery led units (MLUs) or home birth services despite the financial savings associated with these programs. Indeed, maternity care in Ireland has become more medicalized as it has moved almost exclusively into the

hospital over the past 50 years. Kennedy writes: “Women’s unquestioning faith in obstetric-led services ensured the medical model endured until the status quo was challenged in the late 1990s and gathered momentum in subsequent years” (2012, 382). Kennedy further argues that *Changing Childbirth* (1993), the first national conference on maternity services in Ireland and which advocated for woman-centered care and choice, initiated a “critical juncture in which dominant ideas and practices were challenged causing a shift in practice” (Kennedy 2012, 384).

Health services in Ireland are currently considered to be in crisis; the country is experiencing the largest birth rate in the European Union at 16.8 births per 1000 individuals, and Irish hospitals are not well prepared to accommodate all of these births (Mander & Murphy-Lawless 2013, 163). Patients are often left on trolleys in hallways due to lack of space and the staffing to care for them. In 2008, there were 1118 vacant nursing posts, due in part to the almost 11000 trained nurses who left Ireland in the years between 1998 and 2008 citing insufficient staffing, overcrowding, and long work weeks (Kennedy 2008).

The Cork University Maternity Hospital (CUMH) is the third largest maternity hospital in Ireland, and was built to replace 3 smaller units in 2007; these included the Erinville Hospital, St. Finbarr’s Maternity Hospital, and the Bon Secours Maternity Unit in Cork (Cork University Hospital 2012). While this allowed new, state-of-the-art services and updated, modern ambiance, it also meant less accessibility for women who lived outside of the city. Since the 1970s, many smaller maternity units have closed down, leading to greater consolidation of births in the larger centers. In 2009, 57.8% of births occurred in units that handled more than

4000 births annually, while only 2.8% occurred in units with less than 999 annual births (Economic and Social Research Institute 2010, 61). In 2008, 4 units housed over 46% of all births. Nearly 9,000 births occurred at Cork University Maternity Hospital in 2010— despite the intended capacity of 7,000 annual births— indicating that the problem of too few beds has not been solved (Lynch 2011).

Accelerating since the 1970s, the focus in maternity care has shifted from addressing the needs of the consumer to addressing the needs of busy obstetricians. This has resulted in an increased reliance on time and staff saving technologies used in labor units (Kennedy 2008, 28). The cesarean rate is over 25% and these surgical births are “not subject to financial stringencies” despite limited resources (Mander & Murphy-Lawless 2013, 163); that is, the expenses associated with surgical birth are not limited even while hospitals seek to cut budgets in other areas. Increased medicalization and management of birth has been attributed to both “pity for the suffering of women enduring prolonged labor [and] a country with limited health resources struggling to cope with a disconcertingly high birth rate...” (Mander & Murphy-Lawless 2013, 55). Increased medicalization and management have also, however, effectively removed control from the hands of the women themselves and concentrated it in the hands of the medical institution.

Although few women give birth in the home, a relatively new system of DOMINO (Domiciliary In-Out) care has emerged. This system has antenatal care provided in the home by a midwife, who also visits the mother during labor and subsequently accompanies her to the hospital for delivery. The mother is released six hours after delivery, and the midwife provides postpartum care in the home.

The 2001 Kinder Report, a review of a group of maternity services in one region in Ireland, “provides a blueprint for a woman-centered, quality maternity service, which is safe, accessible, and sustainable,” and recommends the provision of community midwifery linked to maternity units, as well as a regional consumer committee for maternity care services (Kennedy 2008, 28). The first hospital-based midwife-led services have only been in effect since 1999 (Millar et al 2008, 40). Although these services, which may include DOMINO schemes, early transfer home, or midwife-led antenatal clinics, have been increasing since those services were first established in Dublin and Galway, they are not available everywhere and only a small number of women, constrained by strict geographical criteria, can access them (Millar et al 2008, 40). There is no national community-based midwifery program in the country. Thus, in most areas, the “choice” that women have in maternity care comes down to public or private care—and this is not an option for all women either, as private care can run into the thousands of Euro even *after* insurance pays its portion (private correspondence, 2013).

Community midwifery, home birth, and the Memorandum of Understanding

In May of 2007, the Irish Nurses Organization gave notice that their clinical indemnity insurance would no longer cover self-employed community midwives (SECMs); insurance underwriters cited increased financial risk for SECMs as compared to other clinical practitioners (Millar et al 2008, 41). SECMs were eventually able to secure insurance via the government’s clinical indemnity scheme, but they were required to get the consent of the Health Services Executives—the

overseers of Ireland's public health services—who required SECMs to sign a Memorandum of Understanding (MOU). This MOU allows SECMs to retain their independence of practice—that is, they do not become employees of the HSE or the government. The MOU also institutes a framework for SECMs to be paid for their work, but does place some constraints on the community midwives' scope of practice (Millar et al 2008, 41-42). SECMs used to be able to decide for themselves who they would accept as clients and who they did not feel comfortable taking on due to risk factors. Under the MOU, however, restrictions on who an SECM may attend came into effect. Women with previous cesareans and women with asthma who use steroid inhalers, for example, may now be excluded from home birth (Millar et al 2008, 42). All women who seek home birth with a government-insured SECM must seek approval from a consultant obstetrician who will “sign off” (or not) on the plan. An unsupportive consultant may thus interpret risk as s/he will, meaning access is further limited by whether the consultant in a given area is supportive of home birth or not. One hospital in Dublin currently does not have a single consultant willing to sign off on a home birth. Millar et al. state that this “unwieldy process that has ‘risk management’ at its heart” interrupts the relationship between a woman and her midwife, as well as the “clinical decision-making autonomy” of a woman (2008, 42).

Further, Ireland is perceived to be one of the most litigious countries in the world (OBoyle 2013; Hoyte 1995; Nelligan et al. 2005); when this perception meets the discourse of risk that surrounds birth in contemporary medicine, “out of hospital birth [is] barely tolerable” (OBoyle 2013, 2). The Nurses and Midwives Act

of 2011 states that midwives must have “adequate indemnity insurance” to attend women in childbirth, yet private insurers refuse to cover home birth midwifery. This means that SECMs are effectively required to practice within the scope set by the MOU. The suitability criteria of the MOU “erodes midwives’ professional autonomy” and are based on avoiding risk rather than on evidence (OBoyle 2013, 2). Other restrictions on midwives’ practice, such as a requirement that midwives practice for 3 years above and beyond their registration experience before being allowed to attend home births, are similarly unevidenced and are hotly contested. The Commission on Nursing (1998) stated that “the increasing ‘medicalisation’ of normal pregnancies had turned midwives into obstetric nurses rather than the independent practitioners allowed by their education” (Dept of Health and Children 1998, 172). Midwives who do not adhere to the strictures of the MOU face fines of up to €160,000 and/or ten years incarceration (Mander & Murphy-Lawless 2013, 164-65). This could be why fewer than twenty SECMs offer home birth services to all of Ireland (OBoyle 2013, 2, Griffin 2014a). The MOU also requires two midwives at every birth (one for labor, with the second intended to arrive at the pushing stage); however due to the low numbers of practicing midwives—only 18 have signed the contract with the HSE to provide home births—SECMs and other home birth advocates argue this requirement of two midwives present at delivery further limits the ability of women to access home birth (OBoyle 2013, 4).

If a midwife chooses to attend a birth outside of the parameters set by the MOU, she can be outlawed from the profession, having not only her insurance, but also her license to practice, revoked. Yet some women, when ‘risked out’ of home

birth, or when unable to access a midwife due to geographic location or other barriers, choose to birth unattended and unassisted, sometimes called 'freebirthing.'

OBoyle writes,

It is not acceptable to the midwife that the decision to birth alone should be the only 'choice' left to a woman. The midwife is forced to give up supporting the birthing autonomy of (some) women in order to maintain one aspect of a limited but pervasive definition of contemporary professionalism, namely: indemnification... Should she choose to subordinate her professional autonomy to the birthing autonomy of the woman—in cases for example where the woman declines to take the midwife's, or the guidelines', advice—and yet continue to 'be with' that woman; the midwife thereby rejects the dominance of the professional stance over the woman. The professional individual, who subordinates her professional status to accommodate the autonomous choices of the woman, thereby undermines the status of the profession and so is a threat to the profession. (2013, 6-7).

In other words, the midwife is required to decide between allegiance to her profession and its policies, or allegiance to the women she serves and her belief in their autonomy.

What Women Want

Whether women in Ireland prefer to give birth in the hospital or at home, many agree that the state of hospital-based maternity care is not what it should be. According to a 2004 survey-based review of maternity and gynecology services in the Dublin area, "no participant...thought that the maternity services were women centered at the time" (Women's Health Council 2007, quoted in O'Malley 2010, 87). However, the Department of Health aims to deliver 'women centered' care (O'Malley 2010, 87). In O'Malley's 2010 study, the medical model was found to prevail in interactions between hospital-based midwives and the women in their antenatal

clinics (87). Resistance “occurs occasionally and fleetingly” in the form of birth plans or via midwife recommendations, but “the medical perspective... prevails in face-to-face interactions, while alternative perspectives are heard as whispers that are easily silenced” (O’Malley 2010, 87-88). As a result, no lasting change occurs.

Byrne et al (2011) set out to discern what kinds of maternity care were actually desired by childbearing women in Ireland. Pregnant women (n=501) were surveyed during early pregnancy while attending out-patient appointments at the Coombe Women and Infants University Hospital in 2010. Over 70% of women wanted shared care between their GP and a hospital doctor or midwife. Only 1.6% of the participants would have preferred a home birth, and of those, only 50% (0.8% overall) would have been considered “suitable on clinical grounds” based on the restrictions set out by consultant obstetricians and the HSE (Byrne et al 2011, 180). The low demand for home births may be partially explained by the recruitment of participants in a hospital setting. Overall, women’s greatest concern when considering models of care was safety for the baby, though they also indicated a desire for an increased range of options for maternity care, while keeping safety the priority.

Despite the fact that maternity and infant care services are free for all women and babies, many women have accepted the idea that they will pay something for care. According to one study, over 1/3 (36.3%) of women paid for private consultant obstetric care, thus buying continuity of care— at least for the antenatal period, as they would likely have a midwife during labor (Daly & OBoyle 2010, 16). These women opt into a higher level of medicalized care for the sake of continuity of

advice and care. “Many of these women would fit the category of low obstetric risk, yet do not get to know and trust midwives... In Ireland some women with purchasing power prefer to ‘buy’ a different model rather than undertake a more structural revolution” (Daly & OBoyle 2010, 16).

Responses to Home Birth

The responses to home birth by policy makers in Ireland have been mixed. In November of 2003, the supreme court of Ireland ruled that Irish health boards have no obligation to provide either home birth services or financial assistance for out-of-hospital (OOH) births. This was at a time when women applied for grants to cover the costs of home birth, but initially often paid up-front, out-of-pocket. Krysia Lynch of the Home Birth Association argued that this ruling made home birth the preserve of the rich, discriminating against poor women, as well as granting consultant obstetricians a monopoly on the provision of maternity care (Garvey 2004). Irish health minister Michael Martin said that, while his department would continue offering women a choice of where to give birth, he felt that the ruling was appropriate, as it was “unrealistic to expect health boards to provide home birth services in all cases” (Garvey 2004, 20).

In 1998, O’Connell et al constructed a survey to study antenatal care and sent it to general practitioners to elicit their perspectives. Of 100 respondents, 92 said they wanted more involvement with antenatal care, and 91 supported short hospital stays for delivery only. Only 32 were in favor of midwife-led home deliveries and even fewer (15) were in favor of midwife-led care. Another 15 respondents were in

favor of combined midwife/general practitioner (MW/GP) attended home birth; approval for MW/GP attended home birth with backup from the flying squad was higher at 34. Respondents stated that if they were to provide home birth services, they would require increased remuneration – a surprising finding given that home birth is generally associated with decreased cost due to fewer interventions. This study was from one region only, though the authors argue that: “it is not unreasonable to suggest that it may mirror the views of G.P.s nationally.” It is important to note that while this study is 15 years old, much of the discourse remains the same today (Daly & OBoyle 2010, Kennedy 2012).

James Reilly, Irish Minister of Health, stated that women should be offered the choice of home birth. He said that his policy has always been to “treat the patient at the lowest level of complexity in a safe, timely, and efficient manner and as near to home as possible. Clearly home birth is as near to home as you can get... I would like to ensure that women expecting their baby have a choice, but that choice has to be always predicated on safety” (Gartland 2012). Similarly, Dr. Sam Coulter-Smith, Master of the Rotunda hospital in Dublin has argued that: “You cannot have a safe home birth service run by independent midwives without an appropriate governance structure.” This statement indicates a lack of support for independent midwives, as well as a lack of confidence in their abilities to appropriately assess and counsel their clients; Dr. Coulter-Smith implies that the self-employment model is insufficient, and that midwives must be overseen by physicians in order to be a viable option. Dr Gerry Burke, a consultant obstetrician in Limerick, stated that encouraging home birth would mean, “a huge change in policy [with] very major

implications in terms of reorganization” (Gartland 2012). Further, he asserted that fewer and fewer women are “appropriate” for home birth, perhaps related to the later age at which women are having their children, some delaying parenthood into their late 30s. Professor Fionnuala McAuliffe of the Royal College of Physicians of Ireland and consultant at the Holles Street Maternity Hospital in Dublin expressed concern that an increase in home births would require an increase in the number of midwives within a system that is already experiencing a shortage of practitioners (Gartland 2012). She asserted that the need for two senior midwives for each home birth would take resources away from the already struggling hospital, but did not address the possibilities of relying on SECMs instead of hospital-based midwives to attend those births as a way to keep needed resources in the hospital while still providing quality care to lower-risk clients.

Even in those instances where individual policy makers or administrators support offering home birth as a choice, they have not demonstrated a commitment to making sure that choice is accessible to all women. Sister Song, an organization that works for reproductive justice for all women, states that, in order to reach true justice, the focus must be shifted away from “a narrower focus on legal access and individual choice... to a broader analysis of...structural constraints on our power” (Sister Song 2014). Thus, in a reproductive justice framework, the question cannot simply be one of choice, but must also include the availability of appropriate caregivers as well as the opportunity for pregnant women themselves to consider the risks and benefits of home birth in their specific situation so that they may make

the decision that is right for them, and further, to follow through on that decision once it has been made.

Implications

“Childbirth as a social process is influenced by the model of care and affects the physical and psychological outcomes for the woman and her family” (Devane et al 2007, 92). With maternal and perinatal mortality rates dropping in high resource countries, emphasis on maternity care has focused more on maternal choice and satisfaction. Ideas of consumer choice are being applied more commonly to healthcare, yet the rise of “risk” constructs increasingly inform how individuals see the everyday world. “The concepts of risk and safety are juxtaposed in the increasing medicalisation of birth that has occurred in Ireland, particularly over the last half century, and the rising rates of intervention that have accompanied it” (Devane et al 2007, 93). Assessment of risk has remained almost exclusively within the purview of professional caregivers (GPs, consultant obstetricians, etc.) to the exclusion of pregnant and birthing women. Women have had little input on policy-based maternity care decisions—their input is limited to the individual level, making structural change almost impossible.

The medical model of care in Ireland emphasizes the needs and conveniences of the hospitals and the practitioners, not those of the women they purport to serve (Reid & Taylor 2007, 249). Until the early 2000s, public health nurses were required to be trained midwives; this is no longer the case, signaling a shift away from midwifery models of care (Reid & Taylor 2007, 249). This is unfortunate in light of

the book, “The Politics of Maternity” (Mander & Murphy-Lawless 2013) wherein the authors argue that women who have midwives, in particular those who have continuous care with midwives from the prenatal period through birth and postpartum care, develop relationships with these practitioners and feel that their voices and priorities are heard and respected. Women, they assert, feel they are more in control and are autonomous decision-makers in their birth experiences (Mander & Murphy-Lawless 2013, 170). Midwives who practice in the hospital may intend to develop these relationships with their clients, but the lack of time and agency of the midwives themselves may inhibit the creation of these relationships. Indeed, midwives who practice in the hospital are sometimes derided as being “with institution” rather than “with woman.” The authors cite Raymond DeVries (1993, 132) – “if midwives were arranged along a continuum, those on either end of the technological spectrum would not even recognize each other as being of the same profession.” Further, the Institute of Obstetrics and Gynaecology has said that although the hospital-centered model of care is important for women with high-risk pregnancies, it can be limiting for the 60% of women who experience normal pregnancy and birth (2006, 8, Kennedy 2012, 381).

In sum, although Ireland’s legislation allows for a range of birthing options and caregivers, and despite the apparent variety of options—from consultant led, technocratic birth to an unmedicated home birth with a community midwife—the existing literature on Irish maternity care suggests that the structures set in place by individual hospitals, the HSE, along with the larger social scripts and discourses

prevalent in Ireland, have made home birth, and woman-centered care more broadly, an elusive goal for those who desire it. Further, the assumption that childbirth is inherently dangerous and best left in the hands of the professionals (read physicians) further removes women from the process, save for individual and immediate input in the form of birth plans or minor requests, thus stifling change on a systemic level.

In the next chapter, I describe the methods that I used to explore the effects of these dominant, institutional narratives in my own study. The power of counternarrative in the slow process of institutional and systemic change is also examined through the stories told by the participants in my study, thus offering an alternative to the technocratic, top-down discourses of maternity care described here.

CHAPTER 3: METHODS

The Power of Counter-narratives

Due to the widespread institutionalization of medicine in many Western(ized) countries, the dominant ideology is one that positions knowledge of medicine and wellness as the purview of a select, highly-educated few. Such institutional worldviews create metanarratives that are generally accepted by many, even as some individuals or communities resist. The funneling of knowledge endorsed by larger metanarratives, as well as the way that this knowledge is re-circulated, contributes to a public understanding of medicine and health based on a limited number of interpretations of information that are promulgated by the highly-educated elite. Metanarratives of health and medicine drive the creation of policy as well as standards of practice for doctors and other care providers. Because they are premised on institutional power, they can be very difficult to change.

Within these broad institutional narratives of medicine, the primary narrative of birth that is circulated in popular culture and the media is one of risk, danger, and pain (Coxon, Sandall & Fulop 2014). This narrative has taught people, in particular those who bear children, to fear birth. The narrative does this work by creating a deeply emotional response to the idea of a poor birth outcome. That is, despite the low risk of a bad outcome occurring, the magnitude of the risk has been emphasized to the point that birth, even when preceded by a low-risk, uneventful pregnancy, is seen as dangerous, frightening, and in need of medical intervention. Further, because medicine is positioned by the metanarrative as the purview of those select few—those individuals who make it through years of medical school,

internship and residency—the hospital is centered as the only appropriate place for that intervention to happen.

Meta-narratives reflect the voices of the dominant group in a society; as a result, voices of marginalized populations are often silenced. Although meta-narratives are pervasive and can feel all-encompassing, there is the opportunity to resist by sharing individual and community stories that broaden, nuance, or even contradict the meta-narrative. Thus, amplifying and projecting the voices and experiences of marginalized and ‘fringe’ populations can reveal a powerful new story; this counter-narrative may exist as a method of resistance, subversion, and survival. Thus, it is through the sharing of individual stories that qualitative research has the potential to not only clarify existing narratives, but also to expose whole new worlds of experiences and ways of being (Inhorn 2006, Cheyney 2008). As a critical feminist medical anthropologist, my work focuses on analyzing systems of power and domination, including the ways that these can function to create hierarchies and concentrate decision-making capabilities into the hands of a select few. In this instance, those creating maternity policy are predominantly males from upper-class backgrounds. Arguably those most affected by these policies are women, of all income brackets with perhaps the greatest impact lived by those of lower socioeconomic status—those who can neither leverage consumer power to lobby for change, nor buy the medical care that might allow them a modicum of autonomy or choice. For this reason, it is important to give voice to counter-narratives, and especially to those that upset the narrow, exclusive story embodied in the institutional narrative of medicalized childbirth (hooks 1984, Harding 1992, Inhorn

2006, Craven 2010). hooks (1984) writes that members of the group that holds the most power in society are not required to notice or value those who hold less power, yet those at the fringes of society are hyper-aware of those in the center;. Indeed, they are required to be, for their very survival depends on it. Sociologist Sandra Harding (1992) builds on this assertion, stating that it is the marginalized of a society that have the most clear understanding of that society, since they are able to see both the image projected by the mainstream, such as that seen in media and “common sense” understandings, as well as the very real places where the society does not live up to its claims. Harding calls this understanding “strong objectivity.”

Inhorn (2006) writes of the benefits of ethnography, particularly regarding women’s health: “Through the in-depth, qualitative tradition of ethnography, anthropologists have documented women’s health concerns around the globe, producing a large and constantly expanding literature that is rich and provocative” (345). Some of the specific benefits identified by Inhorn include making the women themselves the subjects of the narrative so that they can determine and articulate their own health priorities. These priorities and other aspects of health may then be viewed and analyzed within the larger context of social, cultural, political, and economic structures. Ethnography offers a lens into the ways these structures and their attendant institutions constrain women’s health and wellbeing, allowing for a critical feminist, medical anthropological analysis of power. Thus, while institutional narratives certainly have their place in an analysis of birth place, it is crucial that the individuals who are themselves affected by that narrative, and the system from which it stems, also have their voices heard and valued.

Methodologies

This project consisted of participant observation, both during in-person gatherings and on social media pages and groups that host over 800 mothers, midwives, and other advocates of home birth, as well as individual interviews. Initial contact was made through the Home Birth Association of Ireland (HBA), a network of midwives, doulas, women who have had or plan to have a home birth, and other advocates of birth setting choice. I chose HBA as my initial contact point because of their commitment to helping Irish women access the maternity care they need and want. HBA is the only national group that specifically advocates for greater access to home birth; other groups work for better maternity care more generally, such as the Association for Improvements to Maternity Services in Ireland (AIMSI), or for greater autonomy under the law for women to make their own reproductive decisions, as with the Irish Family Planning Association. However, these groups do not focus on home birth with the clarity and specificity of HBA.

In September of 2013, I contacted the Home Birth Association first via email, and later via Facebook, where their online presence is most strongly felt. The Facebook messenger platform also allowed for group conversations without the lag time of email. Through this platform, I was able to “speak” with the HBA coordinator, the regional contacts support officer, and the regional representatives for Cork and Kerry counties. I explained my project and the kind of support I was looking for: introductions to potentially interested parties, resources such as publications and information, and a letter of support to be included in my IRB application. These representatives of HBA and the home birth community were

extremely helpful, offering a letter of support for my research to be included in my proposal, and, after I obtained IRB approval in November, adding me to pertinent Facebook groups. They also helped me to develop an internship, which consisted of writing for the HBA newsletter and gathering recent research to be highlighted on the HBA webpage. The internship spanned the months of December 2013 through May 2014 and allowed me to gain more insight into the current situation of home birth in Ireland, and also gave me the opportunity to help a community that had already been so supportive of me and my work. This collaboration also enabled me to stay abreast of current events in the maternity field in Ireland, and facilitated ongoing communication with the home birth community at large, as well as with HBA and study participants.

Participant observation began in November of 2013 and occurred largely on Facebook support group pages, as well as through some face-to-face gatherings of maternal-child health researchers and advocates in Cork. I continued participating via the internet throughout my project, including long after formal data collection was completed. Facebook pages are a primary source for online community for many women who had or wanted to have home births, as the home birth community is not only small, but also spread out over great distances. Interactions on the HBA page were primarily political discussions and conversations about current developments in policy and practice, whether at national, regional, or even hospital-specific levels. The page that specifically catered to Cork and Kerry counties consisted of a mix of political discussion, sharing of birth stories, friendly encouragement, and relationship building. Both Facebook pages were also used for

sharing resources and information about upcoming events, which hospitals were most or least supportive of home birth, and new research.

As a participant-observer on social media, I watched the pages for content—they were, and continue to be, an excellent source for keeping up to date on current events and developments in the home birth community—as well as an ethnographic platform for observing the relationships and networks present in this active community. I introduced myself as a home birth advocate and as a graduate student in Anthropology and Women Studies, and engaged in conversations with other group members on the similarities and differences between the Irish and U.S. maternity care systems. These interactions helped me to establish rapport while enabling me to understand not only the current political climate, but also the priorities, the primary causes for excitement or concern, and the myriad of barriers and supports that the participants faced in their quest for in home maternity care.

As my introduction to the home birth community that works with these issues on the ground, I spent my first day in Ireland attending a home birth symposium hosted by the Community Midwives group from the National Maternity Hospital in Dublin on November 25, 2013. The symposium gave me a glimpse into the nature of the relationships between different factions of home birth advocates and policymakers, and also provided a backdrop of history and context to situate the current state of home birth access and policy in Ireland. Representatives from maternity hospitals were in attendance, as well as self-employed community midwives (SECMs), doulas, student midwives, and women who had had home births themselves. There were also presentations on recent research, including the UK

home birth study (Birthplace In England Collaborative Group 2011) and an investigation of the unmet demand for home birth in Ireland (OBoyle and Kenny 2013).

Shortly after the symposium, I attended an HBA-sponsored support group held in the home of one of the regional contacts for the Cork area. These meetings are held every other month, and offer a place for women to gather to share experiences, ask questions, and find resources regarding birth in general and home birth more specifically. At this meeting, I was able to interact more specifically with women who were exploring the idea of home birth in County Cork. The host of the meeting also provided me with the opportunity to present my study protocol and share a letter of introduction to begin recruitment of participants for the individual interview portion of my project. As on the Facebook pages, I introduced myself as an advocate and a graduate student researcher, and expressed my interest in hearing from attendees regarding their experiences with the Irish maternity care system.

Recruitment for individual interviews began during the first week of December, and continued through the month. All interviews were conducted between December 1 and December 31, 2014. Potential participants were recruited via Facebook as well as at this support meeting. Potential participants were given copies of a letter of introduction that included information about the study, as well as my contact information and that of the principal investigator (Melissa Cheyney; Appendix A). They were then invited to share information about the study with other potential participants and to contact me with any questions. Potential participants were never asked to give me names or contact information for other

potential participants; they were merely asked to pass on information regarding the study to anyone they knew who might be interested and eligible. This way, I only became aware of specific individuals if they self-identified as wanting more information or as being willing to participate.

To qualify for inclusion in this study, participants must have planned a home birth in County Cork in the past two years. Thus, women who had planned a home birth, but who transferred to the hospital during labor and delivered in the hospital were still eligible for inclusion, as were women who were pregnant and planning a home birth but had not yet given birth. Unplanned home births and babies born *en route* before arrival to a hospital (BBA) were not included, since the study aimed to elicit information about the process of deciding to have a home birth. Eligibility requirements also stipulated that participants must be at least 18 years of age (the age of majority in Ireland) and must speak English. After potential participants had the opportunity to have all of their questions answered and were verified according to the inclusion criteria, they were provided with a consent form to sign and return to me. I also verbally asserted that they could terminate the interview at any time or decline to answer any question at their discretion. Participants were also invited to ask questions of me throughout the interview process whether about the consent forms, the study, or my own positionality.

I made every effort to meet with participants in person, in a place of their choosing. In some instances, meeting in person was not possible and interviews were conducted over the phone or via Skype. All interviews (n=11) were audio-

recorded with the consent of the participant, and audio files were later transcribed. Interviews ranged from 30-90 minutes, with the average lasting around 45 minutes.

Interviews were semi-structured and open-ended in order to elicit the thickest description and to enable themes to emerge rather than being identified *a priori* and asked about with each interview. Specific demographic information was gathered from every participant, but otherwise the interviews followed a conversational pattern. Women who had already had one or more home births were asked to tell the birth story of the most recent home birth, and all participants were asked to explore the factors that went into the decision-making process for that birth and any previous home births. Sample questions can be found in Appendix B.

After transcription was completed in April, 2014, data was analyzed using emergent grounded theory, as described by Charmaz (2005). Transcripts were read for themes by myself and the principal investigator and analyzed using consensus coding (Glaser 1978). Themes emerged from the interview transcripts themselves rather than being imposed by a pre-existing framework or expectation. Many commonalities were found throughout the interview transcripts; these were grouped into categories and subsequently organized into themes and subthemes. These were then shared with participants via email and Facebook during the summer of 2014, and comments, questions, or revisions were solicited. This reciprocal ethnography (Lawless 1992) phase helped to ensure accurate interpretation of the data by the research team.

In the next chapter, I provide an overview of participant characteristics, as well as an analysis of the themes that arose from the interviews. Although a wide

variety of experiences, concepts, and interpretations were shared with me, three themes stood out in particular as common to the participants. These themes are explained individually in Chapter Four, while a larger picture of how the themes interact and what those interactions mean in the lives of Irish women is explored in Chapter Five.

CHAPTER 4: RESULTS

Eleven women agreed to formal, open-ended semi-structured interviews. Of these, 9 identified as White, 1 as multiracial, and one participant did not specify her race. Only 3 participants were Irish citizens, 2 were from the United States, 2 were Swedish, and the remaining four had immigrated from Poland, the UK, Germany, and Brazil. While this project did not delve specifically into the differences and similarities in the experiences of Irish women as compared to those who had immigrated from elsewhere, a significant body of work exists on the experiences of immigrants as they interact with the health care systems in their countries of residence (for example see Shirazi et al 2006, Kusuma et al 2013, and Montealegre & Selwyn 2014). This study, however, assumed equity of access to the various maternity care options regardless of citizenship, due to the structure of the Irish maternity system. However, awareness of those options may have differed based on the length of time each participant had already spent in the country.

The women involved in this study held varying levels of education; one did not finish secondary school, two finished secondary, but did not complete post-secondary degrees, six held bachelor's degrees and two had gone on to complete advanced degrees. Household income ranged from €30,000 per year to €100,000 annually. Two participants did not specify income, but indicated that their families lived on one income. Saoirse¹ described her income level as, "the lowest it can be in

¹ All participant names are pseudonyms

Ireland” with her husband, the sole wage earner, making minimum wage (€8.65 an hour).

Race	White n=9	Multiracial n=1	Unspecified n=1	
Citizenship	Irish n=3	Other European n=5	N. American n=2	S. American n=1
Education	No Degree n= 1	High School n= 2	Bachelor’s Degree n= 6	Adv. Degree n= 2

Table 1. Participant Demographics

Thematic Analysis

In order to interpret my data, I read through the transcripts of the interviews to look for common threads— themes to draw a cohesive picture from the pieces offered by the individuals who participated in the study. Participants’ experiences varied widely in some areas; one participant felt that there was no benefit to being in a hospital for birth at all, while another had “nothing against the hospital” but did not see a reason to birth there after multiple births with no complication or intervention. A few participants had general practitioners (GPs) who were supportive of their choice to give birth at home, while most felt that their physicians were disapproving. Despite the differences in the nuances of stories told by each woman, there emerged three distinct yet interrelated common themes that help to

answer the question of how women in County Cork, Ireland come to choose home birth, despite its cultural rarity. These themes were: 1) negotiating safety; 2) educating and trusting oneself; and 3) finding community.

Negotiating Safety

One of the most prominent arguments against home birth is that it is a less safe option than the hospital for the neonate (birth to 28 days) (see Chervenak et al 2013 and the American College of Obstetricians and Gynecologists 2011). While my participants all agreed that safety was the most important priority when considering where to give birth, their definitions of safety did not always align with those of their general practitioners, consultant obstetricians, or other hospital-based personnel. The established medical system in Ireland— and elsewhere— tends to conceptualize a safe birth as one that ends with a live and uninfected baby and mother (Ruzek 1993, McIntyre 2012, Coxon, Sandall and Fulop 2014). The women I interviewed agreed that this was their highest priority, but also held other visions of safety that were less emphasized by mainstream medical practitioners. These included feelings of comfort and control over the environment-- including an emphasis on the body's ability to birth as opposed to a reliance on technology; continuity of care and a familiarity with one's birth attendant; and the inclusion and participation of family in the labor and birth experience. While several women did not have any particular aversion to hospitals, they did indicate a desire to be free from unnecessary interventions and pressure from nurses and hospital-based midwives. Thus, the decision-making process surrounding where to give birth and

with whom involved a negotiation—a balancing act to find the place most likely to offer all of these aspects of safety. Saoirse said: “It’s not just hospital/home. It’s not about *place*, it’s about *space*... At home, it’s about caring, loving, the baby is the center of that experience. The baby is most important at home... and the mother is very important too.” Thus, despite the clinical conception of safety that begins and ends with a live baby and mother, the emic code for safety is far more complex, encompassing physical safety and bodily autonomy, trust in the care provider and others present at the birth, and ability to surround oneself with family and loved ones.

Clinical Safety

Clinical safety in childbirth, according to dominant metanarratives, is tied to proximity of technology and highly-trained medical personnel. During their pregnancies and home births, though, the safety of mothers and babies was entrusted to the midwives; the latter were expected to know if something was wrong early enough to address the problem. Further, in the Cork system, ambulances are notified of approaching home births two weeks ahead of the due date, again when the mother goes into labor, and finally if they are needed to transfer the woman and her baby to the hospital for intervention. The participants in this study indicated that they felt safer knowing that the ambulance was standing by in case they needed it, but they also spoke of trusting their midwives—not only to identify impending problems, but also to be able to handle issues as they arose and to know where to draw the line between the range of normal for birth and an

emergent complication. Daireann said: “I had great confidence in my midwife who is really experienced, who hopefully would call anything early enough that we could have made it to the hospital in time if there was a problem.” Ciara said of her midwife: “She really made me trust myself. If I had any doubts at all, she always kinda brought me back to Earth and said you can do it!” This trust, and the feeling that the midwife had the mother’s best interest at heart in a way that obstetricians may not have, was shared as a central component allowing participants to feel that they and their baby were safe. This was sharply contrasted with experiences of having been given drugs without consent during some participants’ hospital births. Interviewees reported feeling that their midwives had their best interest at heart and were invested in their wellbeing, while at the hospital they felt that they were “on a conveyor belt” and that the doctors were more interested in moving the women along than they were in ensuring quality care.

Trust

Emotional and psychosocial safety were also entrusted to the midwives. Participants expressed the deeply held belief, whether premised on personal experience or gathered from the birth stories of others, that these needs often go unmet in the hospital. Interviewees who had experienced birth in the hospital spoke of individual hospital personnel as having contributed to both positive and negative experiences. They also frequently described having seen a particular nurse or midwife only once and then moving through the rest of their pregnancy and birth without interacting with the same person again. This lack of continuity of care

stands in stark contrast with the feelings of love and care experienced at home; when a woman retains a community midwife, the midwife is the only practitioner she will see for prenatal care. This allows the client and the midwife to develop a relationship and build trust in each other before the birth. Saoirse said: “A woman is just another woman out of loads of women, and the baby is the same, just another baby. They [hospital nurses and midwives] have only a few minutes to take care of you, and they are just strangers.” Later she spoke of feeling safe at home because, “the baby knows the midwife as well, because she comes every month then every week before the birth.” Continuity of care, knowing one’s practitioner, and knowing who would be attending the birth were important aspects of emotional well-being and were specified as aspects of “safety” that cannot be attained in the current hospital-based maternity system in Ireland.

Family

Having family present during the labor was also identified as an important part of participants’ emotional safety. They spoke of families being “kept at bay” or sidelined during hospital births despite the fact that close family members often were most aware of the needs of the birthing women. When partners *were* able to be present, their voices were often silenced and ignored when trying to advocate for laboring wives. Maire said:

“I knew I had [my husband] on my side for the home birth part of it, but in the hospital his input wasn’t valued at all, and he had a big argument with a midwife there and it all got very heated and nasty... but, when we met with our [home birth] midwife and straightaway she would direct answers at him, she would involve him

in the conversation... he felt involved and felt he had a right to be in the room... that was an important thing for us.”

In other cases, women wanted to allow older children, particularly daughters, to see normal, physiologic labor in an attempt to normalize unmedicated birth and teach older girls about pregnancy and childbirth in ways participants themselves may not have understood until they experienced it. Niamh noted that, if she had to transfer to the hospital during labor, she would be most upset that her oldest daughter would be unable to be present at the birth. She said: “I’d be ok with [a hospital birth], really. It wouldn’t be the end of the world. It’s just that I would have to have another child [laughs] so my daughter could get to a birth.” In this way, Niamh conceptualized safety not only as something she needed to experience herself, but also as something that she could help create for her daughter’s future births.

It is clear that clinical obstetric definitions of safety, while important, are insufficient markers of the safety and security felt by the participants in this study. Elucidation of disparate meanings of safety, combined with the ability to speak across them, may improve the quality of care provided to pregnant women in Ireland. When women’s positions are more fully understood by their care providers, the latter are more likely to be able to meet the needs of their clients.

A pregnant woman’s confidence in her ability to labor and birth her baby successfully—and even to parent—is also linked to her feelings of control over the birth experience, including decision-making processes. As early as 1983,

researchers (Oakley 1983) were drawing connections between post partum depression, the over- or mis-use of technology, and feeling out of control regarding the birth process. Indeed, Devane and colleagues (2007) have pointed to increased elective use of technology as one way that women seek to exercise control over their labors. However, they argue, that this does not constitute a true choice, but is instead an attempt to control some aspect of what the authors consider a poorly constructed system. Further, Christiaens and Bracke (2007) found that increased feelings of control during home birth may provide a buffer effect against the lack of medical pain relief as compared to hospital birth. Thus, although feelings of not being heard or respected by obstetricians may be attributable to a simple communication breakdown, they can have more complex and far-reaching results during and after the birth.

Disparate definitions of safety may also help to expose the priorities of each group. For example, defining safety as simply the end result of a live baby clearly centers the infant rather than the mother, and does not provide for the health and wellbeing of the family in which the infant will be raised. Alternative definitions of safety center the mother and family, thereby providing for the infant's long-term wellbeing rather than simply his or her "being alive" in the first hours or days of life. The midwifery model of care specifically includes "monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle" (Midwifery Task Force). This focus on the whole person within the context of her life and family, paired with continuity of care during labor and birth, not only contributes to higher satisfaction with the birth experience (Sandall et al 2013), but

can also decrease maternal morbidity during labor. For example, Lindgren et al (2011) found that midwives use different techniques to protect the perineum from tearing during birth. One specific example is to protect and care for the psychological space of the birthing mother; one woman cited in this study said, “I feel much more insecure at the hospital as I don’t know who I’m dealing with” (2). This is important, as the midwives report that: “Fear causes tears. When the woman is frightened, her pelvic floor tightens and is more likely to tear” (2). Thus, definitions of safety that are expansive enough to include psychosocial wellbeing are not only more likely to be found in home births with midwives, but may also help to explain the reduced number of complications seen in home birth samples (Cheyney et al. 2014), even though these are less closely associated with “safety” defined narrowly.

Educating Self, Trusting Self

The second theme—educating self, trusting self— stems from the perception that clinical definitions of “safety” stood in the way of the free sharing of information between physician and client. Although participants came to the idea of home birth in different ways—knowing someone who had a home birth, reading about different birth options, or reacting to a traumatic hospital birth— they all discovered that more research would be required in order to access an out of hospital birth. Whether it meant finding accurate statistics on the safety of home birth, searching out a general practitioner whose insurance allowed them to care for women planning home births, or learning the process by which one accesses home birth

services in the area, each interviewee described a compulsion to do research above and beyond the information that was freely offered by health care providers.

Several participants spoke of a lack of information regarding home birth given during appointments with their GPs or at hospital clinics. Although home birth is an option that is offered and is supposed to be covered by insurance through the Health Services Executives (HSE), participants were offered little or no information about the option or how to access it by health care practitioners, despite easy access to information about hospital birth and elective procedures—and despite the Cork Collaboration, a program put in place to better support home birth as an option and make it easier to access.

In some cases, what little information women were given about eligibility for home birth was incorrect. Some interpreted this as mere ignorance on the part of physicians, others attributed it to a political agenda premised on the popular perception that home birth is unsafe and thus, ill-advised. Ciara, in describing how she approached hospital personnel to inquire about home birth, said: “I told the midwife [at the hospital], ‘I’d be interested in having a home birth and could you tell me more about it?’ And I was told ‘no, not on your first baby, it’s not allowed.’ It really surprised me, because the home birth clinic is in [the hospital]. So there’s no way she didn’t know about it.”

Whatever the reason for the failure of doctors to provide facts and resources, this omission led women to seek out their own information. Participants spoke of the process of educating themselves and their partners about birthing options, as

well as the birthing process: “When I got pregnant, I was going to the hospital, but then I started researching, educating myself about it and met with the midwife and everything,” Brigid said. “I learned a lot after I got pregnant, reading books and looking for information on the internet about what was available to me before the birth, during the birth, afterwards— just everything I could find out about in-home midwifery care.” One participant even described trying to fill out the correct forms with her GP, and neither he nor his secretary knew how to properly register her for a home birth due to the extreme rarity of the situation.

In doing their own research, participants felt that they were able to make educated, informed decisions, and, in that process, they found a trust in themselves and their abilities to birth in their own way. They also spoke of finding the confidence to give or withhold consent when faced with decisions about themselves or their babies. One participant, Ciara, had planned a home birth, but ended up at the hospital to be induced when she went past the allowed date for a home birth. If Ciara had transferred during labor, her home birth midwife could have transferred with her, and may have even caught the baby if no major complications arose. Since she did not go into labor spontaneously, however, her midwife was not in attendance and Ciara did not have the benefit of the supportive relationship she and her midwife had built up over the course of her prenatal care. This left her in the unexpected position of giving birth in an unfamiliar place for which she was unprepared. She spoke of her experiences in the hospital, and described how her subsequent research and education have changed how she thinks she would react if she ever had to face another hospital birth:

I felt like when I had my baby, I couldn't advocate for myself. I felt very talked down to the whole time, and my husband, well he's saying, 'well the doctors know what they're talking about, you should listen to them.' But I think for future births, I definitely would speak up. I know that I have the right to make choices for myself and I have the right to have them respected... I didn't know that I could refuse the forceps delivery, I didn't know that I could say no... That's something that I would be more aware of next time.

Although her hospital birth was traumatic, Ciara hoped to be able to use that experience as a foundation for further advocacy and networking with women who had similar experiences.

The process of doing their own research and accessing information from several sources did more than to allow participants to fill in the gaps left by a lack of formal education on reproduction and minimal information offered by GPs and hospital-based consultants. It also allowed space for participants to question the common understanding of birth as inherently dangerous, painful, and in need of medical control. Some participants referred to birth as something that female bodies are "made to do". Others spoke of the process as remembering an "old knowledge," or accessing a personal power to help guide them through their labor and birth. Einin said: "I just think people forget that this is natural, and it's been going on for thousands of years, and I don't understand why we have to intervene with everything... maybe people aren't used to being in touch with themselves and being in touch with their bodies." Other participants thought about the effects of being "out of touch with birth" on a national level, arguing that a cultural fear of pain leads many Irish women to request pain medication at the first discomfort, thus "stifling the good or transformative aspects of labor, along with the pain."

Interestingly, almost all interviewees credited Ina May Gaskin (widely

considered the mother of the U.S. home birth renaissance in the 1970s) and her writings on unmedicated birth as being particularly influential in their preparation for home birth. In Daireann's words: "Ina May Gaskin. That's the big thing. Reading her books really did give me huge, great confidence and knowledge and a sense of empowerment." As participants tapped into these kinds of sources in an effort to educate themselves, they simultaneously describe experiencing the expansion of trust—trust in their bodies, their babies and in their home birth midwives.

Though the women I spoke with were ultimately able to find resources and navigate a planned home birth, it was not without great difficulty, begging the question of how many women in Ireland are never able to find the information and access to a range of provider types that would enable informed choice and shared decision making. Byrne et al (2011) have argued that: "It is the responsibility of those managing the Irish health services to ensure that choices are well-informed, and that choice is delivered in a manner that does not lead to an increase in adverse clinical outcomes" (182). The authors further state that it is the statutory right of parents in Ireland to have access to accurate and impartial information regarding birth options—including home birth. In her 1999 article, O'Connor claims that unbiased information on home birth was at that time only available through the Department of Health and Children (54) –a department which no longer exists. None of the women who participated in interviews for this project knew of a central source for information on home birth; even if a source does exist, it is not well known or well advertised enough to be accessible to most expecting families. Thus, participants all expressed the concern that prospective parents in Ireland are

currently unable to make informed choices about how, where and with whom to give birth—nor, indeed, even to know that this is a basic, foundational right.

Finding Community

With such low rates of births happening outside of the hospital, home birth is culturally uncommon even in Cork where nearly half of the nation's home births occur. This makes it unlikely that women who have home births will find each other simply through everyday interactions. Further, participants described being berated, alienated, and told by family, friends, and health care providers that they were “gambling with their baby's life” by giving birth at home, leading some to remain silent about their plans and experiences. Several interviewees confessed that they had purposely withheld the truth about where they planned to give birth from friends and family in order to avoid these interactions. Niamh said: “I'm not gonna tell my family. [laughs] I mean, I wouldn't not mention it to them afterwards, but I'm not going to deal with the lectures of, what if there's something wrong.” Others spoke of the doubt they felt after hearing the reactions of those around them. Brigid, pregnant with her first child, said: “Because I've never experienced birth before, it's hard for me... when people say, you're having a home birth, you're crazy. I don't know just how crazy I'm being.” During pregnancy and birth, support and confidence can be important factors in a woman's psychological state. These new mothers were unable to access the support of their community during a particularly vulnerable time in their lives. Instead, they were made more vulnerable, not only by the lack of support, but also by the overt social stigma.

In order to make up for this loss of support, participants created or searched out communities of other women and families who fell outside of the mainstream in their birthing and parenting choices and philosophies. This happened predominately in two ways: 1) participants joined groups of other parents who made culturally uncommon parenting choices (like exclusive, long-term breastfeeding or babywearing); and/or 2) they joined Facebook or other social networking groups of parents who were open to their birthing and parenting values. Many study participants found their way to community through more than one of these groups, networking and socializing in as many circles as possible in order to broaden their social safety nets. Several participants stated that they came to consider home birth as an option after attending these parenting groups and meeting other women who had given birth at home. Because of the documented overlap between home birth and other “alternative” parenting choices (Cheyney 2008), participants were able to use the babywearing and breastfeeding groups as pathways into home birth communities. Maire said:

When I was six months pregnant, I happened to bump into another home birth mother at a La Leche meeting here in Cork, and we kind of got to chatting about the whole home birth thing. I didn't think it was for me at all. I hadn't really looked into it. I wasn't against anyone else having one, but I just didn't know anything about it. She mentioned that she had birthed her son in the pool in her house, and so the whole idea of having a home birth was then thrown into the mix for me.

Thus, an existing social support group became a portal to a new way of thinking and birthing for this participant.

These spaces were also invaluable for sharing resources and information, thus filling the void left by the information that women felt GPs and consultant

obstetricians were withholding, sometimes intentionally. Brigid, speaking of the research she did before giving birth, said: "I started comparing how the systems work and everything and talking to moms from [the U.K. and Holland] and moms from here. I also had the chance to talk with moms that had home birth here, so this helped me make my decision." Participants noted that there is quite a bit of overlap between mothers who choose to breastfeed or babywear and those who desire home birth. Although they were described as "alternative" or even "hippie-ish," these lifestyles were often associated with individuals who were well-educated, whether formally in the academy or by having done their own research. Daireann said that women who had home births tended to be "...somebody that's read a few books... and perhaps is already alternative in some ways, like maybe, you know, tries alternative medicine on themselves before the baby's born, or thinks about what they eat, and you know, just sort of not traditional... more educated in terms of whether or not they've gone to college or university or had a wider experience with people."

This broad experiential knowledge was highly regarded among the home birth communities; support groups, conferences, and internet groups were used heavily to seek and share knowledge and resources.

It was also repeatedly noted throughout the interview process that women who had their babies at home were more likely to breastfeed than those who gave birth in the hospital. Ciara stated that she had, "yet to meet a home birth mom that doesn't breast feed." This was linked to both the perceived high levels of education

held by women who sought out home birth, as well as the more individualized care offered by community midwives as compared to hospital-based midwives and obstetricians. Further, the simple fact of being surrounded by people who support breastfeeding—whether or not those people breastfeed, themselves—made the act of nursing more socially acceptable, and therefore more comfortable, at least within the context of these social situations. One participant noted how uncomfortable she was breastfeeding or speaking about natural birth in front of her extended family, but was able to do so with impunity in her birth, breastfeeding, and babywearing social groups.

While alternative parenting groups are more easily accessible to those who live in or near the city, individuals who live in the less populous towns further from centralized communities have only the internet to turn to for community building. These communities included, but were not limited to, the online counterparts to the groups described above, as well as home birth and location-specific pages and groups on social networking sites, such as the Home Birth Association Facebook page or a Counties Cork and Kerry-specific home birth group. Some individuals indicated that they had found these pages in the process of conducting online research into birth options, and that these communities helped them feel confident enough to choose home birth. Others sought out online support after having decided to pursue home birth, knowing ahead of time that they would need additional support that felt missing in their family or immediate social circles.

Whether participants joined or created supportive communities around themselves in the “real world,” in cyberspace, or both, these spaces became the

areas in which they could voice the hopes, fears, and choices that they often felt unable to share with their close friends and family. Maire expressed gratitude that she was close enough to the city that she was able to make it to the in-person meetings, but also utilized the online spaces as well. She said of her experience with various home birth friendly communities:

We have a number of groups for breastfeeding, babywearing, et cetera, and we call it 'the bubble.' So you come and you air whatever views you have about breastfeeding, home birth, that kind of thing, and you know you have a safe listening space, online, that you might not have with your family or your friends and your extended family, on these subjects that are very personal and very close to your heart. So, they are like a little bubble and you do pick and choose your baby groups and your play dates accordingly. At this vulnerable time, you do need to feel protected by your community.

When talking about the value of community and social support during pregnancy, birth and early parenting, study participants are expressing beliefs strongly supported in the literature. Fernández and Newby (2010) found that familial support had a beneficial effect on the health behaviors of pregnant women, Ghosh et al (2010) have shown that the odds of preterm birth decreases with increased social support, and Sherraden and Barrera (1996) found that, while socioeconomic status, social support, and prenatal care were all positively correlated with better outcomes, prenatal care was not limited to doctor's visits, but also included encouragement and guidance from other women in the community (304). Women who have planned and/or attempted a home birth in Ireland assert the need to consider the impact of a paradigm that requires women to hide their pregnancy and birth choices from their family and close friends. While networking and building community has enabled these participants to find a birthing choice that

resonates with their larger beliefs and values, interviewees question the costs of home birth stigma and mother blaming that arises from the powerful cultural norm of medicalized hospital birth in Ireland. Further, although these alternative communities may provide great moral and educational support, the fact that many women interact with them via the internet due to distance means that opportunities for in-person support (in terms of presence during labor or the ability to offer judgement-free space post-partum) are more limited.

Through the analysis of the interviews with these women, I was able to create a snapshot of what it is like to attempt to access home birth in Cork. Whether primiparous or a mother of four, whatever the level of formal education, through a range of income levels and national origins, the participants in this study all faced significant challenges in accessing home birth. The lack of information, the wildly differing definitions of “safety” and “normal birth,” and the difficulty in finding supportive community all made the seemingly simple task of deciding where to give birth into a monumental undertaking. However, through self-education, community building, and the relationships developed between midwives and mothers, study participants were ultimately able to access home birth care. Many participants expressed the hope that the stories they shared with me would ultimately lead to better information and easier access for more women in County Cork and across Ireland.

CHAPTER 5: DISCUSSION

The three overarching themes that emerged during this study are connected as part of a larger schema that helps us to see the ways that the priorities and values systems of the participants diverge from those of the established, mainstream maternity care system, thus leading them to seek out alternative options such as home birth. Any one of the key themes—discovering or developing a concept of safety that differs from one’s provider, finding confidence and trust in oneself through self-education, or finding or creating a community outside of the mainstream that supports a broader range of choices and parenting styles—can function as entry points into an alternative way of viewing, valuing and performing childbirth.

A New Normal

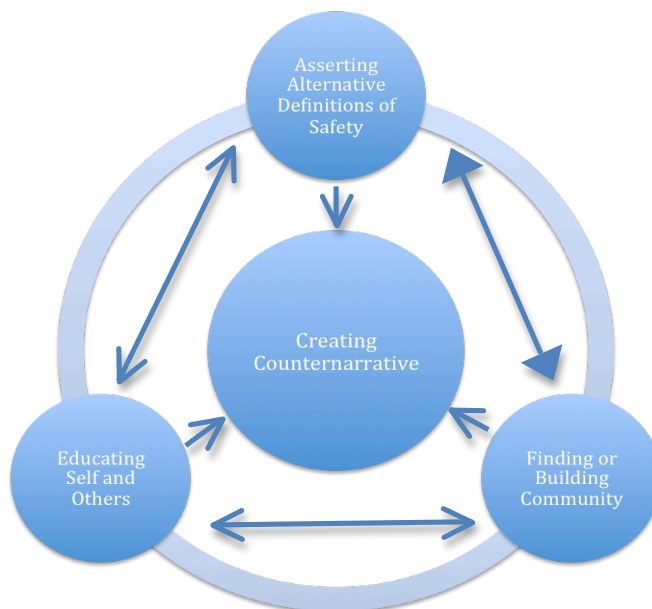


Figure 1.

Women in Ireland come to the decision to opt out of the mainstream, cultural norm of hospital birth in several ways and for varying reasons. For example, a pregnant woman might read about home birth during the information gathering phase that is so common during early pregnancy; that education may be her entry into a wider home birth community which then helps her develop a new definition of safety. Alternatively, she may find herself a part of a community that values attachment parenting and non-intervention, decide to have a home birth as part of that experience, and continue reading and learning about the statistical support for the safety of home birth as part of that process, thus leading her to question the proximity to technology as a key component of safety.

While not all women will relate to all three of these themes, my work suggests that some entry into this schema is common among those who choose home birth in Ireland. This ingress has the potential to create a larger network of people who question the dominant metanarrative of technocratic, medicalized birth, as participation in any one of the thematic areas can overlap or lead to activity in another. As individuals become more involved in these activities of research, meaning-making, and community building, whether by becoming more deeply involved in one activity or by broadening their involvement over several areas, they move further away from their investment in mainstream metanarratives. This then lends strength and weight to a collective counternarrative.

Anthropologists often note that “normal is simply what you’re used to.” In other words, what is normal to one person or group can be seen as utterly foreign, even strange, by another, because the process of socialization into culturally

normative behavior can differ so dramatically both cross-culturally and intraculturally. In addition, normal changes over time. The simple fact that what is considered normal can change, highlights the reality that “normal” is neither inherent nor static, but dynamic and socially constructed. Thus, when a number of people begin to question the mainstream concept of normalcy—for example, the “normal” place to give birth—then a new normal may come to take its place.

Although hospital birth is widely considered “normal” in Ireland, the cycle illustrated in Figure 1 offers a portal into another way of viewing childbirth spaces and places. As individuals exit or reject the cultural norm by doing their own research, by choosing an uncommon birth option, by finding community outside the mainstream, they challenge and even resist the dominant paradigms’ concept of “normal birth.” Although individual, ontological narratives (Somers 1994) cannot create systemic change on their own, when combined with the psychosocial support found in communities of like-minded people, they have the potential to create a powerful collective, counter-narrative that offers not only respite from mainstream assumptions of pregnancy and birth, but can have the revolutionary effect of creating a whole new version of what is normal. In the section that follows, I use Ahmed’s work on affective economies to explore the ways “normal” is created in order to serve the interests of some at the expense of others.

Affective Economies: Creation of Narrative

Philosopher Sara Ahmed’s theory of affective economies (2004a, 2004b) posits that cultural norms do not necessarily carry weight because of any inherent truth; rather, it is in the very circulation of the narrative that it gains credence. This

circulation begins by endowing certain symbols with affect, or emotional weight, in order to elicit support or disdain for an idea, a practice, or even a person or group of people; these symbols are then circulated in both popular and official discourses until they become hegemonic. Ahmed writes:

Such narratives work by generating a subject that is endangered by imagined others whose proximity threatens not only to take something away from the subject... but to take the place of the subject. The presence of this other is imagined as a threat to the object of love” (2004a, 117).

Thus, the narrative creates a subject, in this case an infant, who must be protected from the outside forces that threaten him/her. These forces are sometimes reduced to the vague term “poor outcome.” In other cases, as in the Irish home birth debates, the safety of the infant is pitted against the mother’s birth experience when a mother, for example, is told that by choosing home birth she is prioritizing her experience over the wellbeing of her child. In still other cases, the outside force is given the face of an unscrupulous midwife who would rather put her clients in danger than “allow” them to transfer to the hospital. No matter what face the threatening force wears, however, it evokes an emotional state that renders home birth “crazy,” “dangerous,” and “irresponsible,” and hospitals and their attendant staff, technology, and practices as the safe, normative, rational and responsible option.

Through this lens, the centering of the hospital-based practitioner as normative can be seen as both a product and a major force that drives the circulation of the birth-as-dangerous narrative. The positioning of hospital-based practitioners and insurance companies as the subjects (i.e., as those who stand to

benefit most from this centering) is obscured by the construction of the infant as the subject in this narrative. When Ahmed writes that: “The ordinary or normative subject is reproduced as the injured party” (2004b, 43), it is the infant that springs to mind as subject, when in fact, in this case, it is more likely the medical establishment. “The bodies of others are hence transformed into ‘the hated’ through a discourse of pain... These figures come to embody the threat of loss” (Ahmed 2004b, 43-44). The dominant medical narrative positions home birth midwives and the women who give birth under their watch as “the hated,” as those who are the greatest threat to the wellbeing of innocent babies—and, only incidentally, or less explicitly, to the obstetric institution.

Narratives of safety and risk are given particular weight by the inclusion of the baby. Lyerly et al (2007) write that, when considering “safety” and “risk,” we see a “tendency to pursue zero risk to the fetus, independently of the absolute size of the risk, of competing considerations, or of recognition that fetal risk exists in other acceptable contexts... it is disproportionate to how we think about risk elsewhere, including in the treatment of born children” (981-82). There is something unique or special about the inclusion of the baby, in particular the unborn fetus, that steers the conversation away from a balanced cost/benefit analysis and toward absolute zero risk to Baby even at the expense of Mother.

The circulation of signs or narratives, as symbols that refer to objects, people, or concepts, create emotional responses that Ahmed calls “affective economy.” In this case, the narrative of zero risk both creates and emerges from the positioning of the fetus as sacred, blameless, and in need of protection not only *by* his or her

parents, but sometimes *from* them, midwives, or other potentially harmful agents.

Further Ahmed applies a Marxist analysis of capital to emotion as she writes:

Emotions work as a form of capital: affect does not reside positively in the sign or commodity, but is produced as an effect of its circulation... In *Capital*, Marx discusses how the movement of commodities and money... creates surplus value... as he puts it: 'The value originally advanced, therefore, not only remains intact while in circulation, but increases its magnitude, adds to itself a surplus-value or is valorised. And this movement converts it into capital' (Marx 1976, 252). I am identifying a similar logic: the movement between signs or objects converts into affect... Affect does not reside in an object or sign, but is an effect of the circulation between objects and signs (= the accumulation of affective value)...the more signs circulate, the more affective they become. (Ahmed 2004b, 45)

Applying this lens to the Irish place of birth debate, we see how signs that have come to be associated with home birth and its presumed associated poor outcomes—particularly avoidable pain, suffering, fear, and death—actually function as commodities in this affective economy. In the dominant institutional narrative, those signs are the community midwife, the “hippie” mother who chooses home birth, and all that attends these figures. Thus, although home birth is not inherently scary or risky by its nature, it has become so because of the circulation of this discourse. The dominant narrative skews statistics, conflating relative with absolute risk and ignoring statistical significance (or lack thereof) (See, for example, the Cheyney Wax debate 2014; Cheyney, Vedam and Burcher 2014). It compares unlike situations, or suggests that supporters of home birth believe that all births should happen out of the hospital rather than supporting access for women who desire choice in place of birth. Together these phenomena contribute to the

circulation of the institutional narrative and the creation of an affective economy in which the medical practitioners and insurance companies stand to profit.

Finally, what is perhaps the most effective tool in the circulation of this narrative is the assertion that we can never know which births will end in emergencies, and therefore the safest place to give birth must be in a hospital. Ahmed's example of immigration and the "genuine" versus the "bogus" asylum seeker may at first seem out of context, yet, I would argue, may indeed be applied to home birth:

How can we tell the difference between a bogus and a genuine asylum seeker? It is always possible that we may not be able to tell, and that the bogus may pass their way into our community. Such a possibility commands us (our right, our will) to keep looking, and justifies our intrusion into the bodies of others. Indeed, the possibility that we may not be able to tell the difference swiftly converts into the possibility that *any* of those incoming bodies may be bogus... Such a discourse of 'waiting for the bogus' is what justifies the repetition of violence against the bodies of others in the name of protecting the nation. (2004b, 47)

How can we tell the difference between a "safe" birth and one that will end in emergency? The knowledge that "the bogus may pass [its] way into our community"—that some risk may not show itself or that something could happen despite an otherwise low-risk pregnancy—is a highly effective emotional trigger. This emotional response—the value of this affect—has been enough to convince policy makers and medical practitioners alike that, because *some* births are dangerous, it is the responsibility of policy to restrict and attempt to control the circumstances of *all* births.

Lyerly et al. have argued that: "It is the physician's obligation not to *eliminate*

risk, but to help patients weigh risk, benefit, and potential harm, informed by best scientific evidence and guided by a patient centered ethic” (2007, 982). Yet the obstetric institution and its attendant metanarratives only allow room for one version of “success,” one definition of “safety:” A live, physically unharmed baby at whatever cost to the mother. Because of both the dominance and the rigidity of these narratives, it is extremely difficult to construct a personal or ontological narrative that breaks out of these molds, much less to gain the momentum needed to create a collective counter-narrative. It is not enough to develop personal insight into what birth means, or what role place has in that meaning (See Figure 1). It is in the joining of voices and the creation of community that a counter-narrative is created and sustained. Though I initially set out to answer why so few women give birth at home in Ireland, despite the apparently supportive policies, perhaps it is more surprising that *even* 1% of childbearing women challenge the dominant discourse, with all its affect and all its weight. Yet, the more the dominant metanarratives are challenged, the more their fallibility is exposed and thus the easier they are to challenge. This small but vocal group of women in Ireland may someday prove to be the chink in the armor of technocratic birth, creating an opening just wide enough to let a new narrative take root.

Strategies for Moving Forward

The Health Strategy, published by the Department of Health and Children in 2001, stresses the importance of consumer involvement in future healthcare provision (Kennedy 2008, 28) and the Association for the Improvement of

Maternity Services in Ireland (AIMSI) has stated that papers and studies demonstrating the safety of home birth and MLUs are important, but that the culture of birth in Ireland will not change until mothers as consumers and GPs as “first-line health care professionals” speak out for choice (Kennedy 2012, 388). Mander and Murphy-Lawless agree that women must assert their rights as consumers to influence both local and national policies (Mander & Murphy-Lawless 2013, 180), yet they also acknowledge the problematic nature of assuming that these women have the education, confidence, and access to political channels in order to make these demands (184). Further, they acknowledge the ways that the current system actively discourages both pregnant/birthing women, as well as midwives from making their voices heard. Finally, they question the value of traditional concepts of “autonomy” which emphasize self-government. Rather, they favor a “relational autonomy” that emphasizes the interdependence of people.

Because there is no independent professional organization for midwives in Ireland, or any other organization that can “challenge the inadequacies in the current system at a policy and political level” (Daly & OBoyle 2010, 15), Daly and OBoyle call midwives and mothers to unite and work with other professional groups to seek systemic change. Mander and Murphy-Lawless, too, write about the apparent weakness of midwives as agents of structural change in Ireland. Midwifery is considered a “semi-profession,” meaning it has a limited ability to control its own functioning (2013, 38). Many midwives would like to see a higher level of autonomy in midwifery practice, though while this might increase the respectability of the profession, it would also come with increased levels of oversight and disciplinary

control of members' behavior, which is "distinctly less attractive" (39).

The KPMG Report (2008) states that: "the current number of deliveries could not be provided without active management [of labor]; however that does not mean that it represents best practice" (p 15 as quoted in Kennedy 2012, 391). Over 70,000 women give birth in Ireland annually; Kennedy writes that the cost-effectiveness of midwifery-led care may be what will finally prompt the medical complex to adopt less medicalized systems of maternity care (Kennedy 2012, 392).

These recommendations—more involvement by and inclusion of consumers in the decision-making processes around maternity care, greater respect and autonomy for midwives, more evidence-based care and policies—are echoed by the participants in this study. Further, they suggest more education, both for providers and for consumers. Iona, noting the lack of information about home birth available to pregnant women through the clinics and maternity hospitals, said: "It would be nice if there could be much more teaching about it; maybe not just teaching, but promotion. The message can be put out there that home birth is actually safe, that a woman keeps her own dignity, and [it's] much more comfortable. I think women should be more aware." Brigid agreed, saying: "I think something they [health care providers] can do is to make other moms and GPs in Ireland more aware that this system is available—and make them believe that the system works!"

Strengths and Limitations

This study was designed to elicit deep stories and rich narrative. There are a number of benefits, as well as difficulties associated with qualitative research of this

sort; the time invested with each participant allows the interviewer to build rapport which in turn supports greater disclosure and open sharing by the participant, but also allows for fewer participants than other methods due to the high time investment required. Further, the narratives here show only the individual experiences of participants, and cannot be—indeed, are not intended to be—generalized to the greater population of childbearing women in Ireland.

Limitations

One limitation of this study is the small sample size. In 2012, County Cork was host to nearly half of all Irish home births, yet I was only able to complete interviews with 11 participants. A larger sample size might have offered more insight into some of the experiences that were only briefly mentioned in the interviews I conducted, or offered alternative perspectives on the themes that emerged from the collected data.

The goal of qualitative interviews is to reach saturation, or the point at which no new information is produced by asking the same questions. This is one way to assure that the information is accurate for the population under study and it also helps to identify the outliers. In this study, eleven participants was sufficient to reach saturation on the themes of safety and community; however, had I had the ability to continue enrolling new participants, I could have further developed the ideas surrounding the research and education that participants pursued in their quest to find out everything they could about birth generally and home birth in particular. This theme was clearly an important part of the home birth experience

for my participants, but the boundaries and implications of this theme were harder to define, due, in part, to incomplete saturation.

Another weakness of this study is that many participants were either first time mothers or had only had or planned a single home birth. Therefore, many of them were only recently involved in the communities of home birth advocates. While this helped to ensure that they were telling their own stories and not speculating on the experiences of others, it did mean that they had less of a sense of why other women may or may not choose home birth and what experiences they had that might be shared by other mothers in similar situations. For this reason, I would have liked to speak to more women who had had or planned multiple home births.

I also would have liked to speak to the midwives who attended out of hospital (OOH) births. The original study design included a focus group with midwives, as I anticipated the value of their perspectives, but logistical and time restraints prevented this. SECMs in County Cork are few and, quite literally, far between. Four midwives attend the majority of the home births in that county, and thus are busy and unable to travel outside of their call range to meet together. Given the widely varying schedules and the physical distance, I was unable to organize interviews with the individual midwives much less a focus group with all of them. This is an important first step for future research.

Finally, reciprocal ethnography yielded little feedback from interviewees. After I had conducted all the interviews and done a first round of analysis, I sent the initial results to my participants for their review. This consisted of an email with an

outline that delineated the themes that emerged as I read through the interview transcriptions. The outline included a brief summary of each theme, as well as short quotes or references to the interviews that I felt supported the theme. Participants were invited to review the outline and to express either their support and agreement with the results, or to clarify or correct any interpretations that they felt misrepresented them or that I had analyzed incorrectly. However, few people responded to this invitation for formal response; only three participants responded to the email containing these results. This lack of response meant that I had little information—brief comments from only three participants— from which to draw as I continued my analysis.

Strengths

There are also several strengths to this study. Participant observation— at meetings, conferences, and on the internet— allowed me to follow the stories, difficulties, and triumphs of over 800 advocates for home birth in County Cork and across Ireland, adding richness and validity to the formal data collected during the interview process. Many of my participants were part of the discussions, whether in person or via the internet, and this gave me the opportunity to see how their stories intersected with the larger narratives and events that surround home birth in Ireland—whether these are the metanarratives perpetuated by politicians and hospital spokespeople or the counter-narratives developed by the community of midwives, home birth mothers, and other advocates.

Further, the interviews provided enough data to reach saturation on two of

the three themes that emerged. The themes of safety and community were emphasized throughout the interviews, and participants by and large agreed with each other on both the import of those themes as well as the roles that self-definition and community played in their home birth experiences. Data were further validated by the discussions that occurred during online and in-person participant observation activities.

Finally, those that did respond to my call for formal feedback indicated that they felt that this initial analysis was accurate. One respondent even commented on how interesting it was to see where she fit into the analysis, indicating that she felt that the results resonated with both her personal experiences, as well as her perceptions of the home birth community in Ireland as a whole.

Even given the limitations, this study provides a window into the particular situation experienced by many women in Ireland today. The Home Birth Association suggests that for every woman who has a home birth in Ireland, there are ten who would like one but are unable to secure a midwife, qualify for home birth on clinical grounds, find a consultant to sign off, or otherwise access the birth they want (HBA 2014). While this study cannot be presumed to speak for all of these women, perhaps it can at least serve as a starting point for considering alternatives and improvements to the maternity care system currently used in Ireland.

CHAPTER 6: CONCLUSION

In September of 2014, less than a year after I returned from Ireland, community midwife Philomena Canning had her indemnity insurance suspended pending an investigation into the cases of two of her clients after postpartum transfers to the hospital. Both Canning and the clients themselves assert that the cases were handled according to protocol, and that there was no wrong-doing on the part of the midwife (philomenacanningcampaign.com, Griffin 2014a). Despite the fact that the investigation has revealed no evidence against her, Canning's insurance has not been reinstated. The HSE claimed: "no findings of wrongdoing have been made against [Canning], but it had to act in the interests of public health" (Griffin 2014a, 30). This resulted in Canning's 25 current clients being left without care—some in their last weeks of pregnancy. The HSE claimed that they would provide other midwifery care, but have failed to do so in many cases, instead leaving the women to find their own replacement midwife or to have a hospital birth they did not want. Advocates of Canning and of home birth more generally are questioning why similar investigations have not been launched even when maternal and infant deaths have occurred in the hospital (Griffin 2014a).

Canning's now-former clients—including the subjects of the two cases under investigation— as well as other advocates have sent letters and petitions to the HSE demanding the reinstatement of Canning's insurance coverage or, at the very least, replacement midwifery care for the clients who had been counting on Canning to attend their births. There has been at least one public demonstration, bringing more

than 200 women, many of them current or former clients of Canning, gathered outside Dáil Éireann (the lower house of Ireland's Parliament) to protest the actions of the HSE (Griffin 2014a).

Despite the apparent polarization of the issue –the government and established maternity care system on the one hand and grassroots community of midwives and home birth advocates on the other—there are a few notable exceptions to this split. Senator Ivana Bacik recently called for a review of the Irish maternity care system, stating a need for “greater diversity of maternity care models,” including home birth (HBA 2014), and Professor Louise Kenny explained: “Traditionally obstetricians were cautious and in some cases negative about home birth because of fears of maternal and baby safety. We don't actually have to be” (Griffin 2014b, 18). She also expressed her support for birth centers, specifying: “I am fully supportive of fully independent birth centers that are led by midwives for low-risk women” (Griffin 2014b, 18). The support from these two high profile figures suggests that finding common ground may be possible between the dominant, risk-averse model and the alternative definitions of safety held by the participants in my study.

Coming Full Circle

The current situation with Philomena Canning can be used to illustrate the themes that emerged from my study. Definitions of safety are perhaps at the heart of the conflict. The HSE's claim to be serving the interests of public health by denying Canning's ability to work contrasts sharply with the vulnerability of 25 women unexpectedly left without maternity care. Indeed, even the support from Professor

Kenny is couched in a clinical medical definition of safety rather than on the premise that a pregnant woman is the best person to determine what is an appropriate and acceptable level of risk during her own pregnancy and childbirth. Both the HSE and Professor Kenny are defining safety and risk *for* women rather than listening to the varied and nuanced definitions and priorities of the women themselves.

Current events regarding home birth in Ireland also emphasize the difficult or, in some cases, non-existent communication between the HSE or other health care providers and the women they claim to care for. One of the women whose births were under investigation as part of the proceedings against Philomena Canning told reporter Niamh Griffin that she had not been notified that her experience was part of the investigation; she was shocked when she found out through social media. She claimed that she had never made any complaint against Canning—rather, she was very pleased with the care she was given (Griffin 2014a). The women who had been clients of Canning's were sent letters informing them that she was no longer covered by HSE indemnity insurance, but that the HSE was committed to honoring their choice of home birth. However, the HBA Facebook and Twitter pages are filled with stories from women whose assigned midwife was not notified or available to cover them, who never heard back from the HSE at all, or who were otherwise left in the dark about what to do or where to go next. Thus, they were forced yet again to do the research and self-education to figure out what options were available, and how to access them.

The action and activism to support Canning is just one example of the collective power found in and felt by the home birth community in Ireland. Petitions

and protests were organized quickly due to the already extant networks of supporters. Information and resources were shared freely, as were stories of both roadblocks and successes in finding replacement care, a website was created (philomenacanningcampaign.com) and the Twitter hashtag #IsupportPhilomenaCanning began making the rounds. This and other campaigns for insurance coverage and rights to home birth are a testament not only to the presence of the community, but to the important place it holds in the lives of its members. Home birth, to these women, is not simply a choice; it is a way of life.

Recommendations

Based on the data collected in interviews, as well as the observations I made during the participant observation portion of this study, I have three recommendations to smooth the way towards home birth for the women who are interested in that option. Broadly, these recommendations suggest more education for both health care providers and consumers, as well as changes to the insurance policies for General Practitioners. These recommendations are specific to Cork since that is where my research was conducted, but they may be applicable to other counties in Ireland.

The first recommendation is to teach GPs, consultant obstetricians, and hospital-based midwives and staff more about home birth, as well as how the Cork Collaboration home birth scheme works. This can include both information about the safety and cost-effectiveness of home birth, as well as practical training on the proper procedures and referral systems to help interested parties access home birth. Attendance at a few home births as part of medical training might also enable

a more informed sense of what actually occurs over the course of home-based maternity care. This recommendation is particularly important since Cork sees nearly half of the nation's home births and is home to the collaborative scheme between the hospital and the community midwives. Already a leader in Irish home birth services, Cork has the potential to set a higher standard and provide top quality home birth care to its population.

It was clear from the data I collected that many—perhaps most—women in Cork are unaware that home birth is offered as a maternity care option through the HSE, much less the fact that Cork University Maternity Hospital (CUMH) has a partnership with the community midwives in order to provide seamless care between hospital and home. This means that many women who might desire the option of a home birth do not avail themselves of the opportunity—simply because they do not know that it exists. Thus, my second recommendation is for information about home birth— including safety statistics, clinical suitability guidelines, and instructions for how to access it—to be made available to all pregnant women in Cork. A pamphlet could be provided in physicians' offices when women first see their GP after finding out they are pregnant, thus allowing time for interested parties to inquire further with their physician. Perhaps more importantly, it should be freely offered rather than by request only, and with the same endorsement or lack of bias as information about other medical procedures. This is an important first step in making sure that women have access to the information needed to participate in shared decision-making regarding place of birth.

My final recommendation is inspired by the difficulty many participants faced in finding a GP who was able to refer them to the hospital for an evaluation for home birth suitability. The indemnity insurance that covers most GPs in Cork is restrictive to the point that even the act of referring a client to the home birth clinic is outside of the bounds of coverage. This is despite the fact that, after writing the referral letter, the GP is no longer involved in the process of providing maternity care to the client. Interviewees in my study expressed confusion as to why their GP's insurance provider would care at all given the lack of involvement on the part of the physician. Thus, my third and final recommendation is that insurers provide coverage to physicians and midwives that is appropriate and relevant to their scope of practice, as well as based on the evidence rather than sensationalist beliefs about safety and risk.

The implementation of these recommendations could go a long way toward supporting a perception of the maternity care system in Ireland as being woman- and-baby-centered, while operating under the most up-to-date scientific evidence on safety. It would make a cost effective option more readily available to more women, and could relieve some of the overload currently felt by the maternity hospital. Yet in order to implement these recommendations, the HSE and other policymakers in Ireland will have to be willing to support the community midwives, as well as the women they serve, and, in the process, acknowledge a wider range of normal, a more nuanced definition of safety, and the autonomy of women in their health care choices.

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APPENDIX A: RECRUITMENT LETTER

“Homebirth Decision-making in Ireland: A Narrative Analysis”

Greetings,

We are writing to invite you to share your experiences of homebirth. My name is Leah Houtman, and I am a graduate student in Oregon, USA, working with my advisor, Dr. Melissa Cheyney, a homebirth midwife and an associate professor of anthropology at Oregon State University. We are interested in learning about your experiences for our research on homebirth in Ireland. The purposes of this project are to:

1. Understand the circumstances under which women in Cork, Ireland choose homebirth.
2. Understand the factors that influence women’s reproductive decision-making in Cork, Ireland.

The direct benefits to you for participating in this study are limited. However, we believe that your experiences will help us to understand the strengths of the Irish maternity care system, as well as help us to understand differences and similarities between the Irish system and that of the U.S. This in turn could lead to recommendations that would benefit women in both countries. We believe that your knowledge and experiences are important in this process.

Your input in this study is voluntary, and if you choose to participate you may withdraw at any time.

Participants will take part in different activities depending on their role in the community. If you are a mother who has planned a homebirth in the past two years (whether you gave birth at home or later transferred to hospital to deliver), you will be asked to participate in an individual interview. If you are a midwife who has attended women who have planned homebirth in the past two years (whether they gave birth at home or later transferred to hospital), you will be asked to take part in a focus group. Your responses will be kept confidential whether you participate in an individual interview or in a focus group. We will ask members of the focus group to maintain the confidentiality of comments made during the discussion. However, there is still a risk that comments you make during the discussion may be shared outside of the group.

If you have any questions about this research please feel free to contact us.

Dr. Melissa Cheyney, principal investigator, melissa.cheyney@oregonstate.edu

Leah Houtman, co-investigator, houtmanl@onid.orst.edu

Thank you for your consideration of this request to participate in our study.

Sincerely,

Dr. Melissa Cheyney and Leah Houtman

APPENDIX B: SAMPLE INTERVIEW QUESTIONS

Women who have planned homebirth: Individual Interviews

1. How do you identify racially and/or ethnically?
2. What is your annual household income? (ranges?)
3. How do you identify religiously or spiritually?
4. What is the highest level of education you have attained?
5. What is your nationality?
6. Please tell me the story of your most recent homebirth.
7. Why did you choose to plan a homebirth?
 - a. What were your other birthplace options?
8. What do you think are the most important factors when deciding where to give birth?
9. How important do you feel location is during childbirth?
 - a. Are there other factors that you think are more important than location?
10. How do you think most people in Ireland would describe a 'typical' homebirth mother?
11. Where did you learn about childbirth before you had your baby?
 - a. What were your beliefs or expectations about childbirth before you had your baby?
12. What factors influenced how you currently think about childbirth?
 - a. What are your current beliefs about childbirth?
13. What do you think leads other women to choose homebirth?
14. Why do you think homebirth is so uncommon in Ireland?
15. Is there anything else you want to share that I haven't asked about?