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Free-birth in Ireland

Introduction

Free-birth or unassisted birth is under researched but very many sites on the internet report stories from women who have and tips for women who are considering this choice. Newspaper articles about free-birth signal how sensational such a choice is in contemporary western culture. Several studies have investigated women's reasons for choosing to free-birth (see a meta-analysis by Feeley et al 2015). The concern on the part of maternity care professionals, obstetricians and midwives, is that the risks that professional attendance claims to monitor and to manage may present themselves as real dangers for some women. Such is the power of the professional discourse on risk in maternity services that women's choices are undermined and can be removed. As Miller (2009) has found in her analysis of the birth narratives of free-birthing women in the US, these women use the 'competing discourses of midwifery and medicine to craft a unique sense of agency in birth' (p 51) and thus reclaim what Edwards (2005) has called their 'birthing autonomy'.

Irish Maternity Services

Greater than 99 percent of approximately 70,000 Irish babies per year are born in one of 19 maternity hospitals, and attended by a midwife or an obstetrician (ESRI 2013). Four very large hospitals delivering >8000 babies/yr, three in Dublin and one in Cork, together account for almost 50% of births (ESRI 2013). Antenatal care is offered by the maternity hospitals but for very many low risk women AN care is shared between the hospital and their GP. This shared antenatal care and limited number of postnatal mother and baby visits are funded through the Health Service Executive (HSE) mother and infant care scheme MICS, from the primary and community care budget. Overall intervention rates in labour are high with spontaneous vaginal deliveries nationally at 56.3% and delivery by caesarean section 28.1% in 2012(ESRI 2013).

Irish Home birth services

The Irish Supreme court in 2003 ruled that the HSE could not be obliged to provide home birth choice to women. In 2013 the High Court again supported the HSE's denial of midwifery attended home birth to a woman who had had a previous caesarean section. The HSE's 'National Home Birth Scheme' is dependent entirely on the services of a small number (about 20 mostly part time) Self-employed community midwives (SECMs) who will indemnify their practice only for the lowest risk women. Without clinical indemnification midwifery attendance at birth has recently been criminalised (Nurses and Midwives Act 2011) so these SECMs can no longer attend higher risk women. The Irish Home Birth Association (HBA) report demand for homebirth to be eight times greater than current capacity. Anecdotally free-birthing is on the increase but the HSE has no mechanism either for recording unmet homebirth requests or free-births other than including them as BBA (born before arrival).

Methodology

Following an online survey into unmet demand for homebirth (Kenny and OBoyle 2014) Unassisted home birthers were invited to interview. Their stories were explored for common themes and are presented here as instrumental cases (Stake 1995) in understanding the wider 'case' of Irish home birth services.
Ethical approval was granted by Trinity College Dublin (TCD) faculty of Health Sciences Research Ethics Committee.

(References can be sourced by email from the author coboyle@tcd.ie)

Demographics	Case One	Case Two	Case Three	Case Four
Age	Early 30s	Mid 30s	Mid 30s	Early 30s
Ethnicity	White Middle European	White Irish	White Irish	White Irish
Marital Status	Married	Married	Married	Partnered
Urban /Rural	Urban	Rural	Rural	Rural
Parity / previous birth History	P2	P3	P3	P3
Mode del	SVD, Epidural, Hospital Ireland	SVD Home Ireland, SVD Home Ireland	SVD, MLU UK, Water for labour SVD Home birth in water (Netherlands)	SVD, Epid & augment, Hosp. Ireland SVD, MLU N.Ireland.
AN care arrangements THIS pregnancy	GP shared care	SECM, Declined Antibiotics in pregnancy	GP shared care AN hospital booking	GP Did not attend (DNA) later appts, Booked in Hospital, DNA
IN persons present THIS birth	partner, female friend	partner	partner	mother in law, sister, partner
IN care arrangements For THIS birth	Doula herself, 'Didn't decide 100%,' 'Thinking of HB', 'Wait and see'	'Hoping all would be Ok for HB', 'Thinking about going it alone',	'It was designed to a certain extent and an accident at the same time we just dilly dallied a bit much, when the birth came.'	''it was, you know, kinda planned and it wasn't planned''
PN care arrangements for THIS baby	Ambulance to Hospital for Birth notification & perineal suture. Discharged to PHN care	SECM	Ambulance to Hospital. Birth notification (registered as Hospital birth until corrected). PHN care.	GP locum visit post delivery.
Reason for choosing Free-birth	Not suitable for Home birth scheme Hepatitis C.	Not suitable for Home birth scheme. Group B Strep. during pregnancy. Keen to avoid routine ABs	Unable to access SECM / none unavailable. Aversion to hospital intervention	Unable to access SECM, primarily due to distance (perhaps not suitable due to possible history of shoulder dystocia)

Reasons for free-birthing same as for home birth	Wanted a midwife but couldn't get one	Dependence on emergency services	Non-disclosure	Risk, Blame and self blame
• Poor past hospital experience physical (interventions) / relational (routines , control) / concern about infection risk • Previous out of hospital experience • All multiparous - belief in self to birth • Expectant of normality	• No home birth service in area • Too few SECMs - busy or far away • SECM effectively forbidden to attend by lack of indemnity outside narrow HSE criteria	• Ambulance, GP or Hospital • Needed health professional for Birth notification / registration	• Expressed or anticipated anti-home birth free-birth attitude from others • Unsure about legal status • Anxious not to disclose free-birth attendants /'enablers'	• Seemed informed about risk • Awareness of but non focus on poor outcome for self and baby • No fetal monitoring in labour other than feeling well in self

Discussion

That these women had wanted a midwife attended home birth, and their motivations for out of hospital birth match those of home birthers (Jansen et al 2009) is not unexpected given they were accessed through a home birth survey. There are clearly insufficient midwives to provide home birth support even for those eligible within the home birth scheme (case three). Case four reports distance from the midwife as being a factor but, as with cases one and two, HSE restrictions of their service to the very lowest risk women leaves some women, even with recognised risk factors, to consider free-birth as their only out of hospital alternative . Their decision is a explicit critique of the quality of hospitalised birth. These women, being mulitparous women, have lived experience of their ability to birth. There may be primiparous women and other women who would prefer to have no attendant but there is no formal documentation of unassisted birth in Ireland. These four cases however demonstrate that unassisted birth are happening in Ireland. These case are instrumental in revealing the larger context of maternity services and in particular the 'case' of home birth services in Ireland. The nominally 'national' HSE home birth service is clearly inadequate and inequitable. It is dependent upon too few, privately contracted, midwives whose professional autonomy has been severely restricted by the HSE imposed terms of their indemnification. One woman (case two above) had planned a home birth with a self-employed midwife but when it was discovered she had a group B streptococcal infection, she became ineligible for a midwife attended home birth. The midwife felt obliged to withdraw from planned attendance in labour. The woman decided that as protocol s in her hospital did not allow for conservative management of her and her baby, she would birth at home unattended.

Without a midwife in attendance, these women depended upon the emergency services should they require assistance. They were not unaware of possible risks to themselves and their babies indeed were very aware of an atmosphere of disapproval and likely blame for their decisions should problems arise. This and uncertainly with regard to the legality of unattended birth (it is not illegal) or the legal status of their non professional birth attendants , therefore meant they needed to conceal their decision and 'excuse ' the outcome.

Conclusion

Each of these cases where women wanted but could not access midwife attended, out of hospital birth, stand as an indictment of Irish maternity services, revealing again that women's choice is not a primary service priority in Ireland. Worse, it reveals that the HSE's risk management priority in home birth is apparently the avoidance of financial liability rather than the management of clinical risk. By abdicating their responsibility to 'serve' women they leave the responsibility, liability and frankly, the blame for unfortunate birth outcomes to women themselves. As the AIMS Ireland blog has pointed out Ireland is 'no country for pregnant women'. The Department of Health must reconsider Irish maternity services to make them responsive to women's needs and choices ; responsive to the care needs of all women not just the high risk. There is potential for this in the recently convened Maternity Strategy Steering Group. The HSE may then, in its turn, be directed to facilitate rather than resist the international evidence in favour of providing Irish women with a variety of appropriate of models of care. Midwives then too, rather than being restricted in their autonomy, should be enabled and supported in their role as lead health professional in normal birth, wherever the women should choose to birth.