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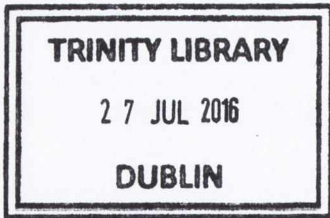
Appendix 1:
Memorandum of Understanding (MOU) (2008 and 2014)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Heads of
Memorandum of Understanding
between
Health Service Executive
and
Self-employed Community Midwife

This Memorandum of Understanding (MOU) is hereby made and entered into by and between the Health Services Executive (HSE) and the Self employed community midwife (SECM)

Purpose

The purpose of the Memorandum of Understanding (MOU) is to formalise arrangements between the HSE and the Self employed community midwife (SECM) relating to the provision of Self employed community midwifery services to eligible expectant mothers wishing to avail of such a service. This MOU does not purport to create an employer/employee relationship and in this regard the SECM retains and maintains her/his independence.

Duties of the HSE

The HSE has established guidelines and a clinical governance framework for the provision, control and supervision of community midwifery service to be provided by Self employed community midwives (SECM).

Each Self employed community midwife who agrees to be bound by the terms of this Memorandum of Understanding and its Schedules is covered by the Clinical Indemnity Scheme (CIS), operated by the State Claims Agency for clinical negligence or medical malpractice arising from the provision of community midwifery services.

On this basis, each Self employed community midwife can avail of insurance cover provided to the HSE by Irish Public Bodies Mutual Insurances for employer's liability and public liability.

Qualification/Experience required for a MOU

Registration in the midwives division of the register of An Bord Altraniais, operating within its code of practice and having up to date experience in all aspects of normal midwifery care.

Experience in a midwifery setting for a minimum period of more than three years.

Required to be up to date in safe clinical practice.

Duties of the Self employed community midwife

Each Self employed community midwife agrees to be bound by this Memorandum of Understanding and will adhere to the contents of the schedules in relation to agreed mechanisms for the provision, control and supervision of their practice regarding the provision of Community Midwifery Services to eligible expectant mothers and to mothers and their babies for the agreed period during and after birth.

The Service

Domiciliary Midwifery Services provided by an Self employed community midwife are such services as can appropriately be given by the SECM and which the SECM, having conducted a Risk Assessment, has established that it is safe to provide such services, the provision of which are not contra-indicated.

Schedules

The following schedules form part of this MOU:

Schedule 1	Contact Details
Schedule 2	Consent
Schedule 3	Professional Conduct and Practice
Schedule 4	Performance Management & Reporting
Schedule 5	Risk Management / Incident Reporting
Schedule 6	Funding/ Payment Arrangements
Schedule 7	Continuing Education and Training / Professional Development
Schedule 8	Dispute Resolution
Schedule 9	Termination

Schedule 10 Service User Centred Care

Schedule 11 Complaints

Schedule 12 Information

Schedule 13 Service Review Mechanism and Change Control

Commencement Date & Duration

The commencement date for this MOU is ______________(Insert Date)

The duration of this MOU is _________________(Insert Date) **or until a revised National MOU is operational.**

Signed by:

For and on behalf of

Health Service Executive Date:

Signed by:

Self employed community midwife Date:

Schedule 1 Contact Details

This schedule sets out the respective contact names, numbers, etc. to be used in the event of notifications under the Memorandum of Understanding.

Please include midwives registration details

Both parties to complete

SECM Name:______________________________

Address:____________________________

____

____

SECM

Telephone:_________________________

Mobile:____________________________

E-mail:____________________________

P.I.N.:______________________________

Date:_________________________

HSE

Telephone:_________________________

Mobile:____________________________

E-mail:____________________________

Schedule 2 Consent

An informed consent must be made and signed by the expectant mother. It should then be signed by the SECM. The consent should not be given by the expectant mother or accepted by the SECM unless the expectant mother has received, read and understands the contents of the following documents:

- *Information For Expectant Mothers Choosing A Home Birth;*

Risk Factors That Identify Women Who May Be At Risk For A Home Delivery;

> *Tables 1 and 2 outline risks suggesting planned birth at an obstetric unit*
> *Tables 3 and 4 outline conditions that will require assessment by a consultant obstetrician*

Indications For Transfer To Hospital Obstetric Service;

- *Your Service Your Say* – HSE Comments and Complaints Policy

- *The Consent Form*

Schedule 3 Professional Conduct and Practice

Participating Self employed community midwives must adhere to the relevant statutory requirements and to operate within the directions of An Bórd Altranais including:

- *Nurses Act, 1985*
- *The Code of professional Conduct for Each Nurse and Midwife* (April 2000)
- *Guidelines for Midwives* (3rd Edition – September 2001).
- *Guidance to Nurses and Midwives on Medication Management. (June 2003, July 2007)*
- *Recording Clinical Practice Guidance to Nurses and Midwives. (June /November 2002)*
- *Any Guidelines issued by the HSE. E. G. Clinical governance pathway of care*

Schedule 4 Performance Management & Reporting

This schedule sets out the mechanisms to be agreed in relation to performance management, periodic reporting arrangements., minimum data set, performance indicators, record keeping , etc.

Each Midwife will keep records as outlined in the Clinical Governance Pathway of Care and any other records as prescribed by the HSE.

Each midwife will participate in peer review mechanisms as prescribed by the HSE.

Each midwife will participate in Clinical Audit as prescribed below.

A national record / audit of planned home births is required so as:

- to describe the outcome in terms of maternal and fetal wellbeing of planned, intended home births
- to describe the outcome in terms of maternal and fetal wellbeing of planned, intended home births that are transferred for hospital care antenatally, intrapartum or postnatally
- to describe the outcome of planned, intended home births having adhered to or not adhered to selection criteria

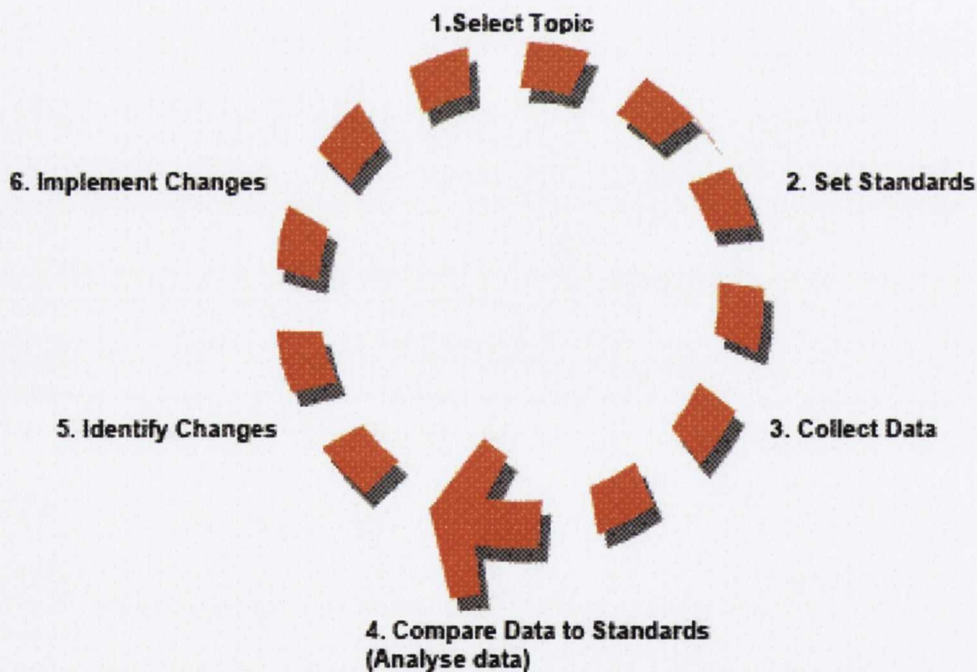
- to ascertain the geographical distribution of planned home births and their distances from maternity hospitals

1.1. Audit System and Audit Tool for Review

Purposes of the audit and review

1. To ascertain is there adherence to the national evidence based guidelines, protocols and standards including selection criteria
2. To change practice where new evidence is produced or made available.

Audit Cycle



Requirements for this audit and review

Audit tool which will audit the national evidence based guidelines, protocols and standards including selection criteria

Procedure

Each midwife will use the audit tool for each home birth. The audit tool is applied to the case notes of each home birth. At the end of the year the

midwife will collate the data and forward the collated data to a national database. An annual standard collation sheet will be used by each midwife. Change to the guidelines/protocols/standards will be agreed by the HSE.

National Audit Tool Completed for Each Planned / Booked Home Birth

Area	**Case 1**	**Case 2**	**Case 3**	**Case 4**	**Case 5**	**Case 6**
Date						
Intended place of Birth						
HSE Midwife / Independent Midwife						
*Selection Criteria as per Guidelines						
Reasons for Antenatal Transfer						
Reasons for Hospital Transfer in Labour						
Actual Place of Birth						
Breastfeeding						
*Maternal Risk Factors identified						
*Fetal Risk Factors Identified						
Reasons for Postnatal Transfer						
*Abnormal Maternal Outcomes						
*Abnormal Fetal outcomes						
*Issues that need Consideration						

* Please identify any selection criteria not adhered to and provide documented evidence to support why not adhered to
* List of possible maternal risk factors identified
* List of possible fetal risk factors identified
* List of abnormal maternal outcomes
* List of abnormal fetal outcomes
* Issues that need consideration, i.e. competency development/peer review issues identified/service issues

Annual Collation Sheet

Number of Births	
Selection criteria not adhered to (list)	
Reasons for transfer to hospital antenatally (list)	
Reasons for transfer to hospital in labour (list)	
Maternal risk factors identified (list)	
Fetal risk factors identified (list)	
Reasons for transfer to hospital postnatally (list)	
Abnormal Maternal outcomes (list)	
Abnormal Fetal outcomes (list)	
Number Breastfeeding • Initially • Three months • Six months	
Number Artificial feeding	
Issues that need peer review/reflection (list). Attach sheet with summary and outcomes.	
Changes needed to guidelines/policies/protocols. Outline stage change at.	

Schedule 5 Risk Management / Incident Reporting

This schedule sets out the requirements of the HSE, Clinical Indemnity Scheme and Irish Public Bodies Mutual Insurances in relation to risk management, adverse incident reporting etc

1 **Risk Management**

1.1 The SECM shall promote a positive and supportive culture for the optimum management of all aspects of healthcare risks in accordance with current best practice.

1.2 The SECM will work to enhance Service User safety through systems to identify and learn from all Service User safety and other reportable incidents, and will make improvements in practice based on information derived from the analysis of incidents and local and national experience.

1.3 The SECM will co-operate with the HSE Risk Management Process and provide such information as is requested for the HSE Risk Register and where appropriate provide timely reports to the Clinical Indemnifiers STARS WEB system.

1.4 Should the SECM identify any area of concern, or serious untoward incidents arising in connection with the Services or any related matter, she/he will notify the Executive in writing, giving reasonable details of the issue and setting out the steps that will be taken to eliminate the risks identified.

1.5 The SECM must ensure that any requirements of their insurers in relation to risk management are complied with.

Schedule 6 Funding /Payment Arrangements

This schedule sets out details of the scale and scope of payments broken into relevant components to cover full and part-fulfilment of the provision of Midwifery services to the mother and the mechanism for the annual review and/or increase to fees on the basis of an agreed index compiled by the Central Statistics Office.

- All payments are subject to Professional Services Withholding Tax (PSWT) in accordance with requirements under tax law

- Payment will be made by HSE directly to the SECM on receipt of all completed documentation including a request for payment.

- Payment will be made by HSE directly to a second SECM on receipt of a confirmation that a second SECM attended at the birth including a request for payment

- Fees will be increased from 1st January each year based on the Consumer Price Index

Fee Schedule		**FEE**
1. A complete service	(11 visits including birth visit)	€2400.00

Deductions will apply as follows:

- Deduction for each consultation less than 11 €140.00
- Non-attendance at Birth €1000.00
- Client transferred to hospital during labour accompanied by the Midwife €70.00
- Client transferred to hospital during labour unaccompanied by the Midwife €140.00

Travelling expenses for seven (7) domiciliary visits as per public service scheme to a an 80 mile round trip maximum

When SECM is accompanied at the birth by a second SECM an all inclusive fee of €160.00 will apply.

Schedule 7 Continuing Education & Training / Professional Development

This schedule sets out mandatory and optional requirements in relation to a process of continued lifelong learning by Self employed community midwives covering areas such as: continuing education and training; practice skills and professional development.

1. Practicing midwives have a professional responsibility to be competent practitioners whose practice is supported with best evidence information. All midwives should be able to provide evidence of continuing professional development and updating of knowledge applicable to midwifery practice to a nominated HSE officer or any other body who requires this information.

SECMs are required to undertake:

a. Maternal and neonatal resuscitation programmes for all registered midwives involved in providing midwifery care to women and their families should be undertaken on a **minimum** of a two yearly basis. (CESDI 2001, NRP 2006)
b. Attendance at emergency drills, should be undertaken as required to maintain competence and should include:
    i. Antepartum haemorrhage
    ii. Postpartum haemorrhage
    iii. Shoulder dystocia
    iv. Management of cord accidents
    v. Breech birth
    vi. Eclampsia
c. Education and training on CTG interpretation should be undertaken on a regular basis for midwives who use this mode of fetal monitoring. (RCOG 2001)

Schedule 8 Dispute Resolution

1 Dispute Resolution

1.1 The parties to this MOU agree to avoid disputes and deal with conflicting issues as they arise. It is expected that any conflicts in relation to this service shall be resolved through direct discussion between representative(s) managing this service on behalf of the HSE and the Self employed community midwife.

1.2 In the event of any dispute between the Self employed community midwife and the HSE arising out of or in connection with this MOU (which shall be evidenced by one party serving on the other a Dispute Notice, setting out in reasonable detail the matter(s) in dispute) the parties hereby agree subject to clause 1.4 to resolve any dispute in accordance with the dispute resolution process set out below:

(a) **Stage 1**

In the event of a dispute arising out of or in connection with the service, a designated representative of the HSE and the Self employed community midwife will meet within seven (7) days of the date of the Dispute Notice to endeavour to resolve the issue within a further fourteen (14) day period from the date of the said meeting. In the event that the issue is not resolved within the said fourteen (14) day period (or other such period as is agreed in writing between the parties) then the parties shall immediately progress to Stage 2, as set out below in Clause 1.2(b).

(b) **Stage 2**

A meeting shall take place between the designated representative(s) of the HSE (not being the representative involved in Stage 1) and the Self employed community midwife, to discuss resolution of the issue. In the event that the issue is not resolved,

within twenty (20) business days from the commencement of Stage 2 (or such other period as is agreed in writing between the parties) then the parties shall immediately progress to Stage 3, as set out below in Clause 1.2(c).

(c) **Stage 3**

If the dispute remains unresolved as between the parties after the completion of Stage 2 then the Self employed community midwife may request the HSE to refer the dispute for full and final resolution to arbitration. If the HSE agrees to refer the matter, the arbitrator shall be nominated by agreement in writing between the parties. In the event that agreement on the appointment of an arbitrator cannot be reached between the parties within fourteen (14) days of the commencement of Stage 3 (or such other period as is agreed in writing between the parties), then the parties hereby agree that the arbitrator shall be appointed by the President of the Law Society of Ireland for the time being.

(i) The arbitration shall be governed by Irish law and by the provisions of the Arbitration Acts 1954 to 1998, and any re-enactment, adaptation, amendment or extension of same for the time-being in force;

(ii) The award of the arbitrator shall be final and binding on both parties;

(iii) The arbitrator shall have power to determine all disputes arising out of or in connection with the Scheme between the parties;

(iv) The seat of arbitration shall be Dublin, Ireland and the language of the arbitration shall be English.

1.3 Arbitration of any dispute arising out of or in connection with the service shall not prevent or delay in any way

performance of its obligations under this service by the Self employed community midwife in accordance with the terms of the service, unless otherwise agreed between the parties, and should a dispute occur, the Self employed community midwife must ensure that Services to Service Users will not be affected.

1.4 The HSE may refuse to proceed with the dispute resolution process set out at 1.2 in any case where the HSE deems the matter frivolous, vexatious, without substance, an abuse of process or adequately dealt with and the HSE shall notify the Self employed community midwife in writing accordingly.

2.0 The provisions of Clause 1.1 to 1.4 inclusive shall be without prejudice the HSE right to withdraw from and terminate the dispute resolution process at any stage.

3.0 The provisions of Clause 2 shall be without prejudice to any other rights of the parties pursuant to this service.

4.0 The provisions of Clauses 1.1,1.2 and 1.3 shall be without prejudice to the HSE's right to terminate the MOU pursuant to Schedule 9.

Schedule 9 Termination of M. O. U.

1 Termination

1.1 In the event of a serious breach of the performance of the service by the Self employed community midwife, which shall be determined at the sole discretion of the HSE, the HSE reserves the right to terminate the service with immediate effect.

1.2 If the HSE exercises its right to terminate this service, the HSE will within a period of forty-five (45) days pay to the Self employed community midwife reasonable and agreed costs accrued to the date of termination, but if this service is terminated by the HSE on the grounds that the Services provided are unsatisfactory, the HSE shall pay to the SECM only the proportion of the Funding which is in respect of the

Services provided prior to termination which meet a standard, which is in all respects to the reasonable satisfaction of the HSE.

1.3 The HSE shall not be liable to the Self employed community midwife for any loss of profit, contracts, goodwill, business opportunity or anticipated saving arising out of or in connection with the termination of this service for any reason or any consequential loss or damage that may arise out of termination of this service.

1.4 Termination of this service for any reason shall be without prejudice to the rights and remedies of either party in relation to any negligence, omission or default of the other party prior to termination.

1.5 In the event of termination of this service for any reason, the provisions of this service shall continue to bind each party insofar as and for as long as may be necessary to give effect to their respective rights and obligations.

1.6 Upon termination of this service, the Self employed community midwife will continue to care for any service User who is receiving services on the effective date of termination until such time that the service User can be discharged or transferred to another SECM or facility. The terms and conditions of this service will remain in effect for services provided to each such service User until discharge or transfer.

Schedule 10 Service User Centred Care

1 Service User Centred Care

1.1 The Self employed community midwife will provide the services to Service Users without discrimination on account of gender, marital status, family status, age, race, religion, disability, sexual orientation, membership of the traveller community.

1.2 All Service Users shall be treated by the Self employed community midwife equitably. The co-existence of public

and private practice within the public system shall not undermine the principle of equitable access.

1.3 The organisation, design and delivery of the service shall be centred on the Service User and their families.

1.4 The HSE and the Self employed community midwife are commited to protecting Service Users, whose safety is of paramount importance.

Schedule 11 Complaints

The HSE's Comments & Complaints Policy, *Your Service Your Say*, applies to this service. Each participating expectant mother will be given a copy of the Policy document by the Self employed community midwife before the commencement of the provision of services by the SECM.

Schedule 12 Information

1 **Information and Confidentiality**

1.1 The HSE shall provide to the SECM such documentation and other information in the possession of the HSE as may be reasonably required to enable the SECM to fulfil her/his obligations pursuant to this MOU but any such documents or information shall remain the property of the HSE.

1.2 Each party will ensure that any information acquired in or in connection with the performance of its obligations under this MOU concerning the other or the other's business, affairs, staff or procedures or relating to the provisions of this MOU and any negotiations or disputes between the parties to this MOU will be treated as confidential and will not be disclosed to any person, other than a person expressly authorised by either party.

1.3 Upon the termination of this MOU the SECM will ensure that she/he holds, manages and transfers all confidential information she/he has received or prepared in connection with its obligations under this MOU in whatever format it is held in accordance with all legal and regulatory requirements.

1.4 Either party may disclose information which would otherwise be confidential:

(a) if and to the extent required by law or for the purpose of any judicial inquiry or proceedings;

(b) if and to the extent required by any regulatory or governmental authority to which that party is subject or submits, wherever situated, whether or not the requirement for information has the force of law;

(c) if and to the extent necessary or desirable for the conduct of any arbitration pursuant to Schedule 8.

(d) to its professional advisers, auditors, bankers and insurers;

(e) if and to the extent the other party has given prior written consent to the disclosure, such consent not to be unreasonably withheld or delayed; or

(f) if necessary for the HSE to meet its obligations.

1.5 Any information to be disclosed pursuant to Clause 1.4 (a) to (g) shall be disclosed only after notice to the other party.

1.6 The provisions of this Clause shall continue to apply notwithstanding the termination of this MOU for any reason.

Freedom of Information

1.7 The SECM hereby acknowledges and agrees that the Freedom of Information Act, 1997 & 2003 (the "**Acts**") applies to the HSE.

1.8 In the event that any information or materials held or prepared by the SECM are the subject of a request for information under the Acts the SECM will procure that any such materials are supplied promptly to the HSE for disclosure.

1.9 The Acts offer certain procedural protection for some categories of information and the SECM hereby agrees to clearly identify any information or records which she/he considers to fall within such categories at the time of provision to the HSE, stating the relevant category and the

reason why it is believed that the document or information falls within that category.

1.10 Notwithstanding Clause 1.9, the SECM hereby acknowledges that the categorisation of the information by the SECM shall not be final or binding on the HSE and that disclosure may be permitted by law notwithstanding such categorisation.

1.11 Unless stated otherwise by the SECM when the relevant document or information is provided to the HSE, it will be assumed that such document or information is eligible for disclosure under the Acts.

1.12 The HSE shall have no liability for any disclosure made by it in accordance with the requirements of the Acts.

Data Protection

3.1 Both the HSE and the SECM shall have regard to their statutory obligations under the Data Protection Acts 1998 and 2003 ("DPA").

3.2 The SECM undertakes to ensure that she/he has all consents, authorisations and permissions necessary to enable the SECM to access and disclose any personal data of a Service User, to the extent that the SECM may require access to or the ability to disclose such data in the lawful performance of her/his functions.

3.3 The SECM hereby undertakes to comply with her/his obligations under the DPA and to indemnify the HSE against any loss, compensation, damages, expenses and costs which become payable or are incurred by the HSE in respect of or as a result of a breach by the SECM of this clause or a breach of the DPA.

3.4 Where personal data regarding Service Users is given by either party to the other for the purpose of this Agreement, it shall be used solely and exclusively for the purposes for which it is expressly provided and for other purposes permitted by law.

4 Information Requests

4.1 The Self employed community midwife will comply with all requests by the HSE and by any committees of the Board of the HSE to supply information and such requests may include without limitation information required by reason of, or relating to or arising out of:

- Parliamentary Questions;
- Freedom of Information Requests;
- Responses to complaints from Service Users and/or advocates;
- The compilation of statistical data in relation to the Service or Service Users.

Schedule 13 Service Review Mechanism & Change Control

This schedule sets out the agreed annual review mechanism and the methodology for agreeing and documenting changes.

The Regional committee/steering group will have responsibility for the review mechanism.

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is executed on the [ ] day of [ ] 201_ between:

HEALTH SERVICE EXECUTIVE, statutory body established under the Health Act 2004 and its successors (the "**HSE**"); and

[Details to be inserted] of [address].

1. **Context**

The purpose of this Memorandum of Understanding is to provide a framework for the HSE and self-employed community midwives to facilitate choice for women in relation to home birth whilst addressing the overarching concern for safety of both mother and child. The HSE is committed to a person centred, integrated model of service delivery which is evidence based and works to current best practice standards of clinical care and customer focus, notwithstanding that where the HSE makes midwifery services available at a hospital or maternity unit within its regional area, there is currently no statutory obligation on the HSE to make midwifery services available in any other place.

In the context of the Health Acts 1947 to 2011 (as amended from time to time), the Nurses Act 1985, the Nurses and Midwives Act 2011 and any regulations made under any of the foregoing legislation and taking account of the Domiciliary Birth Report 2004 and Delivery on choice; Homebirth options for women in Ireland Report 2008, this Memorandum of Understanding sets out the objectives, responsibilities and governance arrangements underpinning the delivery of planned home birth services for expectant mothers provided by self-employed community midwives.

This Memorandum of Understanding, the home birth service agreement and the individual home birth application / consent will be informed by the principles of good corporate governance, transparency and fairness for the mutual benefit of all parties.

In addition, this Memorandum of Understanding, the home birth service agreement and the individual home birth application / consent do not preclude either party from entering into similar memoranda of understanding with other interested parties insofar as no conflict of interest arises.

2. **Definitions and Interpretation**

"CESDI"	means the Confidential Enquiry into Stillbirths and Deaths in Infancy Report;
"expectant woman"	means a low risk healthy pregnant woman who wishes to be provided with a home birth service and who meets the suitability criteria for home births set out in Schedule 2;
"Health Service Executive" or **"HSE"**	means the statutory body established under the Health Act 2004 and its successors:
"home birth service"	means [the provision by a self-employed community midwife of midwifery services to expectant women from the date of first consultation by the HSE approved self employed community midwife up to 14 days

post delivery, in accordance with a home birth service agreement];

"home birth service agreement" means the contract between the HSE and a self-employed community midwife in respect of a home birth service to be provided to an expectant woman;

"individual home birth application / consent" means the application/consent made to the HSE by each expectant woman who chooses to have a home birth in the form set out at Schedule 1 to the home birth service agreement; and

"self-employed community midwife" means a midwife who is self-employed and works independently in the community and may enter into a contract with the HSE in respect of the provision of a home birth service.

References in this Memorandum of Understanding to a statute or statutory provision shall be construed as a reference to the same as it may have been, or may from time to time be, amended, modified or re-enacted. References in this Memorandum of Understanding to Bord Altranais agus Cnáimhseachais na hÉireann or the HSE shall be construed as a reference to the same or any successor body.

Any phrase introduced by the terms "**including**", "**include**", "**in particular**" or other similar expression shall be construed as illustrative and shall not limit the sense or meaning of the words preceding those terms.

3. **Principles Underpinning the Memorandum of Understanding**

The principles which underpin this Memorandum of Understanding are as follows:

3.1 the guiding principle is the identification of safe, acceptable and feasible options of maternity care, which are woman centred, facilitate choice and continuity of care and which promotes partnerships and supports professionals involved in the service delivery;

3.2 homebirth is a safe option for expectant women; and

3.3 a safe outcome for the mother and baby is paramount.

4. **Scope**

The parties shall co-operate with each other in relation to the provision of a home birth service for expectant mothers, without cost to the expectant woman, in accordance with the provisions of this Memorandum of Understanding subject at all times to acting in the best interests of the expectant woman whilst fulfilling the service requirements and statutory remit of the HSE and the professional, statutory and contractual requirements of the self-employed community midwife.

5. **Legislative Framework**

The parties recognise the legislative requirements under the Health Acts 1947 to 2011, the Nurses and Midwives Act 2011 and regulations made under the foregoing legislation and undertake to operate in accordance with such legislation.

Nothing in this Memorandum of Understanding and no action taken by the parties pursuant to it shall constitute, or be deemed to constitute:

(a) a partnership, association, joint venture or other co-operative entity between any of the parties; or

(b) any party the agent of any other party for any purpose.

Neither party has, pursuant to this Memorandum of Understanding or otherwise, any authority or power to bind or to contract in the name of the other party to it. Nothing in this Memorandum of Understanding shall be deemed as a representation, warranty or commitment by the HSE that any person has an entitlement to be provided with, or paid for provision of, a home birth service and shall not be construed as adding to, altering or reducing, the existing rights of the parties prior to entering into this Memorandum of Understanding.

6. **Responsibilities of the HSE**

The HSE, in facilitating choice for women in relation to home birth, will endeavour to carry out its responsibilities under this Memorandum of Understanding within the following parameters:

(a) develop a person centred, integrated model of service delivery which is evidence based and in line with best practice standards of clinical care and customer focus;

(b) develop appropriate guidance and a governance framework (inclusive of clinical governance) for the control and supervision of midwives who are operating as self-employed community midwives;

(c) develop guidelines and information packs for women to assist them in making an informed choice about home birth;

(d) provide information and birth packs to expectant mothers;

(e) work with relevant stakeholders in the development of home birth services for expectant mothers;

(f) promote and encourage collaborative initiatives in relation to the ongoing development of home birth services;

(g) develop and implement quality assurance and clinical audit programmes for home births;

(h) extend the Clinical Indemnity Scheme to self-employed community midwives who have signed a home birth service agreement with the HSE;

(i) develop and maintain a database of self-employed community midwives; and

(j) enter into contracts with self-employed community midwives in respect of the provision of a home birth service.

7. **Responsibilities of Self-employed Community Midwife**

Every self-employed community midwife, in providing a home birth service to expectant women, will carry out his/her responsibilities under the home birth service agreement and this Memorandum of Understanding with due care and skill to the highest professional standards within the following parameters:

(a) provide the HSE with evidence of their current registration in the Midwives Division of the Register of Nurses and Midwives held by Bord Altranais agus Cnáimhseachais na hÉireann;

(b) provide the HSE with a signed statement confirming that the self-employed community midwife complies with Bord Altranais agus Cnáimhseachais na hÉireann' Code of Conduct and Scope of Practice;

(c) provide the HSE with evidence of continuing professional development as set out in Schedule 1;

(d) comply with the requirements of the HSE as set out in Schedule 2;

(e) notify the HSE's designated officer in whose functional area the self-employed community midwife is practicing or intends or proposes to practice; and

(f) enter into a contract with the HSE in respect of the provision of a home birth service.

8. **Governance Arrangements**

8.1 The HSE commits to maintaining a governance framework which is reflective of its ongoing commitment to the development of a person centred, integrated model of service delivery which is evidence based and works to current best practice standards of clinical care and customer focus and is representative of relevant stakeholders (the **"Governance Framework"**). The Governance Framework seeks to balance the requirements at an operational and national level whereby necessary actions and decisions are overseen and integrated at the optimum point. The Governance Framework is as follows:

(a) National Implementation Steering Group;

(b) Clinical Governance Group

(c) HSE Designated Midwifery Officer; and

(d) home birth service agreement.

8.2 **National Implementation Steering Group**

The National Implementation Steering Group, chaired by the HSE's National Director of ISD or his/her nominee, comprises midwifery, obstetrics, paediatrics, community and managerial representatives of the HSE and non statutory agencies, a service user and a self-employed community midwife. It is responsible for the ongoing monitoring of the HSE's policies, procedures, protocols and guidelines on home birth services which is consistent with Government policy and the HSE's Service Plan.

SCHEDULE 1

Qualifications, Experience and Continuing Education & Training / Professional Development

The Self-employed Community Midwife must have a current valid registration as a midwife in the Midwives division of the Register of Nurses and Midwives of Bord Altranais agus Cnáimhseachais na hÉireann and must have relevant midwifery experience in a midwifery setting for a minimum period of three years.

The Self-employed Community Midwife will ensure that at all times, he/she has completed the requisite programmes set out below and will provide evidence of same to the HSE upon request:

The Self-employed Community Midwife is required to:

(a) undertake maternal and neonatal resuscitation programmes for all registered midwives involved in providing midwifery care to women and their families on a **minimum** of a two yearly basis (CESDI 2001, Neonatal Resuscitation Programme 2006);

(b) attend at emergency drills as required to maintain competence including:

(i) antepartum haemorrhage;

(ii) postpartum haemorrhage;

(iii) shoulder dystocia;

(iv) management of cord accidents;

(v) breech birth; and

(vi) eclampsia; and

(c) undertake education and training on Cardiotocograph (CTG) interpretation on a regular basis where self-employed community midwives use this mode of foetal monitoring (RCOG 2001).

(d) . Moving and Handling

SCHEDULE 2

MEDICAL CONDITIONS AND OTHER FACTORS REQUIRING PLANNED BIRTH IN AN OBSTETRIC UNIT

Table 1: Medical conditions requiring planned birth at an obstetric unit

Disease area	**Medical condition**
Cardiovascular	Confirmed cardiac disease
	Hypertensive disorders
Respiratory	Asthma requiring an increase in treatment or hospital treatment or requiring steroid treatment in last year
	Cystic fibrosis
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major
	History of thromboembolic disorders
	Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100 000
	Von Willebrand's disease
	Bleeding disorder in the woman or unborn baby
	Atypical antibodies which carry a risk of haemolytic disease of the newborn
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended
	Infective Hepatitis B or Hepatitis C
	Carrier of/infected with HIV
	Toxoplasmosis – women receiving treatment
	Current active infection of chicken pox/rubella/genital herpes in the woman or baby
	Tuberculosis under treatment
Immune	Scleroderma
	Systemic lupus erythematosus
Endocrine	Diabetes
	Maternal thyrotoxicosis
Renal	Abnormal renal function
	Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy
	Myasthenia gravis
	Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current in-hospital care and / or requiring specialist care.

Table 2: Other requiring planned birth at an obstetric unit

Factor	Additional information
Previous pregnancy complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty [to be discussed with neonataologists]
	Previous baby with neonatal encephalopathy
	Pre-eclampsia requiring preterm birth
	Placental abruption with adverse outcome
	Eclampsia
	Uterine rupture
	Primary postpartum haemorrhage requiring additional pharmacological treatment or blood transfusion
	Caesarean section
	Shoulder dystocia
Current pregnancy	Multiple birth
	Placenta praevia
	Pre-eclampsia or pregnancy-induced hypertension
	Post-term pregnancy [For medical review by 42 weeks]
	Preterm labour< 37 +0
	Preterm pre-labour rupture of membranes
	Term pregnancy (37+0 to 42+0) pre-labour rupture of membranes for more than 24hrs
	Placental abruption
	Anaemia – haemoglobin less than 10g/dl at onset of labour
	Confirmed intrauterine death
	Induction of labour
	Substance misuse
	Alcohol dependency requiring assessment or treatment
	Onset of gestational diabetes
	Malpresentation – breech or transverse lie
	Recurrent antepartum haemorrhage
Foetal indications	Small for gestational age in this pregnancy (less than 5th centile or reduced growth velocity on ultrasound)
	Abnormal foetal heart rate (FHR)/Doppler studies
	Ultrasound diagnosis of oligo/polyhydramnios
Previous gynaecological history	Myomectomy
	Hysterotomy

OTHER NON CLINICAL FACTORS TO BE CONSIDERED IN THE ASSESSMENT OF THE HOME BIRTH APPLICATION BY THE DESIGNATED OFFICER IN CONSULTATION WITH THE SELF EMPLOYED COMMUNITY MIDWIFE

These may include for example:

1. lack of a family/peer support network;
2. inadequate facilities at home; and
3. distance from the midwife or nearest hospital maternity unit

MEDICAL CONDITIONS AND OTHER FACTORS REQUIRING REFERRAL TO CONSULTANT OBSTETRICIAN BY THE MIDWIFE FOR FINAL ASSESSMENT WHEN PLANNING PLACE OF BIRTH

Table 3: Medical conditions requiring assessment by consultant obstetrician when planning place of birth

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease
	Sickle-cell trait
	Thalassaemia trait
Immune	Nonspecific connective tissue disorders
Endocrine	• Hyperthyroidism • Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities
	Previous fractured pelvis
	Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function
	Crohn's disease
	Ulcerative colitis

Table 4: Other factors requiring assessment by consultant obstetrician when planning place of birth

Factor	Additional information
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause
	Pre-eclampsia developing at term
	Placental abruption with good outcome
	History of previous baby more than 4.5 kg
	Extensive vaginal, cervical, or third- or fourth-degree perineal trauma
	Previous term baby with jaundice requiring exchange transfusion
	Retained placenta requiring manual removal in theatre
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation)
	Body mass index at booking of ≥ 35 or < 18 kg/m²
	Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions
	Clinical or ultrasound suspicion of macrosomia
	Para 6 or more
	Recreational drug use
	Under current outpatient psychiatric care
	Age over 40 at booking
Foetal indications	Foetal abnormality
Previous gynaecological history	Major gynaecological surgery
	Cone biopsy or large loop excision of the transformation zone
	Fibroids Female circumcision

Table 5: Indications for intrapartum transfer

• Spontaneous rupture of membranes > 24 hours
• Indications for electronic foetal monitoring (EFM) including abnormalities of the foetal heart rate (FHR) on intermittent auscultation
• Delay in the first or second stages of labour
• Meconium stained liquor
• Maternal request for epidural pain relief
• Obstetric emergency – antepartum haemorrhage, cord presentation/prolapse, postpartum haemorrhage, maternal collapse or a need for advanced neonatal resuscitation
• Retained placenta
• Maternal pyrexia in labour (38.0 °C on one occasions or 37.5 °C on two occasions 2 hours apart)
• Malpresentation or breech presentation diagnosed for the first time at the onset of labour, taking into account imminence of birth
• Either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart
• Uncertainty about the presence of a foetal heartbeat
• Third or fourth degree tear or other complicated perineal trauma requiring suturing

Table 6: Indications for Postpartum transfer

Mother:	Postpartum haemorrhage (>500mls) or any amount that causes the mothers condition to deteriorate
	Pyrexia (38.0 °C on one occasions or 37.5 °C on two occasions 2 hours apart)
	Concerns for psychological wellbeing
	Signs of thromboembolic disease
Infant	Congenital or genetic abnormality
	Respiratory symptoms – tachypnoea (RR>60/minute), grunting, recession
	Cyanosis, plethora, pallor
	Bile-stained vomiting, persistent vomiting or abdominal distension Delay in passing urine or meconium >24 hours
	Fits, jitteriness, abnormal lethargy, floppiness, high pitched cry
	Jaundice <24 hours

8.3 **Clinical Governance Group**

The Clinical Governance Group, *reporting to the National Implementation Steering Group* is responsible for overseeing the clinical aspects associated with the delivery of the home birth service set out in the Agreement between the HSE and SECM. The membership of Group will include key stakeholders from the maternity services both hospital and community, service and education, for example National Clinical lead for Obs/Gynae, Client representative, Bord Altranais agus Cnáimhseachais na hÉireann Midwives Committee, Clinical Indemnity Scheme, Service manager, Director of Nursing and Midwifery Director of the CNME. The Group's terms of reference include

(a) Develop the Eligibility Criteria for SECM to have their name placed on the list of midwives available to provide the home birth service on behalf of the HSE

(b) Approve the inclusion of the individual midwife onto the HSE list of SECM a review of the application.

(c) Maintain ongoing review of all methods of Competency Assurance in collaboration with Bord Altranais agus Cnáimhseachais na hÉireann for SECMs

(d) Maintain ongoing clinical review of the performance of the service

(i) Review quarterly Regional Reports

(ii) Review clinical criteria in Tables 1-6 of Schedule 2 as required

(e) Oversee the development of systems of clinical governance for home birth services

8.4 **HSE Designated Midwifery Officer**

The role of the HSE's Designated Midwifery Officer will be to monitor the provision of the home birth service provided under the home birth service agreement and to facilitate communication and co-operation between the self-employed community midwife, expectant woman and the HSE and non statutory agencies..

9. **Review**

This Memorandum of Understanding will be reviewed two years after the date of execution. In the interim any party may request a review of all or part of the operation of the Memorandum of Understanding.

10. **Statement of Date of Effect**

This Memorandum of Understanding will become operative with effect from the date of its signature by both parties.

SIGNED
For and on behalf of
Health Service Executive

SIGNED
For and on behalf of
[●]

Appendix 2:
Exemplars of Fieldnotes and Diary Entries

I have selected specific fieldnotes and diary entries in an effort to set the scene and provide descriptions of the context and social processes that informed how this study was conducted[191]. The extracts are also used to demonstrate the grounds on which the findings were made. The format of the notes varied, from bullet points and logs of conversations, to diary of observations, and written and audio-recorded personal reflections. For the most part I have transcribed the entries directly as they were written in the field or audio-recorded in an effort to remain as true to the moments of conceptualisation as is possible. I have not overly edited or been rigid in my grammatical approach but nonetheless my entries are legible.

In places I wrote with three distinct headings in mind to guide my reflections and notes; at other times my writing is more fluid.

Events: A brief description of the fieldwork **Reactions:** My feelings about the fieldwork, and my thoughts about the study participants and what the fieldwork had highlighted to me **Relevance:** How the fieldwork related to and informed this study

Although located in a separate Appendix, these reflections are central to and intertwined with my Audit Trail (Appendix 7). I have separated them solely for clarity and for the convenience of the reader.

This Appendix is divided into two parts.
Part I offers examples of extracts of Fieldnotes and Diary Entries across the research study. I have organised them in a way the mirrors the chapters as they appear in the main thesis.
Part II provides some insights into my observation of in-labour transfer.

Part I: Exemplars of Fieldnotes and Diary Entries

Chapter Two:

Section 2.4.1
Diary Entry[1]: *So I have a plan, well I had a plan; I wanted to explore women's experiences and find out what was going on when the planned a home birth but had to transfer to hospital during their labour. I was just going to go out there and ask the women, ask them what they thought, what they experienced, what happened for them, what influence this had on subsequent pregnancies ... excellent. I thought it was excellent to be honest. Talking with my supervisors raised some doubts – talking to the women would give me a great insight but would talking to the women give me a full picture? Would it truly illuminate and allow me a full exploration of the meeting of home and hospital? It wouldn't highlight the views and experiences of all those involved in an in-labour transfer ... did it need to? Would this research truly make a difference if I don't deliberate these questions? They unsettled me; I was much happier when just focusing on women. Like a petulant teenager I considered who else had the potential to be a vital informant - the SECMs of course, hospital-based midwives and*

[191] Enteries are organisted and counted within each chapter.

doctors and yes, I conceded they all needed to be heard. So now I was going to interview women, SECMs and hospital-based practitioners and they would all tell me about their experiences.

But the plan did not sit easy, something was missing, there were other parts to the puzzle that had the potential to explain the picture. I thrashed it out with a colleague and friend – she asked me "what do you need to know, what is missing in the literature"? I know about hospital birth in Ireland, how it was organised, what it offered. I have worked in the middle of it for a number of years. Home birth in Ireland, I had my own experience to draw from but I am beginning to think elements of that were far from 'typical'. I need more than this; I need to immerse myself more become more familiar with the whole culture of home birth. I need to learn about transfer to hospital not only after the event but also before the transfer. There are other questions that I needed to answer –

> *Why a home birth? Do women consider the possibility of a transfer to hospital? How do they feel about the potential of transfer? What impact does this have on the care they receive? What discussion / plans are in place with their SECMs?*

Being present during antenatal care, observing the SECMs and the women together, interacting, planning would enable me to unpick and understand some of these issues.

Chapter Five:

Section 5.4

Fieldnote[1]: *I've just been to Ríona's house observing and antenatal visit with midwife Leah. They spent such a time talking about Ríona's trip to hospital last week, it seems that it was for a haemoglobin check yet there was huge anxiety that they would insist that Ríona be screen for Group B strep (something re her previous pregnancy). It seems like this was something that Ríona and Leah had anticipated and had prepared for yet it was an issue that Ríona was not comfortable about. Before the appointment Ríona was very worried that they would "make her have it" and block her home birth if she didn't. I asked Ríona about this and she told me she felt there was no way she could go against what they said, or that would definitely put her home birth in jeopardy.*

It seemed odd to me during my observation, why would anyone block her having a home birth. But thinking back, this was not the first woman to talk of this, other women were concerned that their home birth would be "taken away" (e.g. Ailis). These women, even though they were deemed eligible according to the HSE criteria to have a home birth, were worried that someone else (i.e. obstetricians) would over-ride their choices. They believed the obstetricians to have that much influence over their choices. I though back to some of the SECMs and how they spoke of their place within the maternity system, during encounters with obstetrician how they have to "play by their rules" (Caitriona). It was really beginning to emerge from the data that the power within these interactions lay with the obstetricians.

They dictated that 'what will happen' and women and SECMs seemed to adjust their behaviour accordingly.

I have gone back to the writings of Foucault, leading me to his theories on power and knowledge. This is helping me to understand some of the processes of power at play in these interactions in the context of a culture of birth where authority remains with the opinions and views of the obstetric community.

Diary Entry[2]: *A potential participant phoned me today about the study to get some more information. She is pregnant and planning a home birth. She quizzed me up and down – who am I, what are my opinions on birth, why am I doing this study? So I told her my background, why the area interests me. She asked me, to my surprise, what my political agenda was, what bigger plan did I have. A little taken aback I reassured her that I had no political soap box that my aim was to inform the maternity services for the good of those who access them.*

But it has being troubling me – am I political? I don't think so, not in an overt way. I'll stand up for what I believe in and won't hide my opinion but I'm not the one leading the protests or writing the letters to the Minister of Health on a weekly basis. So what am I? Well, I am a midwife and therefore I want to make a difference to women's lives. I want to see what is going on during the meeting of home and hospital and see what needs to be done differently, changed, or remain the same. Does that make me political? Should that make me political?

Section 5.6

Fieldnote[3]: *Ailis and other women interviews keep talking about their interactions with midwives when they transfer to hospital (to be honest some even use the title nurse). I don't understand why this is so ... are they not meeting doctors? Sure they must be? I asked Ailis about this, I was at her transfer, a doctor was present I remember her. Ailis's reply intimated that she didn't really know who was who, everyone was wearing scrubs. This was so interesting and something that I had not considered. I know the different roles of midwives and obstetricians within the culture of hospital birth in Ireland, without any introductions or name badges I would be able to differentiate; I had not considered that others would not be in a similar position. (It also highlighted to me that practitioners obviously were not introducing themselves prior to offering care to some women). I decided during subsequent interviews to ensure that I asked a focused question in relation to the presence of doctors and midwives and if the women knew who they met in hospital.*

Fieldnote[4]: (See Section 8.7.2.3) *It was really useful that I was able to sit with Bridget and talk through all my observations of the transfer and the interpretations I made. I couldn't understand why Bridget didn't object to the doctor doing a VE and an FBS, I had assumed that this would annoy Bridget no end and that she would make her feelings known. It was interesting to hear her understanding and the fact that she viewed this as a battle not worth taking on, there were other more important ones to tackle. I suddenly became more aware of the negotiations of the SECM, how they*

choose when they are going to get stroppy and choose when to have a different approach. Bridget's explanation suggested that in her view in the grand scheme of things not causing a fuss about this meant she had more influence in the long run. This I need to look out for in other observations and in the interviews with SECMs.

Chapter Six:

Section 6.3.2

Fieldnote[1]: *If women had a bad experience during pregnancy, if they had to defend their position in relation to home birth, they dreaded any further encounters with the hospital-based staff. They assumed that all HMWs and obstetricians held the same opinion and if they transferred to hospital they would be great with "we told you so". I had not expected that this would be an issue in Ireland; I didn't think that the interactions would be so overtly unpleasant.*

Fieldnote[2]: *The observation session with Siabh and SECM Leah was disappointing; they didn't talk about transfer at all. Were they avoiding it? Is it something that they say they talk about but they don't really? What is going on? At some antenatal session they did talk of transfer at others they didn't. I asked Leah about it and made specific reference to her interactions with Siabh. Leah told me that her visits are "more organic than that Linda, we are getting to know each other over the course of her pregnancy, we talk about these things as they come up or are appropriate". This made me reflect on three very important points, 1) I need to try and observe more than 1 antenatal session between women and their SECM, 2) I need to ask the participants about prior discussions, 3) it was good to know they weren't putting on a show to meet my needs!*

Section 6.5

Diary Entry[3]: *Just "hang out" he said, just "hang out and ask them questions". Well that doesn't tell me what to do, that could be anything. Hang out and do what? I have to figure out how I'm going to gain access and I better know what I need to do if I do manage to gain access ... I won't get a second chance. I really don't see how it can be as 'simple' as just waiting and seeing what happens. I definitely need to read more about this.*

Section 6.6.1

Diary Entry[4]: (See Section 6.6.1) *Oh no, I did not like this, not one little bit. How was I going to do this? 'Just do it' they said, 'go to some births' they said, 'get the midwives to call you' they said ('they' for the most part were ethnographic researchers who were not midwives). Observation of an in-labour transfer, how was I to organise that? Ask the SECMs to call me if someone was being transferred in? Ask the hospital to contact me once they knew a woman was en route? No and no. Too vague, too self-centred at a time of possible emergency, too much to ask of the midwives, a real possibility that my study would not be a priority (naturally), and I would be forgotten, a distinct possibility that I would not get to a hospital in time. The only way around it I can see – I need to be at the homes of women, at home births, to be there if the opportunity to observe an in-labour transfer arises.*

I needed to learn about transfer to hospital not only during and after the event, I also needed to observe 'the before'.

Diary Entry[5]: *All that preparation to sign an MOU and what if at the end of it all I do not observe a home birth or a transfer to hospital? I am so concerned, how can I do an ethnographic study of in-labour transfer and yet I don't know if I will get to observe one? I feel very vulnerable; it's as if I have set out to do something that I really may not be able to do. Why didn't I just stick to interviewing participants?*

Section 6.6.3.1

Fieldnote[6]: *I've just left the Niamh's house following the birth of her baby boy. It was all so fast, I don't know if she even heard me come in as she was already in the second stage of labour. Hardly the time for me to start re-establishing consent! I talked to the SECMs and to my supervisor about this. We decided that I'll just have to use my skills as a midwife to judge an appropriate time. It's not like I'm sneaking in and the women don't know why I am there. I think it is so important that I now meet with all women after the birth of their baby, even those who birth at home. Just to re-establish that they are happy that they were in the study etc.*

Fieldnote[7]: *Writing up my fieldnotes after Lana's transfer to hospital I am thinking about my role in the field. The SECM asked me to drive; she knew my car was outside the door, that it would be quicker than waiting for an ambulance. It also left her free to go into the back of the car and support Lana. Later in the evening, after Lana's transfer and birth, (when I was at home) my husband asked me about the 'things' in the back of the car (Lana had knelt on incontinent sheets), I brushed over it – "oh, I just needed them because I had to bring the woman to hospital". "Linda, are you sure you should be doing that ... are you not there as a researcher"? Am I sure ... well I am actually, Lana needed to transfer to hospital, Bridget (SECM) wanted it to happen asap, I had the means to make that happen. I was not going to sit back with my notebook and just watch as time passed, that would have been unethical. I brought it up at the ethnography platform I attend in the UK (See Section 6.6.4). I explained what happened (I was the only midwife present) and highlighted the concerns my husband voiced re blurring of roles. The two facilitators were, once again, amused by my distress, one stated - "Linda, I don't understand your worry, what else were you to do"? The other facilitator told me I was "over-thinking" it and I just needed to "go with my gut". I am surprised that I need this reassurance in relation to my decisions in the field.*

Diary Entry[8]: *We were having a cup of coffee and just chatting about Jennifer's baby (this was our 3rd meeting). Automatically I started asking her something that was related to the aim of the study. I stopped myself short and apologised, we hadn't 'formally' started the interview yet. Jennifer was blunt in her reply "I know Linda, I know, your questions are for your study ... I'm grand about that, now relax." – I must ensure that I establish my role as a researcher without a sense of 'going on and on' about it.*

Section 6.6.4

Diary Entry[9]**:** *A day at the Ethnography Platform –*
Linda: *so she looked for meconium in the liquor and thankfully there was none there, so ...*
Group Member: *why 'thankfully'*
Linda: *because if there was then the woman would be required to transfer*
Group Members: *Why? Was this discussed? Did the woman realise that or was this just something you knew because you are a midwife? Is this something you realised but if I was there I would not even notice? Is this a significant moment of surveillance but you barely notice because it is second nature to you?*

My reflection – *there are questions I need to consider - are there other significant moments highlighting the culture of care that I miss because, for me they are just 'part of' looking after women and providing care during labour? Are there other things at home birth guided by hospital policy that I am missing because I view them as 'normal'?*

Fieldnote[10]**:** See Chapter 6, Fieldnote 2.

Diary Entry[11]**:** *It was chaotic today in Cait's house, children everywhere (her own, neighbours, nieces) loud and fun. A childminder trying to keep an eye on them all while Cait's husband sat at the kitchen table, laptop open oblivious to it all! And in the middle of it all Siofra (SECM) taking charge of tea making and finding biscuits. The antenatal visit and the midwife were just part of life in this house, we were given space, but at the same time no one wondered at us. There was no big deal, no getting to a hospital, not sitting and waiting, it was not organised to someone else's schedule. This was midwifery care organised to meet the needs of this woman – this was bespoke care. Was this a 'ah ha' moment in my thinking?*

Diary Entry[12]**:** *I must consider this in relation to the limitations of this study. There isn't anything I can about it really. I mean the women who plan a home birth obviously do so for specific reasons and they obviously are pro home birth. So there is the chance that they are participating in this study solely to promote their views on home birth. I cannot see a way to overcome this limitation.*

Fieldnote[13]**:** *the SECM asked me (for example) -*

- *to do an abdominal palpation*
- *if I had any suggestion re another position the woman would find comfortable*
- *to assess the clarity of the liquor*
- *to confirm her auscultation of the fetal heart*

Section 6.6.5.1
Diary Entry[14]**:** *Have just arrived home after a CMA meeting. Some of the members asked me about my study and where was I at. Those who had not engaged before suddenly began to ask me questions, they talked about the information I had sent them and that some of them would be interested in participating. One of them took me aside at the end of the meeting to*

apologise - "you know how it is Linda, we are so busy, I completely forgot to read what you send me .... I must look at it again tomorrow and we can talk". I beginning to feel more reassured about recruitment and this aspect of the study, hopefully all the site preparation is going to pay off.

Diary Entry[15]: *Just off the phone following a chat with SECM Y, tomorrow is Christmas Eve and no sign of X going into labour yet. We (the SECM, the woman and me) all were sure that this baby was going to arrive last week – "on the 20th" X said! SECM Y is trying to work out the logistics of cooking a turkey for 12 people if X goes into labour on Christmas morning! We had a bit of a laugh about it all, but to be honest it was more the laughter of slightly hysterical people ... nothing we can do about it, but I know it will be 'interesting' if the phone rings just as Santa Clause is assembling train sets and the like in our house. Trying to make light of it but finding it a bit of a strain ... sounds like SECM Y and X are feeling the Christmas pressure too ... but it did help to talk out loud to the others who are on the same page.*

Diary Entry[16]: *I'm in!*

Fieldnote[17]: *And so with contractions Iseabeal pushed, and she passed poo and did all those physiological parts of having a baby. She swayed and clung on to her husband, and the SECM stayed near and as her torch shone in a way that allowed us to see but didn't interfere with the lighting arrangements made by Iseabeal, we saw the baby's head appear and disappear and with another contraction crown. And the baby's head was born and came into the world, and then without restitution the shoulders with a funny birth of the posterior shoulder first with the baby's hand alongside the head and the body did a funny – what we later called a birth dance – it came to a point almost of the mid tummy and then no more and had to be guided by the SECM and I moved near and watched her face and waited for any sign that we needed to do something. And Iseabeal took the baby and he cried ... it was all very fast and very amazing. Amazing in that it just happened, why wouldn't it happen ... what was I expecting, I don't know it just all amazed me. Had I forgotten that it could be this simple but yet this spectacular?*

*I love it, I see and hear midwifery. I see women and SECMs working together to meet and support normal birth. In the middle of this I need to ensure that my amazement does not become a biased belief, after all one model of care does not fit for all women! *see Chapter 8.*

Section 6.7.4

Fieldnote[18]: See Fieldnote[7 (Chapter 6)]

So we got to the hospital and I had to find some place to park the car, I couldn't just abandon it outside the door of the hospital. I found this frustrating – I was missing the initial arrival into the labour ward and the initial interactions between women and hospital staff. There was nothing I could do about it; this was the reality of translating ethnography from paper to the research field. On the plus side by the time I arrived into the labour ward the staff were expecting me. When I arrived in they came up to talk to me thus providing an opportunity to introduce myself in the context of my research study and establish if anyone wanted to opt-out or had an

issue with my presence. They invited me to observe from a central position in the ward, where I could see all the events that were unfolding. With all my preparation and field work, this was as near as I could get to the interactions at transfer. In the field this did not concern as I felt in the middle of all that was going on. After, when writing up my notes I initially felt slightly deflated, I felt that maybe I should have tried to organise this observation in a different manner. I spoke at length with the SECM in relation to this, she could not suggest an alternative approach as she felt it was vital that I drove. Having said that when I looked at my notes in relation to the observation and the insights it provided rich data was obtained in relation to the hospital-based staffs reactions to home birth and to in-labour transfer. (See Section 6.7.5.1)

Section 6.7.5.2
Diary Entry[19]: *It is interesting the way the HMWs identify with me, or assume that I identify with them. "You know yourself, Linda"; "sure you know what it is like around here" the two most powerful quotes that demonstrate this. In these incidences I need to ensure that I do not get caught up in the familiarity and that I am clear in relation to their perceptions and experiences and not my assumptions.*

Diary Entry[20]: *I see this as another 'ah ha' moment during fieldwork, a moment of realisation that in spite of the changes that midwifery education since the 1990's (e.g. longer lengths of time allocated to theoretical input for Higher Diploma in Midwifery students, a 4 year undergraduate programme, midwifery education located within the university, an array of postgraduate and masters courses available for midwives) midwives in hospital continue, for the most part, to practice under obstetric supervision. Do they practice according to the definition of a midwife or is the gap between theory and formal education and the reality of hospital life too wide?*

Section 6.8
Diary Entry [21]:
This reading allowed me to hear and see the stories. Focusing on what was relevant and important for the participants of the study. It brought all the voice, across and within groups, to the fore and also providing the opportunity to identify my voice and acknowledge my thoughts, feelings and interpretations of the data shared.

Diary Entry [22]: Reflecting on the VCRM and how it added to my study.
While the work of Nadine Edwards and Ruth Deery led me to VCRM, Natasha Mauthner was my champion. Participating in two workshops helped me to refine how I used the method and how it was appropriate in the context of the aims of my research.

Showing her my Word documents and highlighted coloured texts, giving her an example of how I actually 'did' the reading, allowed her to comment, feedback were greatly received. She also reassured me that yes, it could be adapted across observational data given the aims and objectives of my study. The flexible and adaptable suited the needs of the study.

The 4 readings certainly helped me to become immersed in the data. I read, looked and listened for the stories of all the participants, how they viewed themselves in the context of the culture of birth in Ireland, how they perceived their relationships and the wider complex social contexts and constructions. This allowed me to listen for the dominant discourses and move toward the 'what could be' of critical ethnography. It also enabled me to give voice to the subjugated discourse and in my attempts to move the narrative on from the current dichotomy of birth in Ireland.

The method was not without its disadvantages. The four readings of VCRM were very time consuming, reading with a different focus across so much raw data was not an easy task. While considered ambitious by some (4 step reading, 2 modes of data collection, 4 participant groups), I think it was worth the time I gave it.

I will admit that I struggled at times with the amount of data and wondered if this method had helped me to reduce the data enough? I suggest that there is lack of clarity in the literature in relation to bringing all the 4 readings together to findings that are manageable. In my adaptation of VCRM additional readings of coded data across the 4 readings allowed me to reconstruct categories and themes where links were made between shared meaning, nuances and related ideas. (See Appendix 7).

Diary Entry [23]: *yah ... I am not on my own. This does make sense to others. And to midwives from Germany – that is unbelievable. I think moments like this in a doctoral student's life must be acknowledged as reassuring!*

Chapter Seven:

Section 7.2.1.1

Fieldnote [1]: *conforming, conforming to the organisation. I need to look and listen for this across participant groups and research methods.*

Fieldnote [2]: *I'm just reading the transcript of Eibhlin's interview -* (Reading 3, Reading for Relationships). *I observed the relationship she had with her SECM during her pregnancy and labour at home, their shared views of birth, the way they planned for every aspect of Eibhlin's care. And now it emerges again in Eibhlin's words and the value she places on having the SECM support her when she transferred to hospital:*

> "I felt that she was taking care of me in a way of making sure that everything was done right. I really don't think that I would have gotten through that without her, because nobody would have held my hand in that way. And nobody would have felt safe enough for me to be with…even another midwife; if she was lovely to me she wouldn't understand what I had just come through"

Her narrative raises so many points in this reading – being known, feeling minded, staying safe

Fieldnote [3]: *Drawing on data from the interviews with other participants and on my observations this perception of home birth plays out in interactions with women. Hospital-based practitioners are noted as "impatient", "dismissive", one woman describes it as the "you're in*

hospital now" attitude. The really gives me an insight into women's disappointment that their 'loss' of home birth and the plans they made is not acknowledged in their new plan of care.

Section 7.2.1.2
Diary Entry [4]: *This has really surprised me. I have looked at the data again to make sure that I am not missing something, but the women do not believe that midwife-led care could exist within the current structures. So what I view as "pockets of midwifery" in the maternity hospitals, where midwives are offering midwife-led clinics etc is not held as the norm by these women and therefore, they do not believe that it can exist. This is really important to remember going forward and should inform the development of models of care in Ireland.*

Diary Entry [5]: *This is the case for most women in Ireland, for most women accessing the maternity services it is unknown who will support them in labour. This point provides a critique of the current provision of maternity care and remains an ongoing issue of women's experiences.*

Fieldnote [6]: *It is emerging from the data that eight of the women said that home birth was not their first choice, but an alternative out-of-hospital model was not available to them. Looking across the participant groups it is interesting that none of the healthcare providers have considered this. Home birth for these women, I describe as a "default position". Given the numerous reports calling for a reorganisation of the maternity services and the MidU Study demonstrating the appropriateness of midwife-led units in Ireland this point of 'default position' adds to the critique of the maternity services. Thinking like this reinforces the development of this study to a critical ethnography.*

Diary Entry [7]: *These findings merged to form the sub-theme 'I planned a home birth because ...'. When examining these findings in relation to the literature this data provided a critique to challenge the dominant model of maternity care in Ireland.*

Section 7.3
Diary Entry [8]: *Am in the mist of analysing the data from interviews with hospital-based practitioners. For all my moaning about the lengthy steps of data analysis, VCRM has been really useful to help me explore the participant's story and also the socio-cultural context in which their experiences occur.*

Section 7.3.1
Diary Entry [9]: *Ethnographic moments and flashes of reflection when I least expect it. Was teaching midwifery students this morning. We were talking about abdominal palpations and the merits of continuity of care ... I'm not sure where it went after that but lively discussion ensued. One of the students asked me "so Linda, you think that everyone should have a home birth"? WHAT? How did I give that impression? ... I thought I talked about the merits of continuity of care across different models? This sent me running back to my study ... the way I ask questions, the way I view the*

data. Thank goodness for the reflective process inherent in the step of VCRM, making explicit my responses to the narratives

Fieldnote [10]: *This finding emerged time from the narratives of SECMs. I began to use it to inform my interview and asked the SECMs "what is it like to be an SECM in Ireland". This category and observational and interview data from their experiences of in-labour transfer contributed to the theme* 'Negotiating positions in maternity services in Ireland'

Section 7.3.2
Diary Entry [11]: *I cannot believe that I have to hold myself back during interviews and resist the urge to tell them all about the positive and amazing home births I have observed*

Diary Entry [12]: *To think I had been so worried about the focus of these interviews and the direction of the narratives. Once I started analysing the data I realised that these insights were vital to provide a contextual understanding of the interface and move beyond the descriptive stories.*

Section 7.4.1
Diary Entry [13]:
I'm just after having a phone conversation with a woman who is planning a home birth. One of her friends participated in the study and gave her my contact details. She cannot find a midwife, they all already have women booked for the month her baby is due or on maternity leave themselves or are not taking on women for that month. She has phoned some of the midwives on more than one occasion. She was so desperate and her friend wondered if I would take her on. I felt so bad for this woman. I was very honest with her and told her about the study and my role in relation to home birth. But even in telling her that there was a sense of her trying to persuade me that I should take on my own caseload, she was just so desperate and I was her last hope. I feel so for her, she said that she was just distraught at the thought of not having a home birth. I suggested that she contact her local HSE service, seemingly one of the SECMs said the same thing, but when she spoke to the Designated Midwifery Officer she just told her that there was nothing that could be done about it, that she'd just have to book with the local hospital.

Section 7.5.1
Diary Entry [14]: *The healthcare professionals seem unaware of this, or at least it is something that they do not bring up. I need to look and listen for this in my data collection, maybe I need to even ask directly during interview.*

Section 7.5.2
Fieldnote [15]: *Reading 1 of Geraldine's transcript (Reading for my response to the narrative) – this just smells of 'big brother is watching you'.*

Section 7.5.3
Fieldnote [16]: *Yes they are challenging the status quo in the sense that they are rejected the culturally accepted model of care. However, even in this challenge, it is apparent from the data that the power remains with hospital*

practitioners (especially) and while women attempt to subvert the power they remain aware of it and fear it will dictate their experience.

Section 7.7
Fieldnote [17]: *Trust emerging again in the data, it is also emerging across participants groups and I think it warrants further attention.*

Section 7.7.2
Fieldnote [18]: *I found this really interesting. It plays out in data across the antenatal observations. The women have negotiated a space with SECMs in that their agreed understanding of birth places the midwives in a position where the women trust them and their knowledge. As Eibhlin said "Because I trust her I let her guide the care". It contrasts greatly to the sense of "being told what to do" the women associate with hospital care.*

Chapter Eight

Section 8.2
Diary Entry [1]: *Example of entries to my diary*

- *That was amazing*
- *That just was so special, I was cynical when one of the women said she wanted all the 'magic' of home birth, I was thinking 'ye right'! But it was magical, that atmosphere, the lighting, the warmth Cait just leaning on Siofra and birthing her baby*
- *That was such fun ... we just had great craic, it was so exciting. And it was so exciting when the baby was born, there was none of the panic of rushing to do things and get stuff measured and recorded. It was all on Nessa's terms and however she wanted it to be done.*

Fieldnote [2]: *I hadn't thought of it like this ... how did I miss it? How many women have I said to "stay at home for as long as you can unless x,y,or z happens, especially first time mothers? Now here they are saying it themselves, being at home, in their view gave them every chance to establish labour, labour to progress etc, and again they suggest this would not have been possible in hospital with the routines involved. Is this a point that warrants further attention for women who choose a hospital birth? When do they present themselves to hospital and what structures could be put in place to assist and support them?*

Fieldnote [3]: *again primiparous women taken by surprise during labour. I need to go back to the literature in relation to this.*

Diary Entry [4]: *Reading 1 of VCRM (Reading for the researcher's response to the narrative) has been really helpful here. It has enabled me to acknowledge my own story in the context of the stories the women are telling me.*

Section 8.3.3
Diary Entry [5]: *And again I am so thankful for the Steps of VCRM that guide me to explore past the story to ensure that it includes my*

interpretation of the story and how this impacts on what I am hearing and seeing. Reading 3 and 4 have also helped me to explore the relationships in this experience and the wider socio-cultural influences. This guides my reading and writing for Chapter 9.

Section 8.3.5
Fieldnote [6]: *These women were scared, they were scared of the course that their labour would take and what would be done to them in hospital. These findings highlight where power is located in these women's experiences and how they anticipate that their experiences with those who hold the power will not be centred around their wishes or their needs.*

Diary Entry [7]: *I'm looking across the data ... none of the narratives talk of women deciding that they did not want to transfer. Is that because it doesn't happen? Because of the particular cohort of women and SECMs participating in this study? Or is it because it is something that they are not anxious to tell me about? Little I can do in relation to any of this issues, but I am finding it unusual that the terms of transfer as stipulated by the MOU etc are so readily accepted.*

Section 8.4.2
Fieldnote [8]: *I heard this at interview and I saw this in my observations and it led me to question what causes HMWs to question the care offered by the SECMs and I realised, that in spite of their assertions that they support normal birth, their practice is located, for the most part, in an obstetric paradigm.*

Section 8.4.3
Diary Entry [9]: *This fear of the consequences of working outside the MOU influences the way SECMs practice and the way they offer care. This emerges across interviews and observations and their frustration in relation to this. Their frustration in relation to the way the must negotiate the obstetric understanding of birth in an effort to support home birth and to sustain midwifery practice in Ireland.*

Section 8.6
Diary Entry [10] : *I was so excited when I first heard this, I thought it great and beneficial for all. However, this did not play out as a theme across all the data.*

Section 8.6.1
Diary Entry [11]: *Disheartening, found this interview totally disheartening. I had to put the transcript away for a number of days before I could read it and had to work my disappointment out of my head before I read the participants words to give her voice as I did with the other members of the study.*

Fieldnote [12]: *There is something missing somewhere, it's like the obs is basing her knowledge on historical happenings and is not aware of the most recent history in relation to home birth in Ireland.*

Fieldnote [13] : *Power, power emerging again and again from the data. The belief that hospital practice is based on authoritative knowledge. Such data contribute to the overall position of authority that obstetric knowledge and obstetricians continue to hold.*

Section 8.7.1
Fieldnote [14]: *The sense of frustration is palpable during Myrna's interview. Although HMWs can never predict who will present themselves to the maternity hospital they are very wary and anxious when they hear that someone is coming in from a home birth. The anxiety lies in the fact that they seem to "expect the worst"*

Section 8.8.1
Fieldnote [15] : *"who would do what?". I contacted her afterwards to ensure I understood what she meant "you know Linda, who would manage the labour". SIGH. What has happened to midwifery in Ireland or rather what has not happened to it?*

Section 8.8.2
Diary Entry [16] : *these narratives highlight some of the findings that demonstrate how the HMWs in this study are reconstructing midwifery within the context of the medical model of birth.*

Section 8.9
Fieldnote [17]: *The Confidence.*

Section 8.9.3
Fieldnote [18] : *Extract from the sense I make of this data – "who knows best ... we (hospital) do"*

Section 8.10.2
Fieldnote [19]: *So that was it, they were worn down. These women who knew what they wanted ad had plans and dreams. Reading 4 of VCRM and looking to the broader socio-cultural literature in some way helps me understand this. I will come back to this again.*

Section 8.10.3
Diary Entry [20]: *This is central to what is going on at the interface of home and hospital for these women. They want everything that an SECM has to offer and all their beliefs and hopes of birth center around her presence and support. Then when the going gets tough they are separated from the one person they need most. Makes no sense when you break to down to that level.*

Section 8.10.4
Diary Entry [21]: *I cried then hearing it, I cry now writing it – "my healing baby"*

Part II: Observation of in-labour transfers

1. Ailis and Bridget (SECM)

It was early morning and no one up in our house when the phone call came. The SECM had been Ailis for a while ... she was contracting, in the pool, everything was "*ticking along nicely*" – they would contact me when they felt it was a good time for me to come. Well alright then ... all I could do was wait for the call and take my cues from them. The wait, it wasn't long. Just over an hour later a call came from the SECM. Ailis' labour was "*moving along*", the SECM told me that Ailis' noises and demeanour were changing and this had the potential to be a sooner rather than a later occurrence I should come as soon as I was ready.

And so I arrived, the door was left on the latch for me and I eased my way in ... I was met by the dog, thankfully he and I had become acquainted during my last visit and I really hoped that his previous excited status reserved for meeting strangers would not be an issue this time! I went into the kitchen / living area. Ailis was in the pool facing out to the kitchen, with her husband Malachy at her back. Bridget was in front of her (her back to me) – soothing quietly to her during the contractions. Not with every pain but with the ones that appeared to be more challenging for Ailis (the ones during which she demonstrated a more laboured breathing, more grimace of facial expression and a more moan-y of voice). During this time Bridget gently, in a whisper encouraged - *well done, that is it ... you are doing great.*

They noted my presence – skulking in, trying so hard not to interrupt / interfere with the dynamic that was going on. Bridget came over, we hugged and she welcomed me. Ailis smiled and gave a little kinda waved and a thumbs up sign – no words were spoken, she was busy preparing for the next contraction, to be fair no words seemed needed. I was there, she knew I was there ... what more could be said? I took off my shoes and tried to tip toe around and see where Bridget had put her "bits", I located the oxygen, the suction, her postpartum haemorrhage kit ... the midwife in me making sure that I knew where all the emergency bits were – perhaps? And then I skulked (I use that word again, but that is what it felt like), I sat with my back to the radiator, not in direct view but in a place where I could be seen if I was needed and I could see all. Again not part of the "inner circle" that was going on, so very conscious of not wanting to disturb this little network that I was kinda a part of, yet not. And the dog, that poor dog .... he was distraught, not in a loud whiney way, but in a 'I've no idea what is going' on kinda-way. I am not a huge animal fan, yet he seemed to come to me when Ailis made noises during the contractions – during this time I rubbed him, and soothed him and heard words like – *it's ok, Toby, this pain will pass, she'll be ok, all will be fine ......* coming out of my mouth.

And it continued this little scene of warmth, with little being spoken as Ailis' breathing and noises changed as contractions come and contractions went. And Malachy was beside her, not necessarily doing anything – just being, being present and close I suppose. And Bridget was nearby, not talking, just being near and offering very gently words of support when Ailis' breathing and noises indicated a more challenging patch. The gentle

noise of the baby's heart beat when Bridget listened in from time to time. And me – comforting a dog!

The contractions were becoming less frequent but remained intense – well they sounded it from the noises, and Ailis talked of feeling lot of pressure in her back. In between these contractions she dozed, her head bobbing as Malachy tried to support it but not disturb the moment in the birth pool. Bridget came close to me and said – "*I wonder is she in transition* she whispered, *but that backache ..... it is a fine line between quick and OP position"* and I wanted to question more – to ask what did she think, tell me more about this view, it all seemed so fast to me for a first time labour – but she went back to Ailis' side and it didn't seem like the right time. Of course the words were no sooner out of her mouth when Ailis' breathing indicated that she seemed to be pushing with the contractions ... not big strong, forceful pushes ... but little ones that she didn't seem to notice that she was doing when Bridget asked her did she feel them. And Bridget looked at me and we raised eyebrows – maybe ? ... but no words were spoken. And I noted the time, and I wrote it down in my little notebook, *09.35hrs – pressure, 10.10hrs pushing with pains* ... what was that about – Bridget was maintaining her notes throughout, so why did I feel a need to write times? The hospital time keeper in me or just me noting changes and wanting to keep a handle on them?

The backache and the pressure continued together Ailis' breathing and vocal noises indicated that this was more becoming more challenging. And then there was conversation, in-between the pains Ailis asked Bridget - "*it won't be much longer will it"?* And they talked, about the head pushing down, but Bridget not being able to see anything yet. They talked about a VE – to make an assessment, to see if there was cervix remaining, they talked about resisting the urge to push if the cervix wasn't fully dilated. It was done quietly, together – woman and her midwife, Malachy and I were not part of this, we were just bystanders and Ailis made the decisions without talking to anyone but Bridget. So she came out of the pool. And I did think that this was going to be awful for her –

> *(I was remembering back to when I got out of the pool during my labour and how much I hated it .... how rotten I felt it was and that I really wanted to get back in again and stay in there. I remember being cross with my midwife for suggesting that I needed to walk around for a while to get the contractions going again, how could she ask me to leave my beautiful warm water!).*

But no Ailis didn't seem to mind, and she seemed a lot more mobile than I expected – I'm not sure why, maybe it was because she was just lolling almost in the water, I thought it would be difficult for her to move onto the couch for a VE – it didn't appear to be. And so the VE was done, again just Bridget and Ailis – me in the background and Malachy putting on the kettle ... keeping his distance whilst this was going on. And there was cervix left, and Bridget talked to Ailis about making a conscious effort not to push with the contractions until the cervix was gone.

Ailis talked more now, in between the pains – she asked "*will there be much more of this, it won't be much longer will it"?* And Bridget reassured and explained and talked about the baby's position and the head needing to rotate... and Ailis said that she understood. I stayed near, not part of the three, just near.

After a few contractions – maybe 2 where Ailis tried not to push – she turned around to Bridget looking into her face – "*you breath with me Bridget, I don't know how to do this ...*" and Bridget did, she made sharp, whistle breathing noises very close to Ailis bent head. And I made sharp, whistley breathing noises – I couldn't help myself. It was like I was willing Ailis to find her pattern, to find a way to become comfortable with breathing til that cervix disappeared. And we were there this chorus of whoo, whoo, whooo, noises!

The urge to push and back pain persisted, Ailis questioned with a more pleading tone this time – "*it shouldn't be much longer"?* Pleading more but not in a defeatist way by any manner. Aisling asked to try some entonox, something to try and help her resist the urge to push, and we got it and it whistled away with the noises we were all making already.

I was wondering if I should suggest that Ailis might find more comfort if she returned to the pool - and then, out of nowhere the change happened. Bridget listened to the baby's heart after a contraction with a handheld sonocaid, we could all hear – this time it sounded different ... I focused, it was slower, it took longer to get back to the racing dooo dooo dooo of earlier. I remember looking at them – I could see Ailis' face, she didn't register anything, she was getting her breath after the contraction, Bridget had her back to me, I couldn't see her expression at all. I heard her say – "*oh, I am just going to listen in for longer and see what happens after the next one*" ... her voice was different, it wasn't the soft, singing support of earlier – it was very focused, her words were very clearly enunciated – I think I would describe it as her 'posh phone voice'. I stood up and I remember turning my ear to the direction of Ailis' belly, waiting for the next contraction. I remember waiting to listen so very carefully. Ailis stood slightly more upright and Bridget knelt beside her, sonocaid in her hand, placed on Ailis' abdomen. It happened again, the contraction came and again the baby's heart slowed down after the contraction and took a time to come back to its regular beat. Bridget looked up into Ailis' face and in the 'telephone tone' said "*I think we are going to have to go to the hospital, I don't think we should stay at home any longer*." Bridget was very direct and said that because the cervix was not fully dilated and the baby was not fully rotated it could be too long to stay at home and wait for this to happen with the heartbeat dropping ... next thing we were gathering ourselves to leave.

We talked about this afterwards. Ailis said:

> And Bridget, just said "we're going to stand up" and we stood up, and she just looked me straight in the eye and she just said "we have to go to the hospital now", I said "*ok*"... now I could have said "*will we wait for one more contraction*" but in that moment, and in that

time, and because it was Bridget, I was like "*grand, that's what is going to happen*".

Bridget asked me to phone the hospital and let them know we were coming in as she continued to support Ailis during her contractions and at the same time manoeuvre her toward the front door … so I did, I asked to speak to the midwife in charge of the labour ward, to which I received a clipped "*YES*", I gave her a brief outline of the scenario ... then the midwife on the phone started asking me questions – what was her hospital number, would she need an instrumental, what station was the baby's head at, if we had phoned an ambulance, all in the one breath … Throwing questions at me as I was trying to get off the phone and help Bridget. I asked Bridget about the ambulance – "*no we'll bring her in, it will be quicker than waiting*", to which I received a snort from the midwife on the phone, "*no ambulance, it isn't that big a deal then is it*" and so ended our conversation, she hung up.

I drove to the front of the house .... and we piled in ... and I have this image of Bridget putting an incontinent sheet under Ailis as they got into the back seat – and I do remember thinking that I wouldn't have thought of that, but then Bridget has done this before!

And so I drove, Bridget and Ailis in the back, Malachy in the front. I asked him if he *was ok,* and Ailis starting telling him that everything was "ok, *I just might need help to get the baby out" ...* such hospital-type language I remember thinking.

When we to the hospital grounds I pulled over where Bridget told me and she ran off to get a wheel chair, I climbed into the back of the car with Ailis and I took up where Bridget left off, breathing, breathing through those contractions with her, trying to support her breathing to resist that urge to push. She held my hand tightly or did I grip hers first – I have no idea. But my face was close to hers as we looked at each other during the whoo whoo whoos. I remember her whispering during a pain "*it'll all be ok, Linda won't it"?* Bridget arrived with a wheel chair and a midwife and they piled her into the chair and I had to go and park the car – which at this stage was blocking in 2 cars.

By the time I got to the labour ward Bridget and Ailis were still waiting by the reception area. Shortly one of the midwives came along. The SECM was well known to the hospital midwives, they all greeted her by name and she just went into the room with Ailis and Malachy, they made no fuss made. I was directed to wait by the big desk, the central area of the labour ward. This was where Attracta, the midwife-in-charge, held court, watching and directing the activity of the ward, midwives coming out of rooms updating her on what was going on – "*not in labour ... up and walking around ... pains getting stronger ... looking for an epidural ... syntocinon started ... fully an hour now ... get her reviewed ... ready for the ward*".

The labour ward was dark, dark and brown, with 1970's style to it ... I've no idea if it was 1970's ... that is just how it felt, dark and brown and of clinical purpose. Everything centred around this reception area that turned out to be the "nurses station", an open plan office in the middle of the corridor. A big

White Board on the wall beside it that told of who was in the labour ward and what 'stage' of labour. This was the first point of reference for any midwife as they approached the desk. As I was standing there I introduced myself to the midwives, reminded them of my study (they had known about it). No one had an issue or concern with my presence. Two midwives were doing the outside "sorting" following Ailis' arrival – a chart had to be made, admissions had to be contacted, Ailis was not booked with this hospital, the midwife turned to me and asked – "*why don't these women book with the hospital that is nearest to them, would save us all a lot of hassle"?*. I thought how different this is, Ailis and Bridget had formed their relationship over the last few months, this trusting, close relationship, one that I felt I was trespassing on, and now she is here and they don't even know her, they know nothing about her and what she wanted for this birth, will they even ask ... I need to be aware that is this my issue, was this, at that moment in time even a concern for Ailis? It was an inconvenience making up the chart etc – having said that, a midwife from the antenatal ward phoned to say they had a woman there who needed transfer to the labour ward, this was greeted with the same tone!

A registrar in obstetrics was phoned, asked to come and review Ailis and her case, Attracta told me "*Louise [doctor] will do a VE now in a minute and we'll see what is going on, we do things differently here Linda, we'll have to get her moving along and get this baby out*".

I sat and waited, several people asked me if I wanted a cup of tea, no one asked me to move, no one told me I was in the way, I didn't feel like I was in an unfamiliar labour ward (which it was), I had a professional knowing of what was going on, I could make myself blend. The hospital based midwife (Ava) came out of the room to get something – "*that fetal heart is fine Linda",* she told me as she passed.

Louise (doctor) did a VE and decided to do a FBS *[I discussed this afterwards with Bridget]*, Bridget assumed it was because she was not confident re the handover that the fetal heart had been intermittently osculated and fine before the recorded incidents. The results of the FBS were held as being very reassuring. Attracta filled me in, "*7cms dilated, bit to go yet ... we aren't as generous here as some with VEs, she's starting syntocinon but wants an epidural first, Bridget is going to stay with her"*

At this stage I felt I had overstayed my welcome, again no one said anything but Bridget and I talked and decided that I would go home and she would call me with news when it happened. So I left, and I found my car and I drove home, and the entonox cylinder and the synocaid say in the back seat.

Later the call came from Bridget, Ailis and Malachy had a baby boy.

I spoke with Bridget after the birth of Ailis' baby. We discussed my observations and interpretations and her experience.

Bridget, (SECM):
... it was fine Linda, I mean I didn't really expect it to be any different, I've been here before you know, I know how to handle it at this stage. I was there, I got to support Ailis, I was able to influence the plan of care and help Ailis work through the hospital stuff, you know, the syntocinon and that. I wouldn't have been able to do that if I was here making a big fuss when I arrived, getting their backs up. If they asked me to leave what good would I have been to Ailis then? ... of course some things are grating, their queries of your handover, some of their policies, but you pick your battles and work away in the background, making little suggestions, offering supports and think - what will help this woman in the grand scheme of things?

(Excerpts from Ailis' interview after her experience of transfer are located in Chapters 7 & 8).

Summary of points that informed my thinking:

- The closeness, the little unit of 3 – Ailis, Bridget and Malachy
- Looking to the SECM for guidance (eg with breathing), calm, quite guidance ....
- The asking, almost pleading of how much longer like this but not in a defeatist manner
- The sudden change in the atmosphere, the change in tone of the SECM's voice, the professional clipped and direct expressions, the quick movement to leave
- The agreement to move, no discussion as such was had because none was needed
- The phone call and the tone from the hospital based midwives, business-like and asking questions .....
- The hospital staff knew the SECM and she was able to stay
    - Never once was I asked to move / leave ... regardless of what was going on ... until a decision being made re plan of care and then both Bridget and I felt it was time for me to go
- The inconvenience of an "unbooked" woman ... the inconvenience of another woman coming to labour ward
- The stark difference of not being known .... ie Ailis not knowing or not being known to the midwives and so known to Bridget
- The Dr will tell us all we need to know, "we will make our own assessment"
    - We are not as generous ... (in relation to VE's)
- SECM acceptance of this and her rational underpinning this
- Vast physical difference between the house and atmosphere of warmth and closeness and the clinical feeling of DS
- It all became medicalised ... but it needed to, we transferred because we needed that ... otherwise we would have stayed at home. Ailis' interview notes that she was aware of this; the challenges that emerged from her interview highlight her concern with the way care

was offered after transfer and the routines of hospital birth. For Ailis -

Ailis:

In the hospital it's not your experience, it's not, it doesn't belong to you. It belongs to whoever is looking after you. Because that person is going on lunch now – "I'll be going on lunch now, so you wait an hour before you push, and I'll come back and you can push then", like that's what was said to me ... It's their experience, what suits them ... it's not your experience, it's totally taken away, and it's just whatever is suiting them at the time.

2. **Lana and Bridget (SECM):**

The excerpt from my fieldnotes and writing in relation to my observation of Lana's transfer begins when discussions in relation to transfer became part of her care during labour –

… different positions were tried, different movements were suggested by Bridget, the up and down the stairs was mooted (and my heart sunk, I had been that solider at a different time for different reasons and I hated it) …. And Lana moved and swayed and leant into Jonathan and Bridget … and was her normal sweet self apologizing in-between contractions, but the sense of despair was still there … the sense of doubt while they calmly told her that she could do this …. that she was doing this … "*never again, never again*" she said ... and in spite of it all I grinned, I had never heard her say that before. She went up the stairs and talked to Bridget on the way saying - "*we may have to go in*" and the SECM agreed and said "*maybe, yes maybe .... let's just see what happens with a few more contractions*".

Lana went up and down the stairs a few times and then Bridget asked her to assume a position where she could see her vagina during a contraction, a kinda sitting up, legs open type pose. And she asked if I could observe for 2 contractions and then we would talk and make some decisions. And I felt the weight of responsibility on my shoulders ... I ok-ed my change in position with Lana and watched so intently …. With the first contraction there was a trickle of blood … and I remember looking at it and wondering – oh is there a tinge of meconium there … And obviously Bridget was wondering the same thing as she picked up the pad and looked very closely at it, rubbed it … looked at me and shook her head at me – interesting midwife speak.

And 2 contractions came, and Lana's body pushed down, and 2 contractions went and nothing happened …. And Lana, Bridget and I looked at each other …. We didn't say anything initially, we seemed to know – as least that is the way I am interpreting it … I asked Lana at interview and she said the same thing –

Lana:

> *... there probably wasn't much to say, because I knew, I remember just looking at the two of you looking at my perineum and then ye looked at me, it was written all over your faces ... we were just all in agreement that it* [labour] *just was not working*

Bridget said "I'll phone them and tell them that we are coming in" ... and Lana agreed – "I think so Bridget, I need to go in".

And I don't remember if we explained to Jonathon or if he just got it from all the other bits of the conversation ... I gathered Lana's bag, Bridget phoned the hospital and we made our way in. I dropped them to the door, parked beside the entrance and ran to join them.

No one was particularly putout when I arrived in, I didn't know anyone ... I told them who I was, why I was there. There was a midwife, a midwifery student and a nursing student at the desk ... the midwives were writing notes ... they looked as if they had just been present at a birth ... they just said "that's fine" so I waited where I was.

And suddenly within seconds after we arrived in with Lana and it was bedlam, a midwife dashing with a portable ultrasound machine, opening of theatre, bleeps going off, doctors rushing down the long corridor and in the middle of it all Lana crying out, Bridget at her side the whole time as they went into a different room – and I was sitting, someone had rolled a chair underneath me and tea was placed in my hand and Saoirse [midwife in charge, I knew her] passed me en route down the corridor, turning back to say –"*It'll be fine, Linda, let's just see what Bridget needs.*" I could hear the noises, the screams of pain, the cries that I knew were Lana's and I was afraid, I didn't know what was happening, what was going on. I heard a midwife shout up to the desk – "*call for a Paed, a Senior one there is meconium here*". What? There hadn't been meconium when we were at home; there hadn't been need for this level of panic. What had changed? Another shout "*someone get Dr x ... we need him in here immediately*" ... what was going on ... and Lana's screams of pain, discomfort ... worse – I didn't know ... I didn't know what was going on, if her baby was ok, if they could find the fetal heart ... for the first time over the course of this study I was frightened, really frightened and all I could do was stand and wait and let them all do what they had to do.

Then bodies started appearing from everywhere, doctors running from all directions. Very soon after a baby girl was born and I stood outside the door and heard her cry and I cried. [192]

[192] Aspects of Lana's story have been omitted to maintain her anonymity.

Afterwards:
All was done, the baby was feeding and Lana and Jonathan were gazing at her. Bridget and I were leaving the labour ward ... I was drained after it all and Bridget looked pale and tired. Passing by the desk where the midwives gathered, Saoirse [midwife in charge] called out to us to see if we were ok. She said "*I think we all did good*" and so ensued one of those spontaneous chats reflecting on care that colleagues often have ... she and Bridget hugged and it just seemed like the natural thing for 2 midwives to do after a long and emotional day supporting a woman to birth. The other midwives there said goodbye, one took Bridget's mobile number so she could phone her if Lana wanted her for anything.

I sat in my car, I was exhausted and my emotions got the better of me. Later, when SECMs talked of feeling vulnerable, feeling judged during transfers I thought back to this experience. No comments were made by the hospital-based staff, everyone worked to support Lana, this was a seamless transfer yet I was frightened and drained. I kept wondering of the SEMCs experiences when they are frightened or drained yet the care they offer is called into judged out of context and they felt blamed for issues that arise.

Summary of points that informed my thinking:

- The relationship between the SECM and Lana
- The noises of support not just the words
- The change in atmosphere over a time
- The determine but not emergency tone of the midwife
- The drama of the hospital
- How the situation changed dramatically
- Everyone working together in an emergency situation
- The fear … my fear ….
- The waiting … left outside the door and not knowing what was going on (how many SECMs does this happen to)
- The support of the hospital when needed
- Midwives being midwives together

Appendix 3:
Letters of Ethical Approval

To maintain anonymity, all identifying features (e.g. name of hospital site, site logo on headed paper, signature of the chair of the ethics committee) have been blocked out.

THE UNIVERSITY OF DUBLIN

TRINITY COLLEGE

SCHOOL OF MEDICINE

FACULTY OF HEALTH SCIENCES

Trinity College, Dublin 2, Ireland
Tel: +353 1 896 1476
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Professor Dermot Kelleher, MD, FRCPI, FRCP, F Med Sci
Head of School of Medicine
Vice Provost for Medical Affairs

Ms Fedelma McNamara
School Administrator

email: medschadmin@tcd.ie

Ms Linda Biesty,
Nursing and Midwifery,
D'Olier St,
Dublin 2

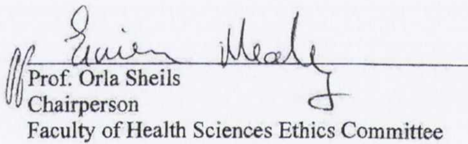
Monday, 28th February, 2011

Study: An ethnographic study of in-labour transfer to hospital for planned home birth

Dear Applicant (s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in December 2010, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely



Prof. Orla Sheils
Chairperson
Faculty of Health Sciences Ethics Committee

Cc Dr. Joan Lalor, Dr. Colm O'Boyle, Prof. Cecily Begley, Nursing and Midwifery

Schools of the Faculty: Medicine, Dental Science, Nursing and Midwifery, Pharmacy and Pharmaceutical Sciences

21st January, 2011.

Ms. Linda Biesty
Lecturer in Midwifery/Doctoral Student
Trinity College
D'Olier Street
Dublin 2.

Ref: C.A. 512 – An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Dear Ms. Biesty,

I have considered the above project, and I wish to confirm Chairman's approval to proceed. The following documentation was reviewed:

- The Standard Application Form
- Appendix 1 – Research Protocol
- Appendix 2 – Letter of Introduction to Directors of Midwifery/Equivalent
- Appendix 3 - Letter of Introduction to Obstetric Consultants/Delivery Suite Midwifery Managers
- Appendix 4 – Participant Information Leaflet for Obstetric Consultants Participant Information Leaflet for Delivery Suite Midwifery Managers
- Appendix 5 – Consent Form
- Appendix 6 - References

Yours sincerely,

NE,

21st April 2011

Ms. Linda Biesty
School of Nursing and Midwifery,
Faculty of Health Sciences,
Trinity College
Dublin

Re: An Ethnographic Study of In-labour Transfer to Hospital for Planned Home Birth

Dear Ms Biesty,

Thank you for submitting the amended protocol for the above study. This was discussed at the Ethics Committee and has received approval.

Kind Regards

Yours sincerely

26th April, 2011.

Re: An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Dear Linda,

Thank you for your letter of 15th March. The Committee discussed the contents of your letter at it's meeting on 31st March and understand that it is not possible for your thesis to be reviewed here before submission to Trinity. The Committee have agreed that you may undertake your study.

We wish you well with your research.

Yours sincerely,

COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH
Ollscoil Átha Cliath

Dámh na nEolaíochtaí Slaínte,
An Chéad Urlar, Foirgneamh na Ceimice (an sineadh)
Colaiste na Tríonóide,
Baile Átha Cliath 2, Éire.

TRINITY COLLEGE DUBLIN
The University of Dublin

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Dublin 2, Ireland.
T:- +353 (0)1 8964255

Ms. Linda Biesty,
School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier St,
Dublin 2.

3 April 2012

Study: An ethnographic study of in-labour transfer to hospital for planned home birth.

Dear Applicant(s),

Further to the approval letter which was sent to you on 28 February 2011, we are pleased to inform you that the amendment (adding one more source of data collection), to the above study is approved without further audit.

Yours sincerely,

Prof. Orla Sheils
Chairperson
Faculty Research Ethics Committee

Supervisors:

Dr. Joan Lalor
Dr. Colm OBoyle
Prof. Cecily Begley

14th August, 2012.

Ms. Linda Biesty

Ref: C.A. 512 – Amendment 1 - An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Dear Ms. Biesty,

I have considered the above amendment, and I wish to grant Chairman's approval to proceed.

Yours sincerely,

Appendix 4:
Research Information Packs

Letters of Introduction

- Letter of Introduction to Self Employed Community Midwives (Gatekeepers and Participants)
- Letter of Introduction to Women who Plan to Birth and Home / Women who have Experienced an In-Labour Transfer to Hospital when Home Birth was Planned (Participants)
- Letter of Introduction to Obstetric Consultants/Hospital Based Midwives (Participants)
- Letter of Introduction to Midwives and Doctors (re Opt-out of study)

Participant Information Leaflets

- Participant Information Leaflet for Women who Plan to Birth at Home
    - Antenatal Observation
    - Labour and Birth (Observation)
- Participant Information Leaflet for Women who have Experienced and In-Labour Transfer to Hospital when Home Birth was Planned
- Participant Information Leaflet for Self Employed Community Midwives
- Participant Information Leaflet for Obstetric Consultants (Interview)
- Participant Information Leaflet for Hospital-Based Midwives (Interview)
- Participant Information Leaflet for Hospital-Based Midwives and Obstetricians (Observation)

Consent Forms

- Consent form for participation in the Observation Session (Antenatal) (Self Employed Community Midwives)
- Consent form for the Observation of Labour and Birth Session (Self Employed Community Midwives)
- Consent form for participation in the Observation Session (Antenatal) (Women planning to birth at home)
- Consent form for the Observation of Labour and Birth Session (Women planning to birth at home)
- Consent form for participation in 1:1 Audio-Taped Interview (women who have experienced an in-labour transfer to hospital for planned home birth).
- Opt-Out Consent form for participation in the Observation of in-labour transfer to hospital during planned home birth (Hospital-based midwives and doctors)
- Consent form for participation in 1:1 Interview (Self Employed Community Midwives /Obstetric Consultants /Hospital-Based Midwives)

Letter of Introduction to Self Employed Community Midwives

School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin 2
Date

Re: An Ethnographic Study of In-Labour Transfer to Hospital for Planned Homebirth.

Dear Self Employed Community Midwife, *(Names will be inserted as appropriate),*

My name is Linda Biesty, I am a Lecturer in Midwifery and PhD Student in the School of Nursing and Midwifery, Trinity College Dublin.

I am very interested in generating evidence from key stakeholders to inform practice regarding transfer in-labour from home to hospital.

Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in-labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers and consultant obstetricians.

This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and 3 maternity hospital sites.

I have prepared an Information Leaflet which tells you about the study and what it means to participate. I am happy to provide more information to you and answer any questions you may have.

Please consider taking part in this study. If you feel that this is something that would interest you, I would be grateful if you would read the Information Leaflet and contact me (my contact details are at the end of this letter and on the information leaflet).

Thank you for taking time to consider my request,

Linda Biesty.

Letter of Introduction to Women who Plan to Birth at Home / Women who have experienced and In-Labour Transfer to Hospital when Home Birth was planned

School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin 2
Date

Re: An Ethnographic Study of In-Labour Transfer to Hospital for Planned Homebirth.

Dear Madam *(Name to be inserted by Gatekeeper),*

My name is Linda Biesty, I am a registered midwife, a Lecturer in Midwifery and PhD Student in the School of Nursing and Midwifery, Trinity College Dublin.

I am very interested in generating evidence from key stakeholders to inform practice regarding transfer in-labour from home to hospital.

Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that some women who plan to birth at home will experience a transfer to hospital and obstetric led care will be necessary. We do not know about the experiences of in-labour transfer to hospital when a home birth is planned in Ireland.

This study will find out what happens when an in-labour transfer from home to hospital is required. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers and consultant obstetricians.

This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and 3 maternity hospital sites.

I have prepared an Information Leaflet which tells you about the study and what it means to participate. I am happy to provide more information to you and answer any questions you may have.

Please consider taking part in this study. If you feel that this is something that would interest you, I would be grateful if you would read the Information Leaflet and contact me (my contact details are at the end of this letter and on the information leaflet).

Thank you for taking time to consider my request,

Linda Biesty.

Letter of Introduction to Obstetric Consultants /Hospital-Based Midwives

School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin 2
Date

Re: An Ethnographic Study of In-Labour Transfer to Hospital for Planned Homebirth.

Dear Dr. / Midwife,

My name is Linda Biesty, I am a Lecturer in Midwifery and PhD Student in the School of Nursing and Midwifery, Trinity College Dublin.

I am very interested in generating evidence from key stakeholders to inform practice regarding transfer in-labour from home to hospital.

Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in-labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers and consultant obstetricians.

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Please consider taking part in this study. If you feel that this is something that would interest you, I would be grateful if you would read the Information Leaflet and contact me (my contact details are at the end of this letter and on the information leaflet).

Thank you for taking time to consider my request,

Linda Biesty.

Letter of Introduction to Midwives and Doctors (re Opt-out of study)

School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier Street,
Dublin 2
Date

Re: An Ethnographic Study of In-Labour Transfer to Hospital during Planned Homebirth

Dear Midwife / Doctor,

My name is Linda Biesty, I am a Lecturer in Midwifery and PhD Student in the School of Nursing and Midwifery, Trinity College Dublin.

I am very interested in generating evidence from key stakeholders to inform practice regarding transfer in-labour from home to hospital.

Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in-labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers, midwives, doctors and consultant obstetricians.

This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and 3 maternity hospital sites.

I have prepared an Information Leaflet which tells you about the study and what it means to participate. I am happy to provide more information to you and answer any questions you may have.

Please consider taking part in this study. If you feel that this is something that would **not** interest you, I would be grateful if you would sign and return the **opt-out** form.

Thank you for taking time to consider my request,

Linda Biesty

Example of Participant Information Leaflet

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Women Who Plan to Birth at Home (antenatal observation)

Are you planning to have a Home Birth?

Are you over the age of 18?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in-labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that some women who plan to birth at home will experience a transfer to hospital and obstetric led care will be necessary. We do not know about the experiences of in-labour transfer to hospital when a home birth is planned in Ireland. This study will find out what happens when an in-labour transfer from home to hospital is required. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers and consultant obstetricians.

Why have I been invited to participate? I don't know who you are but I have asked your midwife to send you this information package to invite to take part in this study because I would like to get a better insight into the experiences of women who plan a home birth in relation to transfer to hospital during labour. I hope that 10 women will take part in the antenatal observation section and 15 women will participate in the postnatal interviews.

Do I have to take part? No. It is your choice whether you take part or not. If you decide to take part you will be asked to sign a consent form, you are still free at any time to withdraw without giving a reason. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you have before entering this study.

What does taking part involve? Please contact me and I will answer any outstanding question you may have. I will contact you a week later and if you are still willing to participate in this study we can make the necessary arrangements.

I have asked *your* midwife to give you this information, and if ye are both willing I would like to be present when ye have the *birth talk* – (the antenatal discussion which takes place around the topic of birth and labour).

If you give me your permission to contact you after your baby is born I will ask you if you transferred to hospital during your labour. If you have I would like to interview you about this experience. If you are willing we will then arrange a time and a date that is suitable for the interview at a location that will suit you.

What will the Non Participant Observation Session be like? I will be present during an antenatal visit where issues regarding birth and labour will be discussed. I will be present as an observer only, I will not be there to offer my opinion or any care. I will ask your permission to write down what I see, hear and interpret about this visit. There is a consent form for the observation session which I will ask you to sign to highlight that you are willing to participate, however you are free to stop / ask me to leave at any point.

What will the interview be like? If you experience a transfer from home to hospital during your labour I will ask if you would like to participate in a 1 to 1 interview. The interview will be a bit like a conversation but it will be tape recorded. I will ask you to talk freely of your experiences of being transferred to hospital in-labour. I will ask you questions about your experiences when you were planning your birth, during your labour, the birth and afterwards and what were the good and not so good parts of your experiences.

The time it takes for an interview varies and will be influenced by how much you would like to say. There is a separate consent form for the interviews which I will ask you to sign to highlight that you are willing to participate in the interview, however you are free to stop/ withdraw from the interview at any point.

How will the information from the Observation Session and Interview be used? The issues which emerge from the observations and interviews will be analysed and will be the findings of this study. The study will be written up as a PhD Thesis. There will also be publications in peer reviewed journals and conference presentations. The thesis, publications and presentations will include summaries and anonymised quotations from some interviews. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, the findings from this study will provide an understanding of the transition between midwifery-led and obstetric-led care through exploring the transfer to hospital is required. The information gained will then be used in planning maternity service developments.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participation? You **cannot** participate in this study if any of the following are true

The Antenatal Observation Session

Women who are:

not planning to have a home birth , **not** receiving care from a self employed midwife,

not over 18 years of age

The Postnatal Interview

Women who:

did **not** experience a transfer to hospital during their labour when they planned to have a home birth

are **not** over 18 years of age

Will anyone know I have taken part? Yes, the midwife who also participates in the observation of the *birth talk*. Otherwise – no. Your identity will remain confidential. Your name will not be published and will not be given to anyone. Any identifying feature will be removed before publication of the research findings. All information will be stored in accordance with the Data Protection Act 2003., However, you are free to discuss your participation with others if you choose

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Stopping the Study. This is not an intervention study, therefore, the likelihood of the researcher stopping the study or your participation in it is very low.

Who has reviewed this study? This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and from 3 maternity hospital sites.

Where can I get further information?

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at

086 xxxxxxx biestyl@xxx.xxx

If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

Participant Information Leaflet for Women who Plan to Birth at Home (Labour and Birth Observation)

(Leaflet in Microsoft Publisher)

Will anyone know I have taken part? Yes, if you agree to my presence during labour and birth, your midwife will be aware that you are taking part in this study. Otherwise no. Your identity will remain confidential. Your name will not be published and will not be given to anyone. Any identifying feature will be removed before publication of the research findings. All information will be stored in accordance with the Data Protection Act 2003., However, you are free to discuss your participation with others if you choose

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

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Where can I get further information?

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at

086 xxxxxxx biestyl@xxx.xxx

If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Women Who Plan to Birth at Home (Labour & Birth)

Are you planning to have a Home Birth?

Are you over the age of 18?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in-labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that some women who plan to birth at home will experience a transfer to hospital and obstetric led care will be necessary. We do not know about the experiences of in-labour transfer to hospital when a home birth is planned in Ireland. This study will find out what happens when an in-labour transfer from home to hospital is required. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers and consultant obstetricians.

Why have I been invited to participate? I don't know who you are but I have asked your midwife to send you this information package to invite to take part in this study because I would like to get a better insight into the experiences of women who plan a home birth in relation to transfer to hospital during labour. I hope that 10 women will take part in the antenatal observation section and 15 women will participate in the postnatal interviews.

Do I have to take part? No. It is your choice whether you take part or not. If you decide to take part you will be asked to sign a consent form, you are still free at any time to withdraw without giving a reason. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you have before entering this study.

What does taking part involve? Please contact me and I will answer any outstanding question you may have. I will contact you a week later and if you are still willing to participate in this study we can make the necessary arrangements.

I have asked *your* midwife to give you this information, and if ye are both willing I would like to be present when ye have the *birth talk* – (the antenatal discussion which takes place around the topic of birth and labour).

If you give me your permission to contact you after your baby is born I will ask you if you transferred to hospital during your labour. If you have I would like to interview you about this experience. If you are willing we will then arrange a time and a date that is suitable for the interview at a location that will suit you.

What will the Observation Session be like?

If agreed, I will be present during you labour and birth experiences. I will ask your permission to write down what I see, hear and interpret about this visit. I am a midwife and have signed an MOU with the HSE. This legally allows me to help and offer care if an emergency situation arises. There is a consent form for the observation session which I will ask you to sign to highlight that you are willing to participate, however you are free to stop / ask me to leave at any point.

How will the information from the Observation Session be used? The issues which emerge from the observations will be analysed and will be the findings of this study. The study will be written up as a PhD Thesis. There will also be publications in peer reviewed journals and conference presentations. The thesis, publications and presentations will include summaries and anonymised quotations from some interviews. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, the findings from this study will provide an understanding of the transition between midwifery-led and obstetric-led care through exploring the transfer to hospital is required. The information gained will then be used in planning maternity service developments.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participation? You **cannot** participate in this study if any of the following are true

The Observation Session

Women who are:

not planning to have a home birth , **not** receiving care from a self employed midwife,

not over 18 years of age

Participant Information Leaflet for Women who have Experienced and In-Labour Transfer to Hospital when Home Birth was Planned

(Leaflet in Microsoft Publisher)

Will anyone know I have taken part? No. Your identity will remain confidential. Your name will not be published and will not be given to anyone. Any identifying feature will be removed before publication of the research findings. All information will be stored in accordance with the Data Protection Act 2003.

However, you are free to discuss your participation with others if you choose.

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Stopping the Study. This is not an intervention study, therefore, the likelihood of the researcher stopping the study or your participation in it is very low.

Who has reviewed this study? This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and from 3 maternity hospital sites.

Where can I get further information?

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at

086 xxxxxxx   biestyl@xxx.xxx

If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Women who Have Experienced an In-Labour Transfer to Hospital Home Birth was Planned.

Have you experienced an in-labour transfer to hospital when Home Birth was planned ?

Are you over the age of 18?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in-labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? Birth in hospital is viewed as 'normal' in Ireland, seeking a home birth is regarded as a deviation, a stepping outside the conventional model of care. It is inevitable that some women who plan to birth at home will experience a transfer to hospital and obstetric led care will be necessary. We do not know about the experiences of in-labour transfer to hospital when a home birth is planned in Ireland. This study will find out what happens when an in-labour transfer from home to hospital is required. This study aims to gather experiences of women, self employed community midwives, delivery suite midwifery managers and consultant obstetricians.

Why have I been invited to participate? I don't know who you are but I have asked your midwife to send you this information package to invite to take part in this study because I would like to get a better insight into the experiences of women who plan a home birth in relation to transfer to hospital during labour. I hope that 15 women will participate in the postnatal interviews.

Do I have to take part? No. It is your choice whether you take part or not. If you decide to take part you will be asked to sign a consent form, you are still free at any time to withdraw without giving a reason. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you have before entering this study.

What does taking part involve? Please contact me and I will answer any outstanding question you may have. I will contact you a week later and if you are still willing to participate in this study we can make the necessary arrangements.

If you have experienced an in-labour transfer to hospital from planned home birth in the last 3 years I would like to interview you about your experiences.

What will the interview be like? The interview will be a bit like a conversation but it will be tape recorded. I will ask you to talk freely of your experiences of being transferred to hospital in-labour. I will ask you questions about your experiences when you were planning your birth, during your labour, the birth and afterwards and what were the good and not so good parts of your experiences.

The time it takes for an interview varies and will be influenced by how much you would like to say. There is a separate consent form for the interviews which I will ask you to sign to highlight that you are willing to participate in the interview, however you are free to stop/ withdraw from the interview at any point. You will be given access to the transcripts of your interviews.

How will the information from the Observation Session and Interview be used? The issues which emerge from the interviews will be analysed and will be the findings of this study. The study will be written up as a PhD Thesis. There will also be publications in peer reviewed journals and conference presentations. The thesis, publications and presentations will include summaries and anonymised quotations from some interviews. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, the findings from this study will provide an understanding of the transition between midwifery-led and obstetric-led care through exploring the transfer for planned home birth where an in-labour transfer to hospital is required. The information gained will then be used in planning maternity service developments.

Are there any risks associated with participating in this study?

None anticipated.

Who is excluded from participation?

You <u>**cannot**</u> participate in this study if any of the following are true

Women who:

- did **not** experience a transfer to hospital during their labour when they planned to have a home birth with the care of a self employed community midwife

are **not** over 18 years of age

Participant Information Leaflet for Self-Employed Community Midwives

(Leaflet in Microsoft Publisher)

Will anyone know I have taken part? Yes, the woman who is involved in the non participant observation of the antenatal discussion surrounding birth and labour. Otherwise - no. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone. Any identifying feature will be removed before publication of the research findings. All information will be stored in accordance with the Data Protection Act 2003. However, you are free to discuss your participation with others if you choose.

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Stopping the Study. This is not an intervention study, therefore, the likelihood of the researcher stopping the study or your participation in it is very low.

Who has reviewed this study? This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and from 3 maternity hospital sites.

Where can I get further information? You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at 086 3407889. If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

If you have any questions about the study please contact :

Linda Biesty

086xxxxxxx biestyl@xxx.xxx

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Self Employed Community Midwives.

Have you experience of transferring women in-labour to hospital care when home birth was planned?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in-labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in-labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland.

This study will focus on complex interactions between women, self employed community midwives, obstetric consultants and hospital based midwives and will provide an exploration of the transfer process in order to understand in-labour transfer from midwifery to obstetric-led models of care.

Why have I been invited to participate? Your name is on the web site of the Home Birth Association. You have been sent this information leaflet because I would like to observe an antenatal visit between you and a woman where you plan to discuss issues surrounding birth, labour and possible transfer to hospital. I would also like to explore your experiences of in-labour transfer to hospital when home birth was planned

Do I have to take part? No. It is your choice whether you take part or not. If you decide to take part you will be asked to sign a consent form, you are still free at any time to withdraw without giving a reason. If you decide not to participate, or if you withdraw, you will not be asked to justify your decision.

What does taking part involve? I am asking you to: Act as a Gatekeeper and make information packs available to all women (over the age of 18) in your care planning a home birth and to

1)-participate in the -

- observation of the discussion surrounding birth and labour (with a woman to whom you are offering care)
- the observation of labour and birth (with a woman to whom you are offering care)

2) participate in an in-depth 1:1 interview with the researcher, to explore and understand your experiences of transfer

3) act as a Gatekeeper and make information packs available to all women (over the age of 18) in your care in the last 3 years who have experienced an in-labour transfer from home to obstetric-led care

What will the Non Participant Observation Session be like? I will be present during an antenatal discussion regarding topic of birth, labour and issues which emerge around the discussion of in-labour transfer to hospital. During this time I will be present as an observer. I will sit, observe and record. I will not participate in the discussion in any way.

If agreed, I will be present during the labour and birth experience of a woman to whom you are offering care. I will ask your permission to write down what I see, hear and interpret about this visit. I am a midwife and have signed an MOU with the HSE. This legally allows me to help and offer care if an emergency situation arises.

What will the interview be like? A second significant element of data collection will involve tape recorded unstructured interviews where you will be invited to talk freely of your experiences surrounding the transfer for women in-labour to hospital when home birth was planned. The time it takes for an interview varies and will be influenced by how much you wish to say. A separate consent form is proposed to formally record your willingness to participate in this interview. You will be given access to the transcripts of your interviews.

How will the information from the Observation Session and Interview be used? The data which emerges from the observation session and the interviews will be analysed and will inform the findings of this study, the write up of the PhD Thesis, publications in peer reviewed journals and conference presentations. The thesis, publications and presentations will include summaries and anonymised quotations from some interviews. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, it is proposed that the findings which emerge from this study will provide an understanding of the structures and processes inherent in the transition between midwifery-led and obstetric-led care through exploring the transfer process for planned home birth where an in-labour transfer to hospital is required.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participation? You cannot participate in this study if any of the following are true

You are a self employed community midwife who has: Not been involved in an in-labour transfer to hospital when offering care to a woman who has planned a home birth.

Participant Information Leaflet for Obstetric Consultants (Interview)

(Leaflet in Microsoft Publisher)

Permission. This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and the Ethics Committee of your place of employment.

Further Information You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at xxxxxxxxx. If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

Where can I get further information?

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at

086 xxxxxxx biestyl@xxx.xxx

If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Consultant Obstetricians.

Have you / have you held a post of 'clinical lead' within your organisation?

Have you experience of receiving women transferred to hospital in-labour when home birth was planned?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in-labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland.

This study will focus on complex interactions between women, self employed community midwives, obstetric consultants and hospital based midwives and will provide an exploration of the transfer process in order to understand in-labour transfer from midwifery to obstetric-led models of care.

Why have I been invited to participate? You have been sent this information leaflet because I would like to explore with Consultant Obstetricians their experiences of receiving women transferred to hospital in labour when home birth was planned.

Do I have to take part? No. It is your choice whether you take part or not. If you decide to take part you will be asked to sign consent form, you are still free at any time to withdraw without giving a reason. If you decide not to participate, or if you withdraw, you will not be asked to justify your decision.

What does taking part involve? Please contact me and I will answer any outstanding question you may have. I will contact you a week later and if you are still willing to participate in this study we can make the necessary arrangements. We will then arrange a time and a date that is suitable for the interview at a location that will suit you.

What will the interview be like? A significant element of data collection for this study will involve tape recorded unstructured interviews where you will be invited to talk freely of your experiences of receiving women transferred to hospital when home birth was planned. You will be given access to the transcripts of your interviews.

How will the information from the interview be used? The data which emerges from the interviews will be analysed and will inform the findings of this study, the write up of the PhD Thesis, publications in peer reviewed journals and conference presentations. The thesis, publications and presentations will include summaries and anonymised quotations from some interviews. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, it is proposed that the findings which emerge from this study will provide an understanding of the structures and processes inherent in the transition between midwifery led and obstetric-led care through exploring the transfer process for planned home birth where an in-labour transfer to hospital is required.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participation? You <u>cannot</u> participate in this study if any of the following are true

Consultant Obstetricians who:

Do **not** have a clinical lead within their organisation

Have **not** experience of receiving women transferred to hospital in labour when a home birth was planned

Will anyone know I have taken part? No. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone. Any identifying feature will be removed before publication of the research findings. All information will be stored in accordance with the Data Protection Act 2003.

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Stopping the study. This is not an intervention study; therefore the likelihood of the researcher stopping the study or your participation is very low.

Participant Information Leaflet for Hospital-Based Midwives (Interview)

(Leaflet in Microsoft Publisher)

Will anyone know I have taken part No. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone. Any identifying feature will be re moved before publication of the re search findings. All information will be stored in accordance with the Data Protection Act 2003.

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Stopping the study. This is not an intervention study; therefore the likelihood of the researcher stopping the study or your participation is very low.

Permission. This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and the Ethics Committee of your place of employment.

Further Information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at xxxxxxx. If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

Where can I get further information?

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at

086 xxxxxxx   biestyl@xxx.xxx

If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Midwives.

Have you experience of receiving women transferred to hospital in-labour when home birth was planned?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in-labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in-labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland.

This study will focus on complex interactions between women, self employed community midwives, obstetric consultants and hospital based midwives and will provide an exploration of the transfer process in order to understand in-labour transfer from midwife to obstetric-led models of care.

Why have I been invited to participate? You have been sent this informa tion leaflet because I would like to explore with hospital-based midwives their experiences of receiving women transferred to hospital in-labour when home birth was planned.

Do I have to take part? No. It is your choice whether you take part or not. If you decide to take part you will be asked to sign a consent form, you are still free at any time to withdraw without giving a reason. If you decide not to participate, or if you withdraw, you will not be asked to justify your decision.

What does taking part involve? Please contact me and I will answer any outstanding question you may have. I will contact you a week later and if you are still willing to participate in this study we can make the necessary arrangements. We will then arrange a time and a date that is suit able for the interview at a location that will suit you.

What will the interview be like? A significant element of data collection for this study will involve tape recorded unstructured interviews where you will be invited to talk freely of your experiences of receiving women transferred to hospital when home birth was planned. You will be given access to the transcripts of your interviews.

How will the information from the interview be used? The data which emerges from the interviews will be analysed and will inform the findings of this study, the write up of the PhD Thesis, publications in peer reviewed journals and conference presentations. The thesis, publications and presentations will include summaries and anonymised quotations from some interviews. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, it is proposed that the findings which emerge from this study will provide an understanding of the structures and processes inherent in the transition between midwife-led and obstetric-led care through exploring the transfer process for planned home birth where an in-labour transfer to hospital is required.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participation?

You <u>cannot</u> participate in this study if any of the following are true

Midwives who:

Have not experience of receiving women transferred to hospital in-labour when a home birth was planned

Participant Information Leaflet for Hospital-Based Midwives and Obstetricians (Observation)

(Leaflet in Microsoft Publisher)

Is there any compensation associated with this study? This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Stopping the study. This is not an intervention study, therefore the likelihood of the researcher stopping the study or your participation is very low.

Permission. This study has received ethical approval from the Faculty of Health Sciences Research and Ethics Committee, Trinity College Dublin and the Ethics Committee of your place of employment.

Further Information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at xxxxxxx If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

Where can I get further information?

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Linda Biesty who can be telephoned at

086 xxxxxxx biestyl@xxx.xxx

If the research team learns of important new information that might affect your desire to remain in they study, you will be informed at once.

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth.

Participant Information Leaflet for Midwives and Obstetricians (Opt-out)

Are you a midwife or a doctor working on the labour ward?

Is it possible that you may be present when a woman, who initially planned a home birth, is transferred to hospital in-labour ?

Researcher: Linda Biesty.

Who am I? My name is Linda Biesty, I am a Midwife, a Lecturer in Midwifery and a PhD Student at Trinity College Dublin (TCD). If you wish, you can read more about me at http://people.tcd.ie/biestyl

I would like to invite you to participate in a study about in labour transfer from home to hospital for planned home birth in Ireland. Before you decide whether you want to take part I would like to tell you why the research is being done and what you can expect if you take part.

What is the purpose of this study? It is inevitable that for a percentage of women availing of care at home that transfer to hospital and obstetric led care will be necessary. The issues surrounding in-labour transfer to hospital when a home birth is planned are unexplored in the context of maternity care provision in Ireland.

This study will focus on complex interactions between women, self employed community midwives, obstetric consultants and hospital based midwives and will provide an exploration of the transfer process in order to understand in-labour transfer from midwife to obstetric-led models of care.

Why have I been invited to participate? You are a health care professional offering care on the labour ward You have been sent this information leaflet because I would like to observe the initial interactions that occur with a woman who plans a home birth experiences an in-labour transfer to hospital

Do I have to take part? No. It is your choice whether you take part or not. If you decide not to take part you will be asked to sign an opt out consent form. If you decide not to participateyou will not be asked to justify your decision.

What does taking part involve? I am asking to observe the initial interactions between all key stakeholders (i.e. interactions between women, self employed community midwives, hospital based midwives and doctors) that occur on transfer to hospital from home birth.

What will the observation be like? If you agreed, I will be present during the initial transfer to hospital. During this time I will be present as an observer. I will sit, observe and record. I will not participate in the dis cussion in any way.

How will the information from the interview be used? The data which emerges from the interviews will be analysed and will inform the findings of this study, the write up of the PhD Thesis, publications in peer reviewed journals and conference presentations. You may ask for a summary of the results if you wish.

Are there any benefits associated with participating in this study? There are no direct benefits to your participating in this study. However, it is proposed that the findings which emerge from this study will provide an understanding of the structures and processes inherent in the transition between midwife-led and obstetric-led care through exploring the transfer process for planned home birth where an in-labour transfer to hospital is required.

Are there any risks associated with participating in this study? None anticipated.

Will anyone know I have taken part? Yes, the other participants involved in the observation session. Otherwise—no. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone. Any identifying feature will be removed before publication of the research findings. All information will be stored in accordance with the Data Protection Act 2003. However, you are free to discuss your participation with anyone you choose.

Who is excluded from participation?

You <u>cannot</u> participate in this study if any of the following are true

Midwives and doctors who: are not present / involved when a woman is transferred to hospital from planned home birth.

Consent form for participation in the Observation Session (Self Employed Community Midwives)

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )

I have read and understand this consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an observation of the *birth talk* – the antenatal discussion which takes place around the topic of birth and labour between me and a woman planning to birth at home ( )
I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights ( )

I have received a copy of this agreement and I understand that the results of this research study will be published ( )

I understand that I may withdraw from this study at any time ( )

Participant's Name:

Contact Details:

Participant's Signature:
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher's Signature:
Date:

Consent form for Observation of Labour and Birth Session (Self Employed Community Midwives)

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):
I have read the study information leaflet ( )

I have read and understand this consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an observation of a woman's labour and birth ( )

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights ( )

I have received a copy of this agreement and I understand that the results of this research study will be published ( )

I understand that I may withdraw from this study at any time ( )

Participant's Name:

Contact Details:

Participant's Signature
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher's Signature:
Date:

Consent form for participation in the Observation Session (Women planning to birth at home)

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )

I have read and understand this consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an observation of the *birth talk* – the antenatal discussion which takes place around the topic of birth and labour between me and my Self Employed Community Midwife ( )

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I freely and voluntarily agree to be part of this research study, though without
prejudice to my legal and ethical rights ( )

I have received a copy of this agreement and I understand that the results of this research study will be published ( )
I consent to have the researcher accompany my midwife during a care episode in my home ( )

I agree that the researcher can contact me after I have had my baby to see if I am eligible and willing to participate in the postnatal interview part of this study ( )

I understand that if the researcher witnesses any harm occurring to children in my home that she is professionally obliged to report such harm to the relevant authorities without my consent ( )

I understand that I may withdraw from this study at any time ( )

Participant's Name:

Contact Details:

Participant's Signature
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher's Signature:
Date

Consent Form for the Observation of Labour and Birth Session (women planning to birth at home)

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )

I have read and understand this consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an observation of my labour birthing experiences ( )

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights ( )

I have received a copy of this agreement and I understand that the results of this research study will be published ( )

I consent to have the researcher accompany my midwife during a care episode
in my home ( )

I agree that the researcher can contact me after I have had my baby to see if I am eligible and willing to participate in the postnatal interview part of this study ( )

I understand that if the researcher witnesses any harm occurring to children in my home that she is professionally obliged to report such harm to the relevant authorities without my consent ( )

I understand that I may withdraw from this study at any time ( )

Participant's Name:

Contact Details:

Participant's Signature:
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher's Signature:
Date

Consent Form for Participation in 1:1 Interview (women who have experienced an in-labour transfer to hospital for planned home birth) An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )

I have read and understand this consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an 1:1 recorded interview ( )

I understand that that I can access my interview transcripts ( )

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights ( )

I have received a copy of this agreement and I understand that the results of this research study will be published ( )

I understand that if the researcher witnesses any harm occurring to children in my home that she is professionally obliged to report such harm to the relevant authorities without my consent ( )

I understand that I may withdraw from this study at any time ( )

Participant's Name:

Contact Details:

Participant's Signature
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully

answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher's Signature:
Date

Opt-Out Consent Form for Participation in the Observation of in-Labour Transfer to Hospital During Planned Home Birth (hospital-based midwives and doctors)

An Ethnographic Study of In-Labour Transfer to Hospital during Planned Home Birth.

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )

I have read and understand this opt out consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an observation of the interactions that occur during an in-labour transfer to hospital, I wish to **opt-out** of this study ( )

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I understand that the results of this research study will be published ( )

I understand that I may opt in to this study at any time ( )

Participant's Name:

Participant's Signature:
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely opted out of this study.

Researcher's Signature:
Date:

Consent Form for Participation in 1:1 Recorded Interview (Self Employed Community Midwives /Obstetric Consultants /Hospital-Based Midwives)

An Ethnographic Study of In-Labour Transfer to Hospital for Planned Home Birth

Researcher: **Linda Biesty**

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )

I have read and understand this consent form ( )

I have had the opportunity to ask questions ( )

All my questions have been answered to my satisfaction ( )

I understand that taking part in this research involves an 1:1 recorded interview ( )

I understand that that I can access my interview transcripts ( )

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights ( )

I have received a copy of this agreement and I understand that the results of this research study will be published ( )
I understand that I may withdraw from this study at any time ( )

Participant's Name:

Contact Details:

Participant's Signature:
Date:

Statement of researcher's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved/ I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

Researcher'sSignature: **Date:**

Appendix 5:
Profile of the Women

Name	When we met	Place of Birth (History)	Reason for Transfer	Observation – Antenatal Visits	Observation -Labour & Birth / Transfer	Postnatal Meeting	Postnatal Interview	SECM
1. Ailis	I met Ailis during her 1st pregnancy	This pregnancy – in-labour transfer to hospital	Fetal bradycardia during 1st stage of labour	√√	√	√√	√	Bridget
2. Lana	I met Lana during her 3rd pregnancy	Previous birth – home births This pregnancy – in labour transfer to hospital	Fetal Malposition	√√√	√	√√√	√	Bridget
3. Eibhlin	I met Eibhlin during her 2nd pregnancy	Previous birth – hospital (Planned) This pregnancy – birth at home, transfer to hospital directly after birth	Transferred immediately after the birth of the baby	√	√	√√	√	Bridget

4. Cait	I met Cait during her 3rd pregnancy	Previous Births - Home Births This pregnancy – home birth	----------	√	√	√		Siofra
5. Riona	I met Riona during her 2nd pregnancy	Previous Birth - Hospital (Planned) This pregnancy – Home Birth	----------	√	√	√√√		Leah
6. Iseabeal	I met Iseabeal during her 3rd pregnancy	Previous births – hospital (Planned) This pregnancy – home birth	----------	√√	√	√√		Bridget
7. Niamh	I met Niamh during her 3rd pregnancy	Previous births – hospital (Planned), home birth This pregnancy – home birth	----------	√	√	√√		Bridget
8. Nessa	I met Nessa during her 3rd pregnancy	Previous births – hospital (Planned) This pregnancy – home birth	----------	√	√			Bridget

9. Sile	I met Sile during her 3rd pregnancy	Previous births - home births This pregnancy – home birth	----------	√	√	√	√	Bridget
10. Caitlin	I met Caitlin during her 2nd pregnancy	Previous birth – home birth This pregnancy – home birth	----------		√	√		Ciara
11. Cara	I met Cara during her 2nd pregnancy	Previous birth – home birth This pregnancy – in-labour transfer to hosptial	Prolonged length of the 1st stage of labour	√			√	Caoimhe
12. Alannah	I met Alannah during her 1st pregnancy	This pregnancy – in-labour transfer to hospital	Prolonged length of the1st stage of labour	√√			√	Bridget
13. Mairead	I met Mairead during her 1st pregnancy	This pregnancy – in-labour transfer to hospital	For pharmacological analgesia during 1st stage of labour	√√√			√	Bridget
14. Jenniver	I met Jenniver during her 1st pregnancy	This pregnancy – in-labour transfer to hospital	Prolonged length of the 1st stage of labour	√			√	Naoise

15. Maura	I met Maura during her 2nd pregnancy	Previous birth – hospital (Planned) This pregnancy – transfer to hospital for IOL	Medical Induction of Labour	√√		√	√	Cliodhna
17. Roisin	I met Roisin during her second pregnancy	Previous birth – home birth This pregnancy – went into labour in hospital (there for another reason), birthed in hospital	Labour onset during a visit to A&E for non-pregnancy related issue	√√		√√	√	Bridget
18. Olwyn	I met Olwyn during her 2nd pregnancy	Previous birth – hospital birth (Planned) This pregnancy – home birth	----------	√		√		Caoimhe

19. Siadbh	I met Siadbh during her 3rd pregnancy	Previous births – home births This pregnancy – home birth	----------	√		√√		Leah
20. Tara	I met Tara during her 1st pregnancy	This pregnancy – home birth	----------	√				Cliodhna
21. Grainne	I met Grainne during her 2nd pregnancy	Previous birth – hospital birth (Planned) This pregnancy – home birth	----------	√				Cliodhna
22. Laoise	I met Laoise during her first pregnancy	Transferred to obstetric care during antenatal period	Transferred to obstetric-care antenatally	√				Caoimhe
23. Doireann	I met Doireann during her 2nd pregnancy	Previous birth – home birth This pregnancy – home birth	----------	√				Caoimhe

24. Orla	I met Orla during her 3rd pregnancy	Previous births – hospital births (Planned) This pregnancy – home birth	----------	√		√		Naoise
24. Ide	I met Ide during her 1st pregnancy	This pregnancy – home birth	----------	√				Bridget
25. Clodagh	I met Clodagh after the birth of her 2nd baby	Previous birth – hospital (Planned) This birth – in-labour transfer to hospital during planned home birth	Prolonged length of the 2nd stage of labour				√	Cliodhna
26. Brid	I met Brid after the birth of her first baby	This birth – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour			√	√	Cliodhna

27. Carys	I met Carys after the birth of her 1st baby Carys had a 2nd baby during the course of the study	First pregnancy – in-labour transfer to hospital during planned home birth Second pregnancy – home birth	Prolonged length of the 1st stage of labour				√	Peig
28. Gwen	I met Gwen after the birth of her 1st baby	This pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour				√	Cliodhna
29. Geraldine	I met Geraldine after the birth of her 2nd baby	First Pregnancy – hospital birth (Planned) Second pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 2nd stage of labour				√	Peig

30. Blaithin	I met Blaithin after the birth of her 2nd baby	First Pregnancy – hospital birth (Planned) Second pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour & meconium in liquor				√	Caoimhe
31. Gilda	I met Gilda after the birth of her 1st baby	This pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour, meconium & fetal bradycardia				√	Caoimhe
32. Armelle	I met Armelle after the birth of her 1st baby Armelle had a 2nd baby during the time of the study	First pregnancy – in-labour transfer to hospital during planned home birth Second pregnancy – home birth	Prolonged length of the 1st stage of labour & meconium stained liquor				√	Peig

33. Aideen	I met Aideen after the birth of her 1st baby	This pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour				√	Enora
34. Ethna	I met Ethna after the birth of her 1st baby	This pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour				√	Caoimhe
35. Norah	I met Norah after the birth of her 1st baby	This pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour				√	Caoimhe
36. Rona	I met Rona after the birth of her 1st baby	First pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour			√√√	√	Bridget

37. Cora	I met Cora after the birth of her 1st baby Cora had a 2nd baby during the study	First pregnancy – in-labour transfer to hospital during planned home birth Second pregnancy – home birth	Prolonged length of the 1st stage of labour				√	Siofra
38. Sinead	I met Sinead after the birth of her 1st baby Sinead had a 2nd baby during the study	First pregnancy – in-labour transfer to hospital during planned home birth Second pregnancy – home birth	Prolonged length of the 1st stage of labour			√√	√	Bridget
39. Ailsa	I met Alisa after the birth of her 2nd baby	First pregnancy – hospital birth (Planned) Second pregnancy – in-labour transfer to hospital during planned home birth	Retained Placenta				√	Kaylin

40. Aoife	I met Aoife after the birth of her 2nd baby	First pregnancy – hospital birth (Planned) Second pregnancy – in-labour transfer to hospital during planned home birth	Prolonged length of the 1st stage of labour			√	√	Kaylin
41. Aoibh	I met Aoibh after the birth of her 2nd baby	First pregnancy – in-labour transfer to hospital for planned home birth Second pregnancy – in-labour transfer to hospital during planned home birth	 Prolonged length of the 1st stage of labour & meconium in liquor			√	√	Caitriona
42. Arlene	I met Arlene after the birth of her 1st baby	First pregnancy – in-labour transfer to hospital for planned home birth	Malpresentation			√√√	√	Leah

Appendix 6:
Interview Guide

I opened each interview with a set question that triggered a personal narrative. The participants were invited to talk about the issues that they considered relevant and I probed with open-ended questions when appropriate. I avoided a rigid interview schedule but as categories emerged I incorporated them into later interviews.

The participants were asked these questions (or a variation of them) (See Section 6.3.2).

Interviews with Women:
Opening Question: Tell me why you planned a home birth?

Followed by opened ended questions inviting the participants to talk about their experiences of in-labour transfer

Questions developed and invited the participants to talk about:

- their expectations of home birth
- their experiences of planning a home birth in Ireland
- their interactions with healthcare professions during pregnancy
- the meaning they place on possible in-labour transfer to hospital during pregnancy
- their labour story
- their experiences of in-labour transfer
    - prior to transfer
    - on arrival in hospital
    - the ongoing experience
- the sense they make of their transfer

Interviews with Self Employed Community Midwives:
Opening Question: Tell me why you became a SECM?

Followed by opened ended questions inviting the participants to talk about their experiences of in-labour transfer

Questions developed and invited the participants to talk about:

- their experiences in relation to home birth
- being a home birth midwife (a SECM) in Ireland
- their experiences of in-labour transfer
    - prior to transfer
    - on arrival to hospital
    - when hospital-based practitioners are involved in offering women care
- what it is like to be an SECM at an in-labour transfer

Interviews with Hospital-Based Midwives and Obstetricians:
Opening Question: Tell me about your experiences in relation to home birth?

Followed by opened ended questions inviting the participants to talk about their experiences of in-labour transfer

Questions developed and invited the participants to talk about:

- their experiences of transfer
  - prior to the transfer
  - when the woman (women) and SECM arrive to the hospital
  - when they are offering care
- what it is like to be a hospital-based practitioner in this situation

Appendix 7:
Audit Trail

My Audit Trail (Adapted from Lincoln & Guba (1985), p. 391)

Examples of my adaptation of the Voice-Centred Relational Method of Data Analysis

- Examples of Coded Data and Sub-Categories
- Examples of Sub-Categories to Categories
- Categories to Themes

My Audit Trail (Adapted from Lincoln & Guba (1985), p. 319)

Elements of the Audit Trail	Exemplars
Raw data	Examples of raw data, extracts from interviews and field notes are offered across chapters of this thesis and in this Appendix.
Data reduction and analysis products	This appendix provides examples of my adaptation of the Voice-Centred Relational Method of Data Analysis and highlights my adaptation of the 4 readings of VCRM across the participant groups. Appendix 2 provides some examples of moments of conceptualisation, in as much as is possible – **the "*ah ha*" moments of this** study.
Data reconstruction and synthesis products	The table – '**Examples of my adaptation of VCRM of Data Analysis' demonstrates how raw** data was coded across the 4 readings of VCRM. Additional readings allowed for the development of sub-categories and categories where links were made between shared meaning, nuances and related ideas. Throughout the process the emic and etic perspectives interacted as interview data and fieldnotes informed the emergent categories and themes (Chapter 7 & 8). Data were then examined with reference to the relevant empirical and theoretical literature (Chapter 9). Examining the themes through a lens of the dominant discourses in maternity care provided a mechanism for understanding the findings which emerged from this study and informed the contribution that this thesis makes to knowledge in an effort to best improve the maternity services for all involved (Section 9.9 Recommendations).
Process notes	Methodological notes and reflections are recorded in Chapter 5 & 6 as well as Appendix 2 and provide a rationale for the development of this study. E.g. • Section 5.4 The Development of this Critical Ethnography • Section 6.6.1 Preparation for Fieldwork – an addition source of data collection was added to the research protocol
Materials relating to intentions and dispositions	Points of reflection are offered throughout the text and extracts from my reflective diary are provided in Appendix 2. These reflections are central to my audit trail.
Instrument development	Appendix 6 provides the interview guide and highlights some interview questions that developed over the course of the study. I met several of the participants on more than one occasion and a number took part in more than one element of data collection. Section 6.9 details how this helped me to refine my questions.

Examples of my Adaptation of the Voice-Centred Relational Method of Data Analysis

Examples of Coded Data and Sub-Categories

Women				
Reading 1	Codes	Sub-Categories	An example from the data	My response to the narrative
Reading for the plot and the subplot, my response to the narratives	**Arranging a home birth** Went on internet and came across home birth **Wasn't a lot of information about home birth in Ireland** Came across a website **Didn't think you could have a home bi**rth with your first baby • Wonders now if she should have thought more about this	Difficult to arrange	*[Cáit made references to how she interpreted* ***her GP's reactions when she talked to him*** *about home birth for the first time:] They* ***[GPs] don't tell you about it, so straight away*** *you feel like they must think there is something wrong with it ... you feel like you are looking for information about something that they do not approve of. And this is when you are just looking for information*	*The SECMs describe the GPs as the* ***'gatekeepers' to the maternity services****. Now I see one of the reasons for the snotty tone that accompanies this. The women in this study met GPs who either* ***didn't support*** *home birth or knew little* ***about it ... either way recommendations,*** *discussions and supports were few and far between.*
	Contacted HBA – they told her about SECMs Assumed no problem getting a SECM SECM difficult to get SECM • Recommended by friend • Family midwife • Midwife in the area • Only one free • The one who would take her on	Finding a SECM	***"it was difficult, difficult to get information,*** *difficult to find a midwife. You really needed to be in the know or part of a little group of home birthers. I found that sense but at the time I was* ***on my own****"*	***I hadn't even considered this to be an*** *issue for women. I assumed that everyone knew what options were available to them, however, when I think back on it now how naïve of me*
	Intense early labours **Surprised when SECM didn't come the second contractions started** **Surprised the SECM didn't stay the whole time** • Needed the SECM there • We should not have been on our own	Early labour – unknown **I didn't know what was normal**	***"I had no idea what to expect, sure I hadn't*** *done it before. I was a bit naïve really. I had no idea in relation to the pain, in relation to the* ***time, I really didn't know what was normal or*** *when I needed to worry. And normally that* ***would be fine ... but when you're tired and in pain it's not easy****"*	*So many of the women talk of unexpected outcomes or events during labour. And even in some of their recalls of their stories I raise an eyebrow (e.g* ***"I was in labour for 3 days kinda things"). I need to be aware*** *that I am very comfortable with birth and I was exposed to birth long before my first personal experiences. This is not the case for many of the women.*
	Length of labour • Seemed to go on for hours • Still x cms • Slow progress • Exhausted • Tried everything	Length of labour • We tried everything	*"The pain, it was awful ... it just kept getting* ***worse and worse. I didn't know how I was*** *going* ***to do it, the water wasn't helping*** *... maybe if I knew it was going to be that sore it* ***would have been better, but I just couldn't*** *believe pain would be like that .."*	

<table>
<tr>
<td></td>
<td>High head
• Needed ARM
Wanting to push for so long
• Cervix not fully dilated
Decrease in FH

Plan made antenatally
• More antenatal discussion needed
Talked so much about transfer antenatally
No need to talk about transfer now
Aware of the length of labour
Sense of enough now – it's time to transfer
Made a plan re transfer during labour
Talked about transfer- hoped they wouldn't need to
• Time for decisions
Not an emergency – SECM introduced the idea that 'we might have to transfer'
• Gave me time to prepair
• Gave me time to get my head around it
• Made me feel like I could make the decision

Nicer than she thought it would be
• So much better than she thought it would be
• Surprised re positive interactions
I met a really good midwife -
• A midwife who protects normal birth
• She was lovely
• She was nice
• Very understanding
• Very human
• Very supportive
• They were fun
• Very positive
• Respectful
• Acknowledged my choices
• Disagreed with my choices, respectfully
Pretty positive
• Professional
• Amazing professional relationship</td>
<td>• I tried to give labour a chance

Preparing for transfer

• We talked antenatally
• We made a plan
• I knew what was coming

Needed time to get my head around to it

• I wanted it on my terms

Nicer than I thought they would be</td>
<td>"we did everything, up and down the stairs, in the pool, out of the pool. I tried to eat something, I tried to get a comfortable position. We just gave it our best shot but just couldn't get it to work"

"I knew where it was heading, I knew what was coming next"

"the SECM was very good; it was left to be my decision even though we sort of know that it would have to happen at some stage ... she sort of basically left it to me to decide it was time to go. So I wasn't hurried into making the decision of anything, it really did come from me. She suggested it 'you know, Carys, eventually you might have to go in' and several hours later when I was still four centimetres, she was saying 'well, Carys, what do you think now'? Immediately I sort of said 'ok, we're gonna have to go', which wasn't, it wasn't a very nice decision to make. But I was happy to have made it myself and I didn't feel rushed or hurried into making it"

"So the midwife knew Caoimhe [SECM] and immediately there was a warm atmosphere there. She was saying some really warm things to us ... taking me in as an individual and she was being quite supportive. And I do think that made all the difference that she knew Caoimhe and that they were able to chat away to each other and she listened to Caoimhe, telling her all about me and what I had planned"</td>
<td>I have been that woman, I have been in that place!

I have observed the relationship that develops antenatally and therefore can see how they would get to this stage. They know each other so well. The SECMs are so aware of the woman's needs etc ... I need to remember that when the women talk of transferring to the care of a HMW that this cannot be mirrored or replicated in a few minutes but there seems to be other ways of doing things.

Again and again this is making a difference ... how the SECM is perceived by the HMW ... what they think about her seems to impact on the way they interact with and support the women.</td>
</tr>
</table>

	• Warm • Lovely • Positive about home birth • Positive about hypnobirthing • Pleasant enough • Everyone seemed happy • Everyone was respectful Thought they • Would be aggressive • Would think her irresponsible • Would think the SECM irresponsible • Thought there would be more people in the room • Would interfere more • Thought she would feel more exposed • Thought she would have to justify why she was transferring in for pain relief • Thought there would be a 'told you so' attitude Anticipated • People giving out that they had to clean up the mess	The interactions- they were positive really I thought they would be awful	*"... the experience was positive really from the beginning ... I thought it was going to be so awful. I thought that people were going to be rolling their eyes and going 'homebirth, so irresponsible and then they end up here and we've to clean up the mess'. I really thought I was going to get a fairly aggressive attitude and I didn't get that at all. They were very professional first of all and then quite warm"* *"They were fine, to be honest it was grand. It wasn't anything like it had been when I was in the hospital during my pregnancy, they treated me just fine"*	*The perceptions that it is going to be awful, the reality different, and the surprise that women associate with this.* *Isn't this the way it should be. This is what I expected and this is similar to my experience. I need to remind myself that this does not seem to be reflective of all women's experiences.*
	The hospital staff acknowledged that I had planned a home birth • This was important • Said they were sorry that she had to transfer • Told her they would help sort it all out No one mention my expectations / wishes prior to hospital • No one acknowledged that my plans had changed • No one mentioned my disappointment	Acknowledging my plans & expectations	*"They said they were sorry that I didn't get my home birth but sure they would help me to get what I wanted in hospital"* *"They (HMWs) knew her (SECM) and they let her stay – that was just great. I really believe that made a difference because she was still there with me not matter what was going on"*	*The difference, for the most part, in women's experiences when the SECM is 'allowed' to stay is unbelievable. This is something that I must read for across the participant groups and it is something that I must look to in the provision of maternity care.*
	They knew the SECM • Allowed SECM to stay • They had respect for SECM • They knew the SECM and would not let her stay • Hospital had respect for me cause they knew my SECM	They knew the SECM They respected the SECM They let the SECM stay	*"... we arrived in and the bloody same obstetrician was on duty and she walked in and she goes 'So, we meet again'. And it just went from bad to worse ... absolutely bad to worse"*	*Oh how typical to meet the same doctor!*
	Awful – Went from bad to worse • *So we meet again* • Met the dr who was awful antenatally	as soon as I got there I knew the *vibe* was wrong	*"... it was so bad from the start, every little thing ... it was a terrible, terrible experience. Ok I wasn't going to have my home birth but it didn't have to be terrible ... and that was her fault [HMW], I blame her, it was her attitude ... I got nothing off her, I didn't have to feel so scared, you know she didn't have to make me*	*While women highlighted the trust they place in individuals rather than the routines of the institution, this can also result in them blaming the individual for the way they act and the impact that this*

	Interaction was cold • No Strength left her – she didn't want to fight As soon as I got there I knew the vibe was wrong • I knew from the way they asked me questions, the reactions to my answer • They were busy • I was taking up too much time • I was taking them away from women who wanted to be in hospital • I was being awkward • I was being a silly woman asking them silly questions they didn't have time for	It went from bad to worse I met the dr from the antenatal visit I was taking up too much time	*feel like I had done something wrong ... "* *" I really wasn't sure what was going on. I tried to ask questions, but I didn't really understand some of the answers or they didn't answer me ... it's all a bit of a blur now, I just remember feeling so lost and so not in control of what was going on"*	*has on their negative experiences.* *I am so horrified ... this woman is made to feel like she cannot ask questions, how awful, I think, that must feel. How that contrasts to the episodes of care with endless questions I have observed when with SECMs and women.*
	Didn't get a good vibe from the Dr • She wouldn't listen to me • Didn't trust her No one told her what was going on • I needed someone to tell me that it was ok not to know what was going on • Asking questions just pushed the staff away Dr ignored SECM • SECM took a step back and let hospital midwives interact with dr • SECM whispering in the woman's ear	No one listened to me No one told me what was going on • Asking questions pushed the staff away The dr ignored my SECM	*"She [obstetrician] completely discounted everything and ignored everything the SECM said, she wrote down on the notes [I requested the notes afterwards], she wrote down "presented at whatever..." and she had "transferred from home" but she hadn't written down that I had been labouring at home or anything that Peig had said. She [doctor] refused to interact with her [SECM], refused to talk to her and wasn't interested in listening to anything she had to say. So I just felt she'd hardly be interested to hear my version of events either or what I wanted"*	*Who would have thought it in 2012????*
	This was exactly what I did not want it to be like, this is going to be all the awful stories that I have heard before This is going to be all the things that a home birth would have avoided	All that I did not want it to be	*"It was a dreadful, dreadful experience. Having to fight with someone at that intense stage of labour, not being listened to, your wishes ignored, the SECM's opinion disregarded ... I mean who told that doctor that it was her opinion above all things"?*	
	Shocking and brutal birth Just wanted the whole ordeal over Told she was making too much noise They didn't make me feel like I could do it Dr was 'an ass' They think they are God • Childbirth on their terms Childbirth is only every acceptable when they gave permission for it.	Shocking and brutal I lost my voice	*"I was traumatised ... it wasn't so much the procedures, although they were bad, it was the feeling that I had no say in what was being done to me"*	*Awful, dreadful, traumatic, horrible, having to fight, bad to worse ... what a very sad description of women's encounters with healthcare professionals.*

Women			
Reading 2	Codes	Sub-Categories	An example from the data
Reading for the voice of **the 'I'**	Anxious but not wanting to be anxious SECM encouraged her to be faster – only realised the seriousness then SECM was very reassuring during transfer	Transfer, I felt – Anxious	*"I didn't know that this was normal, I didn't know that you could feel like this and because of that I was anxious and couldn't relax. That couldn't have helped, I didn't want to feel like that but that was the way I felt in the moment"*
	Happy to transfer because SECM suggested it **Didn't want to take any risks** We decided to do what was safe	Wanted to do what was safe	***"I never thought I'd leave the house, I mean that was not what I had every planned to do. But it just had to happen, I wasn't taking any risks, so when the SECM suggested it well that was the line that I had to take"***
	Because the SECM said it, knew that it needed to happen • Trusted SECM completely	I trusted my SECM	*"... because of this trust I let Bridget [SECM] guide my care. I knew her, I trusted her and I knew that her intentions are from a place of love for me and for my baby. She knew what I wanted and would protect that as best as she could"*
	Relieved Just wanted to get the baby out • **Never thought of outcome, just needed 'help'** • Believed hospital staff would help her • **Couldn't stay at home if labour wasn't progressing** • Knew it was the right thing to do • Transfer supported her worry • Transfer was the only decision that could be made	I was relieved	*"And Bridget [SECM], just said "we're going to stand up" and we stood up, and she just looked me straight in the eye and she just said "we have to go to the hospital now", I said "ok"... now I could have said 'will we wait for one more contraction" but in that moment, and in that time, and because it was Bridget, I was like "grand, that's what is going to happen'".*
	Just wanted the exhaustion to end Just wanted the pain to end Just wanted to feel better Wanted to go to hospital – thought something was wrong • **Didn't feel comfortable** • **Didn't know how much longer she could tolerate the pain**	I just wanted this to end	***"I had enough, I was so tired and in so much pain, I just wanted it to end. I wanted it all to be over"***
	• Felt like the baby was stuck • Supported by SECM and partner • Reassured that there was no need	Transfer for a reason	*"**I needed to give it a chance to work, and it didn't. I tried it** but the baby was too big and **I needed to go to the hospital and that was just it, no big mystery, it was fine**"*
	• Tried to give labour a chance • She needed to get back into control Felt lost		*"**I was so lost, I think it was just from the tiredness and just not knowing what else to do. Maybe the next time it'll be better because I'll k**now what to expect. But I needed to find a way to get back on top of what was going on, try something else. We thought that going to **hospital would help with that**"*

	• Didn't know what to do now • Didn't know what else to try Lost spirit Lost will to labour WANTED to transfer to try and get the control back. So sad Cried and cried Letting go of the dream Tears	I was lost I was letting go of my dream	*"I just so wanted to have the baby at home and I just cried and cried and cried. We were all crying, I needed the time to cry and get used to the idea ... it was letting go of my dream ... I was thirty-nine that day and was thinking 'well, I don't know whether I'm gonna get another opportunity for this [homebirth] ... I was very sad ... but I understood that I needed to transfer ..."*
	Scared • What would happen in hospital Guilt • I was the reason for transfer, I couldn't do it • I was one of the failed home births • I was the 'I told you so' of home birth doubters • Felt I'd let the SECM down	I was scared I felt guilty	*"I felt like it was my fault, it was my fault that I couldn't do it and that I was letting everyone down. And I said that to the SECM as we got into the car – you know I was telling her that I was sorry for needing to transfer. She was looking at me like I had completely lost it"*
	Disappointed in her own body Didn't feel comfort or support from SECM Wished that someone would guide her This is not working • Obviously I had to go in Woman decided enough is enough – I'm going into the hospital	I was disappointed I decided that I needed to go in She was no longer helping me	*"And I figured I've done the birthing pool and I've done a shower, I've done the stairs, I've done the back of the chair, I've done the back rubs, I don't know what else I can do and so I kind of jumped up after that vaginal examination and said "right where are you bringing me because I'm not staying here any longer?" I was just three centimetres, nearly twenty-four hours, I'd used up everything. She [SECM] said "I was thinking we could do this, we could do that" ... but I said no, I'm not gonna go for a walk at two o'clock in the morning so that was that. So I said 'I think I'm gonna go into hospital'"*
	Supported to have as natural a birth as possible • Midwifery student was brilliant • Did not interfere • Natural birth, just unplanned environment • Hospital midwife got me to the place where I was ready to have my baby • Everyone encouraged her to have a normal birth • Talked about home birth, talked about her wishes for labour • They talked about avoiding unnecessary intervention Natural birth without unnecessary interventions	Supported to have a normal birth	*"I had a birthing plan with Cliodhna [SECM] and we had worked on it for seven months, what we wanted, our experience, what she wanted us to experience out of it ... and it was really strange because the midwife went with our exact birthing plan. I don't know if she read it but she had our file in anyway because Cliodhna had handed it to her ... and although she didn't really do anything like, well she did, she was there, but she just let me do it on me own and it was so much easier than someone panicking around, there was no 'push' shouted like the last time in hospital. She just stood there and just let me do it and it was great. She was brilliant, so calm the whole way, she kept saying to me "Come on, you're doing this on your own, you're doing it on your own, it's brilliant", she was encouraging, it wasn't a big deal, it was just having a baby, it felt the way it was supposed to feel, I didn't experience that with the others [births] and when we had to transfer I didn't think I'd have it this time either ..."*
	Accepts that all interventions were necessary • Would have liked to avoid the interventions, but they	Interventions – but I needed them	*"... it was a disaster, but what could anyone do about it? No, of course I didn't plan for x, y, z but that's what had to happen, there was nothing else for it ... no one could change*

	were necessary • We tried everything at home, we needed to try something else Had faith in the hospital staff – they knew what they were doing	There is a place for intervention	*that ... so yes, I was devastated that my plans didn't work out but not devastated about the care in home or in hospital, everyone did all they could"*
	Determined to do this herself • She would tell them what she needed • Found her strength • They just did what she asked them and let her get on with it	I found my strength They *allowed* me to get my own way	*"I was so proud of myself, I had a natural birth without unnecessary interventions ... when it got to the point when they were stressing interventions, the drip and stuff, that freaked me out ... but I held firm and I only took what was completely necessary. I was very happy with the birth, I had a natural birth"*
	She did what I asked • She left me alone, that is what I wanted • They really worked with me or I was able to work with		
	The midwife made me feel like – • I couldn't ask questions • I couldn't say no • Like I had to defend my decisions • Made me feel weak, made me feel that I couldn't do what other women were doing • SILLY • Like I was taking up their time • Like I was awkward • She was board, she wanted to go for her lunch	I was a silly woman	*"I asked about skin-to-skin, "We do that anyway as standard", almost 'stop being silly', I felt like I was silly, I was a silly woman coming in with her fantasies and I needed to just let them do what they were doing and get on with it. I was a silly woman asking for silly things, taking up too much of their time"*
	Hospital is not your experience, it is their experience, it doesn't belong to you it belongs to whoever is looking after you. In hospital they do what suits them ... it is theirs not yours. This is so different to the SECM who does what you want and works around you	I lost my voice	*"They started talking about syntocinon and that I needed it and I wasn't sure, I just wasn't ready for that. They broke my waters, I wanted to walk around, and see if that made a difference to the contractions. But no, they didn't think that was enough and the sister came back in and said that the time was passing, she was very sort of businesslike and she pointed to her watch and told me "Now in here you will have x length of time to get to fully dilated or we will be going for a c-section, so you need to make a decision and we need to get on with delivering your baby"... so when it is put to you like that, in the heat of all that is going on and they are looking at the clock, what can you do"?*

Women			
Reading 3	Codes	Sub-Categories	An example from the data
Reading for relationships	SECM • This was the midwife for her • Felt a connection • Trusted the SECM • SECM made her feel safe • SECM instilled confidence • **Knew she wouldn't have to worry about anything with** SECM there • Got to know her so well during antenatal time • Brilliant Antenatal care so brilliant, so personal SECM & I – • Had the same philosophy about birth • Just clicked • In tune from the minute we met • Knew she was the midwife for me • No one else could have guided me that way • SECM knew how I needed her to be with me • **This SECM just 'gets' it** • Were in the same space, of the same mind-set, on the same wavelength • Singing from the same hymn sheet • She wanted for me what I wanted for me • SHE KNEW ME • **We didn't have to talk –** look said it all The SECM was /is – • The most amazing midwife • Care was a meaningful conversation, not a check list • Asked questions because she was interested not because she needed to move onto the next person • My husband loved her too TRUST • I trusted her	An amazing MIDWIFE I trusted my SECM implicitly Because of this trust I let the SECM GUIDE the care Me and *my* SECM • This was *the* midwife for me **I didn't have to worry about** anything	***"I felt safe in her care, I knew she would see me right"*** ***"she was amazing, from day one we just clicked, everything about her –*** *the way she thought about things, the way she said things, the way she looked after me. I just felt at total ease in her company, so did my husband. We looked forward to her visits, we were sad when they were over and you know it staged like that they whole way during the care for every part of it, the* ***transfer, everything"*** *"she just knew what I wanted, not just about the labour and the birth but about everyone. After the baby was born she went out and bought me x to eat. Because all during the pregnancy that was what I said I would like afterwards, and she knew that they were at* ***home but obviously I hadn't brought them into hospital*** *...* ***I mean with all that was happening to remember that, I was very touched"*** ***"we just knew each other so well, she just knew exactly what I wanted when I wanted it*** *because* ***we had spent so long talking about it when I was pregnant"*** ***The thing about [SECM's name] and I don't know if it's the same with other midwives, is you just trust her implicitly, it's incredible, she's an amazing woman ... you just trust her*** *implicitly,* ***I can't explain it, she's just the most incredible woman in the world and I knew***

	• I trusted the instincts of the SECM • I trusted her implicitly • Because of this trust I let the SECM GUIDE the care • We had an honest communication • No conflict in relation to decisions • When the SECM was happy I was happy • The SECM didn't flap, we took our lead from that • When the SECM was anxious I was anxious • Wanted the SECM in hospital with me, not husband, that was the level of trust • Knew whatever the SECM did was in her best interests		*one hundred and fifty million percent that she was on my side and that I didn't have to worry about anything ... when you're in [name of hospital] or with any other person you feel like you're constantly battling to have the birth that you kind of want, and I just knew I didn't have to do that with [SECM].* *"Bottom line, I knew if it wasn't good to be at home then [SECM] would tell me and we would just have to go to hospital"*
	SAFE • I felt completely safe when the SECM was there • Would not have been able to get through without the SECM • Was never anxious when the SECM was there • SECM was looking out for me • Not scared when the SECM was there • SECM instilled confidence in me		*"... because of this trust I let Bridget [SECM] guide my care. I knew her, I trusted her and I knew that her intentions are from a place of love for me and for my baby. She knew what I wanted and would protect that as best as she could"*
	Felt minded	Reassurance for the SECM	*"I had no doubt in my mind ... IF my midwife didn't like something that was happening and she would just tell me that we had to transfer, no two ways about it ... sure that is why she is here"*
	Biggest fear in relation to home birth – transfer • Felt SECM would make that decision and she would have to go with it • SECM kept telling her they would not transfer unless she was happy to do so	Accept whatever labour brings	*"we talked about transfer, and I said I'll leave it up to you [SECM], I told her I'd rather avoid it but that it would be her decision. And she said 'Armelle, if you go into hospital, well first of all you'll need to go into hospital and you'll want to go'.*
	SECM talked about transfer antenatally SECM said to be prepared Knew if something was wrong they would transfer Knew that there was always the possibility of transfer Intended to accept whatever labour brought	Knew if something was wrong they would transfer	*"I don't remember the difference or transition or anything, but I do remember the SECM saying "change positions" a couple of times and then she said "look, the baby is not coming, we're going to have to transfer", and we'd already had a plan, ... we had discussions about what could happen and I knew that if this happened I was transferring and what to expect"*
	SECM said- • Maybe we should go in • You need to consider transfer • We'll have to transfer • I'm transferring you in • We have to go to the hospital now [decrease FH]	And so the midwife said .... She just looked at me and I knew	*"... there probably wasn't much to say, because I knew, I remember just looking at the two of you looking at my perineum and then ye looked at me, it was written all over your faces ... we were just all in agreement that it [labour] just was not working"*

	• Didn't need to say anything – she knew from SECMs face • We can go to hospital you know • Its time to go • Advising you to go to hospital at this point • We might have to transfer • We may need to consider going in • I think we need to transfer – lets go and get help • Suggested that they should go in • We decided, after this length of time, that hospital would be a good idea	We didn't have to say anything	*"she just looked at me and said 'I think we need to go now, I think we need them' and that was it, we knew this could happen and it was awfully disappointing but it was what it was"* *"they allowed her to stay with me and that was so good. I don't know if I could have been so together if she wasn't with me every step of the way"*
	SECM stayed • She felt safe • The staff in hospital view SECM as an expert / authoritative figure • They had respect for SECM • Would not have gotten through transfer without SECM • SECM was there for everything • Staff were careful to explain things when SECM was there • Wanted the SECM there to PROTECT her from unnecessary intervetions • Knew the SECM wouldn't let them do anything to her that she didn't want • SECM strong support • SECM BRIDGED THE GAP • SECM WAS THE CONTINUITY • THE SECM TRANSLATED FOR EVERYONE, IN BOTH DIRECTIONS	They let the SECM stay • I felt safe • The SECM protected me • SECM minded me • I knew the SECM would not let them do anything to me I didn't want The SECM was the continuity and the bridge	*"I felt once Bridget was there nothing was going to be done that I didn't want done. I kept thinking if she is with me then everything will be ok, because she'll be for me and she'll mind me if I'm not able to mind myself"* *"I knew she would be on my side. I knew she would take into account what I wanted ... she wouldn't let anyone do anything to me that was not necessary, she would be my advocate really and she would make sure that everything that happened was what I wanted to happen"* *"... and I remember at one point they [hospital-based practitioners] said something and I was like "what?" I mean at this stage we were so shattered we really had no clue what they were talking about and the SECM translated it into language we could actually understand. It was really a relief, to have the SECM there. It was just that, that bridge of care, you know between the hospital and us and also the consistency of her"*
	I was nice to the midwife so she would have to be nice to me • I just wanted her to use my name • I just wanted her to be nice to me • Needed to 'kiss ass' to get anywhere • I WANTED HER TO GIVE ME SOME SIGN THAT I COULD TRUST THEM • Begging for a gesture of trust	I just wanted the midwife to be nice to me Give me some sign to trust you • Do something so I will trust you	*"I was nice to her [HMW], I was really nice and I wanted her to be really nice back to me ... we went into the room, "Hop up on the bed". She put that thing on me, all the things I didn't want, I never wanted to be tied down to a bed .... And she was asking me questions I can't remember about what, but she never put her hand on me and said 'I know this isn't what you wanted but we'll do our best to ... to make you feel at home' ... or anything ... I don't know what I expected but not this, it was so cold. I kept using her name after every sentence in the hope that she would use my name back ... just something*

	• Begging for them to do something that would make me trust them •		*to feel like there was a connection with this person ... nothing she gave me, nothing"*
	SECM was not allowed to stay • Knew SECM wouldn't be allowed to stay • Knew she'd just have to get one with it • Wanted the SECM to stay – they • This caused a lot of problems • Wonder if outcomes would have been different if she was there • Wonder if she would have got the epidural quicker • Relying on decisions and plans made antenatally even though the situation was not completely different • SECM on corridor outside waiting • Kept sending husband out to SECM to ask questions, seek reassurance … • Would have preferred if SECM was in the room	The SECM wasn't allowed to stay • Asking this caused problems • I needed the SECM there (questions in the hallway) • Would it have been different if the SECM was there?	*"I didn't trust them then at that stage, I just was begging them for reassurance, and I didn't believe them ... there was no trust, and then there was no big gesture of trust. No one said 'I promise you now I'm not going to let anybody come in here and do that, I'm going to make sure that you know exactly what's going on at all times. Just, it's fine, relax, don't worry'. I was worried, and I wanted to shout 'do something to help me trust you ... give me some sign that you have my interests at heart' ... but nothing ... "* *"Caoimhe told me she'd hang around for a while, so I sent Cian [partner] looking for her whenever I needed a question answered. I wanted her answers because I trusted her so much to explain to me if there was anything wrong with what they were suggesting. You know, it would have been an awful lot more relaxing if I could have had Caoimhe there, making decisions with me rather than sending someone out looking for her"* *"I had no faith in her [the obstetrician], I didn't trust that she would do what I needed because I had asked for it. That sounds awful I know, but I just had no confidence in her so I got my husband to call a friend of ours [a more senior obstetrician] because I knew he'd tell her what had to be done"*
	The midwife I met was – • I didn't know her • Abrupt • Only ok • She didn't care about me • She didn't understand me • She didn't know me • She was very medicalised • Very anxious • Gave out to me • Telling me off • Scolding me • Fraught and difficult • Knew from her reaction to my answers that the vibe wasn't good	I had to focus on strangers It was difficult with the midwife I met • She didn't care about me	*"I didn't know them and they didn't know me, sure where was that to begin with"* *"... it was so bad from the start, every little thing ... it was a terrible, terrible experience. Ok I wasn't going to have my home birth but it didn't have to be terrible ... and that was her fault [HMW], I blame her, it was her attitude ... I got nothing off her, I didn't have to feel so scared, you know she didn't have to make me feel like I had done something wrong"*
	High alert • I had to be on high alert • Watch the midwives & drs • Makes sure they didn't do anything that I didn't want • Watching their every move	High Alert	*"In the hospital it's not your experience, it's not, it doesn't belong to you. It belongs to whoever is looking after you. Because that person is going on lunch now – "I'll be going on lunch now, so you wait an hour before you push, and I'll come back and you can push*

	THAT'S **THEIR MINDSET, ITS NOT MY WAY**		***then", like that's what was said to me** ... It's their experience, what suits them ... it's not your experience, **it's totally taken away"***

Women			
Reading 4	Codes	Sub-Categories	An example from the data
Reading for the cultural and political context and social structure	Heard friends talking about home birth Sister-in-law had a home birth • Felt if she ever had a baby it would be at home with midwives Had exposure to home birth • Automatically the route she choose • **Didn't realise it made an impression til she was pregnant** • Knew a SECM could do everything • **Knew she didn't need a dr** • Felt if she ever had a baby it would be at home with midwives **Why a home birth?** Home birth sounded more natural Wanted to be surrounded by her family Wanted to labour in water Wanted the MAGIC of home birth Not risky, as safe as hospital • Felt she would feel comfortable and safe • Comfort of her own home • Comfort of her own environment Felt a SECM would best met her needs Wanted one midwife looking after her Wanted to know the midwife Wanted a midwife with the same philosophy as her • Liked the way care was organised around home birth Wanted to know the midwife • **Didn't want a midwife in labour you hadn't chosen** Read about the advantages of home birth	I had exposure to home birth Heard the home birth stories Where else would you be? I wanted the magic of a natural birth and of home birth I felt safe in my own home I wanted one midwife The advantages of homebirth, the	***I don't know, I never thought of anything else for me*** *Mairéad started to tell me what home birth meant to her. She never considered it until she was pregnant, [when] someone in her village said she seemed like a **'home birthie' type of woman. She laughed as she told this and said that she wasn't sure what that** meant, but it instilled curiosity and she went to a meeting with other women who were into home birth and natural birth and suddenly she understood what that comment meant. **She felt yes, she was a 'home birthie' type of woman; she wanted to be at home, with all** her family around her. Laugh and dance and sing and cry out as she laboured, eat her **own homemade food and 'do what she pleased with her placenta'. Sh**e seemed to find it amusing as she looked at me and smiled – "**so I suppose, Linda, I was always destined for it even if I didn't know it."*** *"Just that it's my experience, it's my pregnancy, it's my birth, it's my baby. I wanted to do it kind of my way, in a way, in the comfort of my own home"* *"**it's about more than home birth really though ... it's about having someone there who** knows you so well, who knows what you want. And is with you throughout your pregnancy and birth. This midwife comes to help you aft**er you've had your baby** .... **That's why it means so much to me, because it is all so personal and that is what I want"*** *I went in [to the websites on home birth] and I read it and then I found another website, the NCT on home birthing or something ... I read that. Now for the first day or two I **thought it was bonkers, but I couldn't stop reading it, I thought it was mad and then I** kind of did more research and more research and I thought, I just got interested in it and then it kind of took the fear out of it. I always wanted, when I was younger I always wanted to have a birth with no pain relief because my Mom has done it five times and I **said well I obviously can do it and I know all my friends were like 'oh I'm getting as much drugs as I possibly can'. So** I always kind of knew I wanted that, but this was kind of a completely new avenue for me so I just did the research and, you know, it just seemed*

	Started reading about interventions in Ireland **Why not a hospital birth?** Experience in hospital during first birth influenced choice • Not a great experience • Clashed with the midwife • Awful birth • Shocked and traumatised after it Had exposure to hospital birth • Had heard about friends experiences in hospital • Didn't think hospital birth would work for her • Didn't trust their ideology in relation to birth Never sick didn't even have a GP Wasn't into hospitals • Didn't like hospitals I was not sick Hospital wrong place to be when not sick Birth normal, not a medical event Its different if you are sick No reason to go into hospital • Was worried she would catch something in the hospital Afraid to have baby in a hospital • You wouldn't be in control in a hospital • You wouldn't have choices in a hospital • You would be told what to do in hospitals • Worried that she'd be vulnerable and loose autonomy • Hospital too stressful • Hospital impersonal place for sick people Drs do not have a role in normal birth • Didn't want to get into an argument with them about normal birth Wanted to avoid Un necessary interventions • Started reading about interventions and the consequences of some of them Experienced long waiting times at hospital Did not want what hospital birth in Ireland offered There was nothing else I didn't want home but I didn't want what the hospital had to offer	disadvantages of un-necessary interventions Previous experience in hospital I've heard about hospitals I'm not sick I wanted to avoid un-necessary interventions In hospital they tell you what to do Doctors have no role in normal birth There was no other option available I didn't want home but I didn't want	*right ... because you're brought up and hospital is the way to go and that's just the way it is so I was just like well obviously I'll go to hospital, I mightn't have any pain relief but that's the way ... it wasn't that I was afraid or anything but I just presumed you had to go to hospital, you know, I didn't know there was any other choice, [but] when you read all the information and stuff about, you know home birth ... well, it just seemed right* *Lana started explaining, in her experiences, what the local maternity hospital offered. She suggested that "the doctors there just call the shots", it didn't seem to matter if you were experiencing a normal pregnancy and labour, Lana believed that "your care will be on their terms" and defined by them, not by your needs ... A lengthy discussion was had in relation to the role of midwives and how hard (in Lana's experience) some of them try but really it doesn't make much difference because "at the end of the day, the doctor is the boss".* *"I have never really been into hospital my whole life I've never really been to a doctor really so the idea of giving birth in hospital just was alien to me, really strange and I didn't really like the idea of it ... giving birth in a, you know, where people are sick ... the bright lights, the stress, the noise".* *"I don't want any intervention, I don't want internal monitors, I want to do it normally, as much as possible, and if it's really needed then intervene but not just straight in there. But I'm afraid that won't be the way it is in hospital, if I go in there all of that will go out the window"* *"I just see birth as a non-medical process, so I don't think you need to be in the hospital unless there's a medical reason, that's where I'm coming from on it"* *"I don't need a doctor, I am not sick"* *"Doctors have no role in 'normal'. They don't, Linda. They just come in and make it all complicated when it was fine in the first place. They are not needed when there are no problems"* *"I do not want what maternity hospitals in Ireland offer. I know how busy the hospitals are and how this could affect me ... I want to try and avoid this at all costs"* *During the course of this antenatal visit Caoimhe asked Olwyn to tell me why she had decided on a home birth, her reply [was] "there was nothing else for me" ... she didn't want a home birth (initially) but she really didn't want to engage with the local maternity*

<table>
<tr>
<td></td>
<td>No birth centre
No midwife- led care in hospital

Antenatal Encounters
Other people put fears in her head re home birth
People thought that she was bonkers
People thought that she was Brave
• Brave
• Wondered why people kept telling her that
• What was she brave about? What was she missing?
Midwives told her that she was brave
People thought that home birth was dangerous
Thought she was putting their lives at risk
• People in hospital suggested that she was risky
• The negativity didn't put her off home birth
• Didn't tell her in-laws that she was having a home birth
• Didn't tell her mother that she was having a home birth
Stopped telling people in the hospital that she was having a home birth
• It just got their backs up
Their reactions put her off engaging with hospital staff

Booked into a hospital
• THEIR TERRITORY NOT MY SPACE
• People not very happy there
• Wasn't very comfortable there

Taking away home birth
• Terrified home birth would be taken away when baby was breech, protein in urine, BP raised @ hospital antenatal visits
• What if they found something and decided she couldn't have home birth
Antenatal encounters reminded her why not a hospital birth
Antenatal encounters would not encourage her to engage with hospital
Why would she go back to hospital after that?

Rows with dr / Huge argument with Dr @ booking</td>
<td>what the hospital had to offer

Brave & Bonkers

Homebirth – risky and dangerous

I didn't say anything to the GP after that

I didn't say it again to the midwife

I stopped talking about it unless they asked me

I only talked to SEMC

Hospital could block home birth

Afraid hospital would say no to home birth

We had huge rows</td>
<td>hospital. What Olwyn wanted was a birth centre; she described this as "the best of all worlds". When this was not available to her she planned a home birth as her second option

"… and you just know from the way that they look at you when you say you are having a home birth. You just know that they don't approve and that they think it's not the way it should be. You shouldn't have to deal with that negative reaction … it's so difficult and upsetting"

"… another time I was just going in for routine bloods and urine and that, and she said "oh you're very brave now, you're very brave - this girl is having a home birth – Jesus I wouldn't do that now", you know that kinda attitude … it made me not want to go into the hospital, it didn't make me not want my home birth

"And so the midwife was doing the scan and we got talking about stuff and so I told her that I was going to have a home birth. She looked a bit horrified to be honest and said "you are brave aren't you, I don't know if I'd do that" and I sounded like I was doing something that was just so off the Richter scale, you know, something that was so irresponsible and dangerous altogether"

"My own GP then refused to see me at first, and then he told me 'are you sure you're going to kill your child?', and I was sitting there just going 'of course I'm not intending on killing my child', and he was like 'well, I've been at births you know, and everything happens in a split second and I've been at ones where literally, where if you hadn't done something within three minutes that child would not be here, so what are you going to do then"

"On like my last, my thirty-week visit, I had actually got into such a state that my blood pressure was a bit high, I was so afraid of seeing the negative doctor ... [referring to a previous, negative interaction with an obstetrician in relation to home birth] that I got myself into a state! I was like "oh, if I have high blood pressure, then they'll take the home birth off me" … that's what used to worry me, that it would be taken away, like that they could decide 'no'".</td>
</tr>
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	• Very aggressive • Very anti home birth • If you going to have a home birth don't come back to our hospital • Hospital would have nothing to do with her if she having a home birth • Why would she go back to hospital after that? • Very upsetting, horrible antenatal experience • Booking experience was awful Was told by Dr @ antenatal clinic that • the baby would need to be resuscitated • that she was ridiculous for considering a home birth	*Do you realise that ....* • The dr told me I was ridiculous • The dr told me my baby would need resuscitation • The dr told me the hospital would have nothing to do with me if I wanted to have a home birth	*"When I went in to my consultant appointment at the hospital, and I said "oh I'm thinking about having a home birth" like I wasn't thinking about it, I was having one, but I was trying to word it. And he said "oh, you know your baby will die, your baby will be floppy, the baby won't breathe" ... And I said "well, there will be resuscitation equipment there, so the baby will be resuscitated" you know. Everything he said, I had enough knowledge to know that could happen at home, that could happen in a hospital" ...* *"... so in the middle of it all she (doctor) looked up at me 'after all that is going on you are still going to have a home birth, I think that is just mad'? I felt so alone and unsupported in the decision and I'll be honest I did have moments of doubt with the voice in my head telling me I was ridiculous"*
	Midwives at maternity hospital so encouraging re decision to have a home birth • Midwives suggested a tour of labour ward • Fantastic midwife showed her around labour ward • Respected her autonomy • Didn't agree but respected the decision • Not what I'd do but you know what you're doing Dr at hospital told her that they were there if she needed them	Dr didn't agree but respected my decision Told me to come back any time	*"I saw the consultant and she said "well you know where we are, and now we have a record of you" and "you know we are here if you need us" ... that was so positive, I didn't expect that"*
	Don't hate the system, that comes from my SECM, she doesn't hate the hospital system, she goes to hospital to get their expertise when its needed. There are reasons for transfer .... We knew what was necessary and transfer was necessary • I just wanted the baby out • Home birth safe, transfer for a reason That's the way they work – its just not my way	It's the way they work, it's just not my way	*"... well we had to transfer, it was right thing to do. It was the safe thing to do. So that was it really, what else could I do"?* *"At that stage the baby just needed to be born, I knew that, they knew that. No, it wasn't what I wanted and it wasn't the way I wanted things done it was the hospital way, but I just have to accept that was what was needed"*
	ROUTINE Met by wheelchair • You have to get in They kept asking me the same questions • Midwife did not care about me • She thought the dr was God • They just did their routines anyway	Care by rote Care was routine Divide very big	*"... they're looking after themselves because it's their job; they're not looking after you. They're just doing it by rote, you know"* *"It's just such a difference, such a different way of being during birth. I mean I knew that, that's why I choose a home birth in the first place, but still, you don't really realise it until you're in the middle of it ... not much you can do about it then"*

	Divide between home and hospital too big • Service too disjointed • We are doing it the hospital way • They were too busy • Had to argue re choices	You have to be strong • You have to fight	*"It was exhausting, being on high alert the whole time watching everything they did and [said], and having to challenge every suggestion, that wasn't really a suggestion, it was more of an instruction*

Examples of Coded Data and Sub-Categories

SECMs				
Reading 1	Codes	Sub-Categories	An example from the data	My response to the narrative
Reading for the plot and the subplot, my response to the narratives	Some positive, some not so positive Positive – if they agreed with your plan of care There is a reason for transfer Had to transfer because of MOU Rules & guidelines re transfer MOU **Things don't just happen** – they build up Transfer not done lightly Always a need for the transfer SECM KEEPS AN EYE ON THINGS SECM watches things and gives the women space to self focus SECM & Women – **can't break the bond** SECM & Women – **can't break the trust** SECM caught between the hospital based midwives and the women You were considered stroppy if you wanted to stay Not allowed to stay **Some midwives adamant that you don't stay** Not worth the fight Not invited to stay Some midwives apologized but they could not let you stay Can be frosty and fraught **You pretend you don't notice**	Relief when they agree with you Transfer – good or a bad thing There is always a reason Not done lightly **SECMs don't stay at home and** make matters worse **Can't have blind faith** Natural that you want to be with the woman Still a midwife Still *their* midwife Caught between women and hospital midwives You have to take a step back **Pretend you don't notice**	***"don't get me wrong, sometimes it can be ok.** You meet someone who is ok with home birth and ok with you and then you just work together to make is as good as it can be when **things haven't gone to plan**".* ***"I've transferred this woman in for a reason, I don't do it lightly but I do it safely. Why can't** they see that?* ***"... and it's great when I can stay, because I can** support the woman and help her with all the new decisions she now has to face, you know the things she had not planned for and maybe there are some that are now really needed and she needs me to explain why. Because she knows me, **it just makes sense that they come from me**"* ***"being there gives me a chance to ensure that they don't over**-do the interventions if they are **not needed**"* ***... you're in the middle of both of them. And she's [hospital midwife] saying "she needs an ARM" and the woman is looking at you going "but why do I need an ARM, I said I didn't want to have one". And you see both sides ... so at this stage I ... am just honest with everyone ...*** *"This is not the time [at transfer] to take on the system, no, this is the time to make sure it is as **good as it can be for this woman. I'd worry that** going in there being awkward or, you know,*	*I have observed this in some of the interactions and I have experienced this myself. I assumed this to be the norm until I started looking deeper into the issues. A lot of the SECMs and the **women talk of the 'luck' associated with** who they meet when they go into the hospital. It is so random and really there has to be a better way to organise the services and collaboration between home and hospital?* *The SECMs and the women talk +++ about the benefits of the ongoing presence of the SECM after transfer. Women talk of the support it offers them, the continuity of care. The SECMs are more pragmatic in that they see the need not only to support the women but also **the belief to 'keep an eye' on the** intervention focused hospital staff. How interesting is this, and also so interesting that they do it in a subtle non-confrontational manner.* *A lot of the midwives in this study talked of the ways they worked to gain entry to the hospital. Prior to gaining entry these SECMs had to gain acceptance which was based almost on terms and*

			***shouting the odds, it just won't work** ... **and then** you have the woman stuck in the middle of all of that"*	*conditions set down by the hospital-based practitioners (doctors & midwives).*

SECMs			
Reading 2	Codes	Sub-Categories	An example from the data
Reading for the voice of **the 'I'**	Trust Because of their relationship it makes the issue of transfer easier Women trust SECMs SECMs need to trust the women Trust is built up antenatally Partner at ease with SECM Honest re • The possibility of transfer • **Things [usually] don't just happen** Antenatally – Prepare women for what may be a head • Prepare women for what happens at transfer • Prepare women for what happens in hospital • **'alternative' birth plan** • Prepare women re options Difficult to talk of transfer when you want to support home birth and normal as much as you can • Difficult to walk / talk to transfer when you support normal and home birth Labour – Prepare women for where labour is going Gives women a chance to get their head around things Transfer to different hospitals is difficult Historically you were expected to leave the hospital Animosity in the past Things have improved	Trust in the SECM & Women relationship Prepared women for transfer • Antenatally • When possible - during the transfer • Debrief postnatally Everyone judging Immediately Judged Written off before you speak Risk You are risky	*My fieldnotes demonstrated time and time again that I observed the trust in the relationships between women and their SECM, and also that I noted a confidence in the SECMs experience of this trust. They knew what they meant to the women, they knew how to establish a relationship with them and work at developing it over the course of the pregnancy. I observed how this played out in moments of transfer to hospital and how the women talked of it afterwards. The SECMs spoke of themselves in **these moments as being the midwifery guide to the woman's birthing experience**.* *"**Of course I have to talk about it [transfer]** ... **I can't pretend it doesn't happen**. **And** hopefully I do it in such a way that I am realistic without being overly negative ... it is just hard to get that balance. It can be really hard with the first-**time mothers 'cause you know you are talking about so many things at this stage in their pregnancy**"* *"**Yeah, this is difficult becau**se I kind of feel this woman hired me because she would like to have a home birth, so my role is to support her, so if I start talking too much **about 'transfer' I'm actually going to reflect on her that this [home birth] is not normal, you know** ... **but I have to do it, that's my role so I just find a way. We know** each other so that helps me to bring it up when the time is right, and begin to prepare **for it**".* *"**They [hospital midwives] think you are outside the barrier or whatever. You aren't** just pushing the **boundaries, you are outside them. You've decided on a pathway that is considered 'risky' and you must be ignoring the risks if you are prepared to be outside** the hospital system".* *"... **just an assumption that it all went pear**-shaped and we caused it or **that we didn't** do anything to sort it out"*

	Hospital staff judge your decisions You feel like you did something wrong WRITTEN OFF BEFORE YOU SPEAK You were viewed as risky	Vulnerable Judged You are risky	*"**before you even open your mouth they have written you off and assume that you did something that caused this to happen and it's all your fault for being at home in the** first place and not in hospital where women **having babies should be** ... **well in their minds, that's not what I think** ..."*

SECMs			
Reading 3	Codes	Sub-Categories	An example from the data
Reading for relationships	Their (hospital staff) views of risk varied BEING KNOWN • SECM reputation may proceed them • If you'**re** known positively you will have a positive interaction • Other do not want to be associated with a SECM Hospital midwives judge you • The view facts in isolation • You are written off before you speak They think that we are judging them • **We've more important things to be worrying about** • SECM caught between the hospital based midwives and the women **Some hospital based midwives don't** • Understand home birth • Understand the role of SECMs • Understand normal birth **They've lost their passion** for normal birth Forgotten normal birth They are dismissive of SECMs	Experiences of transfer vary – it depends on who Depends on who you meet Being known It is fine – they know me The barriers go up Historically fraught relationships Historical mistrust Trust Transfer – difficult because you know they think you mad They **don't get home birth** **They don't understand home birth** Your decisions are judged out of	*I've **observed the SECMs pick specific** hospitals when transferring women because they know that they will be more readily accepted in some than others. I have witnessed them phone the hospitals before transfer, ask for certain HMWs, explain the situation to them before they transfer. I saw them attempting to have a connect and a knowledge of the midwife they would meet in the hospital.* ***"I've earned their respect over the years, I've worked with them and I've never given them grief. They know me, they know my work, we get on ok"*** *"**you can see** it, you can see them get arsey with me the minute I walk in the door. What **can I do about it, I just go about doing what I need to do**".* *"Is it worth it? Is it worth being labelled as dangerous? I am not a dangerous midwife; I am not a dangerous person. Is it worth having everything you do, the care you give challenged to the nth degree just because it is not tied to the medical management of labour? I am not sure that I can be like this, living on my wits and trying to anticipate the reactions of the hospital to everything I do before I do it. That is certainly not the mind-set to have when you are caring for women"* *"I worry, I do. What if I transfer someone in, for a good reason, and then something happens – a poor outcome. Even if my practice was fine will **they blame me 'cause I didn't** do 2-hourly VEs or have a CTG or whatever ... they are not comparing like with*

	Different understanding of risk Different understanding of safety But you (SECM) transfer for a reason – you need their support Feel the animosity Used to dread it • Have to put that dread aside You are judged • Had to work hard to get over that You are risky, you work outside the system • Facts viewed in isolation The system does not support SECMs They think you are mad They think you are risky Transfer confirms their views	context **They've forgotten normal** Facts viewed in isolation But you transfer for a reason You need their support	*like and they are not considering a labour that started out as a normal physiological labour and then something happened and then I did something about it – we* ***transferred. No, they'll start judging me against routine hospital care and saying "this wouldn't have happened in hospital" and then I'll be hung out to dry"*** ***"We've seen what happens if you go in shouting the odds ... they have held*** *the reins* ***for too long, that approach isn't appreciated, you have to find other ways to change the system,*** *you have to work with them, that's what will make it better for women and for us"*

SECMs			
Reading 4	Codes	Sub-Categories	An example from the data
Reading for the cultural and political context and social structure	Birth is normal **Birth doesn't have to be high tech** Interventions not always needed Birth is not all about risk I get to be a midwife at home I get to practice midwifery This is midwifery Continuity of care Historical influence Historical lack of Trust Territorial labour ward staff **Hospital staff can't relate to you** **We've come to hospital for a reason** **Isn't transfer a good thing** Why are you judging us	Believe in normal birth Believe in birth at home Home birth = change to be a midwife Home birth= continuity of care Vulnerable Judged The system doe**sn't support you** Blame	*"feel like a true midwife"* *"a way to remind me what it is all about and how birth can be"* **"a way to remember to** *"wait patiently, yet attentively for birth"* ***"home birth is what keeps me sane"*** *"I talk to my friends who are midwives in hospitals, and tell them the goings-on* ***[in relation to interactions at the time of transfer]. Some say I'm brave, others think I'm mad, I just feel so vulnerable"***. ***"There is always blame attached and you are so vulnerable in this. You're dealing with*** *a system* ***that doesn't approve of home birth anyway so when the chips are down, their*** *beliefs are confirmed and they are not shy in telling you. So while we are vulnerable and out there during home birth we are even more vulnerable and unsupported during transfer"*

	Must stay within guidelines MOU guides your practice MOU keeps you blame free No one can get you MOU tells you what to do MOU is always there It takes over Care isn't woman centred its MOU centred	Can't have blind faith MOU	*"... sometimes it is not that 'black and white' and that is the problem when you are trying to justify what you did, and sometimes what you didn't do, to people who view it to the letter of the MOU. Delay in the first stage of labour, I mean what obstetrician is ever going to agree with me in relation to this, in Ireland, the home of active management ..."?* *"I think the MOU is good, it has good guidelines, and sets things out the way it has to be. And as long as you keep within the MOU and local guidelines, then you are fine, no one can touch you and say that you did something wrong"*
	Some positive, some not so positive • Positive – if they agreed with your plan of care • Negative - No interaction, professional disrespect Role of SECM not acknowledge Care prior to transfer not acknowledge	Professional dismissal and disrespect Vary Historically fraught interactions No recognition of your professional role Territorial hospital staff	*"... and then she [obstetrician] just said "I am in charge now". And I was like ... ok, Leah, back off a little here 'cause no one is getting anywhere with this. And yes, I was annoyed, I knew Susan since the start of her pregnancy, I knew what she'd planned for her birth, I was there during the early hours of labour, it was as if none of this was relevant. But I knew I had to take a step back and just let them run it their way if there was any hope of me being able to do anything"*
	Take a step back – subtle way to move boundaries Take a long time to build bridges • Head down • Chipping away • Never getting stroppy • Plamas Opportunities nationally were lost Took a long time Had to earn the respect of the staff	Subtle subvert behaviour Worked to build bridges	*"... we come in for a reason, we have to remember that and it's often because interventions are needed ... if they see you as reasonable during this interaction you are setting the groundwork and then it makes it easier to question something you think is not warranted"* *"I've worked hard to form relationships with the. They didn't know me to begin with but I made sure that I was involved in everything and involved them in things, you know consultations about aspects of women's care and the likes ... I had to, I do need them on side, I need to work with them"*

Examples of Coded Data and Sub-Categories

HMWs				
Reading 1	Codes	Sub-Categories	An example from the data	My response to the narrative
Reading for the plot and the subplot, my response to the narratives	Home birth bad name- because of some outcomes Everything would have been fine if it was a hospital birth BABY UNWELL Upsetting	Home birth – bad rep	*"**I've heard the stories, babies coming in with** mec and things. Sick babies going to NICU and **that's what scares me. When you're told that you're expecting a home birth to come in you think and assume the worst really**".*	*This really tallies with the findings from the SECMs – they feel that they are judged before they enter the hospital at all, and really it sounds like the HMWs are saying that is exactly what they are doing.*
	Fraught historical relationships Gossip which is not helpful Judgements based on few cases Good when SECM known to hospital midwives Others bad reputation Stressful **Don't know 'what' is coming in the door**	Reputation of the SECM	*"A few independent midwives have a bad reputation as far as [hospital name] are **concerned. There's been a few bad outcomes, it's like word of mouth**"* *"**I definitely think that** the midwife should stay with the woman when they transfer. It just **makes sense. They know her, they've been with** her, surely we can all work together on that **one**".*	*I have observed this, the hesitation in the HMWs. The uncertainty when you **phone them to talk of transfer**. It's almost like they are holding their breath until they get a handover and find out what is going on. Where has that come from, what have they heard or experienced in the past? Or is it just a fear of birth outside hospital?*
	SECM presence Would help – to bridge between women and hospital midwives Helpful to get women to do what they [hospital staff] need them to do Hospital midwives feel like they are intruding on SECM woman relationship Great relationship between SECM and women	The presence of the SECM – double edged sword	*"So I felt nearly I was being put on the spot to a certain extent, I found that difficult. It was as if **the midwife was questioning, well, 'why are you doing this, why can't she get into the bath, why can't she get into the shower, why does she need the CTG on at all?'** I found that really **difficult**".*	
	Difficult when hospital v home midwives don't agree Who would do what? Roles????	Who would do what?	***"... they can come in, but only as a support, we're providing the care. But it's not ideal, like I think it's fine but other have found it hard, there's a bit of 'them and us' in the room then.***	*Lots of the SECMs and the women talk about this. It surprises them that there is a tension between midwives. The SECMs feel that the HMWs cling to the routines and protocols of hospital and judge home birth according to these. The HMWs have a sense that the SECMs are working, with the women against them.*

HMWs			
Reading 2	Codes	Sub-Categories	An example from the data
Reading for the voice of **the 'I'**	Women are angry with you Hospital-based midwife - Bad wolf **Not 'letting' / 'allowing' the woman what she wants** **They remain in 'home birth mode'** Transferred for a reason	Them and Us Blame We are the bad wolf	*"... **some of the women come in and they are so cross, they are disappointed that they didn't get their home birth and that everything has gone down the swanny and really** trying to interact with someone new in the **middle of this disappointment** ... **and** someone who is doing something that you did not want to happen. So yea, they can be **very cross with us and fight against everything we need to do ... and sometimes for the sake of it, it's so hard and we are just trying to do what needs to be done . So it's not nice, it's not nice to be a midwife in the middle of all of this when you are just trying to do your bit to help them**".*

HMWs			
Reading 3	Codes	Sub-Categories	An example from the data
Reading for relationships	Interaction solely for handover Everyone too busy Challenging with SECMs Frustrating Frustrating for Paeds Poor handover Difficult - **Midwife not doing what the woman 'want' / think** should have happened **Women don't want interventions** Poor, strained, angry, not pleasant Them and US Blame Women looking for someone to blame Midwives feel like the women treating them like it is their fault Women do not trust hospital midwives You have to coax them You have to persuade them	Interaction for facts Frustration Poor communication Poor handover Too busy to interact Expectations? Atmosphere – challenging You have to plámás them	***"often we don't have much time for chatting we just need to know what was going on. You know even if it's not an emergency you do need to just get going and do your job".*** *"... **poor document, poor recall of times, and this made it difficult to figure out when** she was fully, what had been going on during that time, you know what she had actually been doing to try and sort **this out** ... "* *"... **she [the woman] barely even talked to me, it was as if she sort of felt I couldn't help her, it was like I didn't understand that her plans had changed or I wouldn't get what she was talking about, so she didn't ask me anything, she dir**ected all her questions to her midwife [SECM]. It was very hard, I think that's why I remember it so **well because I felt out of place, I didn't feel the way I usually do when I'm in work. I** was doing my best to try and meet her needs given that things had **changed ... I wasn't** stopping her from having a normal birth, it was just the way that things had changed"* *"**It can be really hard, a horrible atmosphere. I remember one time I felt like I was saying "no", "no", "no" to everything the woman wanted, just bec**ause she wanted **stuff that we couldn't do because of the meconium, so it was like it was my personal** fault that this was happening.*

HMWs			
Reading 4	Codes	Sub-Categories	An example from the data
Reading for the cultural and political context and social structure	Question their decisions / care / professional judgement Everyone has different views Difficult interactions when SECM disagrees with them Got them to sign the notes **Severity of case going 'over SECMs' head** **Different 'scope of practice' to SECMs**	Disagree with care They have a different scope **It's not 'normal' now**	*"... **everyone wants to work with ev**eryone but what is the point in the SECMs coming **in and then picking the bits they agree with and then the bits they don't. I mean, they** came in for a reason, things are not normal now, so how can they start deciding that **they only want some bits**"?* ***"what was going on was daft, at home for that length of time, what was she thinking"?***
	no friction transfer for analgesia **woman 'sees / understands' the reason for transfer** friction **woman does not 'see' the reason for transfer**	Depends on the reason for transfer	*"**She just came in for an epidural; the pain was just getting too much at home.** So we got that sored and we had a great time then. She felt like she had given it her best shot, **it didn't work so she came in to us, as simple as that**".* *"**well there was meconium in the waters so what could she do, she had to come in and** she knew that. So she was cool about it all and really we just kept an eye on her and **didn't do much different to her midwife at home. She was happy with it all**".*
	We could do that too We do normal births We could do DOMINO **We don't see much 'normal birth'** Difficult for us to facilitate what the women expected We try to be woman centred	**We 'do' normal you know**	*"**we can support normal birth too you know. I think there needs to be more** DOMINO **and then the women wouldn't think that there isn't normal birth in here, cause I do think that is what a lot of them think**".* *"**We do our best, no matter what is going on, we do our best to be woman**-centred, we **try and give them choice** ... **but** sometimes it's **not possible and** that's **when the guidelines etc have to be there**".*

Examples of Coded Data and Sub-Categories

Obs				
Reading 1	Codes	Sub-Categories	An example from the data	My response to the narrative
Reading for the plot and the subplot, my response to the narratives	**I don't see normal** **I'm only involved when problems arise** Only called when there is a real problem Not an ideal time for the first encounter	**I don't see 'normal'**	*"the ones that stand out in my mind would be ones where they would have more negative connotations than positive, because I suppose by their nature, when patients are transferred from a home situation into hospital, they are transferred* ***in because there is an issue** ... **we tend to see the** ones who **are complicated** ... **we don't see the thousands that don't have a negative experience**"*	*This is what they see; they see more complex cases or cases when there is tension on transfer. They talk about not seeing normal home birth, to me it* ***sounds like they don't see 'normal'*** *transfers. One of the obstetricians mentioned something about HMWs or jnr docs calling them when the woman does not want the care offered. They have no seamless experiences of transfer to inform their opinions.*
	Transfer for a reason Need to adhere to our protocols Come in because its needed **Transfer because it's not normal**	Transfer for a reason	*"**we've always taken the view that** ... **she's** getting transferred in for a good reason. And once they get transferred in then they should be properly managed according to our hospital* ***protocols**"*	*"**properly managed" what does that** even mean? Like the care at home* ***wasn't 'proper'? Or is it only 'proper'*** *when it adheres to the components of active management?*

Obs			
Reading 2	Codes	Sub-Categories	An example from the data
Reading for the voice of **the 'I'**	**It's like it's my fault** **I'm held responsible** **I didn't cause this** I **didn't make this happen** They want to blame me	I get blamed **I didn't stop their home birth**	*"**I think these people are just very distrustful of** hospitals, of obstetricians ... they are just distrustful of me"* *"**Oh goodness it is not my fault that things have not gone according to plane,** yet women come in (some women) come in with such an attitude, ready for a fight, like it is my fault that her labour has taken this course and it is my fault she needs synto or* ***whatever**"*
	I am responsible **It's my call** **It's over to me then** **It's my case** I am in charge	**I'm keeping everyone safe**	***"Sometimes you need to tell the midwife 'it's not your call anymore so butt out here'** ... **it's very difficult if you have someone who doesn't want us to intervene when we feel that it's the right thing to do, based on the evidence** ... **and our experience, we know what needs to be done and it's our responsibility to do it"**.*

Obs			
Reading 3	Codes	Sub-Categories	An example from the data
Reading for relationships	No hospital will keep this group of women happy **I'll never get it right**		*"**so that group** of women who want to deliver at home with an independent midwife, **invariably are often a group of women who are anti home birth anyway**".*
	Difficult to have empathy with *these* women • No time for debate • **Women won't listen** • **It's too busy**	**They're never happy**	*"**I suppose we would try and deal with it like we would any other patient, but if there is** any reluctance to be there it is very difficult to have the same amount of empathy with **that person if they than if they don't want to be there**"*
	Women need to be better prepared **I don't know what they are told** **Women's plans** Acknowledge that they change **Can't always follow plans**	Women need to be better prepared Plans **can't always be followed**	*"**I don't know what these women are told** ... **but you wonder how realistic it is**"* *"**, I mean we're not in charge of giving the people information, so I don't know what they know or don't know or what they expect** ... "*
	Convincing re the need for intervention When they disagree, it becomes a little unstuck		*"... **the group I think who are often very disappointed in the outcome because they have this view that you should have a birth plan and that is the way it should go**".*
	Transfer for a reason • Need to adhere to our protocols Convincing re the need for intervention • convincing • coaxing • When they disagree, it becomes a little unstuck • A lot of these women ***won't listen*** no matter what we say	Convincing women that they need interventions the need to adhere to our protocols	*"**persuade women that they need what we are suggesting**"* *"**I mean you've almost got to talk somebody down. It's like they've pushed themselves into a corner, and you've got to coax them out of the corner, and convince them that** the action that you are proposing to take **is not that bad, and you're doing this to try** and expedite delivery to maintain safety, you get them round to seeing this"*
	Anecdotal drama Outcomes = gossip We have no contact with SECMs Difficult and challenging Transfers are problematic The situation was so bad Awful cases years ago	I question the professional judgment of some of the SECMs	*"for X number of weeks a year they (SECMs) need to come in and they work within the service, they keep up to date with everything that they need to keep up to date with, and that they show that their practice is compliant with guidelines and protocols and that their service is compliant with what one would expect, standards that one would **expect**".* *"... **there's nothing wrong with home birth, I don't have an issue with it, but it needs to** be regulated properly. The criteria need to be tighter, regulation needs to be tighter, for the women having a home birth in the first place and then for the management of*

	Critiquing / queering the professional judgment of the SECMs Midwives should not work alone Questioning the governance structures of home birth / SECMs Tighter structures and protocols	Who governs the SECMs? No faith in *their* governance system	***care"*** *And if, as a professional, if you buy into that, then I think that can sometimes colour the relationship, it can change the boundaries that you normally work within. And as soon* ***as you change the boundaries that you work within, then you're lost, because what's*** *the new boundary?* ***What's the next limit? You know what's the next line? Or where is*** *it? Or you know when do we cross that next time, and then make the move to hospital"?*

Obs			
Reading 4	Codes	Sub-Categories	An example from the data
Reading for the cultural and political context and social structure	Risk in birth Need to be near when things happen Is it the best place to be Do wishes overtake safety Delay in transfer Because SECMs not affiliated to a hospital Query some of the people at home Query some of the decisions midwives make Close relationship of the women & SECM Sometimes the SECMs take a step back Midwives move goalposts Midwives act like a friend	I question the safety of home birth	*"...* ***should women be at home, should they be at home for their first baby*** *...* ***would the*** *evidence support that? And look at the number of transfers, does this indicate that they* ***shouldn't have been at home to begin with*** *... "* *"I suppose my anecdotal experience of the system so far I think would suggest probably that* ***– and I'm only talking about a small number of cases –*** *but the care is probably not good enough ...* *"... the ones where the patient comes in and is dealt with and the outcomes is good, they are not remembered. The ones that are talked about are the onese where the management was deemed unsatisfactory in the community in that transfer should have been done earlier. Either the patient did not want to come in or the midwife did not* ***want to transfer them in"*** *"****I think sometimes the needs and the desires and th****e wants of the patient have been* ***moved onto the midwife and she has bought into this idea that this woman doesn't want*** *something at all costs. And therefore I think in some situations the midwife has moved* ***her goal posts, moved the limits*** *...* ***and this is dangerous*** *... "*

Examples of Sub-Categories to Categories

Women	
Sub-Categories	Categories
I had exposure to home birth Heard the home birth stories Where else would you be? I wanted the magic of a natural birth and of home birth I felt safe in my own home I wanted one midwife The advantages of homebirth, the disadvantages of un-necessary interventions	I wanted a home birth
Previous experience in hospital **I've heard about hospitals** **I'm not sick** In hospital they tell you what to do Doctors have no role in normal birth I wanted to avoid un-necessary interventions	**I didn't want a hospital birth**
There was nothing else **I didn't want home but I didn't want** what the hospital had to offer	There was no other option available
Difficult to arrange Finding a SECM An amazing MIDWIFE I trusted my SECM implicitly Because of this trust I let the SECM GUIDE the care	Planning a home birth – finding a midwife
Brave & *Bonkers* Homebirth – risky and dangerous	**You're brave** Home birth is risky and dangerous
I didn't say anything to the GP after that **I didn't say it again to the midwife** I stopped talking about it unless they asked me I only talked to SEMC	I stopped telling people
Hospital could block home birth Afraid hospital would say no to home birth	**They'll take away my home birth**
	A lasting impression
Dr didn't agree but respected my decision Told me to come back any time	**We're here if you need us**
We had huge rows *Do you realise that ....* • The dr told me I was ridiculous • The dr told me my baby would need resuscitation • The dr told me the hospital would have nothing to do with me if I wanted to have a home birth	Why would I go back after that
Me and *my* SECM • This was *the* midwife for me **I didn't hav**e to worry about anything Reassurance for the SECM Accept whatever labour brings Knew if something was wrong they would transfer	Talk of transfer I know my midwife will tell me if I need to transfer
Early labour – unknown **I didn't know what was normal** Length of labour • We tried everything • I tried to give labour a chance	When plans change, my labour went off track
Preparing for transfer • We talked antenatally • We made a plan • I knew what was coming	I needed time to get my head around it

Needed time to get my head around to it • I wanted it on my terms And so the midwife said .... She just looked at me and I knew We didn't have to say anything	She didn't need to say anything, I knew that look
Transfer, I felt – Anxious Wanted to do what was safe I trusted my SECM I was relieved I just wanted this to end Transfer for a reason I was lost I was letting go of my dream I was scared I felt guilty	Making sense of the decision to transfer
I was disappointed I decided that I needed to go in She was no longer helping me	I had to initiate it myself
Nicer than I thought they would be The interactions- they were positive really I thought they would be awful Acknowledging my plans & expectations They knew the SECM They respected the SECM They let the SECM stay	I was lucky, I met a good midwife
Supported to have a normal birth Interventions – but I needed them There is a place for intervention I found my strength They *allowed* me to get my own way They let the SECM stay • I felt safe • The SECM protected me • SECM minded me • I knew the SECM would not let them do anything to me I didn't want	Against all odds I still did it my way
The SECM was the continuity and the bridge I just wanted the midwife to be nice to me Give me some sign to trust you • Do something so I will trust you The SECM wasn't allowed to stay • Asking this caused problems • I needed the SECM there (questions in the hallway) • Would it have been different if the SECM was there? I had to focus on strangers It was difficult with the midwife I met • She didn't care about me High Alert	Who will I trust?
as soon as I got there I knew the *vibe* was wrong It went from bad to worse I met the dr from the antenatal visit I was taking up too much time No one listened to me No one told me what was going on • Asking questions pushed the staff away The dr ignored my SECM All that I did not want it to be Shocking and brutal Felt like I wasn't able to do it	It was all I didn't want it to be
I was a silly woman I lost my voice It's the way they work, it's just not my way	It's not my experience it's the hospitals

Care by rote Care was routine Divide very big You have to be strong • You have to fight	

Examples of Sub-Categories to Categories

Self Employed Community Midwives	
Sub-Categories	Categories
Believe in normal birth Believe in birth at home Home birth = change to be a midwife Home birth= continuity of care	Yes, of course I support home birth
Trust in the SECM & Women relationship Prepared women for transfer • Antenatally • When possible - during the transfer • Debrief postnatally	The women know me and I know them
Relief when they agree with you Transfer – good or a bad thing There is always a reason Not done lightly **SECMs don't stay at home and make matters worse**	You hope you called it right
Can't have blind faith	The MOU is never far from your mind
Experiences of transfer vary – it depends on who you meet Depends on who you meet Being known It is fine – they know me	Seamless transfers
The barriers go up Historically fraught relationships Historical mistrust Trust	The barriers go up
Everyone judging Immediately Judged Written off before you speak Risk You are risky Vulnerable Judged You are risky	**They think I'm risky**
Transfer – difficult because you know they think you mad They **don't get home birth** **They don't understand home birth** Your decisions are judged out of context **They've forgotten normal** Facts viewed in isolation But you transfer for a reason You need their support	**They don't und**erstand **I'm still her midwife, you know**
Natural that you want to be with the woman Still a midwife Still *their* midwife Caught between women and hospital midwives You have to take a step back **Pretend you don't notice**	Caught in the middle
Vulnerable Judged **The system doesn't support you** Blame	Vulnerable, I feel vulnerable

Professional dismissal and disrespect Vary Historically fraught interactions No recognition of your professional role Territorial hospital staff Worked to build bridges Subtle subvert behaviour	Their world, their way

Examples of Sub-Categories to Categories

Hospital-Based Midwives	
Sub-Categories	Categories
Home birth – bad rep Reputation of the SECM	**I support home birth but …** Historical Hurt
Interaction for facts Frustration Poor communication Poor handover Too busy to interact	I just wanted to find out what happened
Disagree with care They have a different scope Depends on the reason for transfer **It's not 'normal' now**	We do things differently here
The presence of the SECM – double edged sword Who would do what? **We 'do' normal you know**	Vulnerable
Them and Us Blame We are the bad wolf	Good cop, bad cop
Atmosphere – challenging You have to plámás them Expectations?	A group you will never please You have to plámás them

Examples of Sub-Categories to Categories

Obstetricians	
Sub-Categories	Categories
I question the professional judgment of some of the SECMs Who governs the SECMs? No faith in *their* governance system I question the safety of home birth **I don't see 'normal'** Transfer for a reason	**I'm not against home birth but …**
I get blamed **I didn't stop their home birth** **I'm just keeping everyone safe**	Good cop, bad cop
They**'re never happy** Convincing women that they need interventions the need to adhere to our protocols	A group you will never please?
Women need to be better prepared **Plans can't always be followed**	What do they expect?

Categories to Themes

Women			
Categories	Sub Themes	Themes	Global Theme
I wanted a home birth **I didn't want a hospital birth** There was no other option available to me	**I planned a home birth because …**	Challenging the model of maternity care in Ireland	
Planning a home birth – finding a midwife	The journey to home birth		
You're brave Home birth is risky and dangerous I stopped telling people	Discussions of risk	Impressions and interactions during antenatal care	
They'll take away my home birth	Moments of power		
Talk of transfer I know my midwife will tell me if I need to transfer A lasting impression **We're here if you need us** Why would I go back after that	Foundations of trust	Surprises of transfer	From my space to their place
When plans change, my labour went off track I needed time to get my head around it **She didn't need to say anything, I knew that look** I had to initiate it myself Making sense of the decision to transfer	**Great expectations and women's spaces** **Navigating transfer in women's spaces**	Transfer, trust in the decision	
I was lucky, I met a good midwife Against all odds I still did it my way Who will I trust? **It was all I didn't want it to be**	A seamless meeting	Positive and not so positive interactions at transfer Guarding birth	
It's not my experience it's the hospitals	Birth in a different space	Locating safety in individuals, not routines	

Categories to Themes

Self Employed Community Midwives			
Categories	Sub Themes	Themes	Global Theme
Yes, of course I support home birth	Healthcare professionals views of home birth	Being a midwife	Negotiating a space in-between
The women know me and I know them You hope you called it right The MOU is never far from your mind	Calling time on home birth is disappointing but there is always a good reason	Framing the decision to transfer	
Seamless Transfer Historical Hurt The barriers go up	**It's all who you know**	Building bridges across suspicion and mistrust	
I'm still her midwife, you know Caught in the middle	To be there or not to be there	Caught between women and regulations	
They think I'm risky **They don't understand** Vulnerable, I feel vulnerable Their world, their way	Judge and jury	Negotiating positions in maternity services in Ireland	

Categories to Themes

Hospital-Based Midwives			
Categories	Sub Themes	Themes	Global Theme
I support home birth but … **I'm not against home birth but** …	Healthcare professionals views of home birth **We don't see normal**	Cultural duality in midwifery practice	Inhabiting a contested space
Historical Hurt	**It's all who you know**	Locating safety in the routine of hospital birth	
I just wanted to find out what happened We do things differently here Vulnerable	Handover	Deconstructing midwifery	
Good cop, bad cop			
A group you will never please You have to plámás them	My jurisdiction, my responsibility	Midwifery in obstetric spaces	

Categories to Themes

Obstetricians			
Categories	Sub Themes	Themes	Global Theme
I support home birth but … **I'm not against home birth but …**	Healthcare professionals views of home birth **I don't see normal**	At home with home birth?	Occupying a confident space
Historical Hurt	**It's all who you know**	Skewed perceptions of transfer Independent midwives – too independent	
Good cop, bad cop What do they expect? A group you will never please	My jurisdiction, my responsibility	Authoritative knowledge and cultural power	

Appendix 8:
Dissemination to Date

Publications:

Biesty, L. (2012) The best laid plans of women and midwives. The Practising Midwife, 15 (3), 45

Conferences Presentations:

Biesty, L., Lalor, J., OBoyle, C., Begley, C. (2015) Choosing home birth in Ireland. 5th International Nursing & Midwifery Conference, NUI Galway (30th & 31st March)

Biesty, L. (2014) Walking a space 'in between' - an outsider with a professional insider status Ethnography Symposium, University of Liverpool Management School & Keele University (28th & 29th August)

Biesty, L., Lalor, J., OBoyle, C. (2014) The home and hospital interface of maternity care in Ireland - experiences of Self Employed Community Midwives during in-labour transfers An Interdisciplinary Maternity Care Conference, Optimising Childbirth Across Europe (9th & 10th April)

Biesty, L. (2012) An ethnographic study of in-labour transfer to hospital during planned home birth. Participant Observation - the challenges 13th Annual Interdisciplinary Research Conference and Student Colloquium (6th November)

Biesty, L., Lalor, J., OBoyle, C. (2011) An ethnographic study of in-labour transfer to hospital during planned home birth - to be there or not to be there ...? Ethnography Symposium, University of Liverpool & Keele University (5th – 7th Sept)

Biesty, L. (2011) Transfer from home to hospital for women planning a home birth - women's experiences in Ireland International Confederation of Midwives (ICM) 29th Triennial Conference (19th – 23rd June)

Biesty, L., Lalor, J., OBoyle, C. (2011) An ethnographic study of in-labour transfer to hospital for planned home birth- the beginning 3rd International Nursing & Midwifery Conference, NUI Galway (3rd & 4th April)

Appendix 8:
Prior knowledge of Home Birth

Prior knowledge of home birth

The diary entries I made before entering the field of home birth highlight my assumptions about the women who planned a home birth. I did not expect them to have similar backgrounds, or to place themselves in similar socio-economic brackets. I presumed that there would be differences in their obstetric histories, their support systems, and their reasons for planning a home birth. However, I did not expect their knowledge about home birth to be so varied.

> **Diary entry (before data collection):**
> *What do I think the women in this study will be like?* [Part of my answer follows] ... *I expect that the women who plan a home birth in Ireland are very well informed in relation to birth, the maternity services and the role of the midwife. I think that must be, otherwise how, in a country where home birth is not readily available to all women, and most women birth in hospital, why would they choose home birth. In a sense I feel that they will have 'done their homework' and planned for labour and birth. I expect these women to clearly know what they want in relation to birth and have definite plans as to how they will achieve this.*

It surprised me that some of the women$^{(n=18)}$ planned a home birth at a time when, as they indicated, their knowledge about home birth was 'minimal'.

> **Field notes and diary entry following an interview with Cora:**
> I*'m just after coming away from an interview with Cora; I'm in a bit of a daze about some of the things she said. I have to say I was really surprised; she came upon home birth when she did an internet search for pregnancy. She had never really thought about it before, never knew what it was about, thought that you would not be 'allowed' to have one for your first baby. She couldn't remember why she decided that she wanted a home birth and said maybe it was because the HSE told her SECMs were hard to find – "once someone tells me I can't have something then I really want it". I was really surprised that this would be the rationale underpinning your choice re place of birth. When I asked about this, she said 'no, that was it' and suggested that it was even hard to remember now how it all started. But it has to have been more than that, the fact that she went as far as talking to HSE and asking what her options were, there has to be more to it than she can remember today?*

Sineád:

It was just by chance ... I met a girl that I'd been in a business course with I asked her, did she have an epidural ... she was like 'well actually no, I'd a home birth; I was 'what? a home birth', I didn't know you could have them. I just kind of got the idea off her like, but I still thought I couldn't do it because we're on the dole[193] *like and I thought you'd have to come with about five grand or something to do it like.*

Clodagh:

I had my first 2 boys over 10 years ago, in the x [name of maternity hospital], *and that was grand. And then 2 years ago I was a birthing partner for my sister and was talking with the nurses in the hospital, you know, while she was sleeping. And they started talking about home birth, they probably thought I knew something ... I don't think they realised she was my sister, I think they thought I was one of these birthing partner doulas ... I had never really heard much about home birth before this but I remembered some of the stuff they said about being in your own house when I got pregnant with this one.*

For some of the women,$^{(n=7)}$ home birth was not a route that they had considered prior to their pregnancy because they did not know much about it. It was something that they just 'stumbled upon' when they talked to other women, when they sought information in relation to pregnancy and birth, or when they googled 'birth'. Often their discussions or searches were not focused on place of birth but rather involved general queries about pregnancy and birth, and the area of home birth was an accidental finding (e.g. Sinead was searching for information on epidurals, Blaithin was trying to find support for backache during pregnancy, and Armelle was looking for websites covering birth in Ireland). As one of the women said: home birth was something that *"... caught my interest, sounded nice, seemed like a good idea, I wanted to hear more about"* (Olwyn).

The participants in this study who had not previously considered home birth thus discovered a model of care that they thought would meet their needs during pregnancy and birth. I observed discussions during antenatal care that provided insights into the women's needs and how the SECMs planned with them in relation to this.

[193] Dole – refers to unemployment benefits paid by the Government of Ireland.

Gráinne and Cliodhna (SECM) (observation):
Gráinne talked of choosing a home birth, after the birth of her first baby she made new friends within a 'mother and baby group'. Several of these women were "more into natural birth" and a few of them had home births. Gráinne suggested that this was something that she had never, in her life, even considered but the more she heard about it the more sense it made, especially for someone with a toddler. She talked of being able to stay at home, of not needing to disturb her daughter's routine or the worry of her feeling excluded from what was going on.

Armelle:
I went in [to the websites on home birth] and I read it and then I found another website, the NCT on home birthing or something ... I read that. Now for the first day or two I thought it was bonkers, but I couldn't stop reading it, I thought it was mad and then I kind of did more research and more research and I thought, I just got interested in it and then it kind of took the fear out of it. I always wanted, when I was younger I always wanted to have a birth with no pain relief because my Mom has done it five times and I said well I obviously can do it and I know all my friends were like 'oh I'm getting as much drugs as I possibly can'. So I always kind of knew I wanted that, but this was kind of a completely new avenue for me so I just did the research and, you know, it just seemed right ... because you're brought up and hospital is the way to go and that's just the way it is so I was just like well obviously I'll go to hospital, I mightn't have any pain relief but that's the way ... it wasn't that I was afraid or anything but I just presumed you had to go to hospital, you know, I didn't know there was any other choice, [but] when you read all the information and stuff about, you know home birth ... well, it just seemed right

Their growing attraction to the idea of home birth surprised these women in that it was a way of giving birth of which they had previously had little or no awareness. It was not something that they had previously considered as an obvious choice, and yet the philosophy espoused by supporters of home birth resonated with other aspects of these women's lives.

Maireád and Bridget (SECM):
Maireád started to tell me what home birth meant to her. She never considered it until she was pregnant, [when] someone in her village said she seemed like a 'home birthie' type of woman. She laughed as she told this and said that she wasn't sure what that meant, but it instilled curiosity and she went to a meeting with other women who were into home birth and natural birth and suddenly she understood what that comment meant. She felt yes, she was a 'home birthie' type of woman;

> *she wanted to be at home, with all her family around her. Laugh and dance and sing and cry out as she laboured, eat her own homemade food and 'do what she pleased with her placenta'. She seemed to find it amusing as she looked at me and smiled – "so I suppose, Linda, I was always destined for it even if I didn't know it."*

These women had to do their own 'detective work' to secure information about home birth. They indicated that specific details were difficult to locate when you did not know where to look. Happening upon the websites of the Home Birth Association, Cuidiú ('Caring Support for Parenthood'), and the Community Midwives Association provided some support, or at least led the women to the names of the SECMs and their contact details. Confusion about the process and the role of the SECMs was evident during the women's early stages of pregnancy. Clodagh, Sineád, Ríona and Armelle were all surprised about what the SECM could do.

> **Ríona and Leah (SECM) (Diary entry following observation):**
> *I was surprised by some of the interaction I observed tonight, it put me in mind of some of my thoughts after other observation sessions. Ríona and Leah spent time talking about the layout of the room during Ríona's labour, where she wanted the pool to be, where the table would be moved to. This was a 2 fold discussion Leah told me afterwards, 1) to get Ríona to really focus on the environment and what way she would like it to be and 2) to help Leah figure out where she would position her equipment etc. As the SECM explained this Ríona started to ask questions about the 'equipment' and what would Leah have with her. It became obvious that she had not thought of oxygen, suction, emergency equipment, suturing instruments etc ... Ríona was intrigued to hear all that travelled with Leah and how she might make use of her pack. I was so surprised, Ríona had chosen to birth at home, with a SECM, yet there was a considerable amount that she did not seem to know about the skills of a SECM and when these may be required.*

I had not anticipated that women would not be aware of, or would not have considered, the competencies that midwives needed in order to support women at home. Less dramatic examples emerged from other data: e.g. women did not realise that SECMs could cannulate, could administer Anti D, would carry Entonox.

At this early stage of their pregnancies, women did have interactions with other healthcare professionals (in primary care settings and the maternity hospitals), but the option of home birth was not a topic initiated by any of these. For the most part, the first healthcare professional women had contact with when they realised that they were pregnant was a GP. The models of maternity care suggested by the GPs focused on hospital-based care; home birth was not suggested, nor was it encouraged. In some cases it was actively discouraged, with warnings that the women perceived to be dramatic and frightening.

> **Aideen:**
> *I found out I was pregnant and went to the doctor just to confirm the pregnancy ... the doctor said to me something about the hospital, about the birth, are you planning to go in to hospital? And I was like, I hadn't even thought about the birth, I was just thinking about now, 'oh My God I'm pregnant', so ...she was the one who mentioned it, and I was like 'Oh I don't think I'll be going in to hospital, I'm pretty sure I'll have the baby at home', the doctor was like 'well you know we don't recommend that, we don't recommend a home birth ... especially on a first baby'.*
>
> **Cora:**
> *My own GP then refused to see me at first, and then he told me 'are you sure you're going to kill your child?', and I was sitting there just going 'of course I'm not intending on killing my child', and he was like 'well, I've been at births you know, and everything happens in a split second and I've been at ones where literally, where if you hadn't done something within three minutes that child would not be here, so what are you going to do then?'*
>
> **Gilda:**
> *They [GP and obstetrician] never explained, never told me about other options, never talked about midwives or about midwife care. I was cross, I was so cross about that ... had I known from the beginning what I could have had ...*

The more women learned about home birth, the more they questioned the lack of attention, promotion and support it receives as an option of maternity care. They all suggested that other women were not considering home birth because they were not aware that you 'could have a home birth in Ireland'. They also felt that healthcare professionals were not fulfilling their health promotional role of informing women of all their options.

These women's experiences highlight the extent to which the reins of information about the model of care remain firmly in the grip of the supporters of hospital-based birth. Home birth remains an unexplored option for many women in Ireland. The interactions with GPs, as described by the participants of this study, give some insights into the reason for this. GPs are described by SECMs in this study as "gatekeepers to the maternity services" (Rosa, SECM). Given the historical influence of the Mother and Infant Care Scheme and the provision of maternity care within the scheme by GPs and hospital doctors (see Chapter 4), further exploration into this gatekeeper role and how it maintains the *status quo* of the maternity services is required.

> **Cáit and Siofra:**
> [Cáit made references to how she interpreted her GP's reactions when she talked to him about home birth for the first time:] *They* [GPs] *don't tell you about it, so straight away you feel like they must think there is something wrong with it ... you feel like you are looking for information about something that they do not approve of. And this is when you are just looking for information ...*

The experiences with GPs reveal a 'them and us' culture; all the women felt that their knowledge and choices were at odds with healthcare professionals [except SECMs], describing how members of all the participant groups of this study felt that their encounters featured disapproval, misunderstanding and little insight on the part of those with a different opinion.

The process of choosing a place of birth and model of maternity care appeared to be less complex for women who had some previous knowledge of or exposure to home birth. Thirty- five of the women highlighted experiences of home birth that ranged from their experiences as healthcare professionals, supporting family and friends during a home birth, and hearing home birth stories from other women. Some of these women had lived for periods in countries where, they suggested, home birth was more common than in Ireland. The decision to plan a home birth, as described by these women, was almost organic in its development; it appeared to be something that did not take much deliberation; rather there had almost been

an assumption that this was the route that they were going to take. During my fieldwork, women went to great efforts to ensure that I was aware of any of their background issues that related to their choice of home birth.

> **Ailis and Bridget (SECM):**
> [Ailis said:] *I don't know, I never thought of anything else for me.*

Gwen, Alannah, Lana and Aideen just 'knew' that home birth would be the option that they would choose if they ever became pregnant. Ailsa, Niamh, Siabh and Roisin recalled making the decision instinctively; home birth had obviously made an impression at some earlier stage in their lives. They suggested that they had not thought about it until the moment they started planning for birth and then it was the only option they could consider.

> **Ailsa:**
> *I knew when I got pregnant and started thinking about it that home birth was what I wanted ... I didn't need anything else, just us and our midwife and our pool ... that was it!*