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Trinity College Dublin School of Nursing and Midwifery

Using Participatory Action Research to Develop Antenatal Education in Preparation for Motherhood

A Dissertation Submitted to the University of Dublin, Trinity College, for the Degree of Doctor of Philosophy

April 2012

Vivienne Brady

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Summary

Using Participatory Action Research to Develop Antenatal Education in Preparation for Motherhood

Background:

The current growth in the use of maternity services in Ireland is reflected by a 5% increase noted in births nationally between 2007 and 2008, with 75,587 births notified to the National Perinatal Reporting System (NPRS) in 2008 (Economic and Social Research Institute 2010). How services are provided in response to this demand is an indication of how women are situated and positioned in Irish society (Kennedy 2004). Antenatal education (ANE) is offered by every maternity unit in the Republic of Ireland on the premise that it prepares women for birth and motherhood. Notwithstanding this, there is evidence to suggest that conventional models of hospital-based antenatal education fail to meet women's social and psychosocial needs (Barclay *et al.* 1997, Kennedy 2002, Matthey *et al.* 2002, Schott 2003) in preparation for motherhood (Nelson 2003, Nolan and Foster 2005). Critiques of traditional methods of ANE suggest that class facilitators have normalised and fostered acceptance of an increasingly medicalised, technological model of childbirth through the medium of antenatal education (Oakley 1980, Fleming 1992, Kitzinger 2005), at a time during pregnancy, when women anticipate change and are open to outside influences (Chalmers 1997). Minimal consultation with women in planning and developing services is a feature of maternity care in Ireland and is absent most certainly at strategic policy levels (O'Connor 2006, Devane *et al.* 2007). This is despite government and independent recommendations that consumer involvement in health research, service planning and development is a vital component in promoting openness and accountability in addressing issues of inequality within the healthcare system (KPMG 2008, DOHC 2005, DOHC 2001 and Kinder 2001). According to Sang (2003), the use of research methods of inquiry in health services has neither challenged nor indeed, shifted the structures and cultural assumptions of hierarchy which influence the function and resources within them. The research presented here was undertaken to contribute towards ameliorating just one aspect of this serious deficit in maternity services in Ireland. It was envisioned that hospital-based ANE, relevant and grounded in the needs and life experiences of women, could be developed, with a view to supporting women's

decision-making processes, and understanding of, pregnancy, birth and early motherhood.

Aim:

To develop antenatal education in preparation for motherhood, based on knowledge created in collaboration with mothers to be, mothers and antenatal educators.

Methodology:

This research was guided by a participatory worldview, using a Participatory Action Research (PAR) approach influenced by feminist concerns and grounded in the interests and experiences of women and antenatal educators. An action research cycle of constructing, planning action, taking action and evaluating action was used. Information was gathered over a period of twenty three months through a variety of techniques; however, group meetings (n=18) of between four and twelve participants; pregnant and postnatal women, and antenatal educators, and individual conversations with pregnant and postnatal women (n=7) were the principal methods of data gathering. Conversations were analysed using the Listening Guide, a voice-centred relational method which involved multiple consecutive readings of each conversation. Ethical approval was granted by the relevant research settings and the University.

Findings:

Cycles of action research are described throughout the findings chapters. Women portray their learning needs for pregnancy, birth and motherhood. Various themes including loneliness, coping after birth, and, the relevance of knowledge that is grounded in the real-life experiences of other mothers are highlighted. Practice issues, and enabling and restraining forces for change are identified by antenatal educators. A theoretical model of antenatal education is proposed. This research highlights the conflicting views of women as recipients of maternity care and of antenatal educators as facilitators of learning and, as gatekeepers.

Conclusion:

The goals of Participatory Action Research have been identified as achieving emancipation and empowerment for oppressed groups and highlighting social problems through cyclical processes of research, learning and action. It is doubtful whether this

research has proved emancipatory against the very rigid setting and unequal status of the participants involved. In terms of empowerment, the therapeutic nature of our discussions appears to have strengthened participating women's awareness and desire to reflect and consider their experiences of maternity care. We have highlighted the social problems of the maternity services through our cyclical processes of research, learning, and attempting change through action. We have begun to uncover the power relations at the intersection where dominance and subordination meet. Creating awareness about these particular intersections however, is merely one step in a larger political debate about women and carers, as they are situated in the maternity services. Time, and future reports about the research project will reveal the true extent of the sustainability of change achieved, beyond engagement in the field.

Dedication

For my daughters, Eve and Ella.

Acknowledgements

I am thankful for the support of my supervisors, Joan Lalor and Jo Murphy-Lawless, who shared their knowledge and navigated this path patiently with me.

Thanks also to my friend and mentor, David Coghlan, to Declan Devane for his gentle honesty and insight, and to Geralyn Hynes, for being the very best of 'critical friends'.

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CHAPTER ONE: OVERVIEW AND CONTEXT OF THE RESEARCH

1.1. Introduction

The purpose of Chapter One is to present an overview of the thesis and to situate maternity services in Ireland with reference to context, background and affecting forces. Burke (2009) proposes that most women in Ireland need maternity and reproductive services in their lifetimes. Currently there is increased demand for maternity services, with a 5% increase noted in births nationally between 2007 and 2008 (Economic and Social Research Institute 2010). The most recently available statistics from 2010 suggest that the birth rate of 16.8 per 1,000 population, notified to the National Perinatal Reporting System, is the highest current birth rate of any of the 27 European Union countries (Economic and Social Research Institute ESRI 2012). The way maternity services are provided in response to this demand is an indication of how women are situated and positioned in our society (Kennedy 2004). Antenatal education (ANE) is offered by every maternity unit[1] in the Republic of Ireland on the premise that it prepares women for birth and motherhood. Notwithstanding this, there is evidence to suggest that conventional models of hospital-based antenatal education fail to meet women's social and psychosocial needs (Barclay *et al.* 1997, Kennedy 2002, Matthey *et al.* 2002, Schott 2003) in preparation for motherhood (Nelson 2003, Nolan and Foster 2005). Critiques of traditional methods of ANE suggest that class facilitators have normalised and fostered acceptance of an increasingly medicalised, technological model of childbirth[2] through the medium of antenatal education (Oakley 1980, Fleming 1992, Kitzinger 2005), at a time during pregnancy, when women are anticipating change and are open to outside influences (Chalmers 1997).

---

[1] In the nineteen publically funded hospitals, antenatal education is offered by in-hospital professionals, with the exception of one setting who employ external contractors.

[2] Davis Floyd refers to this as the technocratic model, she cites Reynolds (1991), 'the term technocracy implies the use of an ideology of technological progress as a source of political power' (Davis-Floyd 2003, p.47). Technocracy not only includes technological power but also bureaucratic, hierarchical and autocratic aspects that are culturally dominant; a feature of the technocratic paradigm of care is intolerance to other ways of thinking or knowing. In a technocratic model of birth the female body is viewed as a machine requiring maintenance (Davis- Floyd 2003).

1.2. Hearing Women's Voices

There is a dearth of research in Ireland designed to elicit women's views and expectations of antenatal education in preparation for motherhood. Consultation with women in planning and developing maternity services in Ireland is virtually non-existent, particularly at strategic policy levels (O'Connor 2006, Devane *et al.* 2007). This is despite government and independent recommendations that consumer involvement in health research, service planning and development is a vital component in promoting openness and accountability in addressing issues of inequality within the healthcare system (KPMG 2008, DOHC 2005, DOHC 2001 and Kinder 2001). The findings of a recent participatory research initiative in the UK with maternity service users and providers (twelve groups of between 8 and 20 each) in association with the James Lind Alliance revealed that women agreed prioritised research areas when offered opportunity to come together (Cheyne *et al.* 2012). Much has been written about the historically polarised and deeply political battle between the obstetric male and the predominantly female midwife[3] (Donnison 1988, Rich 1995, Murphy-Black 1995); however, women as mothers are largely ignored in this debate and left without voice (Oakley 1984, 1993, DOH 1997, Edwards 2001, 2005). Bob Sang (2003, p. 55) expounds the fundamental importance of hearing voice at 'every level in every process' in developing services that are responsive and sensitive to need. Plans to incorporate women's [patient] involvement are meaningless, unless the issue of power in the health service is identified and addressed (Sang 2003). According to Sang (2003), the use of research methods of inquiry in health services has neither challenged nor indeed, shifted the structures and cultural assumptions of hierarchy, which influence the function and resources within them. The research presented here was undertaken to contribute towards ameliorating just one aspect of this serious deficit in maternity services in Ireland. It was envisioned that hospital-based ANE, relevant and grounded in the needs and life experiences of women, could be developed, with a view to supporting women's

[3] According to Oakley (1993, p. 71), the rise of medical dominance over midwifery was achieved partly by the opinion that essential to caring for the childbearing woman adequately was the necessity to view the female body as a machine to be 'supervised, controlled and interfered with by technical means.' Thus, in the absence of understanding aspects of childbirth, control, management and mastery of birth had to be achieved (Oakley 1993).

decision-making processes, and understanding of, pregnancy, birth and early motherhood.

1.3. The Concept of Agency

The significant omissions related to hearing women's voices in developing maternity services in Ireland indicate that some discussion related to power and agency is necessary before we proceed. To clarify, the aspect of agency presented here relates specifically to what Miller (2005, p. 17) describes as 'the ways in which women engage with, or reject, scientific or medical discourses.' According to Patricia Kennedy (2010), the introduction of a pilot study of two midwifery-led units (MiDU)[4] in July 2004 emphasised, for the first time in Ireland, the centrality of the mother and infant to maternity care. Prior to this, maternity services were consultant-led with widespread and varying degrees of Active Management of Labour (AML)[5] (Kennedy 2002, 2010, Begley *et al.* 2009). This resulted in the normalisation of a highly medicalised hospital-based model of birth, a context in which 'the mother's voice is sometimes lost' (DOH 1997, p. 28, Gray 2000). In her analysis of the unchallenged norm of obstetric medicine in Ireland, Jo Murphy-Lawless (1998, p. 4) describes personal agency as 'a political

[4] MidU stands for 'Midwifery Unit' and refers to the randomised control trial of two midwifery led units in the Maternity Unit, Our Lady of Lourdes Hospital, Drogheda and the Maternity Unit, Cavan General Hospital, subsequent to the recommendations of the Kinder (2001) report for midwifery led care.

[5] Active management of labour was initiated by obstetrician Kieran O'Driscoll of the National Maternity Hospital Dublin in the 1960s and was embraced as an international model of obstetric care (Kitzinger 2006). The tenets of this particular approach are based on limiting the duration of labour, avoidance of physical and emotional trauma, the reluctance to induce labour and personal attention throughout the labour and birth process (O'Driscoll *et al.* 2004). The role of the midwife is clearly outlined, and that is, 'to be acutely conscious of the need to keep every woman in labour on a tight emotional rein from the point of her admission until her baby is born, because the further she is allowed to slip down the emotional incline, the more difficult it becomes to recover her composure' (O'Driscoll *et al.* 2004, p. 94). The birthing environment 'is designated an intensive care area...in this way, the consultant obstetrician becomes involved in the conduct of labour on a regular basis as never before; hence the origin of term 'active management of labour'' (O'Driscoll *et al.* 2004 p.4). Oakley (1986, p.112) has argued that 'any kind of medical assistance runs the risk of turning the mother into a passive object rather than active subject. According to Downe and Dykes (2010), active management of labour continues to dominate hospital practices via protocol worldwide, regardless of local context.

struggle for each woman against a dominant institutional voice...'[6] In maternity services, expression of personal agency is hampered by how women are situated as recipients of care in a system that is marked by a lack of awareness of the changing contexts of women's lives, a strong allegiance to a biomedical model and confused messages regarding the issues of 'safety'[7] and 'choice'[8] (Devane *et al.* 2007, p. 95). According to Murphy-Lawless (1998), these terms are ambiguous because obstetric thinking and practice are dominated by issues of risk concerning the unborn child. In this way, agency is removed from women as mothers, through expected and unquestioning adherence to a hospital-based obstetric mindset that is presented in the best interests of the foetus (Murphy-Lawless 1998, Buckley 2009). In her narrative analysis of women's experiences of becoming mothers, Tina Miller (2005) suggests that the concept of agency is influenced also by social division (the influence of social difference and division is discussed on pages 30, 62, 74, 75 and in the Discussion Chapter Ten).

1.4. Agency and Power

The concept of structure within Giddens' (1984) 'structuration' theory is perhaps critical to a discussion about relinquishing personal agency and consequent compliance to knowledge imposed within institutional[9] boundaries. At a very basic level, knowledge that is bound by institutional context is described in terms of 'structure' that

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[6] Elsewhere, agency is defined as 'expression of independence through self-protection, self-assertion and control of the environment' (Marshall 2011, p. 337).

[7] Safety has been described as an ill-defined and ambiguous concept (Devane and Begley 2004). The impact of risk and safety discourse in preparation for motherhood is explored in the findings chapters Six, Seven and Eight and the Discussion Chapter Ten.

[8]Bauman (1998) suggests that the concept of 'choice' is compromised in complex situations in a society that lacks mutual support.

[9] In this sense, Giddens' (1984) use of the term 'institution' refers to maternity care settings.

manifests as 'rules and resources'.[10] Rules exist 'as techniques or generalisable procedures applied in the enactment or reproduction of social practices' (Giddens 1984, p. 21). Thus, rules consist of knowledge of procedure related to how to act and respond in various social situations (McGrath 2009). Of relevance to the research presented here, Giddens (1984) refers to the rules implicated in the reproduction of social system; that is, Giddens' 'structure of signification'[11] which indicates the pervasive influence of power in social life and in human action (Giddens 1984, p.31). Language in the form of modes of discourse[12] plays an important part because the rules of language are applied to procedures implicated in practical daily activities (Giddens 1984). Also relevant to this research is Giddens' (1984) 'structure of domination', where activities take place with positive or negative sanction.[13] Giddens (1984, p. 175) suggests that the constraining aspects of power are experienced as negative sanctions of various kinds, 'ranging from the direct application of force or violence of the threat of such application, to the mild expression of disapproval.' Continuing this theme, compliance with obstetric science is promoted with the strong cultural and social messages that women receive: that birth is dangerous and layered with risk and is not achievable without medical intervention (Murphy-Lawless 1998, Davis-Floyd 2003). This is coupled with the ideology that technology keeps women and babies safe (Davis-Floyd

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[10] Rules are inextricably bound to resources, incorporating 'transformative relations' to the reproduction of social practices. In this way 'structural properties thus express forms of domination and power' (Giddens 1984, p. 18).

[11] Anthony Giddens (1984) describes three types of structures: 'structures of signification', where meanings are attributed to one's own activities and those of others, for example, symbolic orders and modes of discourse, 'structures of domination'; 'activities take place within sanctions which are tacitly or self-consciously applicable to them; for example, political and economic institutions and 'structures of legitimation'; 'the regulative aspect or the moral/norm elements are those that demarcate the appropriate or legitimate ways' such as legal institutions (McGrath 2009, p.86, Giddens 1984).

[12]Soo Downe and Fiona Dykes (2010) acknowledge the resonance of how power and ideology shapes discourse; thereby, effecting systems of knowledge in dialectical relationships.

[13] In her analysis of hospital-based antenatal education, Margaret Mason (1998) suggests that information givers may be subject to negative sanction to prevent discussion related to obstetric risk.

and Davis 1996, Murphy-Lawless 1998, Davis-Floyd 2003). Thus, according to Davis-Floyd and Davis (1996, p. 238), 'a reassuring cultural order is imposed on the otherwise frightening and potentially out-of-control chaos of nature'. Women tend towards compliance if they are led to believe that they or their baby are at risk (Murphy-Lawless 1998, Edwards 2008, Buckley 2009); therefore, agency in this sense is curtailed.

Drawing on Michel Foucault's observations about power, a distinction should be made between power and what Foucault (1976, p. 36 and 1979, p. 156) refers to as 'disciplinary power', as a means to control or produce behaviour. Such distinction can be made with Christiane Northrup's (1998, p. 717) reference to power that is from within, as enabling, or as 'fuel for change'. Indeed, Anthony Giddens (1984, p. 175) suggests also that power, as well as being a potential constraint, can be 'a means to get things done.' Disciplinary power in contrast, is a manipulative and subtle form of power that is difficult to detect, unless the subject of power attempts resistance, and its success is proportional to the ability to conceal power mechanisms (Foucault 1991, 1998, Lukes 2005). Foucault (1991) refers to practice professions and corresponding institutions (hospitals, schools and prisons) as sites of disciplinary power. To illustrate this, Barbara Katz Rothman (1996) offers a reminder of the concrete methods in which medical power influences and transforms the experience of birth for women and how the birthing mother is converted to a powerless patient. These methods include the removal of familiar environment and clothing and the making public of the woman's intimate form, in addition to the need for medical confirmation for certainty. Further, she notes that the conduct of managing people is akin to other institutions, and is achieved by invading personal space and 'transforming individuals into units of management' (Katz Rothman 1996, p. 254). Foucauldian perspectives of power are discussed in Chapter Two and also on pages 38, 43, 155, 202 and 316 and 317.

1.5. Working Definitions for the Research

The concept of motherhood is associated with a variety of meanings inextricably bound with creativity and nurturing (Kennedy 2004). Becoming a mother is a developmental life event, which involves passage from one's familiar reality to an unknown reality, the process of which is unique to each woman (Mercer 2004). For the purpose of this study, 'motherhood' refers to birth and the adjustment that a woman makes in the first 12 weeks after birth, through learning to care for herself and her baby. The term

'antenatal educator' is used predominantly in maternity care units in Ireland to describe a healthcare professional facilitating antenatal education. For the purpose of this research, this term is used also to refer to a midwife, physiotherapist and dietician facilitating ANE in a public maternity hospital in the Republic of Ireland, as distinct from ANE that is accessed through alternative or private means.

The term 'antenatal education' will be referred to throughout this work to signify other terms used synonymously in the literature such as, prenatal/client/childbirth education/preparation and parent/mother craft. For the purpose of this work, pregnant and postnatal women are predominantly referred to as 'women co-researchers' and antenatal educators, as they are commonly known in hospital-based ANE are referred to as 'ANE co-researchers.' According to Marshall and Reason (2007), participation in inquiry means that we build relationship with participants as co-researchers, as distinct from research subjects. In an ideal setting, this means that the whole person is engaged and that understanding is based on her own experience and actions and is not filtered through an outsider's perspective.

1.6. Reviewing the Use of the Terms 'Mother', 'Mothering' and 'Motherhood'

The word 'mother' is both a verb and a noun (Rich 1995); to become a mother is to mother. The words 'mothering' and 'motherhood' are also used to describe 'mother'. The term 'motherhood' may be described as, 'a variety of meanings tied up with creativity and nurturing and not solely the physiological labour of woman as mother' (Kennedy 2004, p. 11). The concepts of 'mothering' and 'motherhood' however, are distinctly different as 'motherhood implies the act of having given birth, to have become a mother' (Marchant 2004). In contrast, 'mothering' extends to include the role of parent even when the child reaches adulthood (Marchant 2004); furthermore, the emotional and physical mothering skills that are required can be shared by more than one responsive adult (Nolan 2003). This is evident throughout history as women have helped each other to birth and to nurture children (Rich 1995). The terms 'mother' and 'motherhood' will be used for the purpose of this work.

1.7. Structure and Format of the Thesis

There are ten chapters including this first introductory chapter. Chapter Two presents an overview of antenatal education and motherhood in Ireland and information about the nature and context of the services.[14] Chapter Three presents the philosophical underpinnings and ontological position relating to this research and how this influences the selected orientation or methodology of Participatory Action Research. The process of operationalising the methodology is described in Chapter Four. Chapter Five explores the significance and method of analysis using voice. The findings of the research are presented in Chapters Six, Seven and Eight. A theoretical model of antenatal education in preparation for motherhood is presented in Chapter Nine. A discussion Chapter follows and this explores how women know birth, the parallel and diverse discourses of ANE co-researchers and women co-researchers, and learning about and application of the participatory action research process to maternity care settings.

1.8. Conclusion

In Chapter One, I have presented some discussion about how maternity services in Ireland are situated with reference to context, background and affecting forces. I have introduced the concepts of agency and power and how agency and power are defined for women as recipients of maternity care. I have presented the working definitions for the research including a review of the terms used to describe 'mother', 'mothering' and 'motherhood'. Finally, I have provided an overview of the structure and format of the thesis. In Chapter two, I present a discussion about how becoming a mother and antenatal education is situated in Ireland and an exploration of the relevant literature.

[14] Unless otherwise stated 'Ireland' refers to Republic of Ireland.

CHAPTER TWO: SITUATING ANTENATAL EDUCATION AND MOTHERHOOD IN IRELAND

2.1. Introduction

The purpose of this Chapter is to situate becoming a mother and antenatal education in Ireland. An exploration of the literature about becoming a mother and its relevance to this work is presented in addition to the contextually relevant historical, social and cultural forces related to antenatal education. Developments in the United Kingdom in antenatal education are presented also because they are considered most germane to the Irish context.

2.2. Becoming a Mother

According to Melissa Benn (1998), parenting may be regarded as one of the most important public health issues; however, a dearth of information about the vital skills required for motherhood exists. More than a decade following Benn's publication, a meta-synthesis of the results of nine qualitative studies[15] by Nelson (2003) related to the transition to motherhood, indicates that despite antenatal preparation, new mothers can feel overwhelmed and unprepared in becoming a mother. Perhaps crucially, Rich (1995) identifies a lack of general discussion about the mixed feelings of exhilaration, tenderness, confusion, and powerlessness, experienced through bearing and rearing an entirely dependent other (Rich 1995, Cusk 2008, Figes 2008). Ann Oakley (1979, 1986) has suggested that it is the moment that a woman becomes a mother that she faces the reality of what it means to be a woman in society. Once a woman gives birth to a baby, she is a biological mother but she only becomes a mother in the social sense when she begins to care for her child and she is perceived by herself and others to be a mother

[15] Four studies used grounded theory methodology and five used phenomenology (Nelson 2003). In this metasynthesis, Nelson (2003) has not presented an operational definition for her use of the term 'maternal transition', but discusses individual maternal experience after birth. Exclusion of research focusing on maternal transition in specialised or challenging circumstances, such as significant maternal mental or physical illness, postpartum depression and drug addiction among others, limits description of the experience of maternal transition to well, adult mothers and healthy infants (Nelson 2003).

(Oakley 1986, Stern *et al.* 1997). She shares with other mothers a unique mindset[16] (Stern *et al.* 1997, p. 17), which develops and progresses from some point during pregnancy and after several months of caring for her baby when she recognises herself as a mother 'in her own eyes'. In her seminal research exploring women's experiences of becoming mothers, Ann Oakley (1986) observed that no-one can tell another what pregnancy, birth and motherhood will be like and communication of these experiences is hindered by the gap between mother and expert. Experience changes the way people behave, even experts.

The role of mother is demanding and all consuming and has some similarities with other occupations; however, it is distinct in that mothers are always on call (Benn 1998, Stern *et al.* 1997, Nystrom and Ohrling 2004), and mothers are, according to Western society, ideally, what women are supposed to be (Oakley 1979, Chodorow 1999, Choi *et al.* 2005). There is a dominant ideology of women as 'natural' mothers, immediately able to care for their babies and ultimately fulfilled in the role of selfless carer and nurturer (Woollett and Marshall 2000). Once a natural mother, a woman becomes a person with no other identity (Oakley 1979, 1986, Rich 1995, Barclay *et al.* 1997, Cusk 2008, Figes 2008). Indeed, Rubin (1984 p. 52) suggests that 'childbearing requires an exchange of a known self in a known world for an unknown self in an unknown world.' Nelson's (2003) aforementioned metasynthesis reveals that although there are commonalities in how women perceive motherhood, becoming a mother is not experienced in the same way by all mothers. The challenge therefore, for carers and supporters, is to identify what each mother needs and to offer support to suit each woman as new mother (Nelson 2003).

2.3. Cultural and Societal Attitudes towards Motherhood

While it may be argued by some that the desire to have a baby stems from a purely biological drive, it is also held that women need motherhood and babies need their mothers, and this relationship is inextricably bound to cultural values and societal attitudes to family life (Oakley 1986). Motherhood not only suggests irreversible biological change but also implies sustained unconditional acknowledgement and

[16] Stern *et al.* (1997, p. 5) refers to this unique mindset – the process of 'giving birth to the motherhood mindset.'

awareness of another human being, which begins with the ritual[17] of pregnancy and childbirth and continues through to learning how to nurture (Rich 1995). A woman's status as child-bearer is a major fact of life (Rich 1995). Tina Miller (2005) argues however, that becoming a mother is potentially disruptive to one's sense of self and making sense of motherhood is complicated by the interchanges between dominant moral, biological and social discourses.[18]

Having a baby requires restructuring of the woman's life and self-perception (Barclay *et al.* 1997), in order to somehow combine a child's needs with self-need (Oakley 1986). The mother can no longer be what she has previously defined as herself; she loses herself in societal expectations and, at times, to patriarchal[19] control. This control is even manifested in her inability to express her true feelings (Rich 1995), as mother-love is supposed to be persistent and unconditional, and negative emotions such as anger should not co-exist with mother-love, indeed, 'female anger threatens the institution of motherhood' (Rich 1995, p.46). In becoming a mother, the woman's body undergoes irreversible changes; her mind changes irrevocably and her future as a woman is fashioned by the event that is birth and motherhood, whatever her decision or path (Rich 1995). There is typically an alteration in lifestyle and grief for former life, career and status (Cusk 2008, Symonds and Hunt 1996, Rubin 1984). According to Oakley (1986), becoming a mother is compounded by the lack of formal training or instruction in preparation for the realities of motherhood, with the result that women can have unrealistic expectations of themselves as mothers (Kitzinger 1992).

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[17] Kitzinger (2005) indicates that societal ritual guards the margins of life, the 'in between states and the whole process of becoming. Ritual acts are symbolic; they represent another layer of meaning... Birth and death are surrounded by ritual in virtually every society (Kitzinger 2005, p. 1).

[18] Tina Miller's (2005) research involved narrative analysis of seventeen women's accounts of their experiences of becoming mothers. Women were interviewed on three separate occasions during pregnancy and after birth, and completed an end of research questionnaire to elicit their experiences of participating in the research.

[19] In this way, the patriarchal system depends on the mother to birth her baby but isolates and alienates her from her birth process, while expecting her teach her child to behave conservatively and to obey the laws of the system (Rich 1995).

2.4. Historical Connotations for Woman as Mother

The functions of women and men in relation to the home and unpaid domestic burdens are the result of social, historical and cultural processes, as distinct from innate biological attributes (Hareven 1993). A highly significant and gendered division between private and public spheres emerged with the advent of industrialisation, which saw paid productivity shift from the home to the outside world - the revered and predominantly male domain (Martin 1987) and Felski (2000). The daily activities associated with domestic responsibility, however, have fallen historically within the realm of female responsibility (Bennett 2002).

A 'culture of domesticity' developed in the seventeenth and eighteenth centuries, where the activities of the home became the central focus for middle class women while their male partners were ascribed the role of provider (Bennet 2002, p. 9). With the exception of the exploitation of working class women who were forced to enter paid employment (Harding 1998) and who became the principal labour source of the industrial revolution (Bennet 2002), women traditionally stayed within the confines of the home and domestic constraints and were largely denied active participation in higher education and professional life. The woman's role could be redefined, as it was briefly, during periods of social conflict when the two world wars forced women outside the home and into industrial and war time activity. These periods were self-limiting, however; in the instance of the Second World War, once war subsided, women were generally encouraged to resume domestic life with the ideological goal of rebuilding society (Bennett 2002). Following the war, women were expected to resume the activities traditionally relegated to them; those concerned with pregnancy, birth and childcare (Oakley 1979). It should be acknowledged that the exclusive role of homemaker has been influenced by other factors, predominantly social class, ethnicity, age and educational status, (Bennett 2002) and economics, as women were forced to juggle motherhood and paid work in times of economic hardship (Kennedy 2002, Benn 1998). For the rural and working classes in the nineteenth and twentieth centuries, the boundaries between domesticity and paid productivity were always blurred, as home was a place of domestic activity and intense industry, which was necessary to supplement the family income. In the pre-industrial era this involved all family members, including the very young (Rich 1995), while in the modern period until well

into the twentieth century, older children went out to work. Motherhood was intensely physical and marked by hard labour, successive pregnancies and continuous nursing; women were forced to engage in outside work, often with no credible option but to leave small children in inadequate care (Rich 1995).

Mid-twentieth century societal expectations of having a baby included loss of paid employment, the assumption of new roles as 'mother' and of becoming a housewife (Oakley 1979). Still, motherhood required (or was synonymous with) domestic work. The notion of conflicted ideology and the suggestion that 'domestic contentment' may not be possible was not embraced historically by society (Oakley 1979, p. 2) or in contemporary social discourse. Indeed, Benn (1998) indicates that Western society and culture do not acknowledge the maternal strength and resolve that is required to raise a child (Benn 1998). Motherhood is socially constructed as a critical aspect of femininity[20] (Choi *et al.* 2005). For many women, becoming a mother is the accepted norm. To be like other women in this way, to succumb to societal expectations of being a 'womanly woman' is easier and requires less guilt (Rich 1995, p.129, Miller 2005). Oakley (1986) proposes that suddenly having no other occupation than enforced domesticity and the continuous role of carer can seriously affect a woman's sense of self in addition to the demeaning prospect of emotional and complete financial dependency on another.[21] It has been suggested in the past, that commitment to the domestic responsibilities of 'home' has prohibited the female pursuit of paid work, due to fear of neglect of the feminine duties of homemaker and mother (Hareven 1993, Rich 1995). Historically, inequalities existed among heterosexual couples, particularly in relation to unpaid domestic work and distribution of income (Jamieson 1998, Janes 2003). Power was attributed to the main earner - traditionally the male, with the belief that the male provider was entitled to the domestic services of the female other. This ideology of

[20] To explain, 'feminine' extends beyond biological determination and is socially and culturally constructed; therefore, the male sex is masculine, the female is feminine and there are associated behavioural expectations of each (Abercrombie *et al.* 2006).

[21] Gender inequality manifested through the financially dependent woman as unpaid carer and the 'male bread winner model' (Coakley 2004, p. 208), provided the impetus for foundation of the welfare state in Ireland and England in the nineteenth century where upon marriage, women lost individual social rights and were treated as dependents for social welfare and tax.

motherhood is, in fact, enshrined in Irish Law under the 1937 Constitution of Ireland.[22] Article 41[23] of the Constitution on the Family states that the woman's place in is the home:-

Article 41 of the Constitution of Ireland

1. 1° The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law

   2° The State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.

2. 1° In particular, the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved.

   2° The State shall, therefore, endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home

2.5. Contemporary Motherhood

Oakley (1979) has argued that the institution that is motherhood, or the way that women become mothers in society, is connected to societal attitudes towards women that are motivated largely by economics. The production of capital requires the production of workers; therefore, traditionally, women's primary role was to reproduce. Women who were working in paid employment outside the home presented a significant problem in terms of perpetuating the workforce (Oakley 1979, Murphy-Black 1995). Additionally, it was considered that they neglected their children by leaving the home for outside work (Rich 1995). Over a decade following Oakley's (1979) assertions, Kitzinger (1992) suggests that motherhood is less valued because the human world is over-populated and has surrendered human failings in favour of technology and science

[22] This philosophy; however, is not sustained by relevant policies for services supporting women in becoming mothers (Murphy-Lawless 2011b).

[23] According to McTiernan (2011), the current Fine Gael/Labour programme for government contains a commitment to mark the 75th anniversary of the Constitution of Ireland with a convention in 2012, to amend areas of the Constitution to reflect social change. The current reference to women's special position in the home is considered outdated and is expected to be considered by the constitutional convention (MacCormaic 2011)

(Kitzinger 1992). Hence, mothers in Western societies are no longer the recipients of any reverence that they may have been afforded in times past, and the role of carer is less valued by society (Vincent *et al.* 2004); the mother is expected to continue to balance the responsibilities of enforced domesticity, carer and, for many, paid employment.

Women worldwide are forced to take responsibility for the home in addition to paid work and this remains a key aspect of contemporary womanhood (Kennedy 2002, Benn 1998). In the Irish context, male unemployment figures are steadily rising and have increased dramatically over the last three years (CSO 2011). Many women return to work as the only wage earner and suffer consequent strain in doing so (Benn 1998); however, women also seek paid employment, not solely for financial gains, but to realise and secure their very embodiment and meaning (Lupton and Schmied 2002, Benn 1998). In this way women as mothers are compelled to combine efforts to secure paid work and motherhood, often with negative emotional consequences and physical exhaustion (Benn 1998). In some situations women are forced to assume the role of primary or lone carer in addition to balancing the demands of employment outside the home (Kennedy 2002, Figes 2008). According to Devane *et al.* (2007) in Ireland, the numbers of women of childbearing age in the labour market have dramatically increased over the last decade creating pressures for women as mothers, not least the challenge of making satisfactory childcare arrangements (Devane *et al.* 2007, Kennedy 2002). Despite acknowledged difficulties in combining paid work with the costs of childcare (Devane *et al.* 2007, Murphy-Lawless *et al.* 2004) acceptable child care arrangements are not supported by governmental policy (Marchant 2004, McCarthy 2004). It appears that there is no one solution; women are many things at many times; mothers at home and mothers with professional lives also, and still the struggle continues to secure affordable, quality childcare, 'assuming the best and fearing the worst' (Benn 1998, p.113). It may be argued that although there are varied perspectives and assumptions about becoming a mother, important arguments at policy level are far removed from the heart of the matter and from women who struggle against issues such as class, poverty, the restraints of paid work and child care, among others concerns (Benn 1998).

2.6. Mother and Paid Employment in the Irish Context

Historically, women's options for paid work in Ireland were curtailed by their domestic responsibilities until the 1960s. Lefebvre (1961), as cited by Felski (2000) indicates that domestic constraints have deprived women of personal and economic growth, which accordingly has stunted 'human evolution' (Hayden 1981, p. 39). Consistent with this idea, it is argued that the association with the mundane and ordinary, expressed through family and household responsibility, has resulted in economic subordination of women (Abercrombie *et al.* 2006). Where one group is dependent on another, the weaker group does not have the same access to equal economic or social growth or opportunity, as in the case of women who are financially or otherwise dependent on male counterparts or the State to survive (Janes 2003).

In Ireland in 1973, the 'marriage bar'[24] or ban on married women working in the public service, was removed (Ferriter 2004, p. 722). Although by the late 1970s, there were higher percentages of women working outside the home, there was a marked absence of women in positions of power, or at a level that could influence policy and legislation[25] (ibid). Societal discrimination for mothers who were alone persisted and there was increased poverty and financial insecurity related to the availability of solely part-time paid work for lone female headed households (Ferriter 2004). Political and media representation of women in Ireland idealised women as professionals, thus sidelining the needs of women not engaged in paid work (Ferriter 2004). Lack of public status for women as mothers, has been carried through to impinge upon groups that are already

[24] The effects of high unemployment rates worldwide in the 1930s were addressed in Ireland by the 1935 Employment Act which brought about introduction of the Marriage Bar which required women on marriage, to relinquish their paid employment in the public sector.

[25] Diarmuid Ferriter (2004) refers specifically to the Dáil. The Oireachtas, or parliament in Ireland comprises the Dáil (lower house and most important) the Seanad (upper house) and the President. The functions of the Dáil are to elect a government and Prime Minister (Taoiseach), to pass the budget, enact legislation and provide a form of accountability of government to the people (Social Policy Monitor 2012). Legislation that is passed by the Dáil must also be debated and approved by the Seanad (Social Policy Monitor 2012). In a recent Seanad Éireann Debate Vol. 213 No. 3 Senator David Cullinane (2012, p. 9) argued that women are under-represented in politics and 'outside of politics.' 'Funding, child care and unsocial hours' were signalled as barriers to women's involvement in politics (Cullinane 2012, p. 9).

subject to class and other inequalities. According to research for the Economic and Social Research Institute (ESRI), poverty is most likely in lone parent homes (Russell *et al.* 2010). Melissa Benn (1998) asserts that the poor are often overlooked and politicians and policy makers can be far removed from ordinary communities where children are (Benn 1998).

Recent analysis of the changing rates of female participation in the labour market from the years 2002-2010, reveal that numbers of women in Ireland engaged in paid employment have increased gradually, but remain comparably less than their male counterparts (Central Statistics Office CSO 2012). The numbers of men working at home have remained consistent during this time and are significantly less than women; this implies that more women are engaged in the labour market, while also working at home.[26] More recently still, the effects of the economic downturn in Ireland; a reversal of the growth in the Irish economy between 1995 and 2007, has placed considerably more financial pressure on families, with two thirds of women in Ireland active in the labour market in 2007. This is the highest level ever recorded in the State (Lynch 2009) with women representing 42% of the Irish workforce in 2007, compared to a figure of 37% in 1998 (CSO 2012). Instead of being afforded the sacred[27] time and space during pregnancy that is necessary for preparation for impending birth, the new mother finds herself combining the role of mother and paid worker, and her usefulness is measured against the perceived level of her economic efficiency (Murphy-Lawless 2006).

2.7. The Relevance of Postmodernism for Women as Mothers

It appears that the hallmarks of modernity for example, industrialisation of the nineteenth and twentieth century and consequent urbanisation, have contributed to the dissipation of support for women as mothers during that time and in the period of uncertainty that has followed. Other features of modernity are war, environmental

[26] While social pressure may exist for supportive partners to become involved with family responsibilities including childcare (Marchant 2004); provision for this or alternative child care arrangements are not supported by governmental policy (Marchant 2004, McCarthy 2004, Murphy-Lawless 2006).

[27] Reason and Bradbury (2006, p. 11) refer to sacred experience, as 'based in reference, in awe and love for creation, valuing it for its own sake, in its own right as a living presence'.

destruction, economic exploitation and regulation of those undercut by gender, ethnicity, age and religion (Benhabib 1992). A theoretical period of postmodernity (Benhabib 1992) has ensued and, according to Pilley-Edwards and Murphy-Lawless (2006, p. 36), is characterised by 'how we now live in a society shaped by factors such as intensified science and technology including information technologies, a gender revolution, a globalised economy, less stable, more flexible employment patterns, more diverse living patterns, global environmental hazards...' This is a condition that Bauman (2005, p. 2) refers to as a 'liquid life...a precarious life, lived under conditions of constant uncertainty.'

The postmodern arrival of individuality heralds a weakness in the community's grip on its members (Bauman 2005) and, in return, the once rigid concepts used to impose structure and order on society have become unstable. What remains of what Max Weber (1969) referred to as the 'security of stable predictable order' (Murphy-Lawless 1998, p.11)[28] is a culture without ties, connection or engagement (Bauman 2005) and, one might consider, caring. According to Jo Murphy-Lawless (2006, p. 439), in contrast to the bleak values of a 'global consumer culture', good birth stands in stark opposition 'for it represents rootedness, connection and remembering.' The consequences of social change characteristic of post or late modernity for women and families have resulted in the breakdown of community support. The importance of friendships born of necessity (Miller 2005) has diminished due to the presence of large bureaucratic organisations and the influence of 'mass society' (Giddens 2003, p. 115). Over two decades ago, Emily Martin (1987) described the effects of postmodernity on the woman and family; women are separated from other mothers by insular and nuclear family forms, they are isolated from their children through paid work demands, and have lost proximity to support and love. In postmodern times further pressures and discriminations, some less visible, are exerted on new mothers. These include insufficient or no paid paternity leave, pressure to return to paid employment (sometimes low paid) and finding affordable and quality childcare (Murphy-Lawless 2006).

[28] According to Giddens (2003, p. 7), Max Weber was pessimistic about the modern world, viewing it as a paradox in which material progress was obtained at the expense of 'expansion of bureaucracy that crushed individual creativity and autonomy.'

2.8. Motherhood in Ireland and the Medicalisation of Birth

Women continue to be defined as mothers and carers, and birth continues to be heavily medicalised, with increasing use of technology in western cultures (Oakley 2005). This medically imbued cultural representation of birth devalues women's labour in childbirth, just as work in the home as mother and carer is devalued (Benn 1998, Oakley 2005), and suggests that 'women can only be women' with professional, and mostly male, assistance (Oakley 2005, p.119).

The concept of the woman as mother is highly esteemed in some societies (Oakley 1986). Now, in western countries, and in developing countries aspiring to adopt western systems of care, pregnant women are identified as patients who ultimately become the passive and compliant focus of medical professionals. Pregnancy and birth are potentially problematic and associated with disease, requiring management in hospital institutions. Indeed, pregnancy is considered healthy and normal only in retrospect (Percival 1970, Kitzinger 1992, Oakley 1993, 2005). Medicalisation of childbirth illustrates one aspect of women's experience of patriarchal power, whether economic, physical or in this case, institutional, representing the 'alienation' of woman from the birth process (Rich 1995, p.164). This is to the extent that the 'onset' of labour has become a medical decision that also requires diagnosis and medical confirmation; therefore, commencement of labour is synonymous with hospital admission and the assumption by the birthing woman of the role of patient (Katz Rothman 1996, p. 254). Medical emphasis is generally on physical and reproductive success and is quantifiably measured in terms of levels of perinatal mortality and morbidity, as distinct from the emotional, social or psychological aspects of childbirth (Oakley 2005, Larkin *et al.* 2012) and generally without an explicit acknowledgment that the latter factors have an impact on morbidity (Hunter *et al.* 2008, Edwards 2005).

While there are wide variations in the medical management of childbirth internationally, there are universal indicators of women's dominance and subordination by so called experts throughout pregnancy and childbirth (Oakley 1984, Rich 1995, Davis-Floyd 2003). Birth within the dominant medical model is predictably marked by brief encounters with medical professionals and characterised by technical instruction (Oakley 1986, Davis-Floyd 2003). This entails widespread dissemination of generic

information and advice giving, which, if contested or questioned, the suitability of the woman as mother in terms of best interests for her child is cast in doubt (Oakley 1986). Oakley's (1979) conversations with mothers suggest that maternal resolve buckles under medical control, culminating in co-operation and compliance (Oakley 1979).[29] Hence, the belief that the medical powers know all is perpetuated (Oakley 1980, Fleming 1992, Kitzinger 1992) and for women there is a sense of powerlessness and helplessness (Davis-Floyd 2003, Edwards 2005, Kitzinger 2006).

Regaining control of the birth experience means that the woman must re-examine her connection with powerlessness and fear (Rich 1995). The central issues of focus should be how the woman feels about birth and the effects that birth has psychologically, how she copes and how she emerges after birth (Kitzinger 1987). Powerlessness reflects Foucault's (1981) notion of authoritative discourses in which the woman is viewed as a purely functional unit, analysed and, moreover, viewed as a pathological entity. She is subject to medical scrutiny and intervention, yet at the same time allocated the overwhelming responsibility to continue humanity, to face her fear by bearing and rearing children. The importance of a medical framework and involvement in childbirth is established neatly and endorsed through routine clinical and technological intervention for as many mothers as possible (Oakley 2005). Intervention increases the likelihood of abnormality and the perception that medical interference is necessary (Oakley 2005); thus, birth is constructed as an event that requires expert obstetric and technical management (Simpson 2004).

2.9. Woman as Reproductive Machine

Oakley (2005) describes medical analyses of women as mother; of relevance here is the 'reproductive machine'[30] model where the woman is viewed as such, requiring regular

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[29] It is evident in reading these accounts that the woman is apologetic at birth to her husband also, for example, for the sex of the baby. Woman assumed the role of carer and 'womanly woman' without obvious external sign of any inner turmoil or confusion for herself (Rich 1995).

[30] According to Downe and Dykes (2010, p. 66), the industrial 'baby-as-product' of birth (Oakley 1986, Martin 1987, Arms 1994, Wagner, 1994) and more recently Davis-Floyd's (2003) 'late modernist' technocratic model have subsumed birth by control within strict time limits.

medical maintenance to function, also described by Davis-Floyd (2003). This is akin to the 'active management of labour' approach to childbirth.[31] According to Oakley (1979), the view that all labours should be actively managed indicates maternity care professionals' insecurity and uncertainty of birth's 'natural' processes which undermine human expertise. Furthermore, the less accustomed carers are to normal birth settings, the more they fear and are uncertain about normal birth, which makes it difficult for maternity carers to provide the care that women require in such settings (Gaskin 2011).

Currently in Ireland, a pervasive medical model of care has continued to dominate and shape women's experiences of pregnancy and childbirth, where routine intervention in labour has become widely accepted (Devane *et al.* 2005). The scale of such intervention is illustrated by a rising trend in birth by caesarean section with a rate of 22.0% of total live caesarean section births in 2001, compared with a rate of 27.1 % in 2010 (ESRI 2012). These figures represent an increase of 23.2 % in the proportion of caesarean section births over the decade (2001-2010) and correspond with a fall in rate of spontaneous births from 63.2 % in 2001 to 56.5 % in 2010 (ESRI 2012). Over 16 per cent of total live births in 2010 were born by instrumental delivery (breech/forceps, forceps or vacuum extraction) with higher percentages for live singleton births (16.5%) compared with live multiple births (13.3%) (ESRI 2012).

Intervention measures are also reflected in the results of a national survey of maternity care providers (n=22) undertaken in 2011 by Cuidiú (Irish Childbirth Trust), which are presented in the form of an online independent users' guide to maternity services in Ireland. Of these results, data compiled from obstetric led maternity units showed rates of episiotomy in 2011 varied between 27.1% (highest) and 11.8% (lowest). Similarly, percentages of induction of labour ranged from 31.2% (highest) to 15.8% (lowest) (Cuidiú 2011). These data relate to first time and other mothers. Notably, this compilation has highlighted concerns about variability in data recording and the reporting abilities of the maternity units surveyed (Cuidiú 2012).

The influence of the medical model on maternity and gynaecology services in the greater Dublin area (GDA) is confirmed by the findings of the final report of the

[31] The Active Management of Labour model is introduced on page 21.

Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area (KPMG 2008). Medicalised, hospital focused maternity care is attributed largely to the establishment of the Maternity and Infant Care Scheme (1954); a contract between general practitioner and obstetrician to deliver care in the antenatal period. Under this scheme, legal provision for free but means tested (until 1991) maternity services for the woman and baby up to six weeks after birth, has led to under-development of care that is midwifery led, or provided by midwives (Kennedy 2010). The findings of the aforementioned report by KPMG (2008) suggested that an additional factor in perpetuating predominantly doctor-led services is the structure of private medical insurance, and the underdevelopment of primary care based services characterised by shared care between midwives and general practitioners. Included in recommendations of the report is the call for greater choice of maternity services for women through the effective use of midwifery skills, which are currently under used (KPMG 2008).

Prior to the onset of obstetric dominance over pregnancy and childbirth at the beginning of the 20th century, pregnancy, childbirth and motherhood were accepted as a 'continuous entity' (Oakley 1984, p.15, Martin 1987, Kitzinger 1987, Arms 1994). According to Kennedy (2002); however, the establishment of the medical model has influenced a fragmented approach to maternity care. The woman's body and mind are numbed and fragmented by use of medical preparations;[3233] she is separated from her baby, and from other women (Kennedy 2002). First time and other mothers, are separated in hospital-based ANE classes, because of the perception that parous women's accounts of their experiences may be unsettling for nulliparous women (O'Driscoll *et*

[32] Women were rendered unconscious to achieve passive or 'painless' childbirth under medical instruction (Rich 1995). Until the Second World War, ether and chloroform were in popular use among women who could afford obstetric care because midwives were not permitted to administer the drugs, this increased dependence on obstetric control. Prior to this a mixture of scopolamine and morphine was used to induce 'twilight sleep'; women appeared to feel pain during labour but did not remember (ibid).

[33] Oakley (1979) gives accounts of how women were encouraged to receive epidural analgesia not only to quell physical pain in labour but to ease fear of potential actions and harm caused by the hands of so called carers by removing all physical sensation, control and connection with the birth experience. According to Murphy-Lawless (1998, p. 17), 'obstetric science has closed off agency and has accompanied us into an entirely different space.'

al. 2004), yet, 'often what women want is a chance to be together, as mothers' (Benn 1998, p.129). Jenny Kitzinger (1990, p. 104) describes opposition towards women's 'unauthorised' birth stories since before the onset of the National Childbirth Trust (NCT)[34] when, according to Dick-Read,[35] (2010) women's stories of 'suffering' were exaggerated and considered to be a leading cause of labour pain.[36]

The passage into the patriarchal world of medicine and birth culminates for the majority of women, in a very public and male controlled, birth experience (Oakley 1986, 1984, Davis-Floyd 2003, Kennedy 2004, Kitzinger 2006). According to Ann Oakley (1986) women are socialised as mothers, as they attend antenatal appointments and classes and in the Irish context, the role and significance of antenatal classes has been analysed by physiotherapist and antenatal educator, Margaret Mason (1994, 1998) and social policy theorist, Patricia Kennedy (2002). Both accounts assert that antenatal education offers yet another method to control and socialise women into the role of pregnant woman and mother, within the context of an increasingly medicalised world.

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[34] The National Childbirth Trust (NCT) is largest charity for parents in the U.K. offering information, support and antenatal and early days postnatal classes (NCT 2012).

[35] Grantly Dick-Read was honorary president of the NCT and resisted the introduction of Lamaze techniques (Kitzinger 1990). According to Kitzinger (1990), the Dick-Read approach was largely ignored in the U.K. until the establishment of the National Childbirth Trust then known as the Natural Childbirth Association. The Natural Childbirth Association was established by founder Prunella Briance in 1956 to promote the teachings of Grantly Dick-Read; the first meeting about his work was advertised in *The Times* and was attended by one hundred people and a small London based of women continued to meet (Kitzinger 1990). The association obtained charitable status in 1959 and gained the title of 'Trust'.

[36] Kitzinger (1990) quotes Grantly-Read in July Newsletter *Parents* (1954) as saying, 'In many tribes, there is an excellent rule which I wish we could enforce amongst European women...if the childbirth is difficult and it is known that some unauthorised woman has mentioned childbirth to the mother then the offender is subject to severe punishment, even to being thrown out of the Kraal to wander in the jungle amongst the beasts.'

2.10. The Medicalisation of Antenatal Education

Antenatal education is traditionally regarded as one of the main resources for women in preparation for motherhood (Barlow *et al.* 2009). In a systematic review of individual or group antenatal education for childbirth or parenthood, Gagnon and Sandall (2007) offered a broad description of the aims of ANE. These were as follows: to influence health behaviour, to instil confidence in the woman in her ability to birth, to prepare women and their partners for childbirth, to develop social supports and to contribute to decreasing perinatal morbidity and mortality (Gagnon and Sandall 2007).

A more focused function of antenatal education is offered within a biomedical paradigm, which is, 'to define a woman's role in labour and to teach her how to fulfil it' (O'Driscoll *et al.* 2004, p. 79). This statement indicates little acknowledgement of the birthing woman's personal autonomy or, 'capacities and abilities to make decisions and take certain actions based on her personal values and beliefs' (Marshall 2005, p. 13). In the biomedical paradigm, education and training are key components; the woman is educated in a broad understanding of the process of birth and she is trained to achieve what is termed 'the ultimate satisfaction of spontaneous delivery' (O'Driscoll *et al.* 2004, p. 79). Medicalised birth is characterised by physical exposure of the woman, labour is timed and is limited and care is offered by strangers [professionals] who are allocated discrete tasks (Kitzinger 2006). Allocation of discrete tasks to various individuals is a by-product of fragmented care, which during pregnancy, childbirth and the postnatal period is often provided by multiple caregivers (ibid). This situation is best depicted by Jane Gray's (2000) insightful analysis of current maternity services in Ireland,

However, in my view the assembly-line model of care serves purposes other than mere efficiency. Most importantly, it dramatizes the process of childbirth as a set of standardized practices carried out by professionals on inter-changeable women. It functions as a display that continuously reaffirms both the power of obstetricians and the apparent acquiescence of pregnant women within the childbirth regime. The parade of buzzing medical personnel and mass of anonymous, undifferentiated pregnant bodies in the waiting room are both actors and audience in this drama. As an individual woman caught up in it you feel strangely at a disadvantage, since your participation is never invited, it is simply taken for granted. If you are

secretly a confused or unwilling performer you feel isolated, since everybody else appears to play their part unquestioningly (p.8).

According to the biomedical model of care, it is vital that facilitators of antenatal education appear to 'know what they are talking about in strictly technical terms and in relation to actual practice in that institution' (O'Driscoll *et al.* 2004, p. 82). There are indications that women fare better with knowledge of the relevant institutional setting or 'birth rules', which are learnt through the process of antenatal education (Carr 1992, Fleming 1992). This knowledge enables women to navigate the expected norms and rules of behaviour in the relevant maternity care institution more successfully than women who attend less rigidly codified systems elsewhere (Carr 1992). According to Oakley (1984),

There is plenty of evidence to suggest that curricula of hospital-based antenatal education have the narrow objective of transmitting prevailing obstetrical policies to women rather than enlightening them...the result is certainly an integrated service of a kind, but one in which the broader agenda of educating mothers has been entirely subsumed within a specific programming of information about hospital policy...an ideological programming of women for hospital care. (p. 281).

Knowledge acquisition is systematically facilitated in traditional antenatal or 'parent craft' classes (Oakley 1986, Fleming 1992) where, according to Oakley (1986), the medical ideal is the 'patient' who knows enough but not too much (ibid). Gray (2000) illustrates this by stating that hospital-based maternity care is founded upon a 'scripted performance that reproduces both the dominant model of childbirth, and [the woman's] subordination within the regime' (Gray 2000, p. 6). To ignore such dominance is to perpetuate the silence and powerlessness of women who are subordinated; this emerges as an insidious and effective form of social control (Sawicki 1991).

This approach to antenatal education reflects a Foucauldian (1979) position of covert power over a significant population being attained through direct hierarchical observation and training of individuals or 'units', to enforce discipline and thus normalise the masses in specific set ways. Subsequent dependence introduces elements of inequality and power (Foucault 1991). This is not unlike Freire's (1993) description

of how the 'minority oppressor' (Freire 1993, p.122) must divide the majority in order to continue to suppress and dominate. In this way, the stance of patriarchal medical knowledge, which does not account for the real lives of women (Rich 1995), is legitimised to the detriment of all other knowledge[37] (Fleming 1992). Support of one social discourse[38] over another dictates how certain so called choices for women are endorsed or contained, often by government policy (Kahu and Morgan 2007).[39]

2.11. Choosing Antenatal Education as Research Inquiry

A review of the literature about antenatal education reveals few published Irish sources that respond to the identified needs of pregnant and postnatal women in preparation for motherhood.[40] This deficit presents a call for antenatal education to support women in Ireland, particularly in light of the reversal of economic growth and ensuing pressures for women as new mothers (Murphy-Lawless 2006, 2011a). In the Irish context, the absence of statutory provision of community midwifery support (KPMG 2008, Leahy-Warren 2005) forces new mothers, including those who are living in rural areas, to manage without supportive, responsive maternity services. Urbanisation over many decades has increased the spatial distance between, and dissipation of, extended family and lay community support structures, with a strong population growth noted between

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[37] Ways of knowing distinct from scientific knowledge are discussed in Chapter 10.

[38] I adopt Pam Carter's (1995, p. 28) description of discourse as referring 'to specific structures of meanings, categories and beliefs.'

[39] Kahu and Morgan (2007) explore the powerful influence that New Zealand governmental policy (that is designed to meet capitalist needs) has on new mothers. According to Kahu and Morgan (2007, p. 145), motherhood is viewed as inevitable and undesirable, while paid work is valued and viewed as essential to individual well-being and 'a duty of citizenship'.

[40] Research referring to antenatal education in the Irish context includes work by physiotherapist Margaret Mason (1994) and midwives Camille Cronin (2003) and Sylvia Murphy Tighe (2008). A review by the North Western Health Board (2001) was undertaken, and more recently, CUIDIU (Irish NCT) have published statistics about available hospital services on their website www.bump2babe.ie (CUIDIU 2012). Also, AIMS Ireland (2010) has conducted a survey 'What Matters to You', which reported on a small percentage of women attending the services.

2006-2011 in the wider Dublin commuter belt and surrounding counties (CSO 2012). In addition, curtailment of access to informal sources of knowledge for women who are engaged in paid employment and are further removed from family and social support networks compound the factors that militate against support for motherhood (Miller 2005). These conditions have resulted in increased dependence during pregnancy of the woman on the information and support she receives from healthcare professionals (Kettler 2000, McCourt 2006).

Antenatal education programmes have been facilitated in maternity sites in the Republic of Ireland since the late 1950s, without evaluation of their relevance for childbearing women in preparing for motherhood. The research presented here challenges traditional antenatal education processes by encouraging dialogue between women and healthcare professionals to raise consciousness[41] (Freire 1993) and debate surrounding accepted and assumed needs in preparation for motherhood. Education is a group process which, for change, relies on the collective consciousness of the group involved and committed involvement in dialogue, reflection and action (Freire 1993). At the onset of this work, it was anticipated that all co-researchers could work towards commitment to authentic dialogue combined with reflection and action in the interests of working collaboratively together. Participants are referred to as co-researchers because they 'co-create' the findings (Stringer 2007, Koch and Kralik 2006) and in keeping with the principles of PAR are involved in every step of the research process. In this instance, women are referred to as women co-researchers and antenatal educators as ANE co-researchers to differentiate between the two groups. This is discussed further on page 70, 71 and 79.

2.12. The History and Origins of Antenatal Education in the United Kingdom and in Ireland

2.12.1. Antenatal Education in the United Kingdom

It is argued that the origins of antenatal education in the United Kingdom stem from widespread concerns about infant health coupled with suspicion about the general

[41] According to Rowan (2006), there are several schools of thought and approaches to consciousness. For the purpose of this work, the term consciousness-raising refers predominantly to mindfulness and awareness that is a feature of Participatory Action Research and this is discussed in Chapter Four.

adequacy of mothers' skill and desire to care for, and to nurture their infants (Oakley 1984, Murphy-Black 1995). These doubts were endorsed by the high level of infant mortality at the turn of the 20th century, which was attributed at the time to maternal ignorance alone, as distinct from poor environmental factors and limited access to health care (Oakley 1984, Murphy-Black 1995). The mainstream discourse professed by the medical profession, which was notorious for its arrogant and indifferent treatment of women at the time (Rich 1995), was dominated by educating mothers who were blamed for the physical inefficiencies of the nation. These inefficiencies were considered to be a direct consequence of mothers' poor understanding of feeding and infant care (Oakley 1984). This belief brought about the establishment of milk kitchens and mechanisms for maternal surveillance (Oakley 1984, Murphy-Black 1995) under the guise of antenatal education, with the introduction of home visiting and the first U.K. 'School for Mothers' (1917) in St. Pancras. The 'School for Mothers' curriculum focused on training mothers in infant care and also provided medical consultations in addition to subsidised dinners for expectant and nursing mothers (Oakley 1984, p.43).

It is interesting to note that medical control of childbirth was sustained, ironically in some ways, because of middle class England's view of birth as distasteful and associated with other degrading, though natural, biological functions, in addition to women's demands for medical attention (Kitzinger 1990). Respectable middle class women sought medical assistance 'to sanitize the event [birth]; therefore, medical control and interventions were part of the ritual purification and segregation of a rather sordid biological function' (Kitzinger 1990, p. 97). Research undertaken to examine service users and professionals' views about antenatal education offered by the UK National Health Service suggested that the current system of ANE is flawed in terms of accessibility, content and process of ANE, hindered by large class sizes and lack of training and resources for facilitators (Barlow *et al.* 2009).

2.12.1. i. The Foundation of the National Childbirth Trust

The advent of industrialization in the late 18th and early 19th centuries in the U.K. brought about a highly significant and gendered division between private and public spheres which meant that paid productivity shifted from the home to the outside world (Harding 1998). Consequently, in the early twentieth century social division based on class had facilitated middle-class women to stay at home while working class women

entered the workforce (Harding 1998). The purported privilege of remaining in the home fostered women's economic dependence, social isolation[42] and, most significantly for the purpose of this inquiry, culminated in the decline of a traditionally supportive female network of shared wisdom in childbirth and parenting (Nolan 1997, Rich 1995). Thus, efforts were made by middle-class women to initiate and sustain peer and community support networks. In 1912, the 'Women's League for Health and Beauty' was founded in the South of England, with a view to bringing middle class women together to engage in general health interests and to foster female support systems (Kitzinger 1990). Exercise classes provided training for labour and were introduced in conjunction with the National Health Service (NHS). According to Mason (1998), in 1936, Minnie Randall, a midwife and physiotherapist and Margaret Morris, a dancer, devised exercises to encourage relaxation and to increase the flexibility of the pelvic joints. These classes ultimately provided a framework for antenatal education, to 'encourage women to approach labour free from ignorance and fear' (Kitzinger 1990, p. 92). The natural childbirth (or education for childbirth) movement developed spontaneously with women's eagerness for information on aspects of self-care and pregnancy, and preparation for birth. It was pioneered by the National Childbirth Trust (NCT) in the U.K. formally, the Natural Childbirth Association (1956).

According to Jenny Kitzinger's (1990) case study of the National Childbirth Trust (NCT), it was initially viewed with suspicion because of the emphasis the movement placed on natural childbirth. Up until then, during the first half of the 20th century in Britain, women had campaigned vigorously for pharmacological pain relief in labour.[43] Kitzinger (1990) suggests therefore, that the NCT fought to reconstruct the meaning of

[42] Jagger (1983) cites Frederick Engels on the subject of monogamous marriage and its effects in making [bourgeois] women economically dependent by forcing women into a subordination that prevents them from participating fully in society. Engels suggests that middle class women are more oppressed than working class women because of their economic dependence; women reach out to each other in times of need and isolation as in the case of NCT in the U.K. In late modern or postmodern societies, there is a different kind of isolation; we are moving back to segregation, not because we are not working outside the home, but because we have created competitiveness in the work place in addition to isolation from extended family.

[43] This campaign was supported by Association for Improvements in the Maternity Services (AIMS) formally known as the Society for the Prevention of Cruelty to Pregnant Women', who donated a gas and air machine to one hospital (Kitzinger 1990).

birth, but in doing so, promoted natural childbirth birth and motherhood as women's duty and as the foundation of society, endorsing ideologies of feminine weakness, religious morality, gentry and respectability (Kitzinger 1990). Members, who were also midwives and physiotherapists, began private antenatal education instruction, independent of the NHS (Kitzinger 1990). Notwithstanding this, consumer awareness and 'anti-establishment' action ensured that membership grew (Kitzinger 1990 p. 93) and there were branches of the NCT throughout Britain (Kitzinger 1990, Nolan 1997). By the 1960s the NCT began to petition the U.K. Government to end medical intervention in birth (Kitzinger 1990).

Since the 1970s, a 'consumer movement' in maternity care, has challenged the rigid medical view of women as incompetent and presents an ongoing critique of the medical model of maternity care (Oakley 2005, p.119). In the early days; however, the NCT had to navigate the medical establishment to gain access to pregnant women.[44] In order to gain acceptance of lay teachers, as distinct from professionals in teaching pregnant women, the NCT appealed to medical paternalism by requesting obstetricians to be indulgent of women at their time of vulnerability and weakness (Kitzinger 1990). Thus, it was agreed that the obstetrician should approve women's NCT class attendance, once written permission from the presiding doctor was obtained before antenatal education could be offered by a lay teacher.

Lay teachers posed a threat to healthcare professionals by challenging medical monopoly; however, the political dimensions of medical control, despite awareness, were never addressed (Kitzinger 2003). Notwithstanding political tensions, in some ways the NCT was radical in its approach to antenatal education. Televised screening of birth was a regular occurrence at classes; on the whole, media representation of birth, which was deemed a private affair and shrouded in secrecy for many people, was not welcome in the general public domain (Kitzinger 1990). In other ways, however, the NCT had a more conservative approach, as Oliver (2011, personal communication) and Kitzinger (1990) indicate, the educational techniques of the NCT had strong pedagogical influences. Inherent in the educational philosophy of the NCT were the

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[44] The increase in birth intervention rates in the 1970s challenged the NCT relationship with the medical patriarchy.

principles of the Grantly Dick-Read approach to preparation for childbirth and later (1960), the teachings of Lamaze (Kitzinger 1990).

Dick-Read's interest lay in the emotional adjustment of women in labour. Its origins however, are set against the context of a pre-modern era, when it may be argued that women could exercise some agency in birth. His natural childbirth method combined relaxation techniques and the release of conscious control of the body, combined with the advances in physiotherapy that were occurring at the time (Kitzinger 1990, Zwelling 1996). Dick-Read's approach, 'natural birth' was based on the view that pain was a consequence of tension and fear brought about by ignorance of childbirth and therefore, aimed to reduce the fear-tension-pain cycle by combining relaxation and breathing techniques with instruction about labour and birth (Kitzinger 2003).

French obstetrician, Fernand Lamaze introduced his psycho-prophylactic method of pain relief in the early 1950s (Kitzinger 1987, Zwelling 1996). The origins of this method began with the discovery of use of Pavlovian techniques in Soviet hospitals[45] which were adapted by Lamaze during a visit to Russia (Rich 1995). According to Oakley (1986, p. 21), this focused on distraction of the labouring woman through an 'elaborate breathing drill' and emphasised the woman's active participation through every stage of labour. Psycho-prophylaxis involves reconditioning the mind to embrace contractions as helpful, thereby diminishing fear and doubts associated with labour and birth (Kitzinger 2003).

One earlier criticism of this method is that the woman's engagement with her birth process is altered and restrained in her effort to remain distracted and in control at all times throughout the process (Arms 1994). Kitzinger (2001) suggested that this can endorse feelings of failure if events do not go according to plan. By retaining control, the woman should not weaken and yield to pain (Kitzinger 2005), yet many women used this technique in the belief that they may completely achieve pain free experiences. Kitzinger (1987) noted that the powerful physical sensations of labour and birth can be quite shocking; however, in this regard, no instruction is preferable to misconception.

[45] According to Adrienne Rich (1995), Soviet obstetricians in the 1930s and 1940s began applying the techniques of Russian behavioural scientist Pavlov to childbirth. Techniques incorporated Pavlov's theories of conditioned reflex, thus the pregnant woman learned response to pain was altered, this technique was described as verbal analgesia (Rich 1995).

Lamaze insisted however, that there are aspects of birth that a woman cannot control that, while 'a woman is the force which directs, controls, and regulates her labour', her uterine contractions are involuntary in nature (Kitzinger 1987, p. 20). While the early focus of Lamaze was breathing and control of discomfort in labour, the mission of Lamaze International has now evolved to support and protect normal birth (Walker *et al.* 2009). The continued popularity of Lamaze is demonstrated by the existence of a peer reviewed journal dedicated to the approach, *The Journal of Perinatal Education.* Since its inception in the 1950s, Lamaze has evolved from its origins of educational technique to control discomfort in labour, to a philosophy informed by the desire to assist women in making 'healthy' choices in pregnancy, birth and parenting (Hotelling 2011, p. 221).

A commonality of the Dick-Read and Lamaze approaches to preparation for birth is their focus on the woman's expression of control of her body; therefore, reclaiming her control from others (Kitzinger 1990). Notwithstanding this, Kitzinger (1990) laments that the Lamaze principles of self control in labour can mean that the woman is so distracted that she is perceived as 'well behaved' and surrenders completely to her environment. Similarly, Dick-Read's approach of promoting the woman's release of conscious control of her body potentially results in allocation of power to her professional birth attendants (Kitzinger 1990). Gagnon and Sandall (2007) note the similarities[46] in Dick-Read's 'natural birth' and Lamaze's psycho-prophylactic method, some of which form the foundations of contemporary antenatal education programmes.

2.12.2. Antenatal Education in Ireland

According to dominant medical opinion at the end of the nineteenth century, poverty in Ireland precipitated a need for women's education during pregnancy, which was focused primarily on general hygiene and care of the infant (Kennedy 2002). The introduction of the Irish Notification of Births Act (1907) in the early 20th century sanctioned visits by 'sanitary officers' to homes in urban locations to advise mothers on

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[46] Principles include a shared emphasis on education of the physiology of birth, healthy pregnancy, and elimination of fear in labour through relaxation and breathing techniques, in addition to continuous support provided by a known person (Gagnon and Sandall 2007).

matters relating to infant and childcare (Kennedy 2002). Home visiting in fact, was initiated as an effective means of monitoring maternal behaviour; thus, the health visitor was in a position to advise women on matters related to infant feeding and salient aspects of motherhood and infant care (Kennedy 2002). Until then, this information had been shared traditionally by experienced mothers in the community in Ireland (Mason 1998) and elsewhere (Walker *et al.* 2009, Nolan 1997).

Thus began the destruction of a culture where women traditionally sought guidance and support from each other in favour of the authoritative, dominant stance of the medical profession, whose opinions held most forceful influence (Dillon Hurney 2004). According to Oakley (1986), industrialisation and increasing medicalisation of childbirth appear to coincide. There are wide variations in the medical management of childbirth internationally; however, there are universal indicators of women's subordinate treatment and control by alleged medical experts. This entails provision of information and advice which is passed out and if not heeded, the woman is deemed confrontational and lacking in concern for her child. Hence, the notion that the woman is clueless and medical powers know all is perpetuated (Oakley 1986, Kitzinger 1992).

Monitoring maternal activities in Ireland was expedited by the appointment of child welfare centres in urban locations. These centres were made attractive to the poor by introduction of the 'free milk scheme' (circa 1927) and augmented the pervasive assertion that professional knowledge was far superior to intuitive maternal knowledge. The strength of medical opinion illustrates Rich's (1995 p. 33) notion of dominant patriarchy[47] that those who propagate the human condition largely tend to be those who escape derision (Rich 1995). The belief that medical opinion is best was directly responsible for the reduction in breastfeeding at that time. As hospital confinement became more commonplace in Ireland, medical control over infant feeding practices

[47] Rich (1995) describes patriarchy as 'the power of the fathers: a familial-social, ideological, political system in which men – by force, direct pressure or through ritual, tradition, law and language, customs, etiquette, education, and the division of labour, determine what part women shall or shall not play, and in which the female is everywhere subsumed under the male' (Rich 1995, p.57).

became more pervasive[48] (see Dillon Hurney 2004). A significant decline in the uptake of domiciliary care in Ireland since the 1950s (Kennedy and Murphy-Lawless 1998, Kennedy 2004, 2010) has been inversely proportional to increased hospitalisation for childbirth (Kennedy 2002, DOHC 2003), with subsequent acceptance and dependence on medical control.

Acceleration of hospital-based birth and associated intervention is attributed to a number of factors, initially the general concerns in the 1940s in Ireland regarding high levels of maternal and infant mortality. The rise in mortality convinced the medical profession and correspondingly the general public, that hospital deliveries were safer than home births (O'Dwyer and Mulhall 2000). The implementation of the Maternity and Infant Care Scheme under the Health Act (1953), which offered free maternity care for women, had startling impact. This was a contract between general practitioner (GP, or family doctor) and hospital consultant obstetrician. In response to medical fear about loss of income, it emerged that eligibility for the scheme was, in fact, means tested until 1991 (Kennedy 2002, 2010). The scheme's success was followed by the publication of a report by consultant obstetricians, *Comhairle na n-Ospideal* (Development of Hospital Maternity Services) in 1976, which recommended that all births take place in consultant-staffed hospitals with access to hospital-based consultant care[49] (Kennedy 1998, McCarthy *et al.* 2005). These events, in addition to a package of 'Active Management of Labour' (AML) introduced in the National Maternity Hospital in Dublin in the 1960s, have placed birth in Ireland within the locus of medical control. According to Wiley and Merriman (1996), at the time the popularity of antenatal education increased as a method for women to become familiar with the hospital environment in tandem with the rapid rise in hospital birth.

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[48] Similarly in the U.K., 'the safe milk movement', the provision of milk depots, which supplied properly sterilised 'humanised milk', culminated in a significant move away from breastfeeding, coupled with the introduction of home visiting by health visitors who were deemed 'expert' by the state (Oakley 1984).

[49] To acquire the services of consultants, it was necessary that a hospital could potentially provide care for a minimum of 1500-2000 births per year; consequently, smaller maternity units were closed due to insufficient numbers of births per year (less than 1500) to secure consultant services (Kennedy 1998, 2002).

Currently and since their inception, traditional hospital-based ANE programmes are endorsed by the State and promoted free of charge as an important aspect of the maternity services. Hospital-based antenatal education has been viewed as a vital accessory to the biomedical model of care (Oakley 1984, Mason 1994, Nolan 1999, Kennedy 2002, Association for Improvements in the Maternity Services, Ireland AIMSI 2010). There are suggestions that traditional antenatal classes provide a medium to indoctrinate women in routine hospital practices (Oakley 1984, Gagnon and Sandall 2007) and present an opportunity to portray a 'favourable image of the entire maternity service' (O'Driscoll *et al.* 2004, p. 82). In contrast, prior to hospitalisation for birth, mothers living in the community shared their knowledge of hygiene practices and infant care (Mason 1998).

With the move from community to hospital accelerating from the late 1950s,[50] formal hospital-based antenatal classes had been introduced by physiotherapists to promote exercise in preparation for labour and birth[51] in the form of training for labour (Mason 1998). Physiotherapists were solely responsible for antenatal education in hospital settings until midwives became involved in the 1970s to provide instruction for women in preparation for labour (Mason 2012, personal communication). According to O'Dwyer and Mulhall (2000), the introduction of antenatal education programmes in hospitals in the mid 1970s and consequent preparation of facilitators, was the result of the significant and sustained combined efforts of midwifery tutors, directors of midwifery, clinical midwives and physiotherapists. Continuing interest in antenatal education was maintained by ensuring that from the year 1981, a related question was included in the An Bord Altranais[52] (Nursing Board) examination for midwifery

[50] According to Marie O'Connor (1995), in 1956, thirty one percent of births in Ireland were home births, ten years later just 10% of births took place at home.

[51] Sheila Kitzinger (1977) suggests that a partnership of physiotherapist and midwife works well for the purposes of education in childbirth due to the combined knowledge of 'body mechanics' of the former and the experience gained through witnessing birth of the latter (Kitzinger 1977, p. 4).

[52] An Bord Altranais is the statutory regulatory body for nursing and midwifery professions, with responsibility for the registration, regulation and education of nurses and midwives in Ireland. A Statutory Midwives' Committee of An Bord Altranais was established following the implementation of the Nurses Act in 1950 and the dissolution of the Central Midwives Board. According to O'Dwyer and

registration (O'Dwyer and Mulhall 2000). Midwifery involvement was advanced further with the introduction of Active Management of Labour, the seeds for which were sown in 1963 (O'Driscoll *et al.* 2004). Active Management of Labour included and promoted customised antenatal education offered by midwives which, according to O'Driscoll *et al.* (2004), the pregnant woman had a responsibility to attend:

> A serious obligation rests on expectant mothers to take full advantage of the educational facilities available, so as to learn the nature of their role and how best this can be fulfilled. Mothers should never be allowed - any more than doctors or midwives are allowed - to evade their responsibilities in this matter. They should be disabused of the notion that midwives and doctors can be expected to cope with the inevitable turmoil (if women don't attend classes) as part of their normal duties...the disruptive effect of one disorganised and frightened woman in a delivery unit extends far beyond her individual comfort and safety, and there should be no hesitation in telling her so. (p. 105)

The role of the antenatal educator in the active management of labour setting therefore, was to enforce this patriarchal and unsubstantiated philosophy through the doctrine of antenatal education, where the mother had to be 'prepared' before entering the labour ward (O' Driscoll *et al.* 2004). The ANE's role was to convince the expectant mother that she had nothing to fear because she would receive personal attention throughout labour, but also because the duration of labour would be strictly limited (ibid). Mason (1998) identifies that institutions endorsing active management of labour policy may require antenatal educators to adhere rigidly to the principles of active management, as distinct from discussion of care alternatives for women. A review of the literature disseminated by facilitators of ANE programmes in Ireland reveals that class content varies in accordance with the personal and professional orientation of the facilitator, and the local context, that is, the requirements of the maternity institution that the woman is attending.

Mulhall (2000, p. 112) the midwives' committee was concerned with 'the education and training of midwives at pre- and post-registration levels, the regulation of practice and the conduct of midwives prior to the implementation of the EU Directives.' The Nurses Act 1985 superseded the 1950 Act but did not allow for registration of midwifery as a profession distinct from nursing at that time.

2.13. Antenatal Education – Role and Context

Opinion exists that antenatal education should be regarded as the initial step in learning parenting skills (Nolan and Foster 2005); however, previously acknowledged tensions exist between supporting women in preparation for birth and motherhood and the influence of overriding institutional and political ethos of place of birth. Kitzinger (2005) describes the tension thus: 'it is a conflict that divides the childbirth movement: listening and teaching skills versus outspoken criticism and demands for change; individual counselling versus political activism' (Kitzinger 2005, p. 45). According to Kitzinger (2006) and Nolan (2010), the role of the antenatal educator is to empower each woman she meets and to assist the woman in negotiating her birth needs. Rappaport (1995) suggests,

> The goals of empowerment are enhanced when people discover, or create and give voice to a collective narrative that sustains their own personal life story in positive ways. This process is reciprocal such that many individuals, in turn, create, change, and sustain the group narrative. (p. 796).

The notion of empowerment as defined by Rappaport (1995) presents obvious difficulties within the confines of hospital-based birth, where there is little space to first discover and, then negotiate, birth needs. Conflict is evident in the discrepancies that can exist between the information that women want and the information that women receive from antenatal classes (Oakley 1986). This is particularly relevant as maternity care has become increasingly medicalised; the role of the [midwife] in the 'educational' setting, is one of information giver only, thus translating for the woman what the doctor intends to do (Fleming 1992).

According to Oakley (1986) the function of ANE is to dispel anxiety about pain in childbirth in addition to providing information on how to cope with pain, thus acknowledging that pain exists, is functional and is of a very personal nature (Kitzinger 2005). Recognition of the very significant role that pain can play in labour as physiological, but also in relation to the triumphant nature of birth is important (Leap and Vague 2006). Kitzinger (2005) suggests that antenatal educators be sensitive to the

emotional needs of women and families and share with each, the 'psychophysical'[53] journey to birth and parenthood (Kitzinger 2005, p.45). The woman needs to know about the processes of labour and childbirth so that she can be free from fear and, above all, she must learn how 'to trust her body and her instincts'; women need help to believe this but for some it comes more easily (Kitzinger 1987, p. 24).

It has been suggested that antenatal education is useful for creating awareness of the physiological processes and emotional responses in labour (Kitzinger 2001). Pregnancy is a catalyst for knowledge acquisition and some information regarding technical aspects of labour and birth can be achieved through ANE attendance (Davis-Floyd 2003, Nolan 2010).[54] Mostly, classes are timed towards the latter stages of pregnancy and 'constitute the beginning of a cultural process of ritual intensification, which will culminate in the birth of the child' (Davis-Floyd 2003, p. 32). In preparation for childbirth and motherhood, ANEs have the power to encourage and promote the woman's confidence and independence or to contribute further to the socialisation process of the medical or technocratic model (Davis-Floyd 2003). Nolan (2010) and Maestas (2003) observed how antenatal educators' understanding and philosophy of birth underpins and saturates the content and process of ANE classes. Modes of instruction influence very fundamentally how authoritative knowledge is constituted (Jordan 1993).

2.14. Hospital-based Antenatal Education versus Antenatal Education in Other Settings

Antenatal education in Ireland, as it is commonly known, has evolved from being solely hospital-based, beginning in the late 1950s, to an enterprise where classes differ by location, process and content (Cuidiú 2011, Schott 2003). Contemporary in-hospital

[53] Kitzinger's (2005) use of the term 'psychophysical' refers to the physical journey the woman experiences as a new life enters the world and also the often stressful event of becoming a mother which lasts beyond the first year after birth.

[54] The assumption is that facilitation sessions are not dictated according to the regime of a particular institutional model.

sessions are facilitated by antenatal educators with varied backgrounds mostly midwives, with input from physiotherapists and dieticians and occasional contributions from medical practitioners (Cuidiú 2011). Currently, antenatal classes in Ireland are predominantly hospital-based with diverse rates of attendance (Murphy-Tighe 2008). Classes are also held in the community and are offered in a private capacity (Murphy-Tighe 2008, Haughney 2005,) and range from intensive one day events to a number of classes over several weeks (Gagnon and Sandall 2007). Privately held classes which offer more flexibility in terms of timing and location are available only for women with adequate financial resources; this is an example of the widening dichotomy between services, or lack thereof, for rich and poor, or for the powerful and powerless respectively (Kennedy 2002, Edwards 2008). Hospital-based antenatal class attendance is preferred by the majority of women who choose hospital birth[55] (Brady 2009, Murphy-Tighe 2008). In one Dublin maternity care unit alone, almost 80% of first time mothers attending for maternity care participated in the antenatal education programme offered at the same site (O'Driscoll *et al.* 2004).

2.15. Current Approaches to Antenatal Education

In addition to Dick-Read and Lamaze methods, other approaches that have influenced contemporary antenatal education programmes include the Bradley method, or 'husband coached' childbirth. This was pioneered in the 1970s by male obstetrician Robert Bradley in the United States and is characterised by the male partner's support of the labouring woman with minimal obstetric intervention and without pharmacological analgesia (Kitzinger 2001, Davis-Floyd 2003). This approach is attributed to the readmission of support partners from the 1970s in Western countries as prior to that, men were excluded from the birth space (Odent 2008).[56] According to Odent (2008)

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[55] It is suggested that classes facilitated in the hospital setting may offer comfort in providing some familiarity in the nominated birth place. In contrast, classes that are hospital-based can militate against women making contact with other local women with a view to setting up support structures in the community before and after birth. According to Nolan (2003) and Schott (2003), the promotion of friendship and support is an attractive feature of antenatal classes, which may be necessary due to the dissipation of support for new mothers that was traditionally provided by the extended family structure.

[56] Obstetrician Michel Odent (2008) suggests the presence of a male partner at birth presents a hindrance to the woman and is a significant factor in why labours are longer, more painful and more intervention is

among the reasons for the re-inclusion of male support partners to the birth space was the move from home to hospital birth and the absence of female family support with the rise of the nuclear family. Davis-Floyd (2003, p. 79) also suggests that the partner's presence was welcomed in hospitals when it became evident that this support enabled the woman to cope with labour and birth in more 'socially acceptable ways'. The term 'husband coached' is not entirely relevant in contemporary society as family composition within postmodernity includes many different forms (Pilley-Edwards and Murphy-Lawless 2006, Benn 1998) and one cannot assume the presence of a supportive male partner (Kitzinger 2005). Evidence suggests that hospital-based births can inhibit the efforts of the male birth partner due to possible feelings of intimidation by so called hospital experts (Kitzinger 2005).

Sheila Kitzinger (2003) details various approaches to antenatal education in preparation for birth: the Autogenic[57] method is practised widely in Europe and is based on relaxation methods and breathing techniques. The Michel Odent approach promotes peaceful surroundings for the labouring woman to be left undisturbed and psychologically transported to 'another plane' (Kitzinger 2003, p.184). In the 1970s, the work of Michel Odent, in addition to the rediscovery of water birth, replaced formal antenatal education classes with singing groups comprised of women, families and healthcare professionals. Odent developed this work in the hospital in Pithiviers, France, an approach that fostered relaxation and the development of a system of social support (Kennedy 2002).

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required. In addition, Odent suggests that the presence of the male partner negatively impacts the couple's relationship as they begin their journey together as parents.

[57] The autogenic method of childbirth is a self help method designed to restore natural mind and body balance, expectant mothers learn to relax using body awareness techniques by visualising warmth and weight in various parts of the body. Breathing exercises are used to manage pain during labour and birth. A review of mind-body interventions for preventing or treating women's anxiety during pregnancy revealed that autogenic methods might be effective for decreasing women's anxiety before birth (Marc *et al.* 2011). Other mind-body interventions reviewed include biofeedback, hypnotherapy, imagery, meditation, prayer, auto-suggestion, tai-chi and yoga, see Marc I., Toureche N., Ernst E., Hodnett E.D., Blanchet C., Dodin S. and Njoya M.M. (2011) Mind-body interventions during pregnancy for preventing or treating women's anxiety. *Cochrane Database of Systematic Reviews.* Issue 7 Art. No;. CD007559. DOI: 10.1002/14651858.CD007559.pub2.

Active Birth was pioneered by Janet Balaskas in the U.K. in the 1980s and is based on the principles of Hatha yoga and movement throughout labour. The Active Birth method is attributed historically to progressing birthing women from the delivery bed to the freedom of movement on the floor. Balaskas' methods of encouraging mothers to birth in upright positions were considered too radical at one time and resulted in her expulsion from the U.K. National Childbirth Trust's training programme (Kitzinger 2005).

Sheila Kitzinger's psychosexual approach is informed by her observations internationally as a social anthropologist and focuses on the woman as 'active birth giver', the core message is that the woman learns to trust her body and her instincts, incorporating physical and psychic training in preparation for birth (Rich 1995). Kitzinger's method features principles of Dick Read's natural childbirth method and the Lamaze psycho-prophylaxis approach combined with many active birth movements (Kitzinger 2003). More recently, hypno-birthing approaches have been employed, fostering self-hypnosis, breathing methods and relaxation (Mongan 2005).

It would appear that the structure and process of hospital-based Antenatal Education (ANE) has facilitated a means to control women, by providing information that encourages women to comply with a male dominated prescriptive model of childbirth (Oakley 1984, Carr 1992, Mason 1998, Nolan 1999, Gagnon 2004). In addition, the literature indicates that ANE provides a medium to indoctrinate women with the rules of conduct or 'birth rules' (Carr 1992, p. 21). The role and significance of antenatal classes is argued by Mason (1994) and Kennedy (2002) who suggest that antenatal education provides a means to socialise women into the role of pregnant woman and motherhood, against the backdrop of an increasingly medicalised world. The question remains as to whether women feel that this process is acceptable because of the lack of a viable alternative, or whether the process is unquestioned as women perceive that the care that is offered is ultimately the best available.

2.16. Conclusion

To conclude, Chapter Two offers the background and context for this research and how motherhood and antenatal education are situated in Ireland, with some reference to the contextually relevant history and origins of antenatal education in Ireland and the

United Kingdom. The concept of becoming a mother and the cultural and societal attitudes towards motherhood with reference to postmodern influence is discussed. The medicalisation of birth and antenatal education, and current approaches to ANE are explored. The rationale for choosing this topic as research inquiry is also presented. Chapter Three explores questions of ontology, epistemology and how these questions influence the research orientation and methodology.

CHAPTER THREE: ONTOLOGY, EPISTEMOLOGY AND RESEARCH ORIENTATION

3.1. Introduction

In Chapter Three I present my ontological position (how I am in the world), the issues I have grappled with in relation to epistemology (how I know), my theoretical perspectives (how I see) and how these positions have influenced my orientation or choice of methodological approach for this research inquiry.

3.2. Conceptual Framework – The Lead Up or Leading In.

Over the course of this inquiry, my personal views about antenatal education in preparation for motherhood have been altered in accordance with my reading and engagement with the principal people[58] in the field. The impetus for this work focused on my desire to compare and contrast ANE programmes, initially with a problem solving approach, influenced less by personal experience and more by my 'training'[59] as a midwife in a large obstetric-led tertiary referral maternity unit. I had considered that conventional antenatal education provided a positive measure to communicate with and support new parents as distinct from what has been implied in the literature as an implicit means of social conditioning or control (Oakley 1986, Carr 1992). Despite my earlier views that antenatal education supported women as mothers, my experiences in the field[60] and my additional reading, confirmed my belief that without collaboration with those immediately involved, the traditional and mainstream system was flawed. I was keen to develop antenatal education, albeit in response to women's identified needs, but my focus was on developing a model or framework within a masculinist[61] paradigm;

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[58] By principal people, I refer to those involved in ANE at 'grassroots' level (De Vos 2002, p. 106) in this instance, the ANE co-researchers and women co-researchers in the research.

[59] Foucault (1991) refers to training of individuals as a means to enforce discipline. Martin (1997) also discusses the powerful influence of the bio-medical model in training health professionals.

[60] I refer to my conversations with antenatal educators and mothers in preparing the research proposal and question.

[61] The term 'masculinist' is in accordance with Dorothy Smith's (1987) assertion that male dominance is revealed in complex or organised practices and is sustained by silencing women (Smith 1987).

a representation upon which to hang the solution to a problem that I was viewing with a very structured and 'professional' lens.[62] My reading led me to consider issues about women, motherhood and maternity services from the broad perspectives of social theory.[63] I grappled with issues of Modernity[64] and consequences, the role of the state, key leading players and ensuing debates about knowledge and power. This strengthened my capacity to interpret my reading in preparation for field work.

I began to question what it means to be a woman living within complex social relations during a time when she is possibly most vulnerable and open to outside influences (Chalmers 1997, Ketler 2000). I was also influenced by my personal experiences of pregnancy and birth in a large obstetric setting. I pondered the complexities and restraints of social convention, specifically as a recipient of maternity care. I was increasingly aware of inequalities in maternity and health care undercut by gender and, indeed, intersected by other social differences and division, for example, poverty and ethnicity. Thus, my questions were changing from where I initially began my journey. Now I considered how I could contribute in a meaningful way. How could I bring midwives and women together with a shared purpose? Why are women denied the democratic right to contribute actively to the development of policies and processes that affect them? What happens at the crossroads where woman and midwife, or antenatal educator meet?

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[62] Martin (1997) suggests that socialisation in male dominant systems lead women to believe that they are passive and are not expected to question.

[63] Giddens' (1984, p. xvii) interpretation of the meaning of social theory is helpful here, that is the 'issues to do with the nature of human action and the acting self; with how interaction should be conceptualised and its relation to institutions; and with grasping the practical connotations of social analysis...the illumination of concrete processes of social life.'

[64] According to Anthony Giddens (2003) 'Modernity' can be described a period beginning in seventeenth century Europe. A consequence of modernity is globalisation, which is a process of fragmented and uneven development that promotes interdependence without alternative. Modernity is characterised by institutional transformation and of particular significance is the development of the nation-state and systematic capitalist production (Giddens 2003).

At this point in my individual inquiry,[65] I experienced a very personal process of awakening or consciousness-raising (Freire 1993, Maguire 2006). I was presented with a decision: I could decide to maintain conformity through developing antenatal education with a male dominant lens that was arguably a medium to indoctrinate women on policy and procedure (Fleming 1992, Kitzinger 2005). Alternatively, and more fitting for me, I could attempt to use my awareness for change, through dialogue, reflection and action (Freire 1993). I attempted the latter through engaging with the grounded experience and knowledge of those directly involved.

3.3. My Ontological View

Owing to these conceptualisations, the premise that knowledge created with others is more powerful resonated with me and seemed fitting for the purpose of the research. My personal philosophy and the view that underpins this inquiry is the belief that participation and attachment to others is essential to being in the world (Gaya Wicks *et al.* 2008). Judi Marshall and Peter Reason (2007, p. 368) develop this concept in their discussion about 'taking an attitude of inquiry' as they explain that a significant element of being in the world is informed by relational theory.[66]

The notion of relational ontology emerged from research with women and girls in the fields of education and developmental psychology (Mauthner and Doucet 1998) and has been central to feminist political theory and philosophy also.[67] What we perceive as knowledge of the world and of humans originates in our relationships with others and is both historically and culturally situated (Gergen and Gergen 2008). In the same way, pregnancy and birth do not occur in isolation but are influenced by relationship, culture and history. The pregnant woman is in relationship with all others; professional helpers,

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[65] Reason (1994) refers to the importance of acknowledging and exploring links between personal individual practitioner inquiry, the group, and the community and refers to these processes as first person, second person and third person inquiry.

[66] Fletcher (1998) defines relational theory thus, 'an alternative model, called growth-in-connection, that is rooted in private sphere characteristics of connection, interdependence, and collectivity' (Fletcher 1998, p.167). This is in contrast to the postmodern view of separation and individuality.

[67] (See Benhabib 1987, 1992, Ruddick 1989, Gilligan 1993).

family and associates (Kitzinger 1977, Ruddick 1989). A relational perspective considers the 'self in relation' to others, as we are situated in complex social interactions (Ruddick 1989, p. 211, Gilligan 1993). This contrasts with the postmodern western ontological view of the self as discrete, sufficient and rational (Mauthner and Doucet 1998).

It has been suggested that individualistic philosophy in this latter sense drives consumerism[68] and has severe consequences for the human world and 'the more-than-human world'[69] (Reason 2006, p. 199, Reason and Bradbury 2006). Relational ontology is not in keeping with what appears as a postmodern perspective of individuality and fragmentation (Benhabib 1992). In this way, relational knowledge is knowledge as 'social construction'[70] that shifts the focus firmly from individual reasoning to knowledge that is created powerfully through human relationship (Gergen and Gergen 2008). The assertion by Alison Jagger (1983, p. 376) that 'the standpoint of women generates an ontology of relations and of continual processes' reminds us that

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[68] The notion of consumer in health care is problematic as according to Oakley (1993), this implies that professionals provide health services and people consume them, where in fact, it is the person who is healthy or not. Secondly, and more significantly, the notion of consumerism is inappropriate because this embodies the capitalist assumption of a free market society and the patient as a consumer's right to choose. In reality; however, capitalism ensures that the right to choose is unevenly distributed; thus, 'like health, choice is given to those who already have it' (Oakley 1993, p. 55). The alienation of contemporary women, deepened by class and ethnic location, is a historically specific product of the capitalist mode of production. It results from such an historically specific features of capitalism as the fetishism of commodities, the risk of positivist signs (by this Jagger (1983) notes that scientific knowledge is deemed worthy by its objectivity and independence from value laden judgements; this means that in principle, produced claims can be verified by anyone and are generalisable without consideration of context or subjectivity), especially the separation of home from work place accompanied by the characteristic split between emotion and reason, the personal and the political (Jagger, 1983, p. 317). That is not to say that women's oppression stems from capitalism alone, rather according to Jagger (1983), that the abolition of capitalism would be replaced by another form of suppression.

[69] The phrase 'more than being in the world' is manifested through respect for nature and humanity's participation in natural processes, which presents ecological necessity (Reason and Bradbury 2006, p. 10).

[70] The term 'social construction' refers to the origin of understanding, knowledge or meaning is rooted in human relationships (Gergen and Gergen 2008).

concepts of individualism and fragmentation seem inappropriate and irrelevant to discussions about the complex processes of birth, motherhood and reproductive freedom.[71] The immediacy and relevance of exploration of women's and ANEs grounded experience in this research appeared clear; as Freire (1993, p. 75) reminds us, 'the starting point...must be the present, existential, concrete situation, reflecting the aspirations of the people... [we] must pose this...to the people as a problem which challenges them and requires a response - not just at an intellectual level, but at a level of action.'

3.4. Gnoseology (Epistemology and Perspective)

Gnoseology refers to a wider category of knowledge extending beyond one dimensional epistemic or scientific knowledge (usually considered superior) in addition to other less valued ways of knowing such as phronesis (praxis or practical wisdom[72]), emotional and tacit knowledge (Polanyi 1962) not informed by modern science (Eikeland 2007). Since the Enlightenment,[73] the empirical, positivist worldview has formed the foundation of Western inquiry (Toulmin 1992, Eikeland 2007), which has placed emphasis on neutrality and objectivity in research. My commitment to engaging with the grounded experiences and knowledge of women and antenatal educators, in addition to my privileging of relational theory, required that I explored beyond the perceived authority of knowledge derived solely from scientific procedure (Ramazangolu and Holland 2002).

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[71] Jagger (1983) suggests that reproductive freedom as distinct from rights (that of 'something belonging permanently to women in virtue of their unalterable biological constitution' Jagger 1983, p. 320) refers to control over whether and in what circumstances women birth and raise their children (Jagger 1983, p. 318)

[72] Relevant to this research, praxis relates to 'values made visible through deliberate action' (Wheeler and Chinn 1991, p. 2)

[73] The arrival of Enlightenment promised to free Western civilisation from the hegemony at the time of superstition and religious authority. Intrinsic to Enlightenment was the dualism of mind and body; the concept of the mind and body split can be attributed to the philosopher Plato and was sustained with Enlightenment in the eighteenth century, which valued concepts of objective rationality (Newton) and instrumental reason (Descartes).

3.5. My Orientation to a Participatory Worldview

As an orientation[74] and methodological approach, research inquiry through participatory action research appeared congruent with my concept of being-in-the-world. The merit of action research processes in terms of practical and theoretical outcomes that 'are grounded in the perspectives and interests of those immediately concerned', as distinct from being filtered by those of an outside researcher was clear (Reason and Bradbury 2006, p. 4). Emphasis on the authoritative nature of scientific knowledge in which there is no acknowledged connection between knowledge and power, is undercut by the practical principles and value placed on human interests and participative relationship that is inherent in action research inquiry (Reason and Bradbury 2006). Relevant to the research presented here, a disciplined, critical skills approach to the process of creating knowledge, involved drawing on a participatory worldview[75] by using scientific knowledge and taking care to frame it within a human context (Reason and Bradbury 2006). In using scientific knowledge in this way, knowledge becomes subjective-objective (Reason and Bradbury 2006, Fals-Borda 2006), as we rely on different ways of knowing to inform our thinking and doing.[76] As part of this inquiry, the emphasis on other forms of knowing was, knowing that occurred through the process of living and in the voices of ordinary people through ordinary conversation (Maguire 2006). It was essential for those involved in the research to understand how women made sense of their experiences and interactions embedded within a patriarchal maternity care setting,

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[74] I refer to Participatory Action Research as an orientation because according to Minkler and Wallerstein (2003), PAR may be viewed as bringing participation into action research, and as such, is not solely a research method but an orientation, which provides a way to highlight the perspectives of individuals and groups denied the opportunity to inform the policies and process that affect them (Hall 1993, Reason and Bradbury 2006, Brydon-Miller 2007, Stringer 2007).

[75] According to Reason and Bradbury (2006, p. 8), at the centre of the participatory worldview is 'a participatory understanding of the underlying nature of the (interconnected) cosmos we inhabit and which we co-create' and uses democratic, peer relationships as a form of inquiry (Reason and Bradbury 2006).

[76] In reconstructing knowledge, we can ignore the dangers of postmodernist nihilism; it is important to remember that while interpretations vary, concrete realities in the form of atrocity and human disaster remain (Gilligan 1994).

and consequently, how knowledge derived from women was inhibited by power.[77] In addition and in response to the oppressive nature of the research setting, participatory action research influenced by feminist concern seemed fitting. This is best described as an approach that privileges the agency and the lived experience of women on the one hand, while at the same time, problematising the complex ways women's experiences are bound by history and culture (Reid and Frisby 2008).

3.6. Action Research as an Orientation or Methodology

Action research is an emergent, educational and evolutionary process concerned with engaging with the self, others and communities[78] over time (Reason and Bradbury 2006). This method of inquiry draws on an extended epistemology[79], to integrate theory and practice and is concerned with developing 'living knowledge'[80] (Reason and Bradbury 2006, p. 2). Extended epistemology incorporates diverse ways of knowing, which include practical knowledge, knowledge as a social construction[81], reflective knowledge (Park 2006), feminist ways of knowing, experiential,[82] intuitive and bodily

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[77] This discussion is presented throughout the findings chapters Six, Seven and Eight and discussion Chapter Ten.

[78] My interpretation of 'communities' in this instance may be communities of inquiry, as distinct from a collection of people in a geographical area (Abercrombie *et al.* 2006), although they may well be.

[79] John Heron and Peter Reason (2006, p.149) refer to 'extended epistemology' as a theory of how we know; extended because it reaches beyond the primarily propositional knowledge of academia.'

[80] By 'living knowledge', Reason and Bradbury (2006, p. 2) explain that in action research, knowledge is evolving and 'coming to know' is rooted in everyday experience; knowledge therefore, is a verb as distinct from a noun.

[81] According to Davis-Floyd (2003) knowledge is socially constructed to reflect core values and cultural beliefs; this view is held also by Carol Gilligan (1993) who suggests that commonly held values become fact.

[82] I refer to Ketler's (2000, p. 153) definition of experiential knowledge which 'refers to knowledge that is either embodied, based in one's own daily practices, or based in the daily practices of other local, familiar persons'

knowing.[83] The term 'living knowledge' places emphasis on knowledge generation through the telling of personal and subjective experiences[84]; therefore, part of this research inquiry was about recording and reflecting upon the research participants' and our collective decisions in field work and in my writing of the thesis and the beliefs and values that have influenced those decisions.[85] Although practical problem solving is central to action research (Middel *et al.* 2006), crucially, action research is about creating new forms of understanding through reflection[86]on experiences (Reason and Bradbury 2006, Barrett 2006), hence structured reflection was a critical aspect of this inquiry.

Action research is used as a general term to include many variants of action-orientated research; a major difference; however, in current action research approaches is the level of involvement and collaborative efforts between professional researchers and practitioners. Reason and Bradbury (2006) suggest that by working *with* people in everyday living, it is clear that all action research is participative and that all participative research is action research where 'human community involves mutual

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[83] Davis-Floyd (2003) uses the term 'bodily knowledge' in her description of women's prioritisation of authoritative scientific knowledge over intuitive, emotional and bodily knowledge. A discussion about ways of knowing is presented in Chapter 10.

[84] Reinharz (1992) suggests that knowledge is developed through everyday life experience. I discuss personal and subjective experiences to distinguish from positivist research that values and recognises scientific knowledge as objective, detached and observable data. According to Maguire (1987), unquestioned acceptance of positivist research as the only valid form of knowing, inhibits any serious consideration of alternative approaches to social knowledge production.

[85] Maguire (1987) has also written about the value of writing in the first person – and citing Linda Abrams (1983), describes the 'forced and false dichotomy between personal politics and scholarly research, although central to positivist social science and education research, is addressed head on by participative research' (Maguire 1987, p.7).

[86] Reason and Bradbury (2006, p. 2) state that 'action without reflection and understanding is blind, just as theory without action is meaningless.'

sense-making and collective action'[87] (Reason and Bradbury 2006, p. 2). Action research; therefore, is only possible by involving the principal people in the questioning and sense-making that informs the research, and in the action which is the research focus. In the research presented here, it was anticipated from the outset that involvement of women and antenatal education facilitators could contribute to the robustness of the inquiry by ensuring the relevance of the research to the needs of those immediately concerned (Barber *at al.* 2007).

3.7. The Origins of Action Research and Participatory Action Research

The origins of Action Research are diverse but are usually accredited to Kurt Lewin's (1948) dedication at the end of World War II, to involving participants in bringing about change in various settings with a view to generating theory[88] (Reason 2006, Middel *et al.* 2006). Notwithstanding Lewin's contribution to action and change theory, there are other traditions in the action research field of inquiry, including the 'liberationist perspective' of the work of Paolo Freire (Reason 2006, p. 188) and contemporary positivist critique. Action research was originally an American phenomenon; however, participatory research emerged in the developing countries of Africa, Asia and Latin America, with a commitment to confronting issues of social injustice, oppression and political struggle (Kinsey 1987, Martin 1997, Torre and Fine 2006).[89] Over time, PAR has secured increasing emphasis on social aspects (Kemmis 2008) and action research to this end, suffered a decline in popularity in the 1960s because of its association with 'radical political activism'[90] (Stringer 2007, p. 10). Fals-Borda (2006, p. 29) has

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[87] Although participants confirmed that some degree of sense making was achieved through the various processes of our inquiry, whether and how collective action was initiated and sustained is debated through the findings Chapters, Six, Seven and Eight and in the discussion Chapter Ten.

[88] In keeping with Lewin's theory on action research, again the involvement of the principal people affected by the focus of the inquiry is vitally necessary in order to acquire knowledge with a view to changing practice (Kemmis and McTaggart 2005).

[89] Budd Hall (2001) notes however, that participatory approaches to practical problem solving among humans have always existed and continually contribute to activities in support of life and living.

[90] Action research has since regained momentum in the form of community based enquiry and participatory research (Stringer 2007).

outlined the movements since 1970 of a 'deliberate transition' in research inquiry from scientific research valuing objectivity and neutrality to inquiry that was committed to political and social action. This transition was initiated by what Fals-Borda (2006, p. 27) refers to as 'national groups of concerned scholars'- sociologists, theologians and anthropologists, as well as educators, in response to the acknowledged incidence of problems in real life and awareness of the recurrence of structural crises and 'expressions of inhumanity' worldwide, of which there were and continue to be plenty.

The relevance of PAR to this work is its strong emphasis on the political aspects of knowledge production (Reason 1994a). The participatory focus of action research highlights the involvement in the process of inquiry of all members of the community[91] who affect or who are affected by the issue of interest (Stringer 2007) placing as central the reflections and life experiences of that community (Fals-Borda 2006). It was anticipated that issues of power in the relationship between researcher and researched (Martin 1997) and between participants of unequal status in maternity care, as care givers and care recipients, could potentially be addressed as part of this inquiry.

Participatory research has been influenced by the work of Paulo Freire (1993) and his theory that knowledge is linked with learning, through ongoing reflection, action[92] and critical thinking. The re-emergence of participatory research in the 1970s highlighted the debate that people had about participation rights; therefore, the concept of participation was reconceived to define co-researchers, as those who owned the research process and research question (Kinsey 1987). This aspect of involvement of

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[91]Stringer (2007) refers to the community as a 'community of interest' as distinct from neighbourhood or location (Stringer 2007, p. 6). In the same vein, Julian Rappaport (2000, p. 6) states that 'people who hold common stories about where they come from, who they are, and who they will, or want to be, are a community.' Further, Zigmunt Bauman (2004, p.11), identifies two communities; communities of life and fate, whose members share an enduring connection and secondly, communities that are bound together 'solely by ideas and principles'

[92] Freire (2008) suggests that human function is to engage in the world through acts of creation and re-creation.

participants is explored on page 99 of this thesis. Co-ownership of the research presented here was manifested by efforts to encourage joint decision-making at every step of the research process, contribution to the research design, and shared reflections, analysis, and planning for proposed contextually relevant change (Reid and Frisby 2008). It is for this reason that in keeping with a participatory action research approach, women and antenatal educators were and are referred to as co-researchers.

3.8. A Participatory Worldview - Hearing Women's Voices or Adding to the Pervading Silence

The emphasis on conventional and scientific research and the effects of objectification or neutralisation contributed to lack of understanding or insight into the lived experiences of women and men that were grounded in reality (Oakley 2000). According to Sandra Harding (1998), from a gender perspective, this realisation has culminated in a body of feminist research and awareness, which has highlighted aspects of social control over women. It has been argued that social control is initiated and sustained through the patriarchal[93] silencing of women (de Beauvoir 1997, Smith 1987). 'Women's lack of authority to speak, their exclusion from the circle of those who make tradition, who make the discourse, means that the work that suppresses the concrete and material and, with them, the local, particular, and material locus of consciousness is also silenced' (Smith 1987, p. 85). Thus, male dominance that manifests through tradition, organisation, and structure is perpetuated and its very existence depends upon the silence of women[94] (Smith 1987). Conventionality and invasion are expressed through patriarchy within hierarchal structures of power and are replicated through institutions and organisations such as medical and maternity care settings.

In contrast, a feminist standpoint theory, described by Dorothy Smith (1987) is a method that creates a space for the absent experience of women speaking their everyday

[93] Male dominance is usually referred to as patriarchy, women give birth and nurse children, hence the centrality of motherhood and caring to the woman's experience (Chodorow 1999).

[94] It is in the everyday patterns of life and living that hierarchy determined by gender is pervasively reproduced, invisibly, and over time (Smith 1987). Postmodern awareness, however, has highlighted the power dynamics of everyday life with an inherent suspicion of permanency (Felski 2000).

worlds (Smith 1987), highlights the chasm between operational living by women and rule making by men.[95] This, contrary to the established consciousness of society which claims objectivity, not through espousing truth but by excluding subjective experiences through dominant masculine forms that are perpetuated (Smith 1987).[96] The processes of the system are invisible, women are not invited; however, generally speaking, women are situated and located in such a way as to sustain this dominant discourse (Smith 1987). The influence of patriarchy is deep-seated. De Beauvoir's (1949, 1997) writings in the mid-twentieth century indicate that woman is subjected to making personal choices according to how she is defined by man, to the point where women do not possess 'religion or poetry' of their own (de Beauvoir 1949, 1997 p.174).

The context of maternity care in Ireland, which has been described as a power regime, with obstetric doctors as the principal players (Murphy-Lawless 1998, Gray 2000) has been discussed in Chapter Two. To this end, Gray (2000) argues that women attending maternity institutions in Ireland are embroiled in a 'scripted performance' that perpetuates a dominant model of childbirth and the woman's subordination within it (Gray 2000, p. 5). 'Women's voices remain largely unheard because the drama of childbirth continues to be performed within a script that disempowers and isolates them, while reassuring obstetricians that, with the exception of a small and eccentric[97]

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[95] Smith (1987) introduces the concept of 'relations of ruling' that grasps power, organisation, direction, and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power' Smith (1987, p. 3). In this way, Smith is highlighting the influence of business and professional organisations, government and law among others, notwithstanding the influence of discourses permeated through popular text which infiltrate sites of power also (Smith 1987). Thus, consciousness is formed through organisational discourse as distinct from individual or relational in terms of family and kinship influence (Smith 1987).

[96] Smith's (1987) exploration of a sociology from the standpoint of women has 'insisted on a term that brings into view the intersection of the institutions organising and regulating society with their gender subtext and their bias in a gender division of labour'(Smith 1987, p. 3)

[97] Green *et al.* (1990) using a large scale prospective survey of women's expectations of childbirth, provide an analysis of how child bearing women are commonly stereotyped by labour ward midwives. Two main stereotypes perceived were the 'well educated, middle-class NCT type' and the 'uneducated working class woman' (Green *et al.* 1990, p. 126). According to the researchers, perceived stereotypical

minority, most women are content with the service they provide' (Gray 2000, p. 5). This power regime requires safeguarding, in order to survive, in the form of routine power plays which conceal the actual quality of relationship between oppressor and the oppressed (Scott 1990). According to Murphy-Lawless (1998), construction of obstetrics as a scientific discourse has historically favoured theories and practices over women's tangible experiences and continues to do so (Murphy-Lawless 1998, Pilley-Edwards and Murphy-Lawless 2006). This is in spite of the fact that the focus of obstetrics is the female form.[98] It was crucial, therefore, that against this background, women's experiences, as distinct from their male counterparts, as recipients of antenatal education, and the experiences of antenatal educators themselves, who, inadvertently were all female were central in the pursuit of creating knowledge for change and development in antenatal education processes. The change anticipated was space that could hold and privilege personal human agency. In the research presented here, however, an example of how knowledge is circumscribed is illustrated by the sharp rebuttal from an obstetrician to a midwife regarding information that she had offered as part of an antenatal class (this is discussed on page 147).

The influence of a feminist standpoint theory (Collins 2000, Jagger 1993, Harding 1987, Smith 1987) on this research, ensured that the women's perspectives and lived experiences of care, were placed centrally with due awareness that knowledge is socially constructed. Additionally, power relationships between the researcher and the researched, and others, as discussed previously, were highlighted and problematised with keen awareness of the effects of power relations upon the production of knowledge. Finally, a feminist standpoint permeated the research process, in terms of

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characteristics were not supported; for example, women regardless of educational level wished equally to avoid pharmacological pain relief in labour, and women who were less educated had highest expectations for a satisfying birth experience.

[98] The literature indicates that almost all births to childbearing women in Ireland now take place in maternity hospitals despite criticisms that hospital birth provides a mechanism for control of women (Oakley 1984, Nolan 1999, Gray 2000). Currently, there are less than 0.5% of women birthing at home (Health Service Executive 2005, ESRI 2010).

initially how the literature was viewed by questioning dominant discourses, in the methods chosen to hear women's voices and how data were analysed (this is explained in Chapters Four and Five) and how the research findings are shared and disseminated.

3.9. Feminist Thought

Feminism is expressed in various forms; it is a movement that has been shaped by politics, concrete instances, epistemological view and generational differences (Greenwood 2004). In its fullest sense, feminism challenges the practice of domination in all fields (Maguire 2006). One cautionary note about feminisms'- such as liberal, social and radical, is their common focus on aspects of exclusion and the argument that women's issues are fragmented further by ignoring additional possible areas of disadvantage. What I mean by this is that separate elements of social division, such as gender, ethnicity and class, undercut and intersect each other and we place emphasis on one aspect of division to the detriment of another. The effect is that inequality against women and indeed men, with multiple social differences is intensified. To this end, Bradley (1996) suggests that irrespective of whatever side of the social divide one is located it appears that ultimately, the strong exploit the weak.

My earlier readings indicated that women are deprived of choice[99] and even more significantly, that the basic notion of consumerism in maternity care may be problematic (Pilley-Edwards and Murphy-Lawless 2006, O'Connor 2006). Maternity care initiatives are planned and implemented with minimal consultation with women regarding decision-making processes (Devane *et al.* 2007, O'Connor 2006). This is in stark contrast to what Oakley (1980) describes as placing the woman at the centre of her own birthing experience. I became aware of the concept of interconnectedness[100] and

[99] Bauman's (2005) discussion of choice is helpful here, the suggestion that there is an illusion of choice; however is a facade, as old societal restraints are replaced by new restraints which are equally oppressive, yet promoted as essential or necessary.

[100] One distinctive feature of social divisions is that they co-exist, so divisions of gender, race, age and culture for example, are interconnected and undercut each other (Ramazanoglu 1992, Braham and Janes 2003, Murji 2003). Where one group is dependent on another, the weaker group does not have the same access to equal economic or social opportunity, as in the case of women who are financially or otherwise dependent on men or the state to survive (Janes 2003).

the power play between vulnerable groups, State and policy makers and the grip of corrosive control, which ultimately perpetuates social division.[101]

3.10. Accounting for Intersectionality

Murji (2003) suggests that measures for social justice should be targeted at the intersection where divisions meet. My personal perspective is one that supports feminism as a lens to highlight the ways in which all people, male or female, (and in this research, women specifically as mothers) may find themselves oppressed or contained.[102] Thus, Patricia Maguire's assertion that feminism requires commitment to render and challenge any form of oppression is relevant to the research presented here. In our encounters with inequality, Mary Brydon-Miller (2004) suggests that we stop viewing ourselves and others as 'single points' or with the differentiated characteristics that define us. Rather, 'we need to imagine ourselves as existing at the intersection of multiple identities, all of which influence each other and together shape our continually changing experience and interactions' (Brydon-Miller 2004, p. 9). Our diverse experiences and perceptions of birth and motherhood are mediated further by our social divisions (Collins 1994, Miller 2005). The point of intersection is significant because our intersections with others are potential sites for both denial and privilege (Brydon-Miller 2004). It is the point of intersection where the woman engages with the concept of institutional maternity care and carers, specifically and perhaps more concretely, with the experience of antenatal education that is relevant to this research.

Caroline Ramazanoglu (1992) observed how power is differentiated among women. In the research presented here, unequal power distributions existed potentially at the intersections where women co-researchers and ANE co-researchers met, where ANE co-researchers as employees met hospital management, where each individual and group met another and where I met women co-researchers and ANE co-researchers as a doctoral student. Intersections such as these are variable in nature and are often

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[101] Social divisions may be described as deeply rooted, socially constructed differences that are linked to fundamental issues such as race, age, gender and disability (Braham and Janes 2003).

[102] Antenatal educators may also find themselves oppressed or contained within constraining work practices.

overlooked (Brydon-Miller 2004), yet they continually shape our experiences and interactions with others. In her analysis of theories of agency and gender, Lois McNay (2000) argued that one marked change of post-modern times is the transformation of the social status of women, and the restructuring of gender relations and forms of oppression and inequalities amongst women, which are just as restrictive as old and traditional forms of gender inequality. According to Reid and Frisby (2008), the first step to acknowledging the influence of intersections is to introduce and sustain open dialogue. The challenges of how dialogue was initiated and sustained throughout this research are described throughout the findings chapters Six, Seven and Eight of the thesis. I worked to address my biases and to remain consciously aware of power differentials and this was further enabled by my reflections and writing, and through discussions with my action research colleagues and critical friends. Earlier drafts of my writing however, revealed that as a woman and mother, I began to appreciate women's conflicted stance in the maternity services. I placed emphasis on what the women were saying and became aware of the danger in silencing the voices of the antenatal educators. Thus, by putting my focus on the group that I felt was discriminated against, I was potentially marginalising the significance of the burdens carried by the antenatal educators resulting from their intersectionality. A discussion about intersectionality and its implications in this work is presented in Chapter Ten.

3.11. Working with Women to Hear Through Dialogue, Reflection and Action - Feminism and Participatory Action Research

Characteristic of the dominant paradigm of positivist scientific research is the boundary which separates the researcher from the researched (Zuber-Skerritt and Perry 2002). In action research, social systems are involved in which the researcher is immersed in connection (ibid). Despite this, it is important to be cognisant of the view that within a research relationship, another type of control and power exist between the researcher and the researched (Fine 1994, Wolf 1996, Mauthner and Doucet 1998). Thus, the importance of reflexivity in the research process and acknowledgment of the power relations between the researcher and researched, or what has been traditionally referred to in conventional research as the knower and the known (du Bois 1983, Eikeland 2007). In contrast to this approach, an androcentric perspective in social science has rendered women largely unknowable due to lack of focus on context (du Bois 1983). Conventional, specifically positivist research is imposed generally upon individuals and

groups by researchers who are unknown to them and know little about local context and without taking into account the needs of the individual or group (Martin 1997). Byrne and Lentin (2000) suggest that in feminist research, the knower and the known inhabit the same universe and as women, our world is inhabited with double consciousness.[103] Further, Michelle Fine (1994) articulates that in feminist research, women's lives are explored to highlight an issue; however, in doing this, the systems that perpetuate dominance go unscathed or unexamined. Feminist research in contrast, rejects the cold objectivity associated with the positivist paradigm in favour of seeking and creating awareness of women's experiences (Byrne and Lentin 2000).

Since the 1990s, feminist researchers have been interested in PAR as a means to counteract the dominant methods of creating knowledge (Maguire *et al.* 2004). Notwithstanding this, there are criticisms of PAR's predominantly androcentric origins (Brydon-Miller *et al.* 2003, Maguire 2004, Maguire *et al.* 2004). Feminist research has highlighted the gender bias of traditional research (Hall 1992), while participatory research is built on the Freirian view of ordinary man's [and woman's] alienation in the world.[104] In response, a number of action researchers have worked to explore the

[103] Barbara du Bois (1983) speaks of double consciousness, which she describes thus, 'we are in and of our society but in important ways also not 'of' it. We see and think in the terms of our culture; we have been trained in these terms, shaped to them, they have determined not only the ways in which we have been able to perceive and understand large events, but even in the ways in which we have been able to perceive culture and understand our most intimate experiencing. Yet we have always another consciousness, another potential language within us, available to us. We are aware, however inchoately, of the reality of our own perceptions and experience; we are aware that this reality has often been not only named but unnamable; we understand that our invisibility and our silence hold the germs of both madness and power, of both dissolution and creation…' (du Bois 1883, p.112). Deborah King (1988, p.47) refers to multiple consciousness to convey black women's experiences and political awareness of their multiple oppressions and the complex dynamics of 'multiple forms of discrimination' in economic, cultural and social terms in addition to the influence of gender.

[104] Patricia Maguire (1996) suggests that PAR has traditionally underestimated women's isolation in a patriarchal world and incorporates language that is impartial and ignores feminist perspectives (Maguire 1987, 1996).

intersection between gender[105] and action research (Treleaven 2001, Maguire 2006, Barrett 2006). According to Maguire (2006, p. 63), 'feminist grounded action research is not limited to a struggle against gender oppression alone, as gender oppression is structured and experienced in a web of other oppressions.' A commonality between feminism and PAR is the recognition that knowledge is created in the context of human relationships that are genuine and that in order to develop knowledge for change, collaborators must feel safe to voice areas that are problematic (Maguire *et al.* 2004, Greenwood 2004). Prominent commonalities between action research and feminism is the metaphor of 'voice'[106], attention to everyday experience as a source of political knowledge (Smith 1987), and the desire to challenge power relations in research processes and elsewhere (Maguire 2006). For the reasons outlined above, PAR combined with feminist concern is the orientation or methodology considered most fitting for this work.

3.12. Conclusion

Chapter Three presents a description of my ontological and epistemological viewpoints and how these positions have influenced my orientation towards Participatory Action Research (PAR) that is influenced by feminist concern. My research orientation has been explored and I have discussed the commonalities between PAR and feminist research and their relevance to this work. I have introduced briefly the significant concept of voice. I have considered some of the pertinent challenges related to working with women to hear voice, most prominently, the existence of power and unequal status in research and in healthcare relationships. The following chapter explores the process of framing the research through operationalisation of the research orientation or methodology.

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[105] Maguire (2006) attributes this to the 1990s shift in feminism from working with women alone to theorising gender (Maguire 2006).

[106] The centrality of voice to this research is discussed in Chapter Five and throughout the findings Chapters Six, Seven and Eight.

CHAPTER FOUR ORIENTATION OR METHODOLOGICAL APPROACH

'...the questions we ask are the powerful shapers of the world we "see"' (Maguire, 1987. p. 2)

4.1. Introduction

The inherent challenges in writing an action research dissertation, due to the cyclical and iterative nature of action research, are documented by Herr and Anderson (2005) and Zuber-Skerritt and Perry (2002). Consequently, I felt it was necessary to organise this chapter in three sections. The first section states the aim and objectives of the research leading from the core research question. Explanation of the preliminary work that was undertaken in preparation for field work is offered in addition to the unexpected challenges that I encountered in my attempts to secure a research setting. The second section describes the action research cycle and the concrete methods that were used to frame and to operationalise the action research process, and the writing in the third section describes the methodological challenges specific to the research presented here.

Central to the approach of PAR is fostering a dynamic process of encouraging co-researchers to become active agents of change, as distinct from passive subjects (Reid and Frisby 2008, Marshall and Reason 2007, Kemmis and Mc Taggart 2005). According to Bob Sang (2003), all individuals, regardless of position begin to share their thoughts and feelings, when they feel supported and valued. This research therefore incorporates a PAR approach to create space to seek antenatal educators' views and women's views and perceptions of women's anticipated needs in preparation for motherhood. Marshall *et al.* (2011) suggest that action researchers espouse a reflective and inquiring approach to complex and messy human issues and challenges therefore, generally asking 'How to...?' or 'How can...?' questions. Such questions are central to creating practical outcome and new ways of understanding (Marshall *et al.* 2011). Following from the discussion in Chapter Two describing the background and context for the research and how motherhood and antenatal education are situated in Ireland, the core research question is:

'How can knowledge created in collaboration with mothers to be, mothers and antenatal educators inform hospital-based antenatal education programmes to prepare women for birth and motherhood?'

4.2. The Aim of the Research

The aim of this research is therefore, to develop antenatal education in preparation for motherhood, based on knowledge created in collaboration with mothers to be, mothers and antenatal educators.

4.3. Objectives of the Research

1. To create a collaborative space with pregnant women to share their felt support needs for early motherhood.
2. To create a collaborative space with antenatal educators to share their reflections of their experiences as antenatal educators, women and possibly as mothers.
3. To create a collaborative space for women and antenatal educators to work together towards developing a framework for antenatal education.

CHAPTER FOUR SECTION I: PRELIMINARY GROUNDWORK

4.4. Preliminary Groundwork

My ongoing literature search was antenatal class content and information-driven and considered educational processes and popular learning theories. In scoping the research question, I attended a two day workshop about facilitating antenatal education, which was led by an experienced teacher. At that time I revisited and rehearsed skills on presenting information in a relevant and meaningful way based on the principles of adult learning; that adults as learners are self-directed, goal orientated and learning is informed by life experiences (Knowles 1984). Preparation for the inquiry was also influenced by a descriptive survey I had undertaken to elicit the antenatal education needs and desires of pregnant and postnatal women attending a large Dublin tertiary referral maternity unit. Presentation of the results of the survey is outside the scope of this work. Of relevance to this inquiry; however, I identified at the time, that there was no formal national evaluation[107] of women's experiences of antenatal education, and

[107] Antenatal education classes are informally evaluated at local level, although evaluation varies in terms of process, timing and frequency. Telephone conversations and meetings with ANEs (midwives and

that opportunities in Ireland for antenatal educators to learn about facilitating adult learning were limited.[108]

4.5. Telling the Story

Throughout this chapter, I have used reflection boxes as pauses in the narrative to provide some insight into my first-person inquiry, conceptualisations, or my 'making sense of' my engagement in the research. In the strictest sense, this explanation belongs to the 'methods' section of this Chapter but I feel that these reflections are sufficiently significant to warrant early introduction. According to Judi Marshall (2006) all inquiry requires some form of reflection, as part of inquiring is about judging when to be open and receptive and when to be focused. Note-taking is an essential aspect of what Marshall (2006, p.336) refers to as working with her 'inner arc of attention'[109], which is developing the ability to notice, reflect and adjust accordingly. I recorded my interpretations and reflections of events on a digital Dictaphone immediately following every meeting and also when challenges arose in the research, for example, in managing the initially slow recruitment of women co-researchers, which is discussed on pages 108-111. My digital recordings were then transcribed and I listened to each tape and read each transcript several times. I have presented some of my notes here to explain research related events. Other descriptions that I feel are most relevant or depict salient issues related to the research are presented here also. My field notes include my reflections about events and some incorporate my use of structured models of reflection.

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physiotherapists) who shared their programmes with me indicated that programmes were evaluated by women on an ad-hoc basis.

[108] Since 2009, a five credit module focused on Preparation for Birth and Parenthood Facilitation is offered to antenatal educators by the Centre of Midwifery Education, Cork University Hospital and the Catherine McAuley School of Nursing and Midwifery, University College Cork. More recently, a two-day pilot 'Parent Education' Programme has been initiated by the Centre for Midwifery Education, Coombe Women & Infants University Hospital Dublin and the University of Dublin, Trinity College.

[109] Similarly, Marshall (2006, p. 336) refers to 'pursuing outer arcs of attention', which extends beyond the self (although the inner arc attentions are simultaneously occurring) and involves others in actively questioning and testing developing ideas for action where fitting.

There were two proposed research sites at the onset of this inquiry, Hospital A and B. Initially, I approached another hospital prior to securing access in Hospital A and B, and the following reflections illustrate the process of my meeting with the antenatal educator and my subsequent field notes and reflections.

Field note Entry from Reflective Diary 14th May 2008 Meeting with Antenatal Educator (ANE) in initial Site A.

As I was leaving the office, I had the realisation that I was experiencing first-hand what I had merely read about until that moment. This was my place for the foreseeable future and that in keeping with the principles of participatory research; I had relinquished any control I may have had in the conduct of an alternative research inquiry. I am an outsider waiting to be invited; potential ANE co-researchers are powerful and I am powerless. According to Coghlan and Brannick (2010) there is the absolute demand in action research for authentic relationships between the action researcher and the principal people involved, as to how the co-researchers understand the process and significant potential action. I perceived that the ANE felt fearful of change, in keeping with Isabel Menzies (1970) work on social systems as a defence against anxiety. When we met, I re-iterated that she was not obliged to participate in the research. Naturally, in the interests of true participation, it is very important that potential women co-researchers and ANE co-researchers engage of their own free will, otherwise the exercise is futile. As a result of this meeting and my subsequent meeting with the Director of Midwifery, it became very necessary quite early in the research for me to reframe my thinking and my plans by seeking an alternative research setting. I was conscious of timing and concerned that I may be without a site for inquiry. I was overwhelmed by this prospect and turned to my action research colleagues, supervisors and critical friends for support. Thus, reconceptualising this 'problem' as an opportunity to engage in a potentially more fruitful inquiry assisted me in moving on. My thinking was informed therefore, by

1. my reading of Menzies (1970)[110] work on social systems

[110] Isabel Menzies' (1970) interviews with nurses about organisation of care revealed high levels of stress, anxiety and tension. These indicators were incurred through avoidance of confrontation and change, and resulted in self compromise and what Menzies (1970, p. 24) refers to as 'psychic defence mechanisms'.

2. my recognition that action research as an emergent process is open to change (Herr and Anderson 2005, Reason 2006)
3. my personal view regarding the centrality of transparency and fairness in process.
4. I was still disappointed and turned to a model of structured reflection[111], for clarity of thinking and realised that until then, I had interpreted the issue as personal failure. The question, *'how were others feeling and what made them feel that way?'* brought me back to the reflective notes I had recorded after our meeting together and the words that the ANE used to convey her feelings resounded with me:

'I can't do it...I have to think about the patients.' (ANE)

She sounded absolutely exhausted and flattened and seemed under considerable strain. At that point, I realised that this was not about me! I was reminded of my belief in the importance of the research inquiry and question, and with this understanding, I moved on. I was concerned about potentially causing anxiety to the ANE; however, my fears were allayed when she suggested that we could work together in the future.

4.6. Participation or Not

My engagement with this hospital took place over a period of three weeks and involved one meeting with the antenatal educator followed by a meeting with the Director of Midwifery at the antenatal educator's request. These meetings were supported by telephone conversations. Pretty (1995) presents a useful typology[112] that outlines degrees and characteristics of participation and this is presented as Appendix 1. In this situation, there was potential for manipulative or passive participation by the antenatal

[111] In the initial stages of the research, I incorporated Johns' (2004) 14th Model for Structured Reflection, but required this less as the research process progressed (Johns 2005).

[112] Naturally, the danger of using a framework such as Pretty's (1995) is the temptation to reduce participation to simple fragmented steps; however, Martin (1997) suggests that a framework may be useful to stimulate critical dialogue between participants.

educator at the will of midwifery management; however, this was not at all the case. Although the Director of Midwifery supported the research in principle, explanations offered for non-participation were 'problems' that 'predated' and issues related to the antenatal educator's concern about protection of confidentiality.

4.7. Losing Hospital A

As explained previously, in the months before the commencement of this project I had engaged in a descriptive survey to identify the antenatal education needs of pregnant and postnatal women in one Dublin tertiary referral maternity unit. Although this was not a national survey, my preliminary groundwork involved contacting antenatal educators in every maternity hospital in Ireland to elicit information about their programme evaluation methods. As a result of this work, I had identified many ANEs who were passionate and motivated in their approaches to antenatal education and I had developed respectful and cordial relationships with some. It was in this context that Hospital A was selected as a research setting. Gaining access to Hospital A was not at all problematic; the lead antenatal educator, a midwife with whom I had spoken several times by telephone, knew about the research and was eager to be involved. Ethical approval, though a convoluted and lengthy process, was secured and a discussion about access and recruitment strategies with reference to Hospital B is presented in Section III of this current chapter.

4.7.1. Challenges and the Beginning of the End

Our first formal meeting, of which there were five in total (two with the line manager and out-patient department manager and three with the group), took place in September 2008. Members of the team present included the line manager, three midwives (including my key contact) and a physiotherapist. Two of the midwives worked in ANE part time.[113] The Clinical Midwife Manager of the Outpatients Department (OPD) was present as a potential gatekeeper. Through working with this group, key issues, thoroughly documented in my reflective diary, had emerged in relation to fear and motivation for participation and would appear to have been brought about by the issues that I describe in the following passages.

[113] This would be significant later because staff were depleted from the ANE department.

Allocating time for meetings during work time was problematic due to clinical demands, and issues relating to payment for overtime were discussed. Staff meetings with hospital management had indicated that there was a lack of funding for all research and that the service was in debt. As such, members of the team demanded payment to attend our research meetings. A request by the line manager was made to senior midwifery management for payment for over-time and this was refused. The lead midwife (my key contact) was still very enthusiastic about participating in the research; however, non-payment for overtime for part-time staff had implications for the sustainability of the research.[114] I offered goodwill strategies, for example, educational workshops and working lunches, where I could provide food in exchange for their time. This was received well initially; however, as the time for our first formal meeting approached I received an email from the lead midwife to say that two members of the team could not commit to lunch time meetings, as one was starting maternity leave and the other would not attend without payment.

Motivations to participate in the research that were identified by two members of the group were: improving practice and the opportunity to co-author publications. It transpired, however, that the remaining members of the research team were reluctant for change in the current programme, did not wish for their sessions to be 'assessed', as they felt would happen, and could not afford to commit their time. During our first team meeting, I stated my intention to foster transparency and equal responsibility for decision-making and control in keeping with the principles of PAR. This disclosure was met with fear and the defence that there was not enough time or energy to commit to this level of involvement. A turning point was reached when a senior member of the clinical management team voiced her commitment and support and became an active member of our working group. This manager would be present for all meetings and would be included in all correspondence. This was problematic for the other members of the group in terms of the nature and level of their participation (see Pretty 1995, Appendix 1), as from that moment all team members were required by management to

[114] Approval from the relevant research and ethics committees had been obtained for this site, after which I had travelled frequently to promote and discuss the research and to recruit women. This included visits to the various clinics and private rooms to inform the staff of the study.

participate in the research. Despite this drawback, the manager proved very helpful in her support of the research, in allocating time and space for meetings and in providing continuity of communication when other team members eventually disbanded.

In March 2009, I was obliged to take sick leave for a period of six months. Prior to this, there was a team meeting arranged, the second of two meetings with this group, to share this knowledge and, at that time, members gave their assurances of their commitment to the inquiry. On my return (October 2009), although I made frequent contact through email and telephone, there was very little response from Hospital A for approximately a further six months. There were numerous well documented issues related to restriction of public access to the hospital that were covered extensively by the media at the time. In addition, it transpired that during my absence the team had disbanded. Most significantly, the principal antenatal educator (my key contact) had been reassigned to another position; therefore, I was without a motivated insider to sustain interest and drive in the research (Arieli *et al.* 2009). Meetings were arranged to regroup and to revisit the proposed research process again with the assurance of an 'opt out' clause for participants. The other original members remained and it was agreed that work would continue, however, shortly after this time, the midwife replacing my key contact left the hospital to work elsewhere. The remaining group members (part-time), apart from the line manager, appeared reluctant to engage with the research.[115] Pursuing a site without the full engagement of all participants seemed a fruitless exercise; one of the strengths of PAR is involvement of the entire community in the research process. According to Khanlou and Peter (2005), a potential drawback to research that enforces participation of all group members, is that individuals who are reluctant to contribute to the process may feel group pressure to do so. This has obvious implications for the principle of voluntary consent. In this way, group consent may, in effect, surpass individual consent, as the welfare of the group becomes more important (Khanlou and Peter 2005).

4.7.2. Closing the Research Relationship

During this time, efforts to recruit women were continued and over a period of one month, over one hundred and fifty packs were distributed between the out-patient

[115] It later transpired that group members were informed by management that they were obliged to participate in the research.

clinics and private rooms, with no response. I requested another meeting with the team and was informed that there were significant changes to the antenatal education department and that the line manager would meet with me. We met eventually in July 2010 and during our meeting, I presented an overview and the history of the project and we examined the anticipated projections and feasible time frames. The manager explained to me that the ANE classes had been scaled down and they would not be replacing the full time antenatal educator. According to the manager, it was left to one remaining part time member to decide if she would like to participate as the other remaining ANE did not wish to participate because she feared her work may be evaluated.

I regretted the loss of this site for several reasons, following my initial refusal from the first hospital and now the withdrawal of Hospital A; I had unsubstantiated fears for the demise of Hospital B. I felt also from an ethical standpoint that the antenatal educators had committed to the research by sharing their time and energy, particularly in the early stages, and specifically, the original key midwife who had been so eager to share with me. For some time afterwards I maintained contact this midwife whose passion for preparing women for motherhood has remained with me. Perhaps it is wise to remember the words of Tina Koch and Debbie Kralik (2006, p. 148) who suggest that 'the most important relationships are not those that we forge through the PAR process but those remaining once we have left.' Without the trust and integrity of relationship, research of participatory nature cannot hope to be successful (Koch and Kralik 2006).

CHAPTER FOUR SECTION II: THE ACTION RESEARCH CYCLE

4.8. Introduction

Action research is an iterative process and because of this, I have found writing about our research activities challenging. For this reason, I have chosen to share some of the operational methods prior to any discussion about access and recruitment of participants. Thus, an overview of the Action Research Cycle and plan for field work is presented with a view to bringing clarity but also to describe what participating in the action research cycle required in practical terms for each participant engaged with Hospital B.

In its most basic form, the action research cycle consists of Kurt Lewin's (1948) notion of 'pre-step', which identifies the context and purpose of the area of inquiry, followed by three principal activities (planning, acting and evaluating), in a continuing spiral of steps (Coghlan and Brannick 2010). There are criticisms that the Lewinian action research cycle lacks emphasis on analysis; however, it is important to remember that the ARC is a device to assist in acknowledging and framing understanding of action research processes[116] (McTaggart 1996). I have found Lewin's concept of the Action Research Cycle useful to depict the complicated and iterative nature of the research presented here. The action research cycle (ARC) of constructing, planning action, taking action and evaluating action devised by Coghlan and Brannick (2010) was therefore adapted and used as a very flexible framework to guide this inquiry and the five ARCs that lie within it (Appendix 2).[117] Before we proceed, it is necessary to explain the activities that the women and antenatal educators participating in this research, were involved in.

4.9. The Practical Requirements of Participating Antenatal Educators as Co-researchers

Access to and recruitment of antenatal educators as co-researchers is described on pages 104-105. Participation in the research involved taking part in nine group meetings over a period of approximately twenty eight months with the other hospital antenatal education team members to share their views and ideas about antenatal education and to contribute to a discussion about how antenatal education could be developed. As part of the research, some action or practice was undertaken by the group and, following this, a meeting to reflect upon and discuss experience of change took place. On three occasions the antenatal educators' meetings were also attended by pregnant and postnatal women attending the hospital for maternity care. These were referred to as

[116] According to McTaggart (1996), 'it is a mistake to think that slavishly following the 'action research cycle' constitutes 'doing action research... action research is not a 'method' or 'procedure' for research but a series of commitments to observe and problematise through practice a series of principles for conducting social enquiry...'(McTaggart 1996 p. 248)

[117] Each ARC was concerned with activities of constructing (data collection and analysis), and planning, taking and evaluating action.

Collaborative Inquiry Group (CIG) meetings and are discussed on pages 95 and 96. Participation extended also to communication with me via email and telephone. Table One outlines the number of ANEs participating in each meeting in each ARC; and the number of participating women present during shared meetings. ANEs' participation fluctuated in accordance with availability, leave and other commitments. The identifying codes for participants involved in each cycle are presented throughout the findings chapters Six, Seven and Eight.

Table 1: Number of Antenatal Educators Participating in Each ARC

Phase	Date	Number of Antenatal Educators	Number of Women in Shared Meetings
ARC1 Meeting #1	24/02/2010	4	-
ARC2 Meeting #1	24/08/2010	4	-
CIG	13/10/2010	4	5
Meeting #3	03/11/2010	5	-
ARC3 CIG	13/01/2011	5	-
Meeting #2	09/02/2011	6	4
ARC4 Meeting #1	20/04/2011	6	-
Meeting #2*	21/09/2011	4	-
Meeting #3**	19/10/2011	5	2

*Group analysis meeting

**Meeting with PN mothers

4.10. The Practical Requirements of Participating Women as Co-researchers

Access to and recruitment of women as co-researchers is described on pages 108-112. Women in ARC2, ARC3 and ARC4 were invited to take part in three group meetings over a period of approximately seven months; the first meeting for women took place when participants were approximately twenty four weeks gestation of pregnancy.[118] The second meeting occurred approximately one month later with the antenatal educators and postnatal women with a view to revising the ANE programme, prior to

[118] In fact, women who were up to 37 weeks pregnant participated in the meetings; this meant that they were unable to attend any other meetings such as the CIGs during pregnancy.

the pregnant women's attendance at antenatal education classes. Participating women were invited to take part in the revised programme of ANE in preparation for birth and motherhood, which was the outcome of their collaborative meeting with the antenatal educators and the postnatal women. The final group meeting, to explore their experiences of becoming a mother in light of their participation in the revised programme, took place after birth when their babies were approximately twelve weeks old.

The majority of participants were involved in one complete ARC[119]; however, they were also invited to support a new group of pregnant women by collaborating as postnatal mothers in the following ARC. Collaboration of women experienced in childbirth was essential to ensure that any potential power differential between women and antenatal educators was minimised and that women receiving care, attending ANE and participating in the Action Research Cycles were supported in negotiating with the ANE team. In contrast to ARC2, ARC3 and ARC4, women participating in ARC1, were invited to attend just one meeting during pregnancy, in addition to the meeting after birth. This was because there was no CIG meeting in ARC1 with a view to gathering information about the existing programme.[120] ARC1 could be compared to the 'pilot' process in other research approaches (Herr and Anderson 2005). A short anonymous questionnaire[121] was offered to each participating woman to gather characteristics including gestation, age group and category of care (Appendix 3). Table 2 overleaf outlines the numbers of women participating in each meeting in each ARC, coupled with the number of antenatal educators participating in each Collaborative Inquiry Group. The identifying codes for participants involved in each cycle are presented in the findings chapters Six, Seven and Eight.

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[119] Tables outlining the women co-researchers characteristics and activities are presented through the findings chapters Six, Seven and Eight.

[120] Women in ARC1 however, were invited to participate in later ARC CIG meetings.

[121] This questionnaire and all of the research documentation, consent and information forms were reviewed by the National Adult Literacy Agency (NALA) prior to their dissemination, to ensure their comprehension in plain English.

Table 2: Number of Women Participating in Each ARC Meeting

Research Phase	Meeting	Group Size (Women) in Each Meeting
ARC 1	Antenatal	
	- Group meeting	4 women
	- Individual meetings (n=3)	1 (x3)
	Postnatal	
	- Group meeting # 1 (2 women)	2
	- Group meeting # 2 (2 women)	2
	- Individual meetings (n=2)	1 (x2)
ARC 2*	Antenatal	
	- Group meeting	5 women
	CIG	
	- Pregnant Women	3
	- Postnatal Women from ARC1	2
	- Antenatal Educators	4
	Postnatal	
	- Group meeting # 1	2
	- Group meeting # 2	3
ARC 3	Antenatal	
	- One group meeting	5 women
	- Individual meetings	1 (x2)
	CIG	
	- Pregnant Women	3
	- Postnatal Women from ARC1	1
	- Antenatal Educators	5
	Postnatal	
	- Group meeting	2
ARC 4	One Meeting	
	- Postnatal Women from ARC3	2 women
	- Antenatal Educators	5

4.11. Operationalising the Action Research Cycle

In the following passages, I describe how the activities of the Action Research Cycle of constructing (data collection and analysis), planning, taking and evaluating action manifest through the functions of various meetings between researcher and co-researchers. The action research cycles are visually represented below in Figure 1 and this is also presented in Appendix 2.

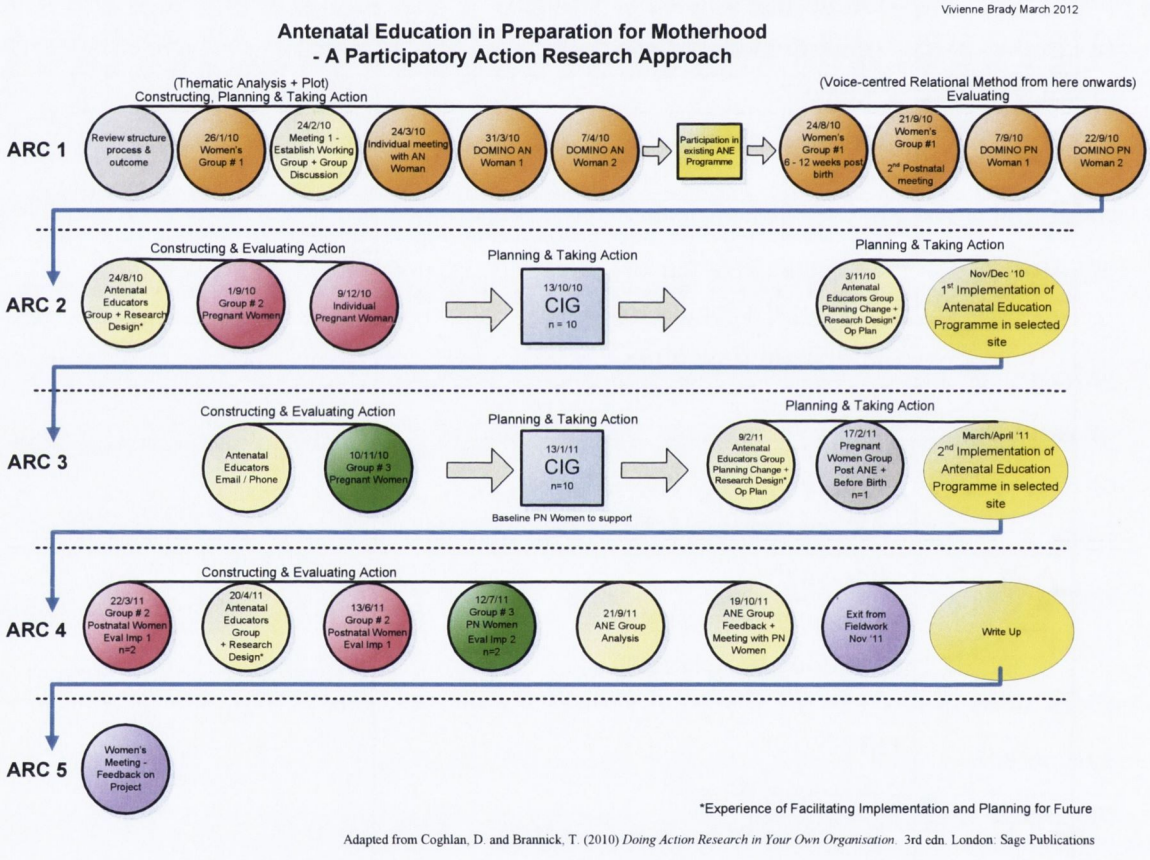


Figure 1: The Action Research Cycle

4.12. Constructing (data collection and analysis)

The constructing phase of the action research cycle is described as engagement of the principal people in 'dialogic activity' to construct [122] pressing issues that require action and the consequent action that is required and taken (Coghlan and Brannick 2010, p. 9). Action research does not endorse any particular method of data collection (Fine *et al.* 2004); however, the focus of this research was engagement with women and antenatal educators; therefore, information was gathered predominantly through working group meetings. I believed that group discussion could encourage learning through interaction (Martin 1997), and the repeated nature of meetings, as distinct from once-off conversations, could foster dialogic relationships between participants (Reissman 2008a).

According to Ospina *et al.* (2008) the diversity of voices captures the complexity of the experience and enhances ideas for potential development for action; therefore, group discussion was the preferred medium. Individual meetings took place also; however, when women could not attend a particular group function, and these conversations allowed more detailed exploration of thoughts and feelings about motherhood.[123] Kamberelis and Dimitriadis (2011) suggest that group work facilitates collective expression and presents the opportunity to challenge positions held about a particular subject.[124] Thus, my aspiration for the consciousness-raising nature of our group meetings was to create a space for expression and creation of new and useful knowledge in the interests of preparation for motherhood.[125] It transpired later, however, that our

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[122] The original term of 'diagnosing' in this model is replaced by the term 'constructing' because according to Coghlan and Brannick (2010, p. 9), there is no singular truth to be discovered because all organisations are socially constructed and 'comprise multiple meanings.'

[123] Women I met on an individual basis were invited to attend later group meetings also but were unable or chose not to attend group settings.

[124] Group work potentially creates space for traditionally marginalised groups to articulate their experiences (Kamberelis and Dimitriadis 2011). The contextual background to the work presented here; however, has made challenge difficult on occasion and this is discussed in the discussion Chapter Ten.

[125] Of relevance to the research presented here, Billie Hunter (2011) in her 2002 doctoral research exploring how midwives experience and manage emotion in their work, notes the usefulness of using

actions would be limited by the context within which the research was set. Notwithstanding this, the diversity of women in the groups, though limited, facilitated learning about what we knew as 'common ground' or the commonalities that women share regardless of background (Belenky *et al.* 1986, p. 13). In the women-only groups, the potentially empowering nature of group meetings was apparent by what Jill Tarule (1996, p. 275) describes as how 'their sense of self and knowing were intimately linked with their assessment of being able to speak about what mattered to them.' This discussion is developed in the Findings Chapters Six, Seven and Eight and in the discussion Chapter Ten.

Meetings lasted between one, and two hours and twenty minutes and commenced with light refreshments and ice breaking approaches. Those present were encouraged to engage respectfully by giving each other space to speak, by listening and by questioning constructively (Martin 1997). Catherine Reissman (1987, p. 175) suggests that the interviewer does not interrupt and collaborates by keeping silent 'to allow the narrative to unfold'. In addition, Reissman (2008a, p. 26) asserts that listening should take place in an engaged and emotionally attentive way. For these reasons, field notes were recorded as an aide memoir immediately following each meeting; notes were not generally recorded during meetings because participants found this practice distracting.

Other methods used to gather and display information were individual and shared reflections, flip charts used during CIG meetings, in addition to the individual and group conversations, field notes and demographic data. The main information sources were the conversations with women co-researchers and ANE co-researchers, separately and together. Conversation 'implies an ongoing though not particularly fluid process, something in progress across time interrupted by life's daily demands. In this process conversers listen, share, interrupt, question and challenge, interpret, shake their heads silently in disagreement or nod in affirmation, get distracted, seek clarification and possibly end up somewhere initially unforeseen' (Maguire 2006, p. 61).

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focus groups to gain insight into how the research topic was understood and managed within the relevant occupational culture, in Hunter's case, Midwifery. Similarly throughout this work, the opportunities presented to me to work with groups of antenatal educators and women, helped me to understand how antenatal education was conceptualised.

In the initial stages of the research, I incorporated a very flexible prompt guide[126] (an example of this is Appendix 4 and, Appendix 5 for postnatal conversations), which was used less as we became more confident in our engagement with each other. For example, following congratulations on their pregnancy or motherhood and thanks for participating, I began conversations with women co-researchers with these words:

> This is a conversation about becoming a mother. I'd really like to understand your views and feelings so please add anything you wish at any time. There is no right or wrong answer.

Group meetings and individual research conversations were recorded and transcribed in full. Once all group participants had consented for group transcripts to be shared (Appendix 6), a copy of the transcript was given to each member of the group for confirmation of accuracy of representation of views expressed.[127] Reflection and feedback relating to the transcript was promoted. In addition, my interpretations of the main messages that appeared significant were offered and women co-researchers and ANE co-researchers were encouraged strongly to refute or agree and to offer their own. This was coupled with my explanation that 'this is what I heard in the data, do you agree or is that something we need to talk about more' with the purpose of consistently seeking clarification (Andrews 2008). Antenatal educators were also encouraged to keep a reflective diary, which they were not obliged to share. In fact to date, no antenatal educators have shared the content of their diaries, but have confirmed without prompt that participating in the research has increased their propensity for reflective thinking and reflective professional practice. Data gathering and analysis are described further in Chapter Five.

4.13. The Collaborative Inquiry Group (CIG)

There were three Collaborative Inquiry Group meetings during the research process and these consisted of a combination of women co-researchers and ANE co-researchers

[126] The prompt for questioning was influenced by our group conversation and also by desire to understand women's experiences.

[127] Please note that representation is discussed in more depth in Chapter Five.

participating in the research.[128] The specific aim of the CIG meetings was planning and discussion about implementing change in practice, as distinct from gathering information exclusively. ANE co-researchers participated in CIGs and a new group of pregnant women co-researchers attended each CIG apart from the ARC4 CIG[129] so that they could contribute to developing the set of antenatal education classes that they were scheduled to attend. All postnatal women-co-researchers were invited to attend the subsequent CIG meetings.[130] The main messages from previous women co-researcher and ANE co-researcher meetings were discussed and analysed, therefore co-analysis and co-construction of ideas for practice development took place and this also reminded participants of their previous meeting's discussions (Miller 2005). Recommendations for action were approved by all members and the co-researchers agreed to potential strategies for implementation of actions in the existing antenatal education programme. Stringer's (2007) *'Look, Think, Act'* model was incorporated to initiate analysis and discussion at group meetings (Appendix 7).

4.14. Planning and Taking Action (Operational Plan Meetings)

ANE co-researchers came together following each CIG meeting to discuss the practical aspects of and operational strategies for progressing ideas for proposed changes emerging from the CIG meetings. As distinct from women co-researchers, antenatal educators potentially had the power to change their professional practices, thus, women co-researchers did not engage in these meetings, as they were specifically related to operational and practical planning. Following the operational plan meetings, it was arranged that the ANE co-researchers would implement the agreed changes culminating in revisions to the existing programme of antenatal education. These processes are described throughout the findings chapters Six, Seven and Eight. The operational plan

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[128] Details of participants in each ARC are presented at the beginning of each of the findings Chapters Six, Seven and Eight.

[129] This is because I exited from the field at this point and the ANE co-researchers had to decide whether to continue action research without me.

[130] Two postnatal women from ARC1 attended the ARC2 CIG and a third postnatal woman from ARC1 attended the ARC3 CIG.

meetings served a practical function: that of planning the content and process of classes in response to suggested actions, in the time and structures available. It may be argued that excluding women co-researchers from this phase was a decision based on hierarchy but in fact, due to the time and clinical commitments of the ANEs, it appeared that this was a necessary practical requirement. On reflection, and on writing this thesis, I have considered that involving women in the operational plan discussions would have presented another opportunity to challenge the potentially restraining institutional and individual barriers to change.

4.15. Evaluating Action

Women co-researchers explored the meaning and impact of the agreed changes to their programme after birth in the postnatal women co-researchers' group.[131] ANE co-researchers met to discuss and to reflect on their experiences of facilitating changes, challenges and strengths, in addition to discussing why certain changes were implemented and others were not. The constructing phase of the second action research cycle took place during the evaluation of the first ARC (Joyce 2005, Coghlan and Brannick 2010). Within these larger action research cycles, multiple cycles of reflection and actions occurred and were interwoven, for example, our discussions regarding the level of women's interest and participation in classes inspired the ANE co-researchers to reflect and develop new and innovative teaching strategies to engage women.[132] Action research therefore is an unfolding emerging process, which evolves through cycles of action and reflection (Coghlan and Shani 2005, p. 538), a process that has not been static and has altered in response to the expressed needs of those involved. The emergent nature of the research presented here is depicted by description of the changes to the research design that have occurred in response to suggestions by co-researchers

[131] All postnatal women had met in their respective groups with the exception of the women whom I had met individually (they were also invited to join the group discussions). Women co-researchers had also participated in CIGs in ARCs 2, 3 and in the group meeting with the ANEs in ARC4.

[132]The antenatal educator offered the example of dividing class attendees into small groups and asking each member of the small group to select one from various items related to pregnancy, birth and the postnatal period contained in a bag and to voice their thoughts about it, with a view to prompting questions and discussions about that particular related topic.

(Appendix 8), in addition to how the research process has evolved in response to engaging in the field[133] (Appendices 17-22). Additional practical changes emerging as a result of the research are discussed in the findings chapters Six, Seven and Eight.

4.16. Ethical Research Practice

Typically, the aim of the study and research design was discussed at the onset of our conversations, in addition to our pledges to respect each other and to listen (Appendix 7). Participatory Action Research (PAR) is a dynamic and evolving concept in principle and practice; therefore, written informed consent (voluntary participation, risk-benefits, confidentiality) was obtained from the women co-researchers and ANE co-researchers prior to each meeting and phase of the Action Research Cycle (ARC). According to Boser (2006), the cyclical nature of action research demands 'negotiation and dialogue among all participants...participants cannot give informed consent to research activities in advance, because the full scope of the process of the research is not determined in advance by one individual' (Boser 2006, p. 12). Morton (1999) and Walker and Haslett (2002) concur that it is difficult to anticipate all eventualities in participatory research, thus the emergent[134] (Reason and Goodwin 1999, Reason 2006) nature of the participatory research design.

Power dimensions need to be taken into account and an iterative approach is required considering the salient issues and reconfirming consent. In this research, the generally accepted emphasis on securing individual informed consent prior to commencing research inquiry prohibited the engagement of co-researchers in the initial stages of the research design and question.[135] According to Brydon-Miller (2008), despite the importance of informed individual consent, an individualistic perspective may be a

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[133] In keeping with Herr and Anderson's (2005, p. 71) reminder and throughout this action research process, 'new questions, new literature and new methods' have emerged.

[134] Peter Reason (2006) describes action research as emergent engagement with practical purposes that are perceived as worthwhile, through many ways of knowing, in participative and democratic relationships.

[135] A key component of participatory research is collaboration with participants specifically in the design, implementation and analysis of the research (Maguire 1987, Reid and Frisby 2008)

conceptual limitation when considering participatory forms of research with diverse populations. A limitation of this research is that the core research question was derived by me.[136] Patricia Maguire (1987) identifies that research is usually initiated by outside researchers and the literature is vague in relation to making the research question of interest to the local community known. As initiator of this inquiry, transfer of control and ownership of the research project to all co-researchers has required considerable time and effort. Briefly, strategies used to this end have been developing and sustaining transparent, timely and frequent communication, in addition to promoting reciprocity (see pages 101 and 102) and the continuous sharing and seeking feedback of research information, events and analysis, the practicalities of this is discussed in findings Chapters Six, Seven and Eight.

As previously highlighted, the core values of action research uphold respect for the knowledge and experience that people bring to the research process, in addition to valuing democratic processes and commitment to action (Brydon-Miller *at al.* 2003). In this instance, respect for the persons was demonstrated in action research by the 'conviction that all individuals have the capacity to contribute to the process of knowledge generation and the right to play an active role in shaping policies and processes that affect their own well being and that of their families and communities' (Brydon-Miller 2001, p. 202). The issue of confidentiality was discussed and all members agreed to uphold the privacy of other persons; we reminded each other, for example, that issues discussed between us would not be repeated outside of the room where the conversations took place. Women co-researchers and ANE co-researchers were reminded that they were free to withdraw from the study at any time without penalty of any kind. They were assured that all standpoints[137] had equal merit and that each person should be afforded equal time to engage and express their views and beliefs.

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[136] This was unavoidable because I embarked upon this research in fulfilment of a university degree.

[137] Standpoint in this way is about moving from the search for one valid truth, according to Reason (2006, p. 190), 'all action is in the pursuit of particular valued purposes; we are no longer pursuing a validity about getting it right.'

The women co-researchers and ANE co-researchers were allocated codes to preserve anonymity. The choice of code allocation in presenting the findings, as distinct from the allocation of pseudonyms, to my mind preserved the integrity of the person, without imposing an alternative identity. Transcripts of the digitally recorded conversations reflected participant code numbers only, which were used in reporting findings. No identifying information was used. Demographic data were anonymous and linked with the code allocated to each woman and were stored safely in a locked filing cabinet. Data were stored on a password protected personal laptop and all identifying details were removed from the raw data.

4.17. Additional Ethical Considerations

Ethical approval to conduct this research was granted by the University and the relevant research and ethics committees. The challenges encountered during recruitment of women co-researchers are described in full on pages 108-112. There are however, specific considerations that I would like to address here, which relate to occasions when potential ethical dilemmas in field work arose. The first was the evident anger and frustration expressed by one woman attending the ARC3 pregnant women's discussion group (W12) about what she suggested was the indifferent nature of her interactions with healthcare professionals during her hospital visits. This, she stated was not attributable to an isolated incident or person, but was a feature of her experience of the institution, and, her anger was related strongly to her previous experiences of pregnancy and care at the same hospital (this is discussed on page 251-252). W12 appeared happy to discuss her feelings freely during our group conversation and when asked, she said that she found sharing the issue with me, and, with other women helpful. Prior to and during this meeting, participating women were aware that issues of relevance to antenatal education would be shared with the ANEs. These issues were raised during our ANE group meetings; however, this matter related to hospital staff in general and therefore, I reflected further and resolved that I am obliged to relate this woman's views as part of a report that I would compile for the Director of Midwifery on my exit from fieldwork. I remained with the women and ascertained their need to talk more. Women valued the opportunity to speak and to be heard and said that this research provided a supportive space to think through, to express and to clarify their thoughts. I thanked

them for sharing and explained that I would communicate their views. They appeared happy with this and had my contact details if they wished to talk again.

The next ethical dilemma relates to the ARC3 CIG2 discussion when one pregnant woman (W3) questioned antenatal educators about the accuracy of evidence that they offer in relation to the practice of episiotomy. This discussion is introduced on page 260. The antenatal educators refuted this practice query emphatically; however, the woman continued to challenge. The conversation shifted eventually towards the allocation of space and time within the institutional setting, and difficulty in balancing information-giving about specific details of practice issues, in this case episiotomy, with the varied and vast informational demands that women have. My perception of my role in this instance was to support the women in frank expression of their views and also to facilitate a shared space characterised by honesty, listening and debate (Koch and Kralik 2006), and so, the conversation continued with both views heard. I remained with the woman afterwards to respond to her questions about evidence and she appeared very happy to have raised the issue in the group setting. The obvious discomfort experienced by the antenatal educators in this instance and ways that this was addressed are discussed in Chapter Eight, beginning on page 258 and in the Discussion Chapter Ten.

Finally, it should be noted that P3 is a leading voice in many of our conversations and therefore, it may seem that this voice is over-represented throughout the findings chapters. This is not intentionally the case but P3, as the most experienced and longstanding antenatal educator, set the initial tone and tenor for our many conversations, thereby reflecting her considerable influence on the research and antenatal education in this particular setting.

4.18. Reciprocity

Reflexive analysis of power relations are prerequisite to the notions of reciprocity and respect in participatory research. Deborah Warr (2004) suggests that reciprocity manifests by sustaining efforts to ensure that the research makes a positive difference to the people involved (Warr 2004). In this research, reciprocity and respect are conveyed in small practical ways, for example, by providing prompt feedback and transcripts to women co-researchers and ANE co-researchers following meetings (Reinharz 1992). Transcripts of the research meetings were presented to all co-researchers with sincere

encouragement to reflect and analyse the transcript content in addition to sharing reflections that women co-researchers and ANE co-researchers may have throughout the research process. Other practical ways included prompt responses to email and telephone queries, punctuality and acknowledgement and appreciation of the co-researchers' practical and clinical demands.

Maiter *et al.* (2008) suggest that reciprocity rests on the ongoing process of establishing equality and exchange of communication and knowledge. Reciprocity is concerned not only with the avoidance of harm but honours active consultation in establishing a working relationship that can be beneficial to all people involved (American Anthropological Association 1998). Following groundbreaking ethnographic research among the homeless in New York City, Kim Hopper (1996, p. 168) reflected that reciprocity might take the form of 'simply being honest in setting up research relationships.' Honesty is vital to any relationship, but to illustrate how honesty formed an essential component of recruitment, it was necessary to be clear from the outset that PAR involves the researcher and all co-researchers working closely together. Consequently, members actively involved in a project to develop and implement a revised programme of ANE could be easily identified. Hospital management knew that the ANE team was taking part in the research and women co-researchers may have mentioned this during antenatal visits. Although we emphasised that details of discussions would not under any circumstances be revealed outside of the group, it was essential that ANE co-researchers realised that they could be identified particularly if changes were made as a result of our collective efforts.

4.19. Reframing Ethics in Participatory Action Research

Mary Brydon-Miller (2008) argues for a review of the basic terms by which research ethics is understood and evaluated and of covenantal ethics, which is founded on the establishment of caring relationships among community research partners and a shared commitment to social justice (Brydon-Miller 2008, p. 244). Covenantal ethics is a solemn and personally compelling commitment to act for the good of others and requires deep commitment to working together to address issues of importance, which in itself is 'a powerful form of moral engagement' (Brydon-Miller 2008, p. 247)

Covenantal ethics examines broader questions of how power relations frame social research discourse, such as:

1. What are the real contributions to the community?
2. Who owns the research findings?
3. How findings are made available to the public.

(Brydon-Miller 2008, p. 246).

In considering the implications of covenantal ethics' demands for this research, contributions to the community are held in developing knowledge for antenatal education that is relevant and meaningful for women and grounded in women's experiences and collaborations with antenatal educators in partnership. The tenets of PAR demand that the research findings are owned collectively by all members of the research group; however, this work was undertaken as funded doctoral work, and as such, has inherent requirements, not least of all completion to standard in the requisite timeframe. Additionally, conventional sharing of research is presented in academic language and published in professional journals and conferences. This distances the original owners of the knowledge (Chandler and Torbert 2003). Michelle Fine (1994) acknowledges the danger of the academic researcher's arrogance in believing that she/he might make a difference; I am guilty of this. At the outset of this work I believed that somehow I could make that difference. I have come to realise that as a researcher I am in danger of exploiting women further by what Michelle Fine (1994) and bell hooks (1991) describe as 'othering' women by speaking for them.[138] This realisation has made it necessary for me to 'work the hyphen' (Fine 1994, p. 135) that is, to probe the boundary where woman and researcher met, to encourage discussion about the situation and contexts within which we work and research, to understand that we 'are all multiple in those relations' and to identify what was not happening between us and why. This is explored in more detail in positionality on pages 117, 127-129 and in Chapter Five in relation to analysis.

[138] My attempt to counter this in analysis and representation has been through use of a Voice-centred Relational Method which privileges the voice of the other and this is discussed in Chapter Five.

CHAPTER FOUR SECTION III: ACCESS, RECRUITMENT AND SPECIFIC CHALLENGES

4.20. Gaining Access

The power to develop the resulting action or change lies primarily with those engaged in the process as facilitators (Streubert Speziale and Carpenter 2007). It was crucial, therefore, to recruit antenatal educators to share their experiences and views of antenatal education, as women, as healthcare professionals and possibly as mothers, in addition to their potential capacity to implement any agreed action or change in their respective clinical practice settings. Although approaches to antenatal education facilitation may vary, ANE is predominantly an everyday occurrence for antenatal educators. This research offered an opportunity to foster ethical and dialogic activity between learner and facilitator, underpinned by acknowledgement of the value of women's experiences (Fleming 1992, Rich 1995). I anticipated that collaboration between antenatal educators and women attending ANE programmes could provide ways to examine every day accepted practices by exploring and understanding the impact of past events on the present and ongoing phenomena that encompassed the dynamics of human interaction (Chandler and Torbert 2003).

My lessons learned from my initial approaches to the first hospital, and the subsequent loss of Hospital A, influenced very fundamentally my initial approach to Hospital B and how I worked to sustain contact and relationships with ANE co-researchers. Initial informal contact was made with the antenatal educators in May 2008 with formal and informal meetings beginning in earnest in September 2008. Preliminary meetings with antenatal educators as potential co-researchers were vital to building trusting relationships that were ongoing throughout every phase of this research. Acquiring the skills to facilitate group meetings of this nature required time and confidence (Herr and Anderson 2005). In keeping with the principles underlying PAR, it was necessary for me to approach the antenatal educators informally to elicit their level of interest in the research prior to formal applications to midwifery management and the relevant research and ethics committees. Formal application was made in July 2008 when the antenatal educators confirmed their interest in participating in the research.

It is important that relationship-building and role-negotiating and the time and resources required for the research are discussed with the principal people involved when negotiating access to the site (Herr and Anderson 2005). If this does not happen, the research is conducted under false pretences. Openness and transparency was crucial from the outset, specifically in relation to the level of commitment required for this research and the ongoing investment in terms of emotional, intellectual and practical commitment. According to Maiter *et al.* (2008, p. 310), 'the underlying strength of the project, and its potential for success, lies in the relationships that are being created, tested, and deepened with each new stage of the project.' Once approval was gained from the University, a letter outlining the aim and process of the research (Appendix 9) was sent to the Director of Midwifery seeking support and access, and a full application to the research ethics committee of Site B was sent. An information pack containing a consent form outlining the eligibility criteria for participation (Appendix 10), information about the study, including a plan with a clear description of the level of commitment required for the study (Appendix 11) was submitted to the antenatal education team for their consideration.

The focus of the earlier meetings with the team was engaging in and sustaining relationships with ANE co-researchers and this trend continued. The antenatal education team in Hospital B was comprised of six team members and at the time of recruitment, all members consented to participate. Prior to meeting the team, I met with the team leader and it struck me that if this project was welcomed by this very engaging and charismatic woman, then I thought, not disrespectfully but perhaps naively, that the other team members would be likely to accept it also. I was possibly naive because as the research progressed, fluctuations in levels of participation outlined by Pretty (1995) became apparent as one ANE co-researcher in particular, opted in and out in accordance with her personal capacity to engage. From February 2011 to April 2011, efforts to involve an additional team member on return from leave, at the suggestion of the physiotherapy manager, were unsuccessful due to the clinical demands that collided with our scheduled meetings. Table Three outlines the occupational details and their number of years clinical experience (greater than > or less than < 5 years) and experience in antenatal education.

Table 3: Occupational Details of ANE Co-researchers

Code	Occupation	Registered (Years) > greater than 5 <less than 5	Experience in ANE (Years) > greater than 5 <less than 5
P1	Midwife	>5	>5
P2	Physiotherapist	>5	<5
P3	Midwife	>5	>5
P4*	Physiotherapist	<5	<5
P5	Dietician	>5	>5
P6	Physiotherapist	>5	>5

*ANE co-researcher left the hospital in June 2011

4.21. Field Work

Once written consent was obtained from each member willing to participate, a team meeting was arranged to plan and discuss implementation of the project. In the early stages of group formation, meetings were cancelled and rescheduled due to participants' work commitments, holidays and other leave. Compromise was reached by facilitating meetings with some members of the team and communicating with others by telephone and group email. Informal meetings and team discussions took place with refreshments during break times and working lunches to facilitate clinical workload. As the research progressed, interest grew and it was unusual for all team members not to be present for meetings, ANE co-researchers attended meetings on days off and annual leave also.

It appeared to me that a key motivating factor for participating in the research was the commitment of those involved coupled with my suggestions that they engage in each stage of the research process. ANE co-researchers were interested particularly in involvement in various potential ways to disseminate research findings such as workshops, conference presentation and publications, and discussion of possible options for dissemination occurred regularly.[139] Issues of representation such as these are a key consideration in PAR; according to Reid and Frisby (2008, p. 99) there are questions

[139] Women co-researchers were also interested in being involved in strategies for research dissemination.

intrinsic to representation of women's voices and experiences such as, who has the authority to represent women's voices and why? Involvement of participants in analysis[140] and dissemination of the research provided a measure to counter against Reid and Frisby's (2008) concerns that representations can enforce rather than transcend [so- called] dominant power relations. The notion of justice as an ethical principle in traditional research methods implies concern for equal opportunities for participation in the research. In action research, justice extends to participation in the ownership and application of the research findings and dissemination of knowledge that is generated from the research process (Brydon-Miller 2007).

To maintain momentum and meaning in the research, we developed relationships through reflexive and collaborative engagement, through telephone contact, individual and group email, and, most importantly, frequent face to face visits (Grant *et al.* 2008). Repeated, short and uncomplicated communication was necessary to sustain energy and interest our inquiry that was set against the context of a demanding clinical workload, in order to provide continuous and contemporary updates, and to engage in collaboration. In addition, regular meetings sustained the impetus for the research and prompted momentum in our discussions to develop practice and to provide safe supports to discuss potential challenges and changes in practice (Brodie and Homer 2009). A bottom-up approach was used; in reality this meant that, as far as I was concerned, no research related decisions would be made without consultation with the ANE co-researchers. If a difficulty arose, we discussed and shared it; for example, we discussed the challenges in recruiting pregnant women and possible solutions prior to arranging meetings to address these aspects with the Director of Midwifery. Antenatal educators were involved subsequently in the design of recruitment strategies for women and documentation used, such as the recruitment posters, information envelope and contents.

I am acutely aware of the potential benefits for me, by engaging with groups of antenatal educators, to further my research and to apply for the award of doctoral degree. We have acknowledged and discussed this, equally, perceptions of my knowledge as an academic may result in co-researchers privileging my interpretations

[140] Strategies to involve women and antenatal educators in analysis are discussed throughout the findings Chapters Six, Seven and Eight.

and reflections about events. While this may have happened initially, this has altered with the passage of time and with my constant iterations of the value of their clinical expertise and experience. Trust, respect and openness developed as our relationship grew and my increasing contact with them facilitated my seeing the situation 'through their eyes' (Hunter 2001, p. 171). In addition, the number of ANE co-researchers actively engaged in the research increased through the emerging process. According to Kathryn Herr and Gary Anderson (2005), achieving 'reciprocal collaboration' requires many years of negotiation with the principal people involved in the research (Herr and Anderson 2005, p. 38). I like the ANE co-researchers immensely as women; I dip into insider and outsider roles intermittently and when I am on the outside, as most clinicians consider me to be, I need their hospitality to gain access[141] to the inner workings of the institution and they give it freely. Indeed, they are the true gate keepers of this inquiry. Barrett (2006) emphasises the significance of insights gained through negotiating access to a research setting and how crucial ease of access is to our ability to develop knowledge that can influence women's experience of birth and motherhood as recipients of care. I am indeed grateful to my ANE co-researchers for their assistance in this way.

4.22. Challenges in Recruiting Women as Co-researchers

It is essential to explore women's first-hand knowledge and experiences in order to create knowledge and social change with women (Hampshire 2000, Fine *et al.* 2004). A requirement of the ethics committees was the establishment of a gatekeeper to recruit women co-researchers. This prevented me from approaching women directly. Posters advertising the study were distributed and information packs were available in all hospital clinics and private rooms. Information packs contained consent forms outlining the eligibility criteria for participation (Appendix 12)[142] and information sheets (Appendix 13) and women who were interested in participating in the research contacted me directly and a detailed discussion of the research took place.

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[141] In this situation, access is in the practical sense, to secure a room booking for a meeting or, for example, floor mats for visiting postnatal mothers and babies.

[142] There were separate consent forms and information sheets for women participating in ARC1 and subsequent ARCs because of the omission of the CIG in ARC1.

I visited Hospital B four to five times a week, to engage with gatekeepers and to explain the research; recruitment however, was difficult and achieved poor responses and midwives stated that the hospital clinics were extremely busy.[143] Accordingly, recruitment challenges were discussed at length on a number of occasions with midwives and clinical midwife managers. With their support, a request was submitted to the relevant research and ethics committees for permission for me to visit the outpatients' departments (OPD) and consultant rooms three times a week in order to recruit women to participate in the research process. This request was approved and, with the support of the Director of Midwifery, I was allocated a visitor's pass. My field notes and reflection below indicates how vital the visitor's pass was in accessing women and in providing me with a purpose.

Field note Entry from Reflective Diary 12th July 2010

I find that approaching women without introduction or direct clinical purpose is difficult and there are a lot of distractions in the clinic. The noise, heat and overcrowding can be off putting; a positive aspect is that I am engaging with women and I can easily gauge if a woman can speak English and would like to talk. It is also an opportunity for me to explain the research, which is of huge benefit because women understand the process and thus can consider participation in full. The visitor's badge gives me purpose and validation, a metaphorical 'crutch' to lean on. I feel that the midwives are more accepting of me now because they don't have to do any additional work that is associated with the research, this is really important because they are so stretched. Prior to my allocation of a visitor's badge and during previous visits to the field to remind gatekeepers of the research, I had felt awkward, obvious and unwelcome. Without place and belonging, the process felt like 'cold calling' without purpose.

The above reflection illustrates very superficially my need for acceptance and the ease that comes with gaining access and recognition of colleagues in the field. This was not

[143] An analysis of the difficulties experienced in the current maternity services in Ireland is presented in Chapters Two and Ten.

always the case, and at times I was very much considered and treated as an outsider. The visitor's pass gave me confidence to engage in field work; however, the process of gaining a visitor's pass was unknown to me at the outset of the inquiry and it took approximately three months to acquire one, including application to the site research and ethics committee and return to the University with amendments based on changes to the research process. The establishment of a gatekeeper is a feature of conventional research that incorporates contractual ethics, thus, privileging neutrality and objectivity and embracing the expert approach (Boser 2006). My involvement in recruiting women meant that I could explain the purpose and proposed process of the research. As I was not wearing a uniform, I hoped that it was clear that I was not providing care, therefore, there was no possibility of perceived coercion and, in addition, I was very clear that there was no obligation to participate.

An introductory antenatal class was provided as part of the antenatal education programme in Hospital B. Prior to this class, I also offered an informal information session and research overview for women attending the class with details of how women who were having their first babies could participate in the research if they so wished. Table 4 outlines the recruitment rates of women as co-researchers and their subsequent participation in the various action research cycles.

Table 4: Recruitment of Women Co-researchers

Research Phase	Recruitment rates	Participation rates	Group Size
ARC 1	360 information packs distributed between October 2009 & January 2010	7 women	Antenatal - One group meeting (4 women) - Three individual meetings Postnatal - Group meeting # 1 (2 women) - Group meeting # 2 (2 women) - Three individual meetings
ARC 2*	59 information packs distributed between April & September 2010	5 women	Antenatal - One group meeting (5 women) CIG - Pregnant Women (3) - Postnatal Women from ARC1 (2) - ANEs (4) Postnatal - Group meeting # 1 (2 women) - Group meeting # 2 (3 women)
ARC 3	40 information packs distributed between September 2010 & February 2011	7 women	Antenatal - One group meeting (5 women) - Two individual meetings CIG - Pregnant Women (3) - Postnatal Women from ARC1 (1) - ANEs (5) Postnatal - One Group meeting (2 women)
ARC 4	No new recruits		One Meeting - Postnatal Women from ARC3 (2) - ANEs (5)

*I received a Visitor's Badge for ARC 2 and onwards

Table Four presents an outline of the number of information packs that were disseminated during each recruitment phase and the corresponding response rate. I

began to recruit from ARC 2 onwards and this had a positive impact, as packs were disseminated more efficiently (that is, less packs yielded a higher response rate). Despite this, recruitment was still very low, and varied between 2% and 17.5%. I felt at the time that women's reluctance to engage in the research was possibly an indicator of the all-consuming nature of the many roles and responsibilities afforded to contemporary women and mothers. An overview of the women's characteristics and their levels of participation are presented in Appendix 14. Information and consent forms for women participating from ARC2 onwards are included in Appendices 15 and 16. These vary from the ARC1 documentation to reflect inclusion of the Collaborative Inquiry Group meetings in the research design from ARC 2 onwards.

4.23. Methodological Dimensions of Key Relevance to this Research

Those people directly engaged in the research should benefit from the inquiry (Liamputtong 2007); hence there is a clear advantage to engaging women in the development of a method of preparation for motherhood through the promotion of open, transparent and equitable dialogue. In this way, participatory research can become 'a tool for self-determined social transformation'[144] in preference to the preservation of inequitable social relations (Maguire 1987, p. 24) but only for those who have the courage and commitment to embrace these concepts. For me, the components of participatory research of investigation, education and action (Maguire 1987) are collective and, in some ways, personal[145] and are held within the medium of the following key methodological principles.

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[144] On transformation, Giddens (1984) reminds us that action in a transformative capacity involves power. 'In this sense, the most all embracing meaning of 'power'…is prior to subjectivity to the constitution of reflexive monitoring of conduct.'

[145] According to Maguire (1987), participatory research requires that all parties (the researcher and the researched) be open to personal transformation and concientisation and assumes that all parties come to the inquiry with knowledge and experience to share. This later became problematic and is developed in the findings Chapters.

4.24. Opening a Space

A key challenge to the research presented here was opening and sustaining an accommodating space that permitted authentic engagement with women and antenatal educators to progress mutual understanding and consensus about action. Fundamental to progressing discussion, analysis and action is the knowledge that decisions and conclusions are legitimate only in proportion to the level of authentic engagement of all involved (Kemmis 2008). In undertaking PAR, a clear understanding of the effects of existing hierarchies 'can prevent us from naively assuming that simply bringing people together allows us to transcend pre-existing relationships of power and privilege' (Brydon-Miller 2007 p. 205). The space in which our communication occurred had to allow for exploration and questions such as: what is the problem and why is it happening? In this way, our collective discussion promoted inclusion and ownership of the problem by naming the focus of the inquiry together (Wicks and Reason 2009, Kemmis 2001). Authentic collaboration requires respect for other people's knowledge and the experiences that they bring to the research process. It was important therefore, that any recommendations for action determined through our collaborative inquiry were acceptable to all involved. Tina Koch and Debbie Kralik (2006) remind us that the key tenets of collaboration include working together for a greater purpose and finding common ground with others, for whom the aim of the research is important. This does not always mean that the shared space is harmonious but it is about creating relationships which are developed through dialogue and trust over time and by balancing the skills of listening and assertion (Koch and Kralik 2006). Through conversation we attempted to collaborate about meanings and together we considered our various interpretations (discussed in Chapters Six, Seven and Eight). As time progressed, the difficulties inherent in securing democratic discussion became increasingly evident, as efforts to make changes that emerged from our discussions were restricted by hospital context and the generally accepted role of the antenatal educator therein. A central theme was the involvement of co-researchers in setting the agenda, participating in collecting information, analysis, and using outcomes[146] (Reason 1994a). In the research presented here, examination of the discussions between ANE co-

[146] The use of outcomes is demonstrated in the practical changes identified in the findings Chapters, Six, Seven and Eight.

researchers and women co-researchers indicated that both groups were anxious to avoid conflict, with the exception of the second CIG meeting and this discussion begins on page 258.

4.25. Support to Address Social Structures that Shape and Constrain Work Practices

Action research is particularly useful in identifying and addressing the social structures that shape and constrain work practices (Kemmis and McTaggart 2005). Thus, at the outset of this inquiry was considered most relevant for review of the current practices of ANE in institutional settings. According to Reinharz (1992), consciousness-raising,[147] in the political and personal sense, is a central part of the inquiry process. Collaborative relationships with antenatal educators and 'critical friends'[148] with the purpose of building alliances across the broader social and political context (Kemmis and McTaggart 2005, Whitehead and McNiff 2006) of ANE are an important part of this work. For the purpose of this work, critical friends are here defined as those who have knowledge in ANE or action research and who can critique and challenge the researcher's assumptions to offer what has been described as 'social validation' (Whitehead and McNiff 2006, p. 103). Whitehead and McNiff (2006, p. 103) suggest that the opportunity for social validation takes place primarily through discussion with critical friends and in 'validation groups.' Since the onset of this inquiry, I have been fortunate to be part of an action research validation group with interdisciplinary colleagues conducting action research. We focus our monthly group meetings on discussions regarding methodological processes (McNiff and Whitehead 2006) and the challenges and strengths inherent in our individual research inquiries. For me, our meetings are reminiscent of what Kenneth Bruffee (1999, p. 8) refers to as 'small transitional communities', which support the move from allegiance from one community (in this case, of scientific knowledge) to another, what Bruffee refers to as

[147] Goldberger (1996, p. 360) refers to critical consciousness as 'an ability to live both inside and outside systems (or different worlds) while retaining a conscious critical awareness of the costs and consequences of moving across the barriers between the two.'

[148] The critical friend is independent of the research and can challenge taken for granted aspects of the research inquiry (Herr and Anderson 2005)

're-acculturation' (Bruffee 1999, p. 8). As with Bruffee (1993), for me, learning could not be separated from the social element that is characteristic of the group and these activities have enforced my action research orientation and understanding.

4.26. Using PAR in Doctoral Research

It has been suggested that action research at doctoral level should be emancipatory in nature (Zuber-Skerritt and Perry 2002). In addition, the doctoral student is obliged to balance working towards practical problem solving and the generation of original and new knowledge (ibid). Despite best efforts to honour the agency of women co-researchers and ANE co-researchers in action research through inclusion, consultation and careful reflexivity throughout all stages of the research process, emancipation and empowerment may not occur, and, are not static even if achieved (Byrne and Lentin 2000). Confirmation or refutal regarding the emancipatory nature of this research comes only from the principal people involved[149], as one may be led to believe that one is empowering others when this is not the case (Brydon-Miller *et al.* 2004). According to Ramanzangolu and Holland (2002 p. 7) '...emancipation also raises numerous problems about how change for the better is conceived, by whom, for whom and why?' To engage in work that is considered truly emancipatory appears to be an onerous task as, to begin with, there are different ideologies of emancipation depending on situation and context (Liamputtong 2007). Byrne and Lentin (2000) quite reasonably suggest that intention to 'emancipate' others ultimately sustains dominance. It is crucial to the participatory success of the research, therefore, to understand the difference between commitment to empowerment and the impossibility of conferring power (Byrne and Lentin 2000).

Awareness is created by asking questions and building critical understanding of context and self and connecting the very personal and the political (Kemmis 2001, Marshall and Reason 2007). The political nature of this research is challenging the status-quo in the form of asking questions and thus raising awareness of organisational practices (Coghlan and Shani 2005). I am concerned for what happens to the women and antenatal educators, once we conclude active participation in the research, and, a

[149] This aspect is discussed in findings Chapters Six, Seven and Eight.

potentially altered state of awareness remains. This aspect of the research is addressed in the final conclusion section on page 330.

4.27. The Role of the Participatory Action Researcher

Central to my role as participatory action researcher is privileging the life experiences and world views of women co-researchers and ANE co-researchers. This requires that the social, cultural and political context of my values and experiences are explicated and my personal ways of seeing and believing are tested (Goldberger *et al.* 1996, Koch and Kralik 2006). The challenge that this has presented throughout the research process is captured partially by accounts of my reflections and conceptualisations throughout the thesis. Achieving and sustaining equal participation and genuine dialogue throughout research that is positioned staunchly against organisational hierarchy has presented challenges; this is alluded to in Chapter One in a brief conceptualisation of power and is also raised throughout the thesis writing.

Over time, considerable efforts were made to negotiate and transform our research relationships into 'meaningful partnerships' to a point that we could work together with purpose. This required a de-privileging of the researcher status as expert (Martin 1997, Fals-Borda 2006, Byrne *et al.* 2009) and the transfer of locus of control from researchers to those known in scientific research as 'subjects' (Herr and Anderson 2005). The subversive nature of hierarchy and power has meant that their influences were not always immediately recognisable to me[150]; power is most efficient when least observable. On a wider scale, action research requires the researcher to examine and indeed make changes to the relevant broader issues, which can include often unseen organisational structures and relations (Maguire 1996). The changes that occurred are explained in the Findings Chapters Six, Seven and Eight and the Discussion Chapter Ten. It is important to be cognisant that the level of participation alters as research relationships develop (Herr and Anderson 2005) and over time, our relationships

[150] The nature of power wasn't always visible and this in a sense was very liberating because it meant that I had no preconceived ideas about the allegiance of the ANEs to any particular ethos. Billie Hunter (2011, p. 159) shares her experience in this regard and benefits associated with withholding 'early imposition of a theoretical construct'; this meant that she was free to pay attention to what she was hearing.

intensified. In writing this thesis, one of the key issues of awareness for me is that my truth is one truth among many (Herr and Anderson 2005).

4.28. Positionality and my Intersectionality

My world view influences my location in the research inquiry from time to time and this is informed by my political views and ideologies and cultural assumptions (Herr and Anderson 2005). My position as mother (and the effects of my contextual experience of childbirth), midwife, woman, researcher and a potential colleague or carer, has caused me to examine the authenticity and impact of my behavioural practices and interactions with others, particularly in the conduct of field work. This manifested in my use of a reflective diary throughout the research to record my thoughts and analysis and conceptualisation of the data (Coghlan and Shani 2005, Coghlan and Brannick 2010). My reflective diary was also used as a memory aid to record recruitment efforts and meeting dates and outcomes. This has been useful also in recording events that led to losing Site A. I have also discussed salient aspects with critical friends and the aforementioned action research validation group to which I belong. I initiated this inquiry as a researcher primarily, but I was also informed by my other positionalities, as were all co-researchers, depending on the particular circumstances and the co-inquirers I was engaged with at the time. Indeed, I am undercut by all of these divisions and there is just one denominator, which is the physical location and institutional setting where our meetings took place. At one stage we had a women-only postnatal group meeting (ARC3) at my place of work because there was no room available at the research site. My field notes following this meeting reflect that I was much more comfortable in that particular space and although the participating postnatal women did not confirm this, in retrospect, my reflections were that they appeared more at ease also.

On reflection, the location of our meetings, a physical space in the hospital, was potentially problematic for women co-researchers, a fact that I did not conceive of at the time. Although it was deemed suitable because of its relatively central location and our meetings could be timed to coincide with scheduled care appointments, looking back, this was not at all neutral ground and symbolised power; whether in the concrete presence or absence of the ANE co-researchers. For these reasons, while this arrangement suited the needs of the ANE co-researchers, who routinely attended meetings after hours and on days off, in addition to scheduled working hours, it was

entirely inappropriate as a location for mixed meetings with the two groups. This fact resonated with me only when I distanced myself physically from the project and stepped away from the co-researchers to write.

4.29. Inside and Outside

Insiders understand the politics[151] of the organisation but their proximity can mean that it is difficult for them to see the whole picture. Outsiders are not permanent members of the team but positioned externally and sometimes referred to as 'friendly outsiders' (Greenwood and Levin 1998, Coghlan and Casey 2001) with limited knowledge of the inherent political and systemic issues. I found that my role dipped inside and outside, for example, at times co-researchers confided issues of significance related to their positioning. An example of how this manifested was their explanation of the tense political and historical context between midwives and physiotherapists engaged in antenatal education. My positioning as a midwife meant that I was aware of this and it also helped me to understand relevant issues.[152] For the research presented here the

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[151] In his analysis of personal power, Carl Rogers (1994, p. 4-5) description of politics is helpful here, which 'has to do with *power and control*: with the extent to which persons desire, attempt to obtain, possess, share, or surrender power and control over others and/or themselves. It has to do with the *manoeuvres, the strategies and tactics, witting or unwitting*, by which such power and control over one's own life and others' lives is sought and gained – or shared or relinquished. It has to do with the *locus of decision-making power:* who makes the decisions which, consciously or unconsciously, regulate or control the thoughts, feelings, or behaviours of others or oneself. It all to do with the *effects of these decisions and these strategies*, whether proceeding from an individual or a group, whether aimed at gaining or relinquishing control upon the person himself , upon others, and upon the various systems of society and its institutions.' He also says '...in sum it is the process of gaining, using, sharing or relinquishing power, control, decision-making. It is the process of the highly complex interactions and effects of these elements as they exist in relationships between persons, between a person and a group, or between groups.'(Rogers 1994, p. 5)

[152]Physiotherapists have been involved in ANE in Ireland since its inception and were instrumental in bringing classes to hospitals (Mason 1998). According to Mason (1998), physiotherapists concentrate on physical preparation for birth while midwives focus on parenting skills. Traditionally, the two disciplines discuss pain relief and the process of labour and this overlap presents some professional conflict (Mason 1998).

historical context of the role of the midwife and physiotherapist is significant in terms of resulting overlap in class content and this is discussed on pages 179 and 244.
My training as a midwife[153] makes me an insider. I understand and can speak the language of midwives[154] and I empathised with my ANE co-researchers' daily professional struggles within a large dominant obstetric-led setting. My role as a researcher sometimes rendered me an 'outsider' also and this afforded me a unique position because, for the most part, I could observe the culture and workings of the particular institutional setting. I could also appreciate how workers in the system with less power could be subjugated by the dominant authoritative ethos of the hospital. This unique and extraordinary knowledge comes about because of what Collins (2000) refers to as the 'peculiar marginality'[155] of the 'outsider-within' (Collins 2000, p. 13). It also presents some personal conflict because my preference is to promote openness and awareness of the forces that motivated me in this research. This is discussed in the findings Chapters Six, Seven and Eight.

Awareness of the impact of my intersections on the research and on me personally, brought me on a journey of what Freire (1993) describes as conscientisation and self-knowledge and action.[156] Acutely aware of my shifting and various positionalities, I engaged intermittently with the inside and outside and experienced varying levels of acceptance and sanction. I experienced increasing acceptance from the ANEs as our relationships grew, yet without them, I was restricted in the general hospital setting. An

[153] As mentioned previously, my training as a midwife reflected the powerful influence of a bio-medical model of care.

[154] The impact of how language and discourse frames understanding is presented in the discussion Chapter Ten.

[155] Patricia Hill Collins uses this term in her analysis of black women's engagement in domestic work in white American households prior to World War II. Although these women formed strong ties with their white 'families' and particularly the children, they knew that they could never really belong; therefore, their social location was one of outsider-within' (Collins 2000, p. 13)

[156] According to Herr and Anderson (2005), as researchers, we have a responsibility to acknowledge and examine positionality in research. This ensures awareness and understanding of the intricacies and complexities of the research question and can also avoid 'blind spots' by forcing the researcher to examine personal beliefs (Herr and Anderson 2005, p. 44).

example to illustrate this was my endeavours to obtain baby blankets for one of our postnatal group meetings; the midwife in charge of the postnatal ward responded abruptly to my polite request and stated that the mothers ought to have their own. In contrast, these practical issues did not appear problematic when the ANEs were with me.

Being an outsider afforded me a different lens; I was not part of the local community hierarchy (Herr and Anderson 2005). Thus, our co-researcher conversations had the potential to be authentic without fear of reproach or recrimination and to facilitate an environment that was conducive to self-reflection and honesty. In conversations, I found myself adopting the position in keeping with the individual or group; I am a mother with mothers and a midwife with midwives because I have experienced both worlds. When the groups came together there was evidence; however, of compromise precipitated by the unequal status of women co-researchers and ANE co-researchers. This was evident in our second CIG meeting, which is discussed in Chapter Eight. It seems fitting to acknowledge Byrne and Lentin's (2000) suggestion that 'perhaps the answer lies not so much in the differences between insider and outsider perspectives but the necessity in being politically and ideologically committed to collaboration, which can empower participants and produce meaningful research' (Byrne and Lentin 2000, p. 45).

4.30. Reflexivity

Action research presents the challenge of first, second and third person inquiry (Reason 1994b). Put simply, first person inquiry addresses the ability of the researcher to nurture self-awareness, and an inquiring approach to how she/he engages in living (Reason and Bradbury 2008). This can be addressed through reflection and mindful and timely action (Chandler and Torbert 2003). This aspect of our inquiry may be demonstrated by my awareness of, and how I managed, my initial feelings of awe for the experienced and confident midwife co-researchers, who had been characterised by a very positive and dynamic reputation for as long as I could remember hearing their names. I was aware of the impact of this by my limited questioning or challenge during our very early informal conversations and my subsequent compulsion to address my inadequacies and any inherent power issues. Thus, I had to grapple with the notion that if I was powerless with the antenatal educators, I could not advocate fully for women

involved in the research if, and when, this was required of me. By ignoring this crucial aspect of our engagement, I was perpetuating the very subjugation that I hoped we could work against; I therefore, had to remain alert for any potential situations where inequality or conflict might arise. To simply write about this aspect, without challenging the status quo, would be denying my position of power over those less powerful (Fine 1994).

Reflexivity refers to attempts to make explicit one's position as researcher and the power relations inherent in the research process (Reid and Frisby 2008). It was necessary that I examined my own practices in terms of how I contributed to any dominance also. Issues of power and control instigated by the researcher and/or due to unequal exchange can cause exploitation of participants, this aspect of power and control is particularly relevant within the context of how women are situated within the rulings of dominant institutions. Mary Brydon-Miller (2004) suggests that researchers should use their knowledge and any personal experience of power and/or powerlessness to generate self-awareness when working with others to facilitate compassionate and democratic practice and participation. My experiences of powerless in the research process stemmed from how I was received in clinical areas during recruitment efforts. On one occasion, a midwife was openly hostile about the research and I reflected about how women were treated if I, as a potential colleague, was met this way. The clinical area was fraught with noise, flurry and tension; in fact, a staff member appeared shocked when I greeted him, and explained that 'people' in the clinic didn't usually acknowledge each other in a friendly way.

Second person inquiry addresses dialogue with others about areas of mutual concern (Reason and Bradbury 2008). For the purpose of this work, second person inquiry occurred through meetings with women and antenatal educators in what was anticipated could be a supportive space for issues to emerge. Emotional safety during meetings was crucial to our discussions and the action research process (Heron and Reason 2006). Identifying the views of women co-researchers and ANE co-researchers and their experiences can be achieved by connecting the spoken narrative and articulating this along with an analysis of the 'invisible or structural institutions which define and shape our lives' (Reid and Frisby 2008, p. 99). Crucial knowledge can be produced through democratic interactive engagement by making diverse women's voices heard and

powerful, through 'ordinary talk' (Maguire 2006, p. 64). Democracy in relation to the research presented here refers to equal participation rights in all phases of the research and emphasis on each voice as it is heard. We discussed how we could disseminate the knowledge that we shared and generated from our small group to the wider community in what is known as third person inquiry. Wolf (1996) reminds us that the essence of the participatory process is lost if analysis and interpretation of the knowledge that is acquired is not adequately and accurately presented (Wolf 1996).

4.31. Quality in Participatory Action Research

PAR emphasises the role of the researcher as being involved in practical problem solving in real-life situations, as distinct from being a detached observer (Greenwood and Levine 1998, Koch and Kralik 2006, Maguire 2006, Reason and Bradbury 2006). This is relevant to what has been referred to as 'consciousness of attention', which invokes timely action and challenges accepted and existing norms in behaviour (Chandler and Torbet 2003). Consciousness in this way refers to the experience of mindfulness and 'presence' in the present; an awareness that is developed and not automatically acquired and is indeed prerequisite to timely action.

Consciousness requires simultaneous awareness of the visible outside world, of one's own actions as one perceives them and of one's own thoughts and feelings (Chandler and Torbet 2003). As we participate in creating our world, we are already 'acting'; our task, therefore, is to judge the 'quality' of our actions (Reason and Bradbury 2006, p. 7). Quality in action research depends on one's ability to be aware of choices that are made and their consequences, in addition to being honest about one's perspective and transparency to the wider public (Reason 2006). In this research, quality is facilitated also by continuous evaluation and reflection throughout the process, and with respect to second person inquiry, quality in action research is demonstrated through sustaining authentic relationships with co-researchers (Heron 1996), in addition to issues of representation discussed previously. According to Grant *et al.* (2008), to establish credibility in PAR, one must ask if the research adequately reflects the expressed experiences and interests of participants involved in the research. Thus, in the research presented here, interpretations of data and findings were shared, discussed and analysed together (discussed in Chapters Six, Seven and Eight). This aspect of co-researcher (I refer to women and antenatal educators) control of the project ensured that local

participant knowledge was not subjugated by my generalisable outside researcher interpretation (Grant *et al.* 2008) and so throughout this thesis refers to 'our research'.

4.32. Conclusion

In this Chapter, I have described the aim and objectives of the research and my challenges in securing a research setting. I have also attempted to describe preliminary groundwork, the principles of the action research cycle and how this was operationalised. I have explored gaining access, recruitment and the practical requirements of participants in taking part in this research, in addition to the theoretical and practical challenges relevant to Participatory Action Research and field work. The centrality of respect and responsiveness between researcher and all co-researchers is illustrated by the continuous theme emphasising relationship. This is evident in origins of relational ontology, resonance with a PAR orientation and choice of tangible and iterative methods of data collection and analysis (Mauthner and Doucet 1998) that all co-researchers are actively involved in. Analysis using a voice-centred relational method that reflects the significance of relational context is discussed in Chapter Five.

CHAPTER FIVE: USING A VOICE-CENTRED RELATIONAL METHOD OF ANALYSIS

5.1. Introduction

Conversations were analysed using a voice-centred relational method known as The Listening Guide (Brown and Gilligan 1992). The centrality of voice in feminist research is well documented[157] and the commonality of voice as a metaphor between feminist and action research is observed by Patricia Maguire (2006). According to Maguire (2006), the long standing feminist preoccupation with women speaking from personal experience has influenced action research. Indeed, 'the telling of, listening to, affirmation of, reflecting on, and analysis of personal stories and experiences 'from the ground up' are potentially empowering action research strategies drawn from women's organising' (Maguire 2006, p. 64). The view that the origins of feminist consciousness-raising activity are reflected in PAR initiatives worldwide is supported by Kamberelis and Dimitriadis (2011). Similarly, influenced by Paulo Freire's work, Budd Hall (1993) suggests that participatory research is fundamentally about the right to speak and 'argues for the articulation of points of view by the dominated or subordinated' (Hall 1993, p xvii). By hearing voice, power relationships are unsettled and inequity is challenged by expanding who participates in creating knowledge in the first instance.

5.2. Issues of Control, Action and Voice

A key feature of action research is the inter-relatedness between power,[158] action, and voice (Hall 2001, Brabeck 2004, Fals-Borda 2006, Ospina *et al.* 2008 and Brydon-Miller 2008). In this research, aspects of voice in terms of representation[159] of the

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[157] Specifically, a different voice (Gilligan 1993); disruptive voices (Fine 1992); voice as metaphor (Belenky *et al.* 1986); feeling voice (Ribbens 1998); silent voice (Rich 1995) and political voice (Aldred 1998). According to Jill Tarule (1996, p. 275), understanding voice facilitates inquiry with women because 'women emphasise relationship and stress voice, listening, and talking as the medium for connecting with others.'

[158] The concept of power has been acknowledged throughout this work, with a conceptualisation of the relevance of power to the research in Chapter One and this is revisited in the Discussion Chapter Ten.

[159] In this instance, representation refers to how knowledge is gained and shared with others, as distinct from voicing over another person's voice. I share how I hear (interpret) alongside women co-researchers

findings from this research are addressed through collaborative group discussion and methods to disseminate this research.[160]

Data analysis began in January 2010 and continued throughout the research process. In the initial stages of field work, conversations with ANE co-researchers and women-co-researchers were explored using thematic analysis (Downe *et al.* 2007). Thematic analysis provided a way to highlight and to offer themes that appeared significant for confirmation or refutability by all co-researchers. Notwithstanding this, the need became apparent for a more robust analytical framework that paid attention to the depth of the complexities of everyday life for women embarking upon birth and motherhood that is set in the context of a technocratic system and also the complexities for the antenatal educators who are entrusted to guide women through the process. As is synonymous with qualitative inquiry, participation and hearing voice has been under constant threat of what Michelle Fine (1994, p. 70) has referred to as the 'Other.' Fine (1994) refers to the work of bell hooks (1991) to explain this. hooks (1991) describes her feelings of marginality; scholars (especially those who named themselves as critical feminist thinkers), do not meet her in the marginal space that she feels she occupies, and she explains her resistance to this in the following way:

I am waiting for them to stop talking about the "Other", to stop even describing how important it is to be able to speak about difference. It is not just important what we speak about, but how and why we speak. Often this speech about the "Other" is also a mask, an oppressive talk hiding gaps, absences, that space where our words would be if we were speaking...often this speech about the "Other" annihilates, erases: 'no need to hear your voice when I can talk about you better then you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then will tell it back to you in a new way... (p. 151-152).

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and ANE co-researchers accounts, and we continue our conversation through joint analysis and discussion of main messages highlighted.

[160] Potential ways to disseminate research are discussed on page 152.

I was moved by this and I looked to the Listening Guide for support to overcome this very disturbing and what seemed to me, to be a very real risk in qualitative analysis. The Listening Guide is a voice-centred, relational method (VCRM) developed by Lyn Brown, Carol Gilligan and colleagues, in their studies of Women's Psychology[161] and Girls' Development at the Harvard Graduate School of Education (Brown and Gilligan 1992). It is voice-centred and relational because the speaker's inner world is accessed by the researcher through the use of voice and through their relationship that develops throughout the research (Gilligan 2011a).[162]

Stern *et al.* (1997) suggest that at the time of their writing there had been little feminist exploration of the inner world and processes of motherhood from the standpoint of women themselves.[163] VCRM captures this standpoint by placing emphasis on the multilayered nature of voice; that is, what is said and what is unsaid. In this way, paralinguistics, facial expression, body language and silences are perceived as 'data' and recorded (Opie 1992, Brown 1998). The multilayered nature of voice is complicated and at times contradictory (Opie 1992) and is intensified also by the postmodern influences of our subjective and relative understanding and interpretation of phenomena (Reason and Bradbury 2006). Nuance in voice became visible through incorporating VCRM, as Nadine Edwards (2005, p. 85) describes eloquently in her experiences of analysis using a voice-centred relational method, 'as their voices danced more freely, I was able to hear coherencies, discrepancies, ironies and contradictions, which forms the rich weave of experience.'

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[161] Carol Gilligan's motivations for this research were influenced by her observations of the dissonance between people's lived experience and how this was discussed within the discipline of psychology (Kitzinger with Gilligan 1994). I was struck by the similarities between Gilligan's observed dissonance and the sustained dissonance between women's experiences of pregnancy, birth and motherhood, as it is perceived in accordance with allegiance to a particular model of care, whether medical or social, and is thereafter socially constructed and accepted as real.

[162] Data previously visited by thematic analysis was revisited using a voice-centred relational method; in essence, thematic analysis provided the first step of VCRM (listening for the plot).

[163] There are notable exceptions: Oakley (1979), and some thereafter, see Figes 2008, Cusk 2008, Benn 1998, Edwards 2001, Miller 2005, and Oakley 2005.

Mauthner and Doucet (1998, p. 138) highlight the emphasis that VCRM places on the multi-layered nature of narratives, in addition to permitting the listener/reader to trace voices across and within a transcript. This, in addition to paying attention and listening for the psychological and social constructs of what is said in listening for the 'I' and other voices in the several readings explained further, that are consistent with the use of the method. According to Gilligan (1993, p. xxvi), the inspiration for listening for a 'different voice' is the fallacy that men represent all humans, and girls and women accommodate their voices to adapt to popular male-dominant images of relationship and goodness through 'false voice'. 'False voice' manifests in an intergenerational cycle of silencing women and a disassociation from self that is marked by inner conflict and conformity to a dominant voice, which, in the research presented here is the dominant voice of medicalised birth. Paying respectful attention to each voice has helped to maintain individuality of the speaker, despite our group work and was therefore, consistent with acknowledging the uniqueness of the experiences of pregnancy and birth. In our research, some voices were louder than others; however, each voice was heard and paid attention to at the time of speaking, by incorporating ground rules and later through use of the voice-centred relational method.

5.3. Relationship, Positionality and the Role of the Researcher

The relational aspect of VCRM refers to the speakers' relationship to themselves, to others and in broader social and cultural contexts (Mauthner and Doucet 1998). It also refers to the relationship that develops between speaker and listener, and is thus congruent with my ontological position that participation and attachment to others is essential to being-in-the-world (Gaya Wicks *et al.* 2008). VCRM is consistent also with the participatory worldview reflected in this research: that of belief in democratic peer relationships as a form of inquiry (Reason and Bradbury 2006).

In addition to offering a potential medium to uncover the essential meaning beneath women's voices, The Listening Guide also incorporates my voice, influence and positionality, not only as a woman, mother and midwife, but most specifically in this instance as a researcher. Tina Miller (1998, p. 60) suggests that the researcher's autobiography is a 'continuous and dynamic thread running through all phases of qualitative research.' In this research, a voice-centred relational method exposes the relationship between the researcher and the person speaking by providing a way of

listening and reading that considers both sets of voices (Gilligan *et al.* 1990). By way of illustrating this, in her seminal work, '*A Different Voice*', Carol Gilligan (1993, p. xvi) states that 'to have a voice is to be human, to have something to say is to be a person. But speaking depends on listening and being heard; it is an intensely relational act'.

In her earlier analysis of antenatal education, birth anthropologist, Sheila Kitzinger (1977, p. 14) also observed the centrality of the interviewer as 'an inherent part of the interview and [the interviewer] affects what happens during it...interviewer and interviewed are involved in a relationship which is going on all the time, even when they are not talking.' In sharing her experiences undertaking research on women,[164] Caroline Ramazanoglu (1989) reflects that her interviews with married, shift-working women were perceived as unequal and biased. This was intensified by a context which prevented the establishment of a trusting relationship between researcher and participant. I was aware of my potentially powerful position as a hospital researcher where women co-researchers were attending for care and I made attempts to address this through a number of methods. I worked hard to build a trusting relationship with women co-researchers and ANE co-researchers through reciprocity. I was grateful for their engagement in the research and explained this. I was conscious of the effects of my authenticity with all co-researchers; I shared myself and they shared with me.[165] I found this very easy to do and my changing positionality helped me. With mothers, I shared my experiences of motherhood, for example, and with ANE co-researchers we discussed clinical work, holidays or whatever was topical at the time. In the interests of developing and maintaining authentic relationship, our range of conversation, while very focused on the topic of inquiry was not artificially limited in any way.

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[164] Ramazanoglu (1989, p. 428) states, 'the political commitment of social transformation distinguishes research *on* women, which can be undertaken from any methodological position, from research *for* women, which is politically and methodologically feminist.' The research she describes is research *on* women taken from a positivist standpoint.

[165]Oakley (1981) describes her experiences of interviewing women as a feminist woman in her research about the transition to motherhood, suggests that personal involvement in the interview process is unavoidable.

There are occasions when my responses may have directed my conversations with ANE co-researchers and women co-researchers, in what I phrased one way and not in another. I am reminded of Phillida Salmon's (2008) assertion that all narratives are co-constructed[166]; this has prompted me to examine and be critical about my questions and responses following each meeting and to consider how they have potentially shifted our research conversations. When I listen to conversations I am aware of occasions where my positionality and experience as mother influenced directly the questions or prompts I used. This is illustrated by an extract from a group pregnancy conversation in ARC2.

Q And have you thought about becoming a mother...I suppose we have spoken about responsibility a bit, about how it takes over your life really in one sense or can do. Are you feeling apprehensive or happy or excited or...?

'Excited' **(ARC 2 W10 31/40)**

'Yeah I'm excited. I mean I'm excited and yeah I'm a bit nervous that my life will come to a screeching halt, life as I knew it. But you know it's just the next phase in life you know' **(ARC 2 W8 28/40)**

5.4. The Art of Conversation

Conversation[167] is a dynamic and two-way process, and I have illustrated how my voice has potentially influenced the peaks and troughs of our research encounters. In the same way, all co-researchers influenced others' accounts. Ramazanoglu (1989) reflects that naturally women do not share all of their experiences that are shaped by the context

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[166] Salmon (2008) suggests that all audiences, whether physically present or not, influence what can and cannot be said. Further, according to Marjo Buitelaar (2006) and Molly Andrews (2008), narratives are shaped by actual and imagined audiences.

[167] Patricia Maguire (2006) describes the nature of conversation as 'an ongoing though not a particularly fluid process, something in progress across time interrupted by life's daily demands. In this process, conversant listen, share, interrupt, question and challenge, interpret, shake their heads sideways in disagreement or nod in affirmation, get distracted, seek clarification and possibly end up somewhere initially unforeseen (Maguire 2006, p. 61)

and other elements of their lives. As Mary Brydon-Miller (2007) and Ramazanoglu (1989) remind us, we are not equally oppressed and we are oppressed in different ways. It follows then that we might share with some more than others. By virtue of the fact that ANE co-researchers held powerful status as hospital employees, as distinct from women as care recipients, each group may have been guarded for different reasons in the information that they shared when they were together in the CIGs. I refer to this again later in the thesis on page 210.

Apart from the initial use of a very flexible question guide, as meetings progressed, the co-researchers and I, and the women co-researchers and I, separately engaging in the action research cycles became more confident. There was no fixed agenda of items to discuss during our research conversations, which, by the very nature of the topic of inquiry, often moved to the personal. Excluding an agenda fostered an ethos of participation (Grant *et al.* 2008) and meant also that women co-researchers and ANE co-researchers prioritised issues of importance and meaning for discussion in addition to topics of interest to pursue. According to Catherine Reissman (2008a), good conversation[168] supports the respondent in telling her story without the need to return to a set agenda as the presence and attention of the 'interviewer' and the way we listen and question shapes the story that speakers choose to tell (Reissman 2008a). I am reminded of moments in our conversations where the use of an agenda would have been out of place. To illustrate this, I offer an example of a woman co-researcher sharing her need to talk about her previous experience of late miscarriage, an opportunity that she had not received in any healthcare setting prior to our group conversation together.

5.5. Needing to Speak

Women co-researchers and ANE co-researchers valued the opportunity to come together to speak and to listen. The narrative below reflects the very therapeutic nature of engagement between the women co-researchers' aided by an empowering responsiveness to 'individual pre-occupations' (Opie 1992, p. 64).

[168] I have replaced Catherine Reissman's (2008a) use of the word 'interviewing' with conversation to reflect the dialogic nature of our engagement in the research.

'...I'm very happy to be part of the research group because I don't think many people get the opportunity to talk about their feelings about their pregnancy...to talk with people who've gone through the same experience with you, so it's nice to be involved and share experiences.' **(ARC3 PN W14 Baby four months old)**

The process of creating space in PAR makes it possible for participants to represent their worlds through voice by speaking about issues of concern in spaces that may have been previously closed to them (Ospina *et al.* 2008). Separate group conversations took place with women co-researchers and ANE co-researchers (Appendix 2) prior to the CIG meetings. This was arranged in cognisance of their concrete unequal status within the institutional setting, as professional care givers and care recipients. It was anticipated that open dialogue could be initiated and sustained in keeping with the research objectives and prior to merging all parties to work together to attempt to implement change. The decision to undertake separate group meetings prior to the CIGs was supported by ANE co-researchers who felt that women would be inclined to speak more freely in their absence. These group meetings also offered the opportunity for women co-researchers to meet each other for the first time prior to meeting ANEs and this proved to be a useful method of developing very necessary informal networks and supports for the women. Friendships developed between them for the duration of and beyond their engagement in the research.

5.6. Concrete Steps to Analysis

Listening and analysis proved to be a very iterative process. In total, I listened to the digital recordings and read simultaneously each conversation transcript a minimum of five times to uncover responses for the following:

Reading 1: Reading for the plot and my response to the narrative
Reading 2: Reading for the personal pronoun or voice of the 'I'
Reading 3: Reading for relationship (with other)
Reading 4: Reading for cultural contexts and social structure (and the institution)
Reading 5: Reading for parallel and diverse discourses and positions of power.

The act of reading and listening as one focused my attention and helped me to stay true to what the women were saying. Readings One to Four have been highlighted

previously by Gilligan (1993), Brown and Gilligan (1992) and Mauthner and Doucet (1998). In this research however, another reading (Reading Five) emerged; as I read and listened to the transcripts I heard two very distinct voices; that of the professional and of the woman attending the service for care.

In technical terms, as far as possible, I listened and read for each of the readings I have identified one after the other and highlighted the messages that appeared meaningful. I also collated these statements in a Word document.[169] I used both methods to ensure that I was thorough; but found that while cutting and pasting proved quicker, highlighting the statements in colour made words and phrases jump out as I listened, read and revisited. I wrote my interpretations beside each statement in a different colour and font. Initially, I tried to present *my* interpretations of the words that I heard and read to ANE co-researchers and women co-researchers. As our meetings progressed, however, I offered my interpretations together with their direct quotations in an attempt to remain faithful to their voices. In doing this, I felt that I was staying true to the analysis method, but other than confirming that the transcripts accurately reflected our conversations, the level of feedback from antenatal educators and women remained consistent.

The analysis that was offered to women and antenatal educators was developed mainly from my reading for the plot (Reading One). The other readings were used to help me to develop my analytical skills and awareness of the salient messages in our conversations. A written record of these interpretations was sent to each member of each group, and aspects that appeared significant from the other readings were highlighted also in discussions that followed. An example of this was my awareness of a pregnant woman in the group meeting voicing her concerns about a controlling family member and how this may possibly affect the woman's relationship with her baby. I focused my awareness of the woman's anxiety about this as a result of Reading Three (for relationship) and we revisited this concern at the postnatal meeting. This in fact, provided the impetus for a group discussion about family support.

[169] Mauthner and Doucet (1998) also describe this process.

5.6.1. Reading for the plot and my response to the narrative

Getting to know the data in the initial stages is a very intuitive process, and this can be difficult to articulate and describe (Mauthner and Doucet 1998). The first reading has two components. In the first instance, the transcript is read for the overall message, the plot or story narrated by the speaker. Reading one also considered kinetics, the words that the ANE co-researchers and women co-researchers used to express metaphor, recurring words and paralinguistics; this type of analysis is common to other methods of qualitative data analysis also, for example, in narrative inquiry (Reissman 2008a, Andrews 2008). In Reading One for the plot, I read also for practical or concrete examples of participation in the research; thus, I could identify instances where women co-researchers and ANE co-researchers contributed to the research design. An example of women co-researchers' contribution to the research design is their unprompted request for facilitation of a second postnatal mothers' group meeting in ARC1 (please refer also to Appendix Eight for co-researchers' contributions to the research design). I read also for the effects of participating in the research on the individual.[170] The second component of Reading one listened and read for my response to the narrative or, what Mauthner and Doucet (1998, p. 126) refer to as the 'reader-response' and therefore attends to reflexivity. As a qualitative researcher, my approach to this work has been influenced by personal and political self-knowing. Other influences relevant to this research are my feminist perspectives of placing value in listening to women speaking about their lives[171] (as women co-researchers and ANE co-researchers) and my participatory worldview that knowledge is better when it is co-created (Reason and Bradbury 2006).

[170] A woman co-researcher could be involved in this research for up to eighteen months from the time of pregnancy, birth and the postnatal period. Over this period of time, they have met other women and the ANE co-researchers outside of the classroom setting and have had the opportunity to engage; on the whole, women have stated that participating in the research has been a positive experience.

[171] Dorothy Smith's (1987) assertion that the existence of dominance that manifests itself through traditional organisational structures depends upon the silence of women is particularly relevant to this research.

The idea that my individuality is not shared[172] was brought home to me by an exercise I undertook in preparation for this work, when I attended a VCRM workshop with Natasha Mauthner and Ruth Deery. Participation in the workshop involved group analysis of a segment of an anonymous transcript, and when members of the group came together to discuss our analyses, we discovered that we had each highlighted different elements of the transcript as meaningful. This emphasises further the necessity for sharing transcripts and interpretations of the research with all co-researchers and, at every stage of the process, to ensure goodness or quality in action research, otherwise referred to as rigour.

Without the involvement of women co-researchers and ANE co-researchers in this process, there could have been the danger that I would have shaped very rigidly our discussions and plans for action with my sole interpretation of the data, as this process is both personal and political (Lather 1991, Fonow and Cook 2005). There should be awareness that data do not remain constant and that our interpretations are connected to how we view the world. According to Molly Andrews (2008, p. 87), 'the more vantage points from which we view phenomena, the richer and more complex our understanding of that which we observe'; thus, ANE co-researchers' group analysis using VCRM, ensured opportunity for the group to consider collectively and individually, women co-researchers' views, felt experiences and their responses to them. It was also an opportunity to revisit an event that they had found disturbing (CIG2). This event and its significance are discussed on pages 258-261.

Group analysis is consistent also with the principles of participation and provided a way to test my interpretation of the data and knowledge created. The importance of involving all co-researchers (women and ANEs) in data analysis is illustrated by Patton's (1975, p. 22), as cited by Maguire (1987, p. 11) analysis that 'two scientists may look at the same thing but because of their theoretical perspectives, different assumptions, or different ideology based methodologies they may literally *not see* the same thing.' Knowing therefore is an intensely political process (Ramazanoglu 1992).

[172] The issue of reflexivity, reflection and understanding of 'one's personal, political and intellectual autobiographies as researchers' and explicating position in relation to women co-researchers and ANE co-researchers is vital (Mauthner and Doucet 1998, p 121).

Mauthner and Doucet (1998, p. 129) are quick to indicate that their discussion of VCRM relates to their 'individual interpretations, understandings and versions of it' as distinct from the 'method' alone. It is acknowledged that 'all research contains biases and values and that knowledge and understanding are contextually and historically grounded, as well as linguistically constituted'[173] (Mauthner and Doucet 1998, p. 12, Gilligan *et al.* 1990). It is also interesting here that Belenky *et al.* (1986) state that women use the metaphor of language, speaking and listening to express their experiences and sense of connection or isolation. This is distinct from the visual metaphors employed traditionally by Western intellectual thinking, promoting 'the illusion that disengagement and objectification are central to the construction of knowledge...unlike seeing, speaking and listening suggests dialogue and interaction' Belenky *et al.* (1986, p. 18). Development of sense of self and voice are therefore inextricably linked (Belenky *et al.* 1986).

It is noteworthy that a decade later, on revisiting the publication of '*Women's Ways of Knowing*' (WWK), one of the original authors, Jill Tarule (1996) differentiates between voice (referring to speech and the individual) and dialogue (referring to speech among individuals) (Tarule 1996, p. 276). This is characteristic of the richness of qualitative data that is open to interpretation and is a particular feature of VCRM, but it also reminds us of the interconnection between power, action and voice articulated by Ospina *et al.* (2008), as the researcher has control over issues that are emphasised or ignored and questions that are asked or muted.

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[173] This notion is very powerful: that language is perceived as something over which one has control, or as agency, an act with consequences (Morrison 1993). An example of this is Martin's (1987) suggestion that the women's beliefs about body image are framed by personal, cultural and social experience and are exhibited by everyday language. Further, an invitation to fight dominant and oppressive voice is issued by Toni Morrison (1993), as part of her Nobel Lecture, 'whether it is obscuring state language or the faux-language of mindless media; whether it is the proud but calcified language of the academy or the commodity driven language of science; whether it is the malign language of law-without-ethics, or language designed for the estrangement of minorities, hiding its racist plunder in its literary cheek - it must be rejected, altered and exposed.' A Foucauldian perspective on the appropriation of language around pregnancy and birth is acknowledged on pages 156-157 of Chapter Six. Anne Opie (1992) cautions also against the appropriation of language in accordance with the researcher(s)'agenda.

5.6.2. Reading for the voice of the 'I' or personal pronoun

This reading focuses on the use of personal pronoun or, put simply, where the respondent uses 'I', 'we' or 'you'. According to Mauthner and Doucet (1998, p. 128), this process focuses attention 'on the active 'I' which is telling the story; amplifies the terms in which the respondent sees and presents herself; highlights where the respondent might be emotionally or intellectually struggling to say something; and identifies those places where the respondent shifts between 'I', 'we' and 'you' signalling changes in how the respondent perceives and experiences herself' (Mauthner and Doucet, 1998 p. 128).

I consider this reading vital to listening to women's voices because doing this created an opening for me to put my interpretations and positionality to one side by focusing when reading solely on the 'I', to unearth and uncover 'how she speaks of herself before we speak of her' (Brown and Gilligan 1992, p. 27-28). Mauthner and Doucet (1998) refer to this process as creating a space between respondents' expressions and the listener's or listeners' own (Mauthner and Doucet 1998). As I became more skilled in research conversation, my questioning evolved from direct searching about specific needs related to antenatal education, to more general inquiry. The extract below provides an example of how my questioning focuses on the 'you' or the personal pronoun; 'how are you now?' and how this influenced the nature of the postnatal woman's response. The first extract below reveals the general response to the question poised in a postnatal conversation with a woman whose baby was four months old and born by elective caesarean section.

Q **How are you now about everything?**

'Totally fine, yeah totally fine but just when you are planning, when I was doing lots to prepare and stuff and then it was like oh well you kind of thing you've to start, all that was for nothing, I had to have a c-section in the end. But totally fine, you know, that was the way it had to be. So that was completely different to how I imagined. I thought I'd have this you know I wasn't really scared of the whole birthing process or anything. But just in terms of motherhood I guess because I had a history of miscarriages I could never *imagine* beyond the end of the pregnancy, I never allowed myself to, so I never imagined what motherhood

would be like. I never allowed myself so I never thought oh I wonder what it would be like, I never went that far. So yeah, yeah, so all I can talk about is what I thought the birth would be like so obviously it was different to what I had planned like.' **(ARC1 PN W1 Baby is four months old)**

To illustrate how the essential meaning for the woman is uncovered in reading for the active 'I' and how she perceives personally her experience, an example of the reading for the personal pronoun or 'I' is given below:

Q **How are you now about everything?**

'I was doing lots to prepare...I had to have a c-section in the end...completely different to how I imagined. I thought I'd have this...I wasn't really scared of the whole birthing process or anything...I guess because I had a history of miscarriages I could never *imagine* beyond the end of the pregnancy, I never allowed myself to...I never imagined what motherhood would be like. I never allowed myself...I never thought oh I wonder what it would be like; I never went that far...all I can talk about is what I thought the birth would be like...it was different to what I had planned...' **(ARC1PN W1)**

Reading for the active 'I' offers more insight to the psychological and emotional effects of the woman's previous miscarriage and possible impact on her preparation for birth and her current pregnancy which at first glance she appears to deny: 'Totally fine, yeah totally fine...'

Until recently, The Listening Guide has been used to analyse conversations with individuals, as distinct from groups, of women (Gilligan 2011b, personal communication).[174] Thus, I anticipated challenges in deciphering ownership of voice while listening to group conversations; in fact, this was not at all problematic. I soon recognised and grew familiar with each voice over the course of our meetings; as I was listening, I could visualise each person speaking and could have traced each individual's

[174] Exceptions to this are Ruth Deery's (2003) action research on engaging with clinical supervision in a community midwifery setting in the United Kingdom and collaborative research by Byrne *et al.* (2004) on early school leavers in Ireland.

story if necessary. Group conversations brought the power of collective voices to life (Brown 1998). In each group, every story was heard as it was shared, and in some ways each conversation continued because I met women co-researchers during pregnancy and after birth, a minimum of twice and up to four times. Meetings with women were repeated more than twice if they followed through as postnatal collaborators in the following ARC. We listened to each other in silence, speaking only to clarify and sometimes to validate. To sit and genuinely listen to what someone has to say requires patience, time, sensitivity and attention (Reissman 2008b). As women together in the co-researcher groups, these aspects were embodied through our sharing of group conversations and stories. When the two groups (women-co-researcher and ANE co-researchers) met for the CIG meetings, it became apparent that there were two distinct voices: that of the professional employee and the woman (Reading Five).

5.6.3. Reading for Relationship (with other)

Reading three focused on how women co-researchers and ANE co-researchers spoke about their interpersonal relationships. Of key relational significance for the women co-researchers were their partners, female relatives and other mothers. Relationships with midwives and healthcare professionals emerged in pregnancy conversations as being of utmost importance. For ANE co-researchers, relationships with each other emerged as significant.

> 'Well this team works very well together, this team we have here, all of us, I think we work really well together, and we all know our areas and we all stick to our own areas' **(ANE Group 1 P3)**

This statement reflects awareness of the distinction in professional roles and responsibilities between ANE co-researchers in accordance with professional guidelines and scope of practice.

> 'There's a good respect for...I think I'd be very reassured that everybody feels that what I have to add is valuable...' **(ANE Group 1 P5)**

ANE co-researchers also emphasised the importance of good relationships with women and their partners and had concerns that women co-researchers did not accurately

represent the views of the general population of women attending the unit for maternity care, specifically in terms of the category of care attended. This is discussed on pages 196-197. They commented that women appeared generally happy with the services based on feedback that they had received informally in classes.

> '...I think if you listen to the ladies that gave their opinions in the meeting the last day, you'd think you were doing an awful job. Whereas, when you talk to more people you find that more people are happy with what they learnt and they have maybe more constructive things to say than those particular ladies' **(ARC3 OP Plan P2)**

Again, in the presence of such an obviously unequal distribution of power, women's position to challenge the facilitators of a dominant regime is tenuous and requires great courage. When vulnerable, the likelihood is that women will not speak or confront potential carers in the interests of preserving relationship (Kirkham and Stapleton 2004). In their analysis of midwives' experience and anxiety related to user involvement in transforming services at Montrose Community Maternity Unit, Nicoll *et al.* (2007) reveal their feelings that women committee members were not representative of their clients. This reflects the experiences of the ANE co-researchers when challenged about information offered in classes related to the topic of episiotomy and this is discussed on pages 258-261.

5.6.4. Reading for cultural contexts and social structure (and institution)

Molly Andrew's (2008) suggestion that no two stories are ever the same is well documented in feminist and qualitative literature and is generally referred to as context; throughout this work I have experienced the power of context firsthand. According to Brown (1998) in her analysis of her research with Carol Gilligan, girls who stay connected to themselves do so at the risk of disrupting conformist expectations of femininity. Feelings of failure ensue because the dominant societal message is incongruous with the woman's thoughts and feelings yet she believes that she must conform to dominant thinking (Gilligan 1993). In this research, the dominant patriarchal regime of maternity care is seen to be disseminated through antenatal education. In Brown and Gilligan's work (1992), the girls who experienced self-doubt

and uncertainty about their strong feelings and sources of anger[175] or conflict also experienced feelings of guilt and self-blame (Brown 1998).

Reading Four for society and culture; 'culture' in this sense reflects institution of care, of one of the postnatal conversations from a selected transcript (ARC3), reflects the sense that experiences of birth are rationalised by women in an attempt to conform to a dominant and patriarchal paradigm. The example below outlines a postnatal woman's description of her experiences of feeding her baby and how this is inextricably bound to her feelings of success or failure as a mother (Marshall *et al.* 2007, Murphy 2000). Her baby is five months old.

> 'I think you feel like you are not really a mother if you can't breastfeed...I couldn't breastfeed him and you feel like a *total failure* because I suppose one of my big goals about being a mother was being able to breastfeed. This wonderful thing image of Mother Nature you have...when you can't do it is a very difficult thing to come to terms with.' **(ARC3 PN W11)**

Q **Were you satisfied with your feeding decision? And are you satisfied now with your feeding decisions? (Baby crying)**

> 'I am now but at the time I was completely distraught and I felt like a total failure. In the end I don't really feel I got any help from (hospital) at all...the most help that I got was from the public health nurse who came around pretty much spent the whole morning with me and I just sat in bed with her, she wasn't in bed with me (laughing) but with him on my breast and we just kind of spent the whole morning trying to get him to latch on. And that worked really well but in the end I just wasn't producing enough milk and therefore people have said that because you have such a big baby he would have never managed on breast milk anyway' **(ARC3 PN W13)**

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[175] The anger is brought about by tension between 'authentic' voice and 'moral' voice; the speaker's begins '...to disconnect from her feelings and knowledge in an attempt to connect to what others want' (Brown and Gilligan 1992, p. 110)

This mother attempts to rationalise her feelings based on popular discourse. There are suggestions that perceived difficulty in latching the baby on the breast and insufficient milk supply are two main factors for early discontinuation of breast feeding (Begley *et al.* 2008, Dykes and Williams 1999). Discontinuation of breast feeding is also linked tolow levels of self-efficacy about breastfeeding (Dykes and Williams 1999, Dennis *et al.* 2002) and diverse emotional, social and practical concerns (Marshall *et al.* 2007). The notion of self- efficacy here is interesting because it seems that confidence about motherhood is what new mothers fundamentally lack (Leahy-Warren 2005). Dykes and Williams (1999) refer to the socio-cultural influence of the biomedical model on a woman's lack of confidence in her ability to nourish her baby in addition to practices by health professionals 'entrenched in regimes, routines and mechanistic approaches which are potentially detrimental to effective lactation' (Dykes and Williams 1999, p. 243). The woman as new mother has had to accommodate herself to her lack of support and is consumed by self blame about her own seeming incapacities:

> 'So that took two weeks after his birth for me to sort of deal with that and come to terms with not being able to breastfeed. And I think a lot of the problem is you are just so full of hormones, you are so tired that you can't be rational. Even if you think you are being rational at the time you just can't be rational. **(ARC3 PN W11)**

This woman co-researcher uses the word 'rational' although she admits that she cannot be (Stern *et al.* 1997). She is torn because she is aware of the demand for her to be rational in a society that has expectations of her to conform to dominant ideologies about motherhood (Oakley 1986, Ribbens 1998, Miller 2005). Caroline Ramazanoglu (1992) reminds us of the feminist awareness that reason and emotion cannot be separated; from a woman's perspective, the concepts of reason and rationality are fashioned by the emotionally charged life-changing event that is motherhood. Thus, Reading Four is important from the feminist standpoint that knowledge is socially constructed and influenced by values and culture that are superimposed on women (Smith 1987, Gilligan 1993). Further, Rappaport (2000, p. 6) supports the theory that community and organisational narratives 'are the text and subtext of culture and context' and have profound effects on individual stories. This is illustrated by the findings of multiple methods research by Svensson *et al.* (2006) to elicit concerns of

new parents and Jane Ribbens' (1998, p. 33) assertion that women as new mothers are 'subjected to unsolicited and unexpected advice and judgements by others'. The nature of these comments are unsupportive and unhelpful to the woman as new mother, an example of this is demonstrated by the following narrative from a postnatal mother whose baby was three months old at the time of our conversation and born prematurely at 34 weeks.

> '...I'm afraid of bottle feeding in public. It's just I suppose winding him is such an ordeal because I mean even as it is going around just with the pram so many people comment you know, yeah if he's crying they go 'ahh he's hungry' and you are like 'No he isn't, I just left my house like 20 minutes ago and I fed him before I left, I might be hungry but he's not.' But yeah, people comment an awful lot. I suppose they mean well but it just doesn't help like you know, he's screaming his head off and you don't know what's wrong with him, and then they tell you well he's hungry. In other words you are neglecting him...it's not helpful' (**ARC 1 PN W2)**

When this woman shared her thoughts with me and one other, there were no signs of obvious distress; however, the fact that she raised the issue suggests that some level of discomfort about the incident had stayed with her. During the course of her participation in the research, I had learned that she felt well supported by her husband and public health nurse who was a regular visitor in the weeks after birth. I remained with her after the conversation to provide support where needed, as was the case with all ANE co-researchers and women co-researchers. All co-researchers were encouraged frequently to contact me by email or telephone if they had any issues or concerns related to the research. As it happened, no-one had particular difficulties related to the research but emailed on occasion, to share thoughts and ideas, and these were merged with my analysis.

5.6.5. Reading for Parallel and Diverse Discourses

The necessity for Reading five emerged through identifying both harmony and discord between the voices of the ANE co-researcher and women co-researcher groups. Thus, while many voices were heard, two distinct voices emerged: those of the 'professional practitioner' and 'recipient'. An example of diverse discourse is the decision to refrain

from mixing first time and other mothers in antenatal education classes. This is in keeping with the dominant institutional misconception that mixing first-time and other mothers in ANE is poor practice because of the perceived risk that first time mothers may be fearful of birth as a result of hearing about other women's experiences. In fact, throughout the research, women have expressed their needs during pregnancy and as new mothers, to meet with other mothers in classes and to share experiences.

Reading Five also highlighted some of the key differences of the aims of antenatal education as perceived by women and facilitators. The following extract is part of an ARC4 conversation that took place between the postnatal women from ARC3 (W11 and W12) and the antenatal educators (P1, P2, P3, P5 and P6).

> 'I think one of the problems is that (hospital) is very much focused on just one event, (baby talking)...which is producing the baby...you could say it has a responsibility to at least give you guidance...just to have, to bring everything together at that point, just picking a number off my head maybe up until the baby's first birthday so you cover those thoughts even if it's just a web link' **(ARC3 W11)**

> 'I know what you are saying, I think that is exactly what we are here for, is that one event and we are here to deliver the baby really and see you through your pregnancy, and then I suppose its GP, community, you know, hopefully that would be somewhere that would have that information, I know you are saying it would be helpful if it was here, but the GP could surely tell you what's there (baby talking…)'

Two frames of reference are evident in the statements above; the woman's way of knowing birth as a continuous entity and the philosophically diverse biomedical approach that child birth is fragmented and punctuated by discrete occurrences.

5.7. Collating and Writing about Interpretations of Voice

Following several readings and listenings of each transcript, there was the task of presenting the data in a whole and coherent form for the purposes of presentation and discussion. Thereafter, I spent a period of seven months from April to October 2011

reading and collating sets of data. This period of time was punctuated by written and verbal contact with women co-researchers and ANE co-researchers to clarify and question. There were several folders and files and as I looked at the narratives before me it appeared that there were commonalities in the women co-researchers' groups and separately in the ANE co-researchers' groups; patterns formed and similarities emerged. At times, the voices of women co-researchers had strikingly different messages to the words of ANE co-researchers; however, at other times, they were similar. These subtleties were captured by Reading Five for parallel and diverse discourses and are presented throughout the findings in Chapters Six, Seven and Eight.

Voice data were organised as digital recordings, verbatim transcripts, summaries of interpretation, in addition to direct quotation, several readings, data sets and eventually, commonalities and themes. I have reflected since that the intricate work of exploring each statement and data set helped to retain the essence and complexity of each woman's perspective (voice) and experience as it was described by the speaker. By presenting the words as they are spoken, in addition to my interpretations I have been careful not to write over another woman's voice (hooks 1991, Kitzinger with Gilligan 1994). According to Mauthner and Doucet (1998), VCRM is distinct from the reductionist nature of most methods of qualitative data analysis that require information to be condensed, coded and categorized, which implies fitting a person into a pre-existing set of categories, whether those of the researcher or those of recognised theoretical frameworks.

Every statement appeared significant in some way; however, I must admit that some were more meaningful to me because of my conceptualisations informed by my reading and my personal and experiential ways of knowing and positionality. The commonalities that I suggest are my interpretations based on what I know and also the intensity with which the women co-researchers and ANE co-researchers spoke. Birth and motherhood are such personal and subjective experiences, and commonalities are an attempt to present the private knowledge that women (women and ANE co-researchers) have shared with me in an accessible way.[176] Similarly, as Jeanne Siddiqui (1999, p.

[176] I refer to dissemination in third person inquiry specifically in this sense.

111) articulates, 'the relationship of the midwife to the women she cares for involves developing an understanding of the abstract concepts of childbirth, parenting and womanhood. Concepts that are indefinable in the general sense and can only be understood in a personal and experiential way.' While I am also mindful of Norman Denzin's (2009) cautions regarding postmodern qualitative research interpretation and representation, that experience is mediated and shaped by 'prior textual and cultural understandings' (Denzin 2009, p. 172), I am required for the purpose of this research to attempt to make private voices public (Ribbens and Edwards 1998, Ribbens 1998, Mauthner 1998, Bell 1998).

5.8. Group Analysis Using a Voice-Centred Relational Method – A Way Forward?

The CIG2 transcript was analysed by the ANE group because this conversation was identified by the group as particularly challenging. Due to time constraints we agreed that we were limited to analyse a relatively short section of one transcript using VCRM; we read approximately six pages and read for Readings One and Two. We read only, as distinct from listening and reading, as the ANE co-researchers had not attempted this process of analysis before. ANE co-researchers stated that they found the process of analysis useful and they reflected on their learning specifically in reading for the voice of the personal pronoun and how this uncovered women co-researcher perspectives.

> 'Well it reinforces the messages, do you know reading it alone you wouldn't take as much from it, you're thinking about each thing that's said, yeah, I certainly won't forget what was said at that meeting now' **(Group Analysis P6)**

The process unearthed awareness of two very distinct voices of care recipients and of professionals and, possible recognition of aspects of common ground or where the two distinct voices might meet.

Q Ok so what are the key messages that came out for you do you think?

> 'There's never any opportunity...to develop any relationship' **(Group Analysis P6)**

'I think probably we're both coming from different angles probably, I think we're trying to get the information across that we think they need and they think some of it is irrelevant, some of it is and it's to get the balance really I think and obviously not to frighten people but to make them feel positive about the whole experience and I don't know, it's sometimes maybe it's difficult to get that right? **(Group Analysis P3)**

This possibility of conflicting discourses is uncovered by the process of analysis and is acknowledged by ANE co-researchers here and the relevance of this for women is discussed in detail in the Discussion Chapter Ten. According to Koch and Kralik (2006), conflict may not always be a negative experience and can result in momentum for change. An example of this in the research presented here is the debate about episiotomy, which enabled me to highlight the challenges of bringing change to an organisation that is governed by a staunchly medicalised ethos of care.

Q What are the other messages?

'Well in the conflict, the conflict between the professional staff and the women's needs, there seems to be [conflict]' **(Group Analysis P6)**

Finally, there is realisation that women are expected to conform to the dominant view, but still the expectation remains. ANE co-researchers state that women relinquish trust, but really the issue here is that women relinquish birth autonomy and their ways of knowing and this is discussed further in Chapter Ten. Women are regarded as patients in the medical model where pregnancy and birth is potentially pathological and risky and, as such, messages that antenatal educators give are shaped by the dominant institutional ethos:

'...the more you know the more in control you are when you get to the labour ward and the happier you will be because you'll know exactly what's going on, so not knowing is not good...[but] I always think there's another element to all of this, we're working within the confines of a hospital setting...' **(Group Analysis P3)**

The ANE co-researcher continued to explain about a very negative response that she received from an authoritarian figure in the institution within which she works. The co-researcher was reprimanded about specific information she offered to women as part of a particular class because an obstetrician deemed it unnecessary for women to be informed about this aspect of their care. The information the co-researcher had offered was factual and correct, and in offering the information she had responded to a felt need. In telling her story, the ANE co-researcher describes her concern and anxiety and suggests that this reproach has potential to silence her. This episode illustrates Marjorie De Vault's (1999) suggestion that speaking out comes at a price for those women who confront dominant discourse.

The process of using VCRM with ANE co-researchers has been valuable in demonstrating the power of hearing another's voice and perspective (Byrne *et al.* 2009) and offers a potential way forward for this group of ANE co-researchers to listen and to act in response to women. As we read, despite using the same analytical framework, our interpretations of conversations varied and this demonstrated for the co-researchers the existence of more than one truth. Thus, using a voice-centred relation method of analysis together explicated and clarified mechanisms for interpretation (Byrne *et al.* 2009, Brown *et al.* 1991, p. 42). Inviting group analysis by VCRM also offered ANE co-researchers an understanding of the workings of the method.

5.9. Challenges Incorporating a Voice-Centred Relational Method

One of the difficulties in using VCRM is the perceived lack of definition around the concept of voice and the many interpretations that voice has; however, I have found Gilligan's (1993, 1994, 2011a) response to the question, 'What is voice?' helpful. She responds that – 'voice means voice' (Gilligan 1994, p. 413). By this, Gilligan (2011a, p. 9) refers to voice as physical: 'an instrument of expression as well as a [well documented] concept or metaphor for the self.' Instrument refers to the physicality of voice, which means physiological, psychological and cultural connection (with thoughts and feelings). Similarly, one can hear when the connections are blocked (Gilligan 1994) and this is why it is important to listen to voices in addition to reading transcripts; in listening we can hear resonance and gauge a sense of connection or distress.

5.10. Representation, Appropriation and Power in Voice

VCRM provided a way for me to moderate my struggles within the postmodern[177] predicament of representation of view, through voice, in addition to *how* this manifests as knowledge that is translated into useful action, by hearing and privileging voice. As Carol Gilligan in conversation with Celia Kitzinger notes, 'the relationship has to be maintained throughout the writing, and you don't write over, or voice over, other people's voices' (Gilligan 1994, p. 411). Thus, in writing the thesis, I present as findings, readings and listenings as they are interpreted and as far as space will allow, in addition to the actual words and statements of women co-researchers and ANE co-researchers.

The participatory nature of this research facilitates working and disseminating our voices together. In some way this perhaps works toward what Anne Opie (1992, p. 53) describes as 'avoiding appropriation[178] and highlighting difference' to empower women co-researchers and ANE co-researchers. Julian Rappaport's (2000, p. 3) analysis speaks of the importance of telling a story where 'minor characters' become central characters as a contributing factor to personal and social change.[179] This is helpful also as it

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[177] Beverly Taylor (2010) reflects on post-modern awareness of the complexity of knowledge, reluctance to accept grand narratives and representation of truths through theories and categorisation (Taylor 2010)

[178] According to Anne Opie (1992, p. 55), 'appropriation is a term which conventionally defines social relations in terms of power relations.'

[179] Rappaport (2000, p. 4) refers to the 'creation of new narratives or modification of existing narratives.' Rappaport (1995) uses the term 'personal story' to depict an individual's communication or representation of events that are unique to that person as distinct from narrative to describe community narrative, which is a story common to a group of people or dominant cultural narratives which are 'over learned stories communicated through mass media or other large social and cultural institutions and social networks (Rappaport 2000, p. 4) that can invoke fear or liberate. The former outcome is when the individuals or groups who 'appropriate' this message are invisible to one another (Rappaport 2000). According to Rappaport (1995, p. 803), 'For some people, these dominant cultural narratives, even if they are very negative, remain so powerful that despite their own desire to escape from them it is difficult to find alternative personal or community stories to replace them.'

presents a reminder of the importance and potentially liberating act of really hearing women co-researchers voices that are silenced by institutional hierarchy.

Rappaport (2000) suggests that social change begins with empowering others to identify and tell their own stories, individually and together. In hearing a story or voice, Brueggemann (1984, p. x), as cited by Rappaport (2000, p. 3) states that 'traditional methods' of reading texts (without paying attention to personal voice), despite claims to neutrality 'have served the ideological ends of the ruling class.' In relation to achieving social change, the importance of listening to and reading for existing voices[180] in a different way, is a step closer to shaping communities, even as communities shape their members[181] (Rappaport 2000). In shaping members of society, the nature of available community and organisational narratives in terms of their awareness of others is a key factor in individual and social change (Rappaport 1995).

5.11. Conclusion

According to Maguire (1987, p. 39), participatory research 'proposes returning to ordinary people the power to participate in knowledge creation, the power that results from such participation and the power to utilise that knowledge.' I feel that in this research, VCRM has provided a channel to uncover and preserve the multilayered nature of voice, yet I have struggled in recognition of Anne Opie's (1992 p. 52) insight that 'although at one point they [feminist interpretations] are liberatory because they open to inspection what has been previously hidden, they are also restrictive in the sense that they can appropriate the data to the researcher's interests, so that other significant experiential elements which challenge or partially disrupt that interpretation may also be silenced'. Hearing voice was and is vital to this research, but in some ways it remains a paradox. In order to hear and (re)present voice, I am conscious that, as a researcher,

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[180] Rappaport (2000, p. 3) refers to 'reading the community narratives of our own time differently, so that they *reveal and expose rather than hide* the terror, is a step toward helping to recast the narratives in ways that liberate' (Emphasis author's own)

[181] By this, Rappaport (2000, p. 4) suggests that the means by which we create our personal life stories involves the assimilation of 'idiosyncratic experiences with the narratives we appropriate from our various communities of membership.'

despite the participatory nature of this work, I had to make choices about my personal interpretations of the information I received and what I have included in this thesis as 'evidence' and how I have presented it (Mauthner and Doucet 1998). Incorporating multiple voices requires being attentive to issues such as (1) the criteria for the selection of quotations, (2) the question whether including extracts from interviews is a sufficient means of weaving other voices into the research report and (3) the question of whether the researcher should be solely responsible for the interpretation (Opie 1992, see for a more detailed review). Questions of this nature related to this research are discussed throughout the findings in Chapters Six, Seven and Eight. This has been compensated somewhat by various efforts to group analyse at each stage of the research, in addition to the emphasis on reflective processes and discussions and our later plans for co-dissemination. I believe that the use of VCRM has, as Opie (1992, p. 53) describes, provided a 'more reflexive analysis to avoid textual appropriation of the researched; and to focus attention on difference as a means of more fully representing the complexities of the social world.'

CHAPTER SIX PRESENTATION OF THE FINDINGS ACTION RESEARCH CYCLE ONE

6.1. Introduction

Action research cycles of constructing, planning action, taking action and evaluating action are described in Chapter Four. Information was gathered over a period of 23 months through a variety of techniques; however, group meetings (n=18) of between four and twelve participants) and individual conversations with women co-researchers (n=7) were the principal methods of data gathering. The findings Chapters Six, Seven and Eight explicate the Action Research Cycles (ARCs) and collaborations with women co-researchers and the core working group of ANE co-researchers and are presented as outlined in visual format in Figure 1. The format of the meetings is outlined below with descriptions of exceptions related to each conversation as they are noted. A large volume of data emerged; therefore, only key encounters are shared here in keeping with guidelines for this academic piece of writing and word limit. The data presented here were chosen to reflect discussions and key collaborative decisions that emerged from our meetings. All findings were shared with the relevant women co-researchers and ANE co-researchers at every stage of the process as previously described. Additionally and, in keeping with the democratic principles of openness and transparency of PAR, women participating in the relevant ARC received the findings from ANE meetings and ANEs received the findings from the women-only meetings. The questions I asked are in bold and the responses are indented. Table Five overleaf outlines the characteristics of women co-researchers in ARC1.

Table 5: Characteristics of the Women Co-researchers in ARC1

Code	Gestation (to nearest week)	Age Group (Years)	Care	Heard about ANE classes	Live alone	Nationality	Main Support Person
W1	21	30-39	SPC	Nurse	No	Irish	Husband
W2	18	30-39	SPC	Early Pregnancy Class	No	Irish	Husband
W3	34	30-39	Public	Midwife	No	Irish	Partner
W4	23	30-39	Private	Hospital Information Evening	No	Irish	Husband
W5*	25	30-39	Public	Midwife	No	Irish	Partner
D1*	32	30-39	Midwifery led	Midwife	No	Irish	Partner
D2*	30	30-39	Midwifery led	Midwife Friend PHN GP	No	Irish	Partner

*Individual conversation

6.2. The First Action Research Cycle (ARC1)

There are many voices in this research and each voice is valued equally. Within the scope and context of this academic thesis, I have selected carefully and with difficulty, examples of conversation to attempt to convey meaning in an authentic way. One pregnant women's group meeting, one ANE co-researcher meeting and two postnatal women's group meetings comprised the first Action Research Cycle and findings are presented in this chapter. As there is a vast amount of data to consider, I have offered as findings, salient messages from key meetings only. It is important to say that throughout the research, verbatim transcripts and main messages from conversations were offered and ANE co-researchers and women co-researchers confirmed their agreement with the contents. Notwithstanding this, my interpretation of the conversations is presented to a larger extent in this academic piece because it is my responsibility to write it. As co-researchers, we have discussed other ways to

disseminate the research in the future: as co-authors, co-presenters and co-facilitators. As stated previously, mine is merely one truth among many (Herr and Anderson 2005).

6.3. The Pregnant Women's Group Meeting

Please refer to Appendix 2 and Figure 1 for a visual outline of meetings.
The first Action Research Cycle (ARC1) conversation began with a pregnant women's group meeting prior to their commencement of hospital-based antenatal education in the chosen research setting. ARC1 sets the scene for discussion and provides context for later meetings and ensuing developments. The aim of the meeting was to create a space for women to explore and articulate their anticipated needs in preparation for birth and motherhood. As with other meetings, the conversation opened with a discussion about ground rules and we began with light refreshments to break the ice. Initial meetings involved the use of a prompt guide (Appendix 4).

Issues of meaning and relevance for the women that are related to birth and becoming a mother emanating from the ARC1 pregnant women's conversation fall into three discrete areas. These are 'information and processes', 'birth and place of birth', and 'early motherhood'. The concept of 'information' can be separated into 'knowledge' needs for pregnancy, birth and motherhood and information about how care is managed in the chosen maternity care setting.

6.3.1. 'Knowledge' Needs for Pregnancy, Birth and Motherhood

From the outset, uncertainty in articulating knowledge[182] needs in preparation for birth and motherhood was apparent amongst all women present. Many took several moments to consider before offering responses which were varied but mostly reflected confusion and uncertainty about capturing and articulating knowledge needs. This is possibly due to lack of space in obstetrics to explore in safety feelings about birth, space which is central to facilitate decision making about pregnancy and birth (Edwards 2001). In addition, Stern *et al.* (1997) suggest that individual mothers know intuitively that they experience powerful and consuming emotions; however, they can scarcely explain these feelings to themselves, let alone to anyone else. Stern *et al.* (1997) suggest that this

[182] My conceptualisations of knowledge are detailed in Chapter 10.

provides a possible explanation as to why there is little feminist exploration of the processes of motherhood from the standpoint of women themselves.

According to Davis-Floyd (2003), for most women, knowledge is equated with information. Knowledge gain is governed principally by procedural information from the premise within a large-scale institution and timing of receipt of information was crucial with respect to having information when it is relevant to a specific stage of pregnancy and/ or after birth but not too far in advance that it may not be remembered.

> 'I'm at the stage I don't know what I don't know but I'd like to know at what stages I need to know the things...if I knew okay, I don't have to worry about certain things until whatever point in time...you don't want to over-worry' **(ARC1 W4 23/40)**

Women suggested that information should be concise, up to date, professional, accurate and factually correct and they voiced preference for freedom to choose frequency and volume of exposure to information and conversations. For this reason, online information was accessed frequently.

> 'I suppose number one is that its permission based, that I've opted in to get the information.' **(ARC1 W1 21/40)**

It was clear from the conversations that information should be available from what was acknowledged as a 'reputable source'. This was manifested by trust in a particular online forum because of the website's advertising affiliation with a well known baby skin care company, and, provides an example of how outside influences, such as the media, shape acceptable discourses around birth and motherhood. It was agreed that the hospital and medical experts provided a most reputable source of information. This is evidenced by the statement below that reflected the unquestioning acceptance of the hospital package of care for birth:

> '...once you go into the hospital you are part of the system and it could be over in ten minutes or it could take two days or whatever the case may be, but you are

part of the system and they will tell you...it's great once you get to hospital because it's someone else's problem then so I reckon' **(ARC1 AN W2 18/40)**

According to Foucault (2004), power, right and truth function in very specific ways. The rule of the 'right' or powerful (the instrument of domination or traditional 'king') decides the truth and the truth dictates the law (Foucault 2004, p. 27). By adopting Foucault's ideas, we can see how acceptable discourse is shaped by the powerful or power of the 'right'. Power in this way is omnipresent and permeates through discourse, practices and also the complex network of relationships where one has perceived authority in relation to others (Kesby 2005). Knowledge in preparation for birth and motherhood therefore, is interpreted as a set of data to be memorised with emphasis on retaining factual information as distinct from knowledge and trust inherent in the embodied processes of birth and motherhood. This is illustrated in the extract below on recognising the signs of labour.

'...like a 'check list' almost, check, check, okay go as opposed to no, there was only two of those so we don't need to worry about it, its fine.' **(ARC1 W2 18/40)**

The notion of 'balance' in information giving was expressed several times throughout the research conversations and forms part of the discussion in Chapter Ten in a section about speaking truth. Choosing information to give and subsequently with-holding information and truth effectively limits choice for women and contributes to the professional's power and control (Deery *et al.* 2010) and women's disempowerment. 'Balance' in information giving is a term that was used by women co-researchers and was emphasised further when I revisited the conversations using the listening guide to uncover meaning. According to Michel Foucault (2001, p.14) in one of his six 1983 lectures, for the 'parrhesiastes',[183] or 'truth teller', telling the truth requires that the teller is sincere in her/his belief and what she/he says is her/his opinion but 'that opinion is also the truth.' Foucault (2001) states that telling the truth requires morality and courage but in her analysis of current maternity services in Ireland, Jo Murphy-Lawless (2011a) reminds us that 'parrhesiastes' contrasts with Foucault's notion of a 'regime of

[183] Foucault (2001) refers to 'parrhesiastes' Greek for truth teller.

truth', as a medium for coercive power reinforces untruth. Caution and balance in receiving information is particularly apparent in listening/reading for the personal pronoun or 'I',

> '...I suppose as a first mother you don't want to be over analysing and thinking oh my God I'm jumping on top of everything but at the same time you don't want to be too blasé…' **(ARC1 W4 23/40)**

The use of the word 'you' may also relate to turn of phrase or dialect. 'You' therefore, may mean not just the woman here, but other women in a similar situation. One interpretation of the use of 'you' in voice is Gilligan's (2011a) suggestion that the woman is distancing (her) self by the language that she uses, thus reflecting dissociation from her true thoughts. Carol Gilligan (2011a) suggests that dissociation occurs in the preservation of relationships, so the woman fears judgment even in the moment that she is telling/sharing her need. In this conversation, there is evidence of an immediate sense of how women work to make meaning of their position and context in the current maternity services and the nature of support that is available. Women co-researchers work very hard to make sense of their position in the maternity services and they describe their feelings of not knowing. In doubting their abilities to speak and to make decisions based on personal knowledge they are rendered silent or not knowing (Belenky *et al.* 1986) and are forced to look to others to guide them, as emotional needs are unmet. This is discussed further on pages 173-174, 187 and 205:

> 'I know at the beginning you are thinking oh what do I need to know, do I need to think about, you know the antenatal classes seem to be more about labour and the end of it and there's this big gap in between where you just don't know...it's almost somebody else taking control and also planning...it's just somebody to almost plan it out and say this is the information you are going to need in the future but don't worry about it until then...it's just somebody telling me what I need to know...I do worry about, that when I'm going to ask you know, be over cautious but then I worry that I won't be cautious enough.' **(ARC1 W4 23/40)**

Informational needs reflected significant occupation with complication and the concept of risk specifically related to pregnancy and childbirth. Information knowledge needs

were named predominantly in relation to 'things that can go wrong' and 'what to look out for' (W3), what is considered 'normal' (W1) and when one should go to the hospital or see a doctor. In her book exploring group practices and organisational change in midwifery, Lesley Page (1995) identifies the concept of 'normal' as defined usually in accordance with the culture within which one works. 'Normal' in this instance, therefore, may be narrowly defined as being consistent with the institutionalised medical setting, as pregnancy and birth in the medicalised setting are considered normal in retrospect (Oakley 1993).

In discussions related to early motherhood, women voiced concerns during pregnancy primarily about 'coping' at home, from practical caring for a newborn to forming support networks with other women. According to Leap (2010) support and community networks are vital to the well-being of women and children. Postnatal depression was identified as salient, specifically how to manage the condition and to highlight awareness about signs of recognition. Concern among new mothers about depression after birth was also reflected in the results of a recent survey of users' experiences of maternity care in Ireland conducted by AIMSI (2010). In our research, women articulated potential gaps in information that could be addressed during pregnancy with the predominant view that ANE appears to have sole focus on birth. Women expressed anxiety about complications of pregnancy and, what was referred to by one woman as sustaining 'safe pregnancy':

> '...the big things for me are safe pregnancy and making sure that you've managed all the symptoms...' **(ARC1 W4 23/40)**

6.3.2. Silencing Need

Anxiety about a potential gap in knowledge needs is exacerbated by reluctance to contact healthcare professionals for fear of being perceived as an unwelcome irritation or nuisance.[184] In their qualitative research exploring the culture of the NHS maternity

[184] Maureen Freely (1995) in her description of personal experience of team midwifery care describes her reluctance to contact the midwives with whom she had developed relationships. She explains, "I was afraid that if I overtaxed their kindness, I would alienate them, and so I made an effort to limit my calls" (Freely 1995, p. 5). In Maureen's case, the midwives contacted her because they knew Maureen and her family circumstances; in the case of a majority of childbearing women in Ireland who attend hospital

services, Kirkham and Stapleton (2004) identified barriers to informed choice included women's perceptions that they were expected to conform to the existing package of care. Many felt that they did not like to impose upon professionals, who already appeared stressed, by accessing the services outside of their planned appointments, even when they were anxious or concerned. Further, in the antenatal care appointments that were observed, women were usually silent (Kirkham and Stapleton 2004).

> 'You don't want to be an idiot coming in three or four times and going home either' **(ARC1 W2 18/40)**

> '...you are so worried you are going to be one of these freaking mothers going in with another pain, you know.' **(ARC1 W4 23/40)**

My attention was drawn to these remarks specifically through Readings Four and Five and they illustrate the significance for women in preserving relationships, in this case with potential carers, at the cost of silencing their own voices (Belenky *et al.* 1986, Gilligan 1993, 2011a). Women co-researchers valued all meetings with healthcare professionals as potential opportunities to promote confidence in preparation for birth and motherhood[185]; thus, preparation for birth and motherhood extends beyond the realm of structured antenatal education classes. According to Barbara Katz Rothman[186] (1996, p. 255) 'birth is not only about making babies. Birth is also about making mothers-strong, competent, capable mothers who trust themselves and know their inner strength.'

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based maternity care, a personal phone call from a known midwife is more likely to be the exception than the norm.

[185] According to Nicky Leap (2010) 'At every stage of our interactions with childbearing women, as midwives we should be adopting behaviours that will maximise the potential for women to take up the power that will enable them to lead fulfilling lives as individuals and as mothers' (Leap 2010, p. 19)

[186] Katz Rothman (1996, p. 255) asserts that 'the standard management of pregnancy and birth undercuts the woman's strength, her trust in her own body, her trust in her competence to mother.'

'I think anything that increases your awareness and makes you aware or gives you the options even if it's not antenatal classes as such in terms of the strict six classes or five classes you do, any sort of education initiatives or interaction with the hospital is helping me to calm down and relax...' **(ARC1 W4 23/40)**

6.3.3. Value in Sharing Experiences

Women co-researchers emphasised the potential value of a hospital-based forum for pregnant and postnatal women to share similar experiences of when something goes wrong during pregnancy or birth. Two women co-researchers (W1 and W4) had previously suffered miscarriages and suggested that time and space should be created to discuss the impact of these events during subsequent pregnancies. Reading Two for the personal pronoun, or 'I', conveys W4's challenges in navigating her emotions related to her current pregnancy when such time and space is not available.

'...I do feel, I don't know how you feel, I'd be interested but I do think it does give a different dynamic to a pregnancy and it's a set of emotions that isn't worth thinking or talking about because you can drive yourself demented if there's not some outlet for that...' **(ARC1 W4 23/40)**

Similarly in the voice of W1:

'I would be the same that I'd be conscious of not speaking about it (miscarriage) at all with my pregnant friends in case it would freak them out...I guess until you've been through it, you don't really understand...I don't know' **(ARC1W1 21/40)**

Notwithstanding the need for support and understanding in this impasse, there is evidence of empathy and perhaps responsibility for other women in group settings. There is therefore, a view that discussion about negative experiences should be avoided for the sake of other women, yet the hurt remains:

'You don't want to be scaring other people, but yet there's huge validity to the feelings you are feeling because it happened' **(ARC1 W4 23/40)**

6.3.4. Cautious Acceptance of Dominant Behaviours

In our conversations, women stated that they chose hospital-based ANE to become familiar with the probable birth environment in addition to gaining knowledge of relevant practices consistent with principal carers. Patricia Carr's (1992) comparison of hospital-based and local health centre classes reveals that women learn 'birth rules' through the process of antenatal education offered in hospital-based ANE and, to this end, fare better by being equipped with knowledge of the workings of hegemonic institutional settings (Carr 1992, p. 21).

'...how the whole thing [birth] is handled and so on, I suppose depending on who's giving the class and what their background is they are going to have a view of how things should be done...not just the birth but like I mean all around the process, I suppose right the way through, everybody is going to have their idea of what is the *best* way of doing something...consultants are pushing one thing and the midwives are pushing something else' **(ARC1 W2 18/40)**

The second reading for the 'I' in response to the question 'why attend hospital-based ANE?' uncovers the depth of uncertainty and the cautious acceptance of standardised norms of care. This woman co-researcher was attending the obstetric led model of care.

'I don't know I'm not really that fond of hospitals generally...I wanted to try and become acquainted with the hospital and some of the staff maybe so I won't feel quite as uncomfortable coming in...I don't really like the idea of having birth like, giving birth in hospital anyway...I suppose, just to see what the options are maybe' **(ARC1 W3 34/40)**.

Underlying principles of trust and belief in the accreditation and validity of hospital-based information emerge in the absence of alternative accessible sources. Reading for

the 'I' in the following extract illustrates the extent that pedagogical teaching[187] shapes, what is considered to be, acceptable discourse. This is consistent with Paolo Freire's (1993) notion of 'prescription', or the imposition of the oppressor's choice upon the oppressed, which ultimately transforms the consciousness of the recipient of the prescription to one that conforms to the prescriber's (Freire 1993, p.29).

> 'I kind of thought it was almost like a pre-marriage course (laughing)...I never even considered that I don't have to go to this...I didn't really give it a huge amount of thought...I just you know the only choice was, do you do one of these weekend courses that's done independently, or do you do it in the hospital and for me...I just felt better having it in the hospital because the element of accreditation and validation was there, whereas externally there's always the ambiguity that anybody can set up a course, so that would be the only choice I would have made about it' **(ARC1 W4 23/40)**

This statement reflects unquestioned acceptance of the status quo but also a lack of antenatal education alternatives for women who cannot afford them. Other reasons that were cited for acceptance of this programme of instruction, was to gain familiarity with place of birth. The dominant message is clear and that is that the biomedical model of antenatal education is valued above other alternatives.

6.3.5. Birth and Place of Birth

Conversations reflect awareness of medicalised birth as the norm and the concession that alternative models of care, though they exist, are beyond genuine grasp. There is acknowledgement of a set approach to birth against which the woman feels powerless. In the extract below, the pregnant woman struggles to reconcile the options that are available to her and, in doing this, places emphasis on factual information as distinct from process or emotion. In an analysis of choice, Katz Rothman (1990) suggests that as so called choices become available for women against a technological backdrop, women are compelled to 'choose' the option that is endorsed socially. In practice, and in the absence of alternative, this means forced compliance with a medical approach to

[187] The pedagogical model designed for teaching children 'assigns to the teacher full responsibility for all decision making about the learning content, method, timing and evaluation. Learners play a submissive role in the educational dynamics' Knowles *et al.* (2011, p. 70).

birth. According to Tricia Anderson (2004), the concept of choice is 'a smokescreen, behind which the patriarchal medical model churns on' (Anderson 2004, p. 259)

> 'I'd like to know about more natural approaches on things as well and choices, a lot more on choices and I know there is a lot more out there than the hospitals, you know in principle they don't really agree with more natural type of things...they obviously want to get you in and out unfortunately...I mean it seems that the main option is lying on your back and if you want to try and do it naturally obviously that doesn't work with gravity...I try to do everything natural if I can in my life and I'm not going to say never, I may well take the drugs but I'd prefer it not to be forced on me...well you know 'you are taking too long in labour now, right time to get these drugs into you and those drugs into you...''**(ARC1 W3 34/40)**

6.3.6. The Role of the Hospital

Women suggested that the role of the hospital was to give information in a very biomedical way and was concerned with measuring performance and managing resources and overcrowding. In this way, they felt that hospital personnel would not support initiatives to establish informal networks for women, this view was; however, concomitant with a belief in the medical expert.

> 'There's somebody to guide you and you'll be told what to do almost. And there's certain security and comfort in that because you trust them, they've got years of experience' **(ARC1 W4 23/40).**

This is countered by awareness of lack of resources and subsequent effects on the experience of labour and birth (Larkin *et al.* 2012).

> '...it's like a conveyor belt, you know that you only have a certain amount of time and if stuff doesn't happen within a certain allocated time they want to speed you up, you know speed up the process...I guess the reality is this hospital is far too small for the amount of people giving birth and you see it in the headlines constantly and how it needs to you know, so I guess I'm a bit nervous about that.' **(ARC1 W1 21/40)**

Two main themes were identified in accordance with life after birth and these are building relationships for motherhood through ANE to cope with anticipated loneliness after birth, and the concept of change.

6.3.7. Building Relationships for Motherhood through Antenatal Education

During this conversation, women refer to informational needs yet they segue back consistently to their emotional needs. Reading 3 for relationship emphasised the desire to build support networks during pregnancy with other women sharing similar experiences, in preparation for the keen sense of anticipated loneliness after birth. Sheila Kitzinger (1977) refers to peer group support; when people are at similar phases in life or disturbed patterns of 'normal' living, they reach out to help and share with each other. This is very valuable community self help (Kitzinger 1977, p. 41).

I have had the privilege to witness how this support can be developed when I visited the Pregnancy and Parents Centre (PPC), an Edinburgh based charity that works with families and local communities. My observations of the PPC revealed that accessibility of information through language (free from medical terminology), a comfortable setting, and an emphasis on confidence building and privacy in labour and birth, were key to the success of antenatal education discussions. Feedback from couples attending the class at the PPC revealed that they enjoyed practical demonstration, and, space to discuss issues enabled their understanding of the mechanics of birth, requirements for preparation and planning (the use of a birth plan) and choice of support partner with a shared philosophy. The importance of the midwife-mother relationship was also established. The PPC espoused a social model[188] of care. It was clear to me that this small intimate setting contrasted directly with the large, impersonal and formal arrangement that provided the context for our research.

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[188]Patricia Kennedy in her discussion of the distinction between social and medical models of birth suggests that the social model of childbirth "adheres to the 'holistic view' of woman, encompassing woman as a social, emotional, physical entity. It views the woman in biographical terms, a person with a past and a future and as part of a larger social structure' (Kennedy 2002 p. 17). This model is synonymous with the natural childbirth philosophy associated with Kitzinger 1977, Odent 1984, Leboyer 1991, Kitzinger 2005 /2006, Dick-Reid 2010).

'I do think there's a very valid point about what you do when you get home, one from an operational point of view, but also from a coping and that interaction point of view...I don't know, some peer support system, it doesn't necessarily have to be hospital led but hospital initiated and then some sort of a way of getting people, forcing that initial awkwardness when you are in class and everybody is sitting doing their own thing, they all get up and walk out themselves just forcing that building relationships and it will happen itself I think.' **(ARC1 W4 23/40)**

According to Brodie and Homer (2009), women want to come together with other women but need the reassurance and safety of knowing that they are structured and organised.

'Sort of rebuilding communities that don't exist anymore' **(ARC1 W2 18/40)**

Schindler Rising and Jolivet's (2009) work on the United States CenteringPregnancy® Programme confirm from their experiences that groups provide an ideal medium for sharing and learning that is not possible to attain from one-to-one meetings. Sharing concerns with other women in a group setting in fact normalises pregnancy experiences and women support and empower each other (Schindler Rising and Jolivet 2009). The concept of normalising pregnancy is distinct from the medical view that pregnancy is pathological and normal in retrospect (Oakley 1993). There is challenge involved in group work, as people compete to talk and sometimes resort to private conversations within the groups and talking together, which happened frequently in our research. The current structure of hospital-based antenatal education however, militates against forming meaningful relationships with other women and this was acknowledged by women co-researchers.

'Yeah they (the hospital) want you in and out as quick as possible (laughing)' **(ARC1 W3 34/40)**

The social problems of industrialisation and urbanisation as a consequence of modernity, have contributed to the dissipation of support for new mothers engaged in new family and social forms. Societal expectation commands women to participate in

society as workers as well as mothers, and this continues to militate against the development of social support networks for women. In addition, widening commuter belts increase the distance between new mothers and family members. Family composition postmodernity includes many different forms (Pilley Edwards and Murphy-Lawless 2006, McTeirnan 2011), and women are less inclined to benefit from the same support that was provided by the traditional extended family unit. A sense of social isolation for new mothers was reflected in our research in what women said they needed, wanted, and what did not have:

> 'Yeah, well you are on your own from the time you have the baby till the time you go back to work and unless you really make an effort to get out there, you know it could be very lonely.' **(ARC W2 18/40)**

These responses are in keeping with the views of women participating in a multiple methods research study (in depth interview, focus group, survey and observation of antenatal classes) by Svensson *et al.* (2006), which explored the concerns and interests of expectant and new parents in Australia (n=205 couples) during the childbearing year. According to Svensson *et al.* (2006) pregnant women were concerned about the prospect of becoming mothers and, loneliness after birth, yet their male partners were preoccupied with concerns about labour. In the Irish context and in the absence of family and professional postnatal community support (Leahy-Warren 2005), women are forced to manage alone and in distress (Murphy-Lawless 2005, Murphy-Black 1990, Martin 1987). Participation in this research afforded women a welcome medium for conversation and companionship. Analysis of the readings reveals women's awareness of the magnitude of obstacles preventing a space within the context of busy and under resourced maternity care settings.

> 'It's a great start [the research meetings], I think one individual hospital is not going to get something off the ground but if you can prove there's a market for it...its more time based and a very small amount of resources. So it's more just to get the message out there that yes, we want this, the women of Ireland.' **(ARC1 W2 18/40)**

6.3.8. Change

The probability of altering one's former lifestyle was predicted by women in addition to identified strategies to retain the sense of self one experienced before pregnancy and birth. The degree of the women's vigilance in this domain surprised me because most of my reading of the relevant literature had examined lack of preparedness and shock in becoming a mother.

> 'I'm hoping it won't change it completely...just try to keep in touch with friends and make sure that, obviously initially you are not going to be able to but keep up social life and keep up just trying to you know get out and do stuff and not be sitting in and that kind of thing, especially in the first six months or so.' **(ARC1 W1 21/40)**

Alteration in lifestyle and former life was anticipated so women felt the need to preserve self identity.

> 'Yeah I think you need a day off a week, just hand over and say "there you are dear, it's my day off". So that you just have one section of your life that's not completely you know, like you say use that day to do normal stuff and meet people.' **(ARC1 W2 18/40)**

My written reflections and notes recorded following the meeting indicate that women co-researchers appeared to converse easily within the group and felt free to clarify issues where necessary. As a researcher, I tried not to influence the emerging data but for the first time, I was aware of the multiple positionalities that I had assumed during the course of our conversation together. I was woman, mother, researcher and midwife simultaneously and separately in response to their stories, in what Michelle Fine (1994) describes as 'working the hyphen' or, uncovering 'how we are in relation with the contexts we study and with our informants, understanding that we are all multiple in those relations' (Fine 1994, p.135). I thanked them and I explained about the follow up in terms of what to expect and the process of feedback. We discussed our next group meeting, which was planned to take place 12 weeks after the woman who was 18 weeks gestation at the time of this meeting had birthed her baby. Digital recordings were

transcribed verbatim and were sent to the women co-researchers for confirmation of accuracy, in addition to my interpretation of the main themes.

6.4. The ANE Co-researchers' Meeting

Please refer to Tables One (page 89) for the Number of Antenatal Educators Participating in Each ARC and Two (page 91) for the Number of Women Participating in Each ARC Meeting and Appendix 2 for visual representation of the Action Research Cycle.

P1, P3, P4 and P5 attended this meeting. The aim of the meeting was to create a space for ANE co-researchers to share their reflections and experiences as antenatal educators, as women and, where relevant, as mothers. Brodie and Homer (2009) reflect that successful team collaboration requires that care values be explicit among team members; I was conscious that this was the first time that we were meeting to discuss these issues directly. Thus, it was important from the outset that we shared open discussions with a view to making known our personal attitudes and philosophies of antenatal education. In this way, it would be easier to decipher whether philosophies related to antenatal education were consistent or conflicted between group members (Brodie and Homer 2009). The unity of the group had long been established, but ANE co-researchers admitted readily that the research discussions highlighted practice issues and strengths. The research also promoted individual and group reflection, which developed further through the course of and between each meeting.

The role of the researcher in PAR is to guide and facilitate open discussion (Koch and Kralik 2006). In this case, sometimes this meant listening and sometimes saying little. In fact, I said very little at this meeting because the ANE co-researchers embraced the prospect to discuss the programme, and once space was created to examine issues of significance together, the metaphorical dam opened. As time went by and as meetings progressed, I became more confident and said less still.

6.4.1. What is Antenatal Education About?

The question: 'What is Antenatal Education About?' opened the meeting. The ANEs views of the aims and objectives of antenatal education were outlined as follows: to inform women about labour, birth and parenthood with the purpose of alleviating fears

and concerns, and to familiarise women with the ways that they can give birth. The value of a supportive environment and coming together with other mothers was also emphasised, albeit within the forum and structure of antenatal education classes.

> 'I think it's also to promote confidence and to make them feel positive and also I think it's a great forum for discussion...it's a good place for them to be free to ask questions...' **(ANE 1 P3)**

For women as recipients of care, 'confidence' is a vague and tenuous concept because achieving confidence is contingent upon the woman learning to navigate her personal complex realities in the fragmented[189] space provided by the structure of current maternity services. The confidence in decision making afforded to the women is framed firmly within a hospital ethos, as distinct from creating space to acknowledge and explore individual context.[190] Jo Murphy-Lawless (1998, p. 250), suggests that within the system of obstetrics we have, discussion around decision making is extremely limited; 'our fears about death and loss are constructed for us but we are left no way to deal with those fears actively, to exercise agency in relation to them.' According to Taylor and Pettit (2007, p. 232), the depth and scope for learning may be limited because 'many learning experiences are not grounded within a sound conceptual understanding of social change processes.' There were occasions when the women in this research were aware of this, for example, in our discussion related to the hospital's role in managing resources with little hope that informal supports for women could be established.

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[189] The current fragmented approach to the organisation and structure of maternity services in Ireland is, according to Kennedy (2002), a by-product of the introduction of the medical model of childbirth.

[190] In her research on birth autonomy, Edwards (2005) describes how, 'these women (interviewees) explained that being encouraged to become strong, competent and caring mothers helps them to protect their babies, and keep them safe, before, during and after birth. Their abilities to do this depends on being encouraged to develop their autonomy skills, by being listened to, trusted, respected, and treated as capable individuals. This enables them to make good decisions' (Edwards 2005, p. 255)

'I would agree with P1 about information, the positives behind what you are doing and make them feel that they can be open minded about decisions, as long as they make *informed* decisions. So what we're doing is informing them so they can make a decision as regards their care' **(ANE 1 P3).**

Differences emerge between what women identify that they need from ANE, that is, grounded exploration of their personal needs and what ANEs suggest antenatal education is about: careful and thorough explanation of the package of care that is offered, and, in addition,

'...probably about giving them guidance for maintaining a healthy pregnancy as well, you know, kind of to encourage what's current in terms of information, what's up to date in terms of research, making sure that they're as well informed to be self caring as they need to be so it's kind of like, preparation for labour, I suppose its mind boggling, the different emphasis' **(P5).**

The 'different emphasis' suggested in the above paragraph refers to the minefield of potentially erroneous information available to pregnant women and new mothers from media online forums and other sources. Thus, there is a subsequent requirement for women to become familiar with available expertise within the hospital setting and when professional guidance in maternity care is required:-

'They might say is it a good idea to get an epidural and I'd say well, I don't think it is, now you can get it, you can get anything to keep you happy but I don't think it's a good time to be getting an epidural. I think sometimes, I found this recently, I think this is the way we've gone in the health service, I don't know if it's a great way, well I'll leave it up to yourself, I'm talking about c-section. I had a lady and she was terribly confused because the doctor said, well we'll leave it up to yourself...I thought to myself, I didn't say it to the women, I said this is where we've lost it, we really have, like we really should be saying to women look, I think you should have this and this is what I would suggest.' **(ARC1 P3)**

P3 highlights the disparity that occurs between women's needs and available services when time and space is not provided to listen and to respond. In the absence of promised government health reform in Ireland (Murphy-Lawless 2011b) that defends birth and supports carers,[191] women in turn are left helpless, navigating a system that is shaped by a deep seated culture of fear and blame perpetuated by hierarchy. A system which, according to Murphy-Lawless (2011a, p. 5), has 'to process women rather than care for them and work with them.' In her recent analysis of the current chaotic state of maternity services in Ireland, exacerbated by economic collapse, Jo Murphy-Lawless (2011a, p. 3) asserts that an 'embedded and deeply conservative obstetric profession which has remained largely unchallenged as the central influence on all levels, from the individual women to hospital policies to national policymaking.' Government support of the medical paradigm is reflected by the perpetuation the two-tiered system public/private of obstetric practice, which permits obstetric consultants to protect their lucrative public/private contracts, renegotiated as recently as 2007 (Burke 2009). As a result of the two tiered system of medical care, midwifery care has been marginalized and in this context, women in Ireland have been denied choice in relation to place of birth and type of care provided (Kennedy 2010). According to Edwards (2008), women and midwives are at a disadvantage to obstetrics because privatisation of health and maternity care is difficult to challenge. Privatisation by its very nature means increasing profits through greater efficiency and throughput, resulting in standardised practice as distinct from practice that is focused on individual need.

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[191] The exception to this is the pilot of two Midwifery-Led Units emerging from the recommendations of the *Report of the Maternity Services Review Group to the North Eastern Health Board* (Kinder 2001). According to Kennedy (2010, p. 147) the 'Kinder report' is an important document as it provides 'a blueprint for a woman-centered, quality maternity service, which is safe, accessible and sustainable.' There is a paucity of planning for maternity care provision with the exception of the aforementioned work and the recommendations for midwifery outlined in the *Report of the Commission on Nursing* chaired by Justice Mella Carroll (Government of Ireland 1998); in addition, there is no national audit of Maternity Hospitals in Ireland (Kennedy 2010). The *Report of the Commission on Nursing* (1998) also recommended the four year undergraduate midwifery degree programme, which commenced in 2006. Patricia Kennedy's (2010) analysis of maternity care provision, suggests that change is consistent with regional initiatives as in the case of the North Eastern Health Services Executive (NEHSE), as distinct from national reform of the maternity services (Kennedy 2010).

The prescriptive nature of the medical model of maternity care is depicted also by the statement below that women make decisions according to their 'best interests'.[192] It may be argued that as recipients of maternity care, women are not autonomous agents and are not generally permitted space for recognition and analysis of the self, in terms of capacity for labour, birth and motherhood, within mainstream institutional settings. This cannot be undertaken without considering the uniqueness of the individual and the complex social and historical context in which all autonomous agents are embedded (Mackenzie and Stoljar 2000). Without a meaningful relationship to uncover these needs, it seems that the woman's naming of her best interests is unattainable and her confidence to question is contingent upon unwavering professional and companionable support.

> 'So just, it's not about you know, dictating a hospital policy, it's not about making sure things go accordingly to what the hospitals plan is, it's just that someone can decide for themselves in the context of knowing what might be, you know, being *confident* to say this is, even to say this is how I'm feeling, this is what's happening or being confident to make contact with key professionals must be important in antenatal education...' **(P5).**

The concept of women achieving control through openness in telling and hearing about birth was debated; telling and timing of information-giving is often motivated by fear of omitting information that may be relevant, and this is illustrated in the extract below. Thus, in order to fit in with a rigid timeframe, there is a generic and standardised approach to class content with a desire to meet all potential information needs, as this next extract indicates:

> 'Well, I think the more informed you are, the better you cope and I think they're more in control when they're well informed because I don't think not knowing things is good for women coming into labour I think they need to know facts, now I wonder sometimes they need to know about forceps and suction and caesarean sections because I do think, it worries them, it frightens them but I

[192] Margaret Mason (1998, p.37) suggests that information with-held in the 'best interests' of the woman is an implicit form of social control.

think then afterwards when they've had a caesarean section you say well thank God we told them about that, you know, because they would be twice as bad afterwards if they didn't know about it.' **(ARC1 P3)**

This reflects a standardised, generic approach to information giving. Standardisation in the U.K. was originally developed to provide care based on research evidence, and has increased more recently in response to clinical governance and managing risk (Deery *et al.* 2010). Despite this, Kirkham (2010a) suggests that standardisation tends to marginalise relationship, as midwifery care is governed by protocol above response to individual needs. For women; however, good relationships are perceived as vital for good birth (Hunter *et al.* 2008, Kirkham 2010a).

6.4.2. The Nature of Information Giving

ANE co-researchers assert that information should be factually correct, up to date, current and should facilitate decision-making, particularly in relation to positive health behaviours, positions for birth, and awareness and acceptance of possible intervention in childbirth, and why intervention might be deemed necessary. Our discussions, however, reveal that the nature of information-giving is coloured by the facts in keeping with the rules associated with a particular package of care. In the context of discussion about instrumental birth, ANE co-researchers felt that women should be aware that the practice of a maternity care setting is shaped by the fear of potential litigation:

'True, rather than creating an expectation that we can, you know, because we're constrained by policy and safety and there's always, I mean the unspoken thing is always indemnity issues, it's the safety of the baby within, and those constraints are placed by indemnity to some extent...if a scenario has ever arisen whereby there has been a legal case, it places limitations around future situations of a similar nature that are not necessarily what everybody might wish to do under normal circumstances, you're constrained, you have to be really honest.' **(ARC1 P5)**

Thus fear, according to Kirkham and Stapleton (2004), specifically fear of litigation, influences how 'choice' in maternity care is presented to women. Kirkham and

Stapleton (2004) suggest that fear of litigation 'has accelerated the trend towards a more conservative and defensive clinical practice not least because health professionals tend to use technology as 'prophylaxis' against being sued.' Further, a 'with-institution' orientation emphasises physical safety of the mother and baby by ensuring the successful completion of tasks (Hunter 2004, p. 267).

6.4.3. What Women Need to Know

When asked, 'What do you think women need to know?' ANE co-researchers stated the uniqueness of each woman and her experience pertaining to pregnancy and birth; in addition to the limited available time frame, complicates identification of individual learning needs. Combined with a pedagogical approach to facilitation of learning that is enforced by the institution, there is the assumption that, as distinct from the adult learner, pregnant and postnatal women are possibly unable to name and negotiate their learning objectives:

> 'Maybe we are telling them too much....' **(ARC1 P3)**

Yet there were examples of active learning through dialogue as distinct from passively receiving information.

> '... helping them know what they don't know, you know, or ask what they don't even know they need to know' **(ARC1 P5).**

ANE co-researchers identified as important information on birth positions, stages of labour, listening to one's body and relying on one's instinct and realistic information about tiredness and general physical well-being after birth.

> 'And I think one of, you asked me what women needed to know and I think a really important thing certainly from a physical point of view is to be practical, that they need to listen to their bodies...to trust that and to, to rely on their instincts to a certain extent.' **(ARC1 P4)**

6.4.4. Not Knowing

There is acknowledgement of women's lack of knowledge about birth, which echoes the earlier conversation with the pregnant women's group. The extract below suggests that this lack of knowledge extends beyond scientific knowledge and into other ways of knowing, which are discussed in more detail in Chapter Ten. The words of this ANE co-researcher illustrate a sense of connected knowing, which is described as 'connecting with the experience of another through empathy' (Johns 2005).

> 'It's a big black hole to them, you know, it's a big black unopened, big locked door isn't it?' **(ARC1 P5)**

ANE co-researchers articulate frustration that women cannot be prepared fully for birth through the current medium of antenatal education, as confined within the structure of the institution. Awareness of the enormity of birth and motherhood fosters a sensitive and mindful approach[193] and this is reflected in the statement from one ANE co-researcher:

> '...it's so profoundly life changing (birth and becoming a mother) that the whole fact of preparing you can only go so far anyway, it's kind of a self limiting thing with antenatal education because it's only going to do so much anyway.' **(ARC1 P5)**

According to Edwards (2005), women acquire knowledge best through conversation with other women, and research conversations with women co-researchers reveal their desire and need for companionship from other mothers. Ann Oakley (1980) refers to this as the subversive power of sisterhood. This desire is particularly marked if information is not achieved through official means. ANE co-researchers acknowledge

[193] According to Christopher Johns (2005), an event or experience, while apparently mundane on the surface because it is routine or commonplace, in practice can be overwhelmingly profound for the individual involved. This is because of the intense feelings that are experienced with a life changing event, as in this case, when a woman draws near to birth and becomes a mother. Ideally, as a result of this awareness, the practitioner becomes more conscious and responsible for the decisions made and the actions taken (ibid).

that making connections with other women throughout pregnancy is helpful; however, there is reluctance to mix groups of first and other mothers in classes due to ANE co-researchers' views that women are fundamentally fearful of birth and fear is exacerbated by conversations with other women.

> 'So every group is a little bit different, you can't, you never mix first time (and other mothers) and I think that's the thing for classes, I don't think you can really mix second and first...I think sometimes (first time mothers learn from other mothers) but I think if someone has a bad story it's not the best for a first time mother, it's terrifying' **(ARC1 P3)**

According to O'Driscoll *et al.* (2004), parous women tend to have 'closed minds' on the subject of labour and it is recommended that first time mothers are separated from other mothers in antenatal classes (O'Driscoll *et al.* 2004 p. 81). The inception of Active Management of Labour (AML) dates back to the 1960s when male dominance was a feature of the major institutions in Irish society; however, Active Management of Labour continues to be 'a near blanket practice in Irish maternity hospitals (Kennedy 2002, p. 14) and its practice is reproduced in the AML handbook, which is currently in its fourth edition.

6.4.5. A Plan for You

A dichotomy exists between acknowledgement of the limited role of antenatal education within the maternity care setting and an acceptance in facilitating a programme of ANE that is influenced by a dominant institutional ethos of care. According to Weber 1995, as cited by Anderson (2004, p. 260), 'the needs of the institution will always outweigh the needs of the individual'. Thus, the needs of the organisation are prioritised and care becomes focused on the needs of the system or system focused, as distinct from woman focused (Hunter *et al.* 2008, Kirkham 2010b). In Kirkham and Stapleton's (2004, p. 118) research relating to informed choice in maternity care, the authors observed that hierarchical structures were reinforced by economic necessity and 'staff justified their behaviour with reference to policies, procedures and guidelines, which tended to be treated as rules.'[194]

[194] I refer to the relevance of rules in Chapter One.

> 'I think they have to know what's happening in the institution where they're going to, and they often bring up birth plans and I would say look, let's do the labour business and tell you what's going on here, tell you the policies here and you can then decide what you like and you can write your wishes down and we will try and meet your wishes. But I have a birth plan for you today, you see what mine is like first, what we'll do here and then you tell me you want that or you don't want that and let us know...our birth plan is a whole package, it's education, it's one to one with every mother, it's tuition, it (labour) would be limited. It's breaking water on admission or syntocinon during labour, mothers will need to go with that. If she's not [in agreement] that's fine...' **(ARC1 P3)**

Fahy (2002, p. 12) suggests that birth plan 'asserts the woman's sovereign rights and acts as a disincentive for the coercive use of disciplinary power.'[195] In fact, as the extract above illustrates, even before the woman offers her birth plan she is subject to the message of the institution's birth plan. She must navigate a complex hierarchy if she does not want the institutional package of care; in this setting, antenatal education is a means to inform women of hospital protocol. According to Murphy-Lawless (2011b), maternity care in Ireland is characterised by midwives who are working in a profoundly medicalised and compromised system that is marked by increasing intervention, with a proportionally inverse number of spontaneous vaginal births, thus, superseding women's needs. In keeping with the unquestioned acceptance of medicalisation and hospital protocol the extract below (from a woman co-researcher) reveals a lack of awareness of an alternative that, for now, is beyond grasp:

> 'Just protocols for different hospitals because they vary and you know she was saying that you have a birthing, like (hospital) have a birthing plan for you and if you want to deviate from that, that's fine, let us know, but this is what we're going to do when you come in the door' **(ARC3 W17 37/40)**

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[195] Fahy's (2002) use of disciplinary power is in reference to Foucault (1991, 1998) concept of organisational power over groups and individuals which requires co-operation of the subject, but is not visible until resistance is encountered.

Downe and Dykes (2010, p.61) acknowledge that 'the current approach to maternity care is located within the dominant paradigm of biomedicine and linearity.' During this discussion, the concept of empowering women was raised as a feature of the role of the antenatal educator and was described thus;

> '...to be self caring within the best of their abilities but when they need professional advice, that's what we're here for...' **(ARC1 P5)**

According to Leap (2010), empowerment is an ongoing and dynamic process of giving and accepting power, in this instance, power and empowerment are restrained by the level of personal[196] and professional autonomy of the ANE co-researchers. Also, it is important to remember that power and empowerment are not products that can be held or allocated but are the effects of the discourses and practices that produce them (Kesby 2005). It is clear that a lack of continuity[197] in how services are structured impedes the development of trusting relationships between women and carers that permit exploration of pertinent issues in a safe and sound environment.

6.4.6. The Role of the Antenatal Educator

Q. What's your role then, what do you see your role as being?

> 'Well, I think my role is to impart knowledge and I think my role is to encourage and build up confidence and make them feel good about themselves, make them feel about what event is coming up, give them as much information as I can. And basically empowering them to make their own decisions but I would say to women, keep an open mind, and you make your mind up on the day what you're doing with the epidurals or Pethidine or mask. I'm going to give you the information now, you go home and think about, I don't want you coming in and

[196] According to Jayne Marshall (2005), personal autonomy is defined thus, 'To recognise and appreciate the person's capacities and capabilities, including the right to certain views, to make certain decisions and take certain actions based on personal values and beliefs' (Marshall 2005 p. 13).

[197] I refer to continuity in the relationship sense. According to Hatem *et al* (2008), 'relationship continuity means a therapeutic relationship of the service user with one or more health professionals over time' (Hatem *et al*, 2008 p. 3)

> the first thing you want is an epidural. I want you coming in and saying 'well, let me see how I'm getting on and I'll make my mind up as I go along', and I also love, they're great people and you have a great time with them, you know, you've great fun, it's not all serious business.' **(ARC1 P3)**

There is desire for relationship and continuity that is not a feature of a fragmented institutional care setting. In stark contrast, Maureen Freely (1995) shares her personal experience of team midwifery and describes how a midwife whom she knew well visited her at home during her pregnancy. Integral to their discussion about evidence related to pharmacological methods of pain relief was the space and time created by the midwife who needed to know the woman's feelings about pain relief, in addition to the stories she had heard and their influence (Freely 1995).

According to Sheila Kitzinger (2006), the role of antenatal educator is to empower each woman she meets by assisting the woman in negotiating her birth needs (Kitzinger 2006). Of course, negotiating birth needs requires that the woman has initial space to consider and name those needs. In the medicalised setting, labour is timed and limited and characterised by professionals who are allocated discrete tasks and the act of birth giving is defined as a mechanical and technological process (Kitzinger 2006, p. 22). The goal of antenatal education within a masculine medical paradigm, therefore, is 'to define a woman's role in labour and to teach her how to fulfil it' (O'Driscoll *et al.* 2004, p. 79). In the research presented here, information about how to navigate the system is offered without the real possibility of exploring the concept of 'choice'[198] that is framed

[198] According to Oakley (1993), the concept of choice is not a feature of the medical model of birth and motherhood, chiefly because of the following: reproduction is viewed as a medical specialised subject, parenthood (as distinct from personhood) is isolated from women's life circumstances, and because women are considered ignorant of reproduction processes. To clarify, Adrienne Rich (1995, p. xviii), in her analysis of motherhood as institution and experience, refers to 'the claim to personhood; the claim to share justly in the products of our labour, not to be used merely as an instrument, a role, a womb, a pair of hands or a back or a set of fingers; to participate fully in the decisions of our workplace, our community; to speak for ourselves, in our own right.' Further, according to Pam Carter (1995) citing Petchesky (1980), in her analysis of feminism and reproduction, choice is too narrow a concept to portray adequately the broader issues of social change needed to augment women's autonomy and sense of control. Carter (1995) contextualises this by outlining the social differences and divisions that undercut women such as colour, gender, race and disability.

within the rules of the institution. Thus, disparity exists between very diverse paradigms of care shaped by the social and medical model, and the woman is caught between with no-one to challenge on her behalf. Once a woman is admitted in labour, her role is to accept the rules of obstetric ritual handed down by what Freely (1995, p. 10) refers to as a 'faceless institution.'

> '...in terms of labour just to echo what you said about the importance of staying open indeed, because if they're very blinkered and very hell-bent on one option they set themselves up for a fall and do feel really disappointed if reality deviates from that, which it can often' **(ARC1 P4)**

6.4.7. Team Working

Several times during this conversation, ANE co-researchers emphasised the strengths of their interdisciplinary approach to class facilitation, thus providing opportunity to share various perspectives, knowledge and skill sets specific to each discipline. Our conversations reflected their ability to debate and differ without negative consequences. They attributed some of this success to respectful delineation of knowledge and related skills, yet observation revealed that, in terms of class content, there was clear overlap between midwife and physiotherapist (Mason 1994); this aspect was highlighted and discussed in later meetings. It is interesting to note that research by Ketler (2000) exploring the social settings and teaching organisation of two differently structured childbirth education courses in Italy, revealed that the absence of division of teaching tasks allowed friendships to develop between facilitators and participating women.

As highlighted in Chapter Four, the use of reflection boxes is my attempt to provide some insight into my first-person inquiry, conceptualisations, or my 'making sense of' my engagement in the research. The reflection box below outlines my preconception prior to analysis of our conversations that the model of ANE required change.

Field note Entry from Reflective Diary 27th August 2010 in Analysis of Meeting 1 with the ANE Co-researchers

Reading One highlighted my prejudice and preconception that the structure and process of this particular model required change, which was influenced by my judgment that the dominant ethos of care was autocratic. As I read, I am surprised to find that the findings emerging from Reading One are not as completely negative as I had anticipated and I think that is a bias that I have to put to one side.

6.5. The Conversation after Birth

The following passages focus on the meeting with ARC1 pregnant women's group after birth and their shared experiences of the programme and institutional setting. Not all women could attend the first postnatal group meeting; therefore at their request to connect with the other women, a second meeting was also arranged. Two women attended each meeting: the first (W1 and W2) and the second (W2 and W4) and conversations were flexible and guided only by occasional prompts. I am grateful to the women who took time as new mothers to return to share their experiences, many of whom travelled long distances and faced additional obstacles in the early weeks of motherhood. One woman particularly (W2) was preparing for her new baby's surgery, which was scheduled to take place the week after our meeting. This drive for human connection with others in shared experiences is illustrated by the women's commitment to be part of the research conversations and highlights the deficit that exists in creating space for women to meet after birth.

> 'The only real opportunity has been to chat in this group actually so that's why I quite enjoyed the first meeting. And I was really eager to see you again to see how everybody had got on.' **(ARC1 PN2 W4)**

Women spoke about their anxieties surrounding motherhood and how they were coping with their new realities from day to day; there is a wealth of information; therefore, findings of key relevance to the research question are shared here and themes from each meeting are presented together. These conversations were analysed using VCRM, and my interpretation of the main themes was confirmed for accuracy by the women involved and were also presented to the ANE co-researchers for discussion. This was

the first group of postnatal women to share their experiences of the current education programme in preparation for birth and motherhood. We discussed some of the issues that were highlighted as important and women were asked to share their experiences of the ANE programme, pregnancy, birth and early motherhood.

6.5.1. Preparation for Birth and Motherhood

Postnatal women voiced the need for information related to hypno-birth, pregnancy yoga, practical information about procedure for caesarean section and preparation for the 'unexpected'. The notion of the unexpected is uncovered in Reading two for the personal pronoun or 'I' in the story. This extract is from a woman who experienced premature birth six weeks before her expected date of birth. It is worth remembering that this woman birthed prematurely and may not have felt prepared in the conventional sense, she had, however, attended the ANE programme.

> 'I was majorly traumatised...this just wasn't part of the plan...I'm not very good I suppose at coping with the unexpected like that... I didn't know he was coming...you are kind of thinking of well what if we had waited a few more minutes kind of thing and you know' **(ARC1 PN1W2)**

When events like this happen, the adult learner reverts to rote rehearsal[199] in the absence of information processing in a way that is meaningful and relevant to the woman's frame of reference. Knowledge becomes procedural and preparation for labour becomes a sequence of discrete events or disconnected happenings that one must commit to memory, as distinct from experiencing innate knowing and embodiment of birth and motherhood that a social model of childbirth fosters. This is also illustrated by postnatal women's desire for written material as memory aids and this is discussed later in presentation of the first Collaborative Inquiry Group meeting.

Kennedy (2002) suggests that the introduction of the medical model of care has culminated in a fragmented approach to maternity care and fragmentation of the

[199] According to Snowman and Biehler (2003), short term memory is limited by the quick disappearance of information when not processed further. This is relevant to this situation as material that is not meaningful to the learner is forgotten unless memorised for later use.

woman's body to the point where the uterus becomes the 'active uterus' and this is reflected in the following extract from one of the postnatal conversations. The statement from W2 suggests the woman's dissociation from her body and imminent birth during her labour and the impact of dis-embodied learning:

> 'You see it all just happened too quickly for me. I didn't know I was in labour number one because I thought okay you've got the three signs and you have tick them off, no it's not that, it's not that no, I'm fine.' **(ARC1 PN1W2)**

6.5.2. Support after Birth

The vast gap between the two models of care that Kennedy (2002) identifies is reflected in the loneliness and isolation that women feel after birth. In the absence of statutory community support in Ireland (Leahy-Warren 2005), women yearn for human connection and for one of the postnatal women co-researchers; one act of giving had a very positive impact. As new mothers, women valued accessibility and support of a healthcare professional in the community.

> 'Yeah, yeah I mean she's kind of past her official visits now but you know, she's in the (neighbourhood) area and she said just give me a shout if there's anything you need or if you want him weighed or anything like that...they're really busy you know, so it means so much for her to say that and you know, I have her mobile number and I don't know where else in the health service people really give you their mobile numbers' **(ARC1 PN1W2)**

The women's group shared their experiences of attending ANE, and my interpretations of the main messages emerging from analysis of the transcripts were offered subsequently to the ANE co-researchers and these were discussed.

Initially, women's group meetings and ANE co-researcher meetings were facilitated separately, as time was limited for the ANE co-researchers due to heavy clinical demands. In addition, I was keen to hear the women's voices without the presence of a healthcare professional that participating women felt could potentially shape their birth experiences in some way. This aspect was discussed with the ANE co-researchers; it was agreed that women may express their views more readily if the ANEs were not

present and we could discuss together any emerging issues at the joint Collaborative Inquiry Group (CIG) meeting. In this way, ANE co-researchers and women co-researchers determined the most important questions and, hence, co-created the findings (Koch and Kralik 2006). It was hoped that in doing this, they would question common assumptions about antenatal education as it is framed within the medical maternity care setting.

6.5.3. Consistency in Information Giving

An example of candid discussion at the women-only group meeting manifested when a postnatal mother expressed her frustrations on receiving conflicting advice from facilitators with regard to adopting positions for birth.

> '...they just need to keep up with the times a bit more. And be more in tune with what's out there and what people are looking at and expecting and stuff like that. So it all just seems very medicalised, they just seem to be really quick to just go 'right and these are your pain relief options.'' **(ARC1 PN1 W1)**

The women seemed confident to highlight these issues in the absence of the antenatal educators, and we discussed the value of consistency in information offered by professionalsto avoid confusion. Although it would be reasonable to assume that there may not be the same level of honesty in sharing with prospective carers, this was an issue that I was particularly mindful to highlight for the later Collaborative Inquiry Groups (CIG). In the role of researcher, I could raise awareness of the issue with a view to working towards consistency in antenatal education without compromising the woman's identity. Inconsistency and conflict in information giving was also evident after birth on the postnatal ward:

> 'I found it all okay, I, the hardest bit for me was I think the day or two after he was born on the (postnatal ward), just having so many midwives telling me so many different things, like I got completely confused...' **(ARC1 PN2 W4)**

The reading for the 'I', where the woman speaks of herself, uncovers her desperation and emphasises the importance of constancy in the informational support that the healthcare professional offers,

> 'I found it all okay... I think the day or two after he was born...I got completely confused...I ended up in tears.' **(ARC1 PN2 W4)**

6.5.4. Fear

Women verbalised fear and actively sought information after birth about relaxation and potential strategies to neutralise fear.[200] According to Kennedy (2002), under the dominant model of care, women are contained in surroundings in which they are anonymous and lack privacy and the luxury of knowing one midwife. Monitoring and intervention are characteristic of obstetric settings (Davis-Floyd *et al.* 2009). Disturbed birth[201] is what women have come to expect; this can mean using sometimes painful interventions and techniques that are perpetrated by strangers in public and turbulent surroundings (Buckley 2009). Analysis of the conversation in this particular instance indicates that fear and expectation of pain are inextricably linked. The desire for discussion about physiology of pain in labour is expressed and meaning for one participant is uncovered in the reading for the personal pronoun or 'I'.

> 'I think they could have gone into...how you deal with fear and pain...I think they (antenatal educators) just jump straight through that...I think you feel pain more when you fear it...I think they gave us nothing about how to reduce that fear...I think they could have done a lot more on that...I think if you're prepared...(they could have done more about the physiology of pain)...I guess I've come from the scientific background... maybe I'm just a bit you know too scientific about it.' **(ARC1 PN1W1)**

[200] The concept of fear in this instance is complex and interrelated and is debated discussion Chapter Ten.

[201] 'Disturbed birth' is described as 'anything that disturbs a labouring woman's safety and privacy' (Buckley 2009 p. 96).

Exploring fear begins with listening and, in the climate of maternity services preoccupied with 'through-put' of women (Martin 1987, Begley 2001, p. 32), it is not possible to consistently support space for human connection and listening. Kitzinger (2006) suggests that women's stories are sometimes difficult for health professionals to hear and may be reframed for their own perspective, at times, in an attempt to defend hospital policy or workers. If this is the case, the emotional impact and intensity of the woman's feelings are not validated and she is left feeling unsupported (Kitzinger 2006). Child-bearing women in Ireland come to birth ill-supported, and exposed to strong cultural messages of risk and danger[202] in childbirth (Kennedy 2002, Gray 2000, Murphy-Lawless 1998) shaped, not only by the medical profession but also by popular discourse, family and friends (Kitzinger 2006). This is coupled with the unrelenting message that technology and various programming techniques will secure safety and that the woman is protected by accepting the package of care (Davis-Floyd 2003). In this conversation, it seems that fear of birth influences how women want to hear information and for some, this means hearing in a limited way. The notion of 'balance' in information giving re-emerges in the postnatal discussion,

> 'I guess maybe for me it would be striking the balance that it wouldn't be unnecessarily worrying people but yet making them aware that things obviously, there are so many things that can potentially go wrong' **(ARC1 PN1 W1).**

6.5.5. Other Mothers

The desire to meet other women emerged in the postnatal groups with proposals for developing informal network support in classes, with the provision of light refreshments as ice-breaking tactics. Women were also aware of the restraining factors in the hospital setting for group engagement and cohesion in classes. In hospital-based antenatal education, class sizes are typically large and facilitated in large lecture-type settings which make human connection difficult. Environmental, structural, and organisational factors prohibit women's engagement and this emerges repeatedly throughout the research findings.

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[202] Note that according to Giddens (2003), risk and danger, though closely related, are not the same. Risk assumes precisely danger, though not necessarily awareness of danger. It is possible therefore, to engage in risky behaviour with an apparent awareness of danger, at the same time it is also possible for someone to take a calculated risk while being aware of the danger that a particular action may bring.

'I guess because the room was so small that you just got your seat because you were afraid of not getting the seat...most people didn't ask any questions at all and I was thinking is it because the group is just so big that you do get that group dynamic when it's too big a group that people don't speak' **(ARC1 PN1W1)**

6.5.6. Becoming a Mother -What Women Need to Know

An overarching theme of the postnatal conversation was the view that class information was primarily concerned with labour and birth and women voiced their needs for information and support in coping with a new baby:

'I think it was all just focused in on the birth' **(ARC1 PN1W1)**

'Well I think that's a very valid point and I don't know if you find it or not but I think that's very much what happened you know, in the antenatal classes you got very good information about the facts of the birth and the labour and preparing for it and then afterwards it was almost the feeling of, I wouldn't say abandonment but just you know, not having had anything to prepare for it. And maybe not everybody needs that but I think first time mums probably do' **(ARC1 PN2 W4)**

The relevance of postnatal preparation for new mothers during pregnancy is supported by the findings of earlier grounded theory research in Australia of first time mothers' (n=55) experiences of becoming a mother (Rogan *et al.* 1997) and more recently (Svensson *et al.* (2006, 2008) and Murphy-Tighe (2008).

In discussions about becoming a mother, women required practical information in the antenatal period about buying clothes and equipment and also practical support about how to care for a new baby:

> 'I found that *horrendously* difficult and I didn't have the first clue about what to do. Do you wake them, do you not, do they have wind, why are they crying, how do I feed it even like? Being on the bed still numb after the epidural and just being left with him and going *I don't know what to do.*' **(ARC1 PN2 W4)**

A hospital-based postnatal class is offered in the days immediately following birth and prior to discharge; however, postnatal women co-researchers doubted the usefulness of classes because of their sheer exhaustion after birth and consequent concentration loss. Women therefore, sought postnatal information during pregnancy.

In our postnatal meetings, it was clear that for some women, the medicalised ethos of the maternity care setting was very apparent:

> 'I guess because I had kind of read a lot there wasn't a huge amount that I kind of didn't know coming from the classes. But what I did find was everything was so medicalised and I can see why, we are in hospital you know giving birth and stuff you know, but I, I had put up my hand at one stage and asked you know where they, what's their view on hypno-birthing and the nurse she just looked at me as if I had ten heads and went 'em, oh I think there might have been two people ever that did that.'' **(ARC1 PN1W1)**

An important component of antenatal education was the opportunity to visit and become familiar with place of birth. Women reflected about visiting the labour ward:

> '...it just meant that I knew where I was going to be and what was going to be happening, whereas you know, it was all an unknown to me before that.' **(ARC1 PN2 W4)**

Postnatal women echoed the concerns about the viability of hospital-based antenatal education in preparing for the profundity of motherhood as a life changing event, particularly ANE that is set within the confines of institutional structure, concerned with throughput of women due to volume and the resulting generic nature of classes,

> 'But all you want at the beginning, I remember saying this at one stage, all you want in those first few weeks is somebody to just tell you what to do. And the truth is nobody can really tell you what to do, sure they can't...experiences are so different that it's impossible for an antenatal class to cater for everything. So I suppose it does by its nature have to be quite general and give little bits of information about a lot of things.' **(ARC1 PN2 W4)**

This extract exposes the failure of the current system to meet the needs of women grounded in their experiences. According to Raphael-Leff (1993), new mothers require confidence and nurturing to be able to mother their babies generously. The constant companionship and reassurance in the early days comes with knowing another, and freedom through relationship, to discuss issues of relevance and meaning grounded in women's everyday experiences of motherhood. Not for the first time in this research I considered that perhaps a new mother needs another mother. According to Michel Odent (2008), the ideal birth companion is a silent supportive mother figure.

> 'I guess until you've been through it (birth) you don't really understand' **(ARC 1 PN W1)**

According to Judith Schott (1994, p. 3), 'In order to nurture a child, a woman needs to feel valued and nurtured herself. She needs to have confidence in her own ability to think clearly and make good decisions for herself and her baby. The way parents are cared for during pregnancy and childbirth is crucial in laying down the foundations of confidence and self esteem.' Lynn Bertram (2008) propounds the benefits of groups in providing the support mothers that need in order to care generously for their infants and in supporting specific needs, for example, loneliness, brought about by isolation from adult companionship, listening, and sharing information and experiences (Bertram 2008). Additionally, groups composed of other mothers provide psychological support, validation and encouragement; women as new mothers talk, share and learn together naturally (Kitzinger 1977, 2001). Reaching out to other mothers for support, validation, witness and encouragement is essential to self discovery in becoming a mother (Stern *et al.* 1997). Stern *et al.* (1997, p. 110) refer to this special psychological environment, in which a mother can feel secure, trusted and encouraged to explore parental skills, as an

'affirming matrix', sometimes known by professionals as a 'holding environment'[203] At the centre of the affirming matrix is a wish for a mother figure, whether real or idealised, to aid and support and to be with. In this way, women seek other women, consciously or not, to share information and to 'observe other mothers in action' because other mothers have the authority of experience (Stern *et al.* 1997, p. 111-112).

Desire to meet experienced mothers is evident in the readings and listenings of the pregnant and postnatal groups; according to women co-researchers, mothers' groups could be initiated by the antenatal educator. This extract is from the ARC 1 postnatal mothers' group:

> '...a lady from the La Leche league brought in another mother who had a four month old and she actually demonstrated breast feeding and lying down breast feeding, different positions. And the mother was fantastic, she actually lay down on the floor for us and the midwife was going to, or the lactation nurse was going to show us a video and she said, 'no, no, no I'll lie down, I'll do it.' So just seeing somebody else breastfeed and in the different positions and talking a little bit about her experience was really good. Having the baby dolls to practise with was great.' **(ARC1 PN2 W4)**

[203] Stern *et al.* (1997) suggests that the 'holding environment' is akin to holding the mother in a 'sustaining embrace' (Stern *et al.* 1997, p. 110)

Field note Entry from Reflective Diary Post Meeting of PN Group 1 on the 24th August

Note: To contextualise, there were two women present at this meeting and, as previously mentioned, W2's baby required surgery of which W1 was not aware, prior to our meeting.

W1 was tearful after our conversation, she said that she was not used to babies who are not perfect, that she 'had not met one yet' and she apologised and said that she 'hoped that she was OK with W2'; she was taken aback and did not know what to say. I am troubled by this and I feel that I have failed her in some way. It is not something that can be said in an email or telephone conversation and, even if I had the opportunity to warn her about it before meeting, I still feel that it was not my place to say it. I suppose to me, it is not shocking and once I found out about the baby's surgery, I was really focused on W2 (his mother) before we met. Both women said that they would like to meet with the ARC1 group again and that they would attend for a second meeting. I also invited them to the Collaborative Inquiry Group meeting in October as postnatal collaborators to support the next group of pregnant women.

I found that offering refreshments and providing a bag for the nappies, yoga mats and baby blankets, so that the babies could stretch, was helpful. I sat on the floor because the women alternated between chair and mat with their babies, it was easier to do and it meant that I was sitting at a lower level, so they could speak freely and with comfort.

Both women did in fact participate in the next Collaborative Inquiry Group meeting.

6.6. Conclusion

In Chapter Six, the First Action Research Cycle is explored. The key findings from four group meetings are presented. The first group meeting highlighted women's knowledge needs for pregnancy, birth and motherhood and the value they place on sharing experiences with other mothers. Women discussed birth and place of birth and their perceptions of the role of the hospital. Two main themes were identified in accordance with life after birth and these are: building relationships for motherhood through ANE to cope with anticipated loneliness after birth, and the concept of change. At their

meeting, the ANE co-researchers discussed their views about their role and function and the purpose of antenatal education and the nature of information giving. They discussed what they feel women need to know and the hospital ethos of care. The postnatal group meetings (two) revisited their views about preparation for motherhood and informational support and highlighted the importance of consistency in information-giving and support after birth. Participating women also discussed fear of birth and their desire to meet other mothers. Chapter Seven describes the second Action Research Cycle (ARC2).

CHAPTER SEVEN PRESENTATION OF THE FINDINGS ACTION RESEARCH CYCLE TWO

7.1. Introduction

The main messages emerging from the antenatal and postnatal group meetings in ARC1 were agreed by the women co-researchers and offered to the ANE co-researchers. This formed an evaluation of the current programme and gave the ANE co-researchers opportunities to reflect on the process and facilitation of antenatal education and to consider possible ways that we might progress. Conversations with women and with ANEs set the context for moving forward to the next cycle and formed an action research cycle of various components of constructing, planning, taking action and evaluating action (Coghlan and Brannick 2010). One pregnant women's group meeting, two ANE co-researcher meetings and one collaborative inquiry group (CIG) meeting comprised the second Action Research Cycle and selected findings are presented in this chapter. We revisited the main messages or themes that emerged from analysis of our first formal ANE co-researchers' group meeting (ARC1), and this generated further analysis and discussion in the second meeting. The antenatal educators were encouraged to reflect between discussions about the themes that emerged and, on occasion, sent emails outlining their thoughts.

Ernest Stringer's (2007) model of 'Look, Think and Act' was used as a flexible guide during the co-researcher meetings as a way of reflecting and thinking about our position. In this way, we incorporated critical reflection to be responsive and aware of opportunities to inform action (Koch and Kralik 2006). It was important to me that the educators felt safe emotionally; in addition, in order to maximise the time spent with women co-researchers in the Collaborative Inquiry Groups, I believed that it was necessary that the ANEs considered how they were positioned in a personal and social, cultural sense. The Stringer model (2007) provided a medium to support this by providing focus on the information that was gathered from previous meetings and to prepare a plan to progress.

7.2. Participation in the Research

Please refer to Tables One (page 89) and Two (page 91) and Appendix 2.
P1, P2, P3 and P4 attended this meeting.

The ANE co-researchers and I met for our second formal meeting and we discussed the aims and objectives of the research, in addition to the ground rules for group meetings. I was eager to acknowledge their expertise in the field and to remind them of the value in our working together. I was also anxious that they were happy to continue participating in the research. When invited to share their views of participating in the research, they confirmed they were pleased to continue and also that they welcomed hearing women's evaluations of the programme.

> 'Well, we have to hear it Vivienne, we need to hear it.' **(ARC2 P3)**

This was particularly evident in the reading for the personal pronoun or 'I' that emerged from the voices:

> 'I'd really like to hear more.' **(ARC2 P1)**

> 'I'd love to know but I don't know if you can tell us...' **(ARC2 P3)**

> 'I want to just find out *what did they say* (laughing)…I suppose they don't know what it's going to be like (birth)...I think that's probably why they are reaching out for us to help them' **(ARC2 P1)**

My interpretation is that the word 'help' here is used in the form of informational support; notwithstanding this, it was clear from the conversations with the ANE co-researchers that they found difficulty sometimes in gauging women's informational needs. There is also acknowledgment that the hospital-based antenatal education may differ from what women need:

> 'We think what they might want to hear but actually, they might want to hear something else.' **(ARC2 P3)**

7.3. Preparing for Birth and Motherhood

One of the main messages from the ARC1 women's group was desire for preparation during pregnancy for caring for a newborn and the value of facilitating postnatal information during classes was debated in detail. Lack of statutory community postnatal support and early discharge home from hospital was considered a catalyst to provide postpartum related information during pregnancy.

> 'I had a talk with the postnatal sister this morning, they are going home so early now, so they are going home some of them after 24 hours, they may not even have had a chance to even bath the baby here and they are going home with very little information about how to look after the baby' **(ARC2 P3)**

> 'Couples have actually come up and asked me after class if there's a class beforehand to teach them how to hold the baby and change the baby and wash the baby *before* the baby is born. And the husbands are terrified.' **(ARC2 P3)**

This was countered by the view from one of the ANE co-researchers that women are possibly unable to consider baby care until after labour and birth; yet a conflicting ideology has emerged from participating women. The exchange below is borrowed from the ARC2 pregnant women's group to illustrate this point:-

Q **They do show you in the postnatal class afterwards…**

> 'It's a bit late isn't it?' **(ARC2 W10)**

> 'But after the baby is born, you (baby) have to wait until I've done the class!!' (All laughing) **(ARC2 W8)**

This is indicative of the very distinct philosophies between the medical and social models of care; the social model is most in keeping with the ideology or belief that pregnancy, birth and motherhood is a continuum, and the medical model is the restricted space allotted to women within the hospital structure and time constraints. This notion is supported by Jane Gray's (2000, p. 6) assertion that 'the cultural salience of active

management means that the woman-centred idea of active birth is alien to Irish obstetric thinking' (Author's emphasis). There is an assumption that expectant parents are less interested in life after birth until concerns about labour and birth are addressed (O'Meara 1993, Nolan 1997 and Singh and Newburn 2000, Renkert and Nutbeam 2001, Svensson *et al.* 2007). Notwithstanding this, Wiener and Rogers (2008), in their small survey (n=83) of midwives facilitating ANE, concluded that interest in parenting issues depended on the style of class facilitation. According to the respondents of their research, when a didactic approach to facilitation was used, women did not appear adequately confident about labour to progress discussion about life after birth. Women were more prepared to discuss motherhood when classes were interactive and involved identification of self-learning (Wiener and Rogers 2008). In the research presented here, women also identified that affording time and space to learn about babies' needs after birth is difficult:

> '...you don't have the time to find out anything...' **(ARC2 PN W7)**

7.4. Being with Other Mothers

The value that women articulated in being together was recounted and discussed several times throughout the meetings with women co-researchers and this is expounded in the literature (Kitzinger 1977, 2005, Leap *et al.* 2010, Svensson *et al.* 2006). It soon became clear that the forum for antenatal classes in large didactic settings, with little scope for conversation beyond the requirements of the hospital curriculum, was an unsuitable medium to foster authentic engagement between women. Engagement, though limited within the confines of this setting, took place between the ANE co-researchers and the women. There was also some scope to meet individual women and couples between and after classes, yet it proved difficult to foster interaction between participating women during ANE classes.

Despite the efforts of the ANEs, they reported severe time constraints, and, while they acknowledged collectively the importance of communication between women, the challenge lay in how to meet this while addressing the demands of the programme. As previously mentioned and raised again in this meeting, efforts culminated in a generic package of information that covers all in any eventuality, coupled with a clear sense of

frustration in trying to accommodate women and individual needs, all the time remaining within the programmatic structure of the institutional ethos.

> '...we are moving from one topic to the other, in classes you have to deal with everyone in the room who all have different experiences and try to do as much as possible. You can't just get one person's experience.' **(ARC2 P4)**

The statement below suggests ANE co-researchers' conviction that they had moved the boundaries as far as they could within the restrictions of the system, in which they are practising,

> 'The other thing I was thinking about is that, we've gone round in circles here and we've tried all sorts of things.' **(ARC2 P3)**

P3 provides the example of how classes originally did not include 'fathers' (partners) and over the years as partners were included, they were welcomed, first in one class (preparation for labour), and subsequently to all classes in response to their requests. In addition, there is acknowledgement of the overriding nature of the classes in terms of medical information and class size that prevents participation:

> 'Yes, and too much medical, or too much information in a short period of time...you wouldn't have bonding in a group.' **(ARC2 P1)**

7.5. Introducing Change

The collaborative ethos of the research was emphasised by pledging that all research based decisions be made in consultation together. A central feature to PAR is establishing greater equality in relationships between co-researchers and the external researcher; this is enhanced by making explicit personal values, assumptions and motives for research decisions (Dickson and Green 2001). Discussions involved frank exploration of bringing about change, particularly issues related to felt ownership in decision making (Brodie and Homer 2009). There was reluctance to bring about any change on the basis of a small number of participant views emerging from one action

research cycle only. ANE co-researchers felt that it was vital to gain understanding of the varying responses and levels of engagement with women and antenatal education across a section of the population. This is demonstrated best by the by the voice of the 'I' in one ANE co-researcher's account,

> 'I'm looking for a broad spectrum of people...I think that in the public clinic you wouldn't have the same enthusiasm for antenatal education as you would in semi-private and private...I think it's important in this study that we *do* have a cross section of people...'**(ARC2 P3)**

The extract above conveys the ANE co-researcher's belief that status in terms of public or private care attendance has the potential to alter women's views and experiences of antenatal education.

7.6. Restraining Forces

In terms of restraining forces that impede change, it was clear that there were organisational restrictions as regards the hospital ethos that had clear aims and objectives, which shaped the content and process of classes. The outcome for this was a very programmatic approach to information-giving. In his analysis of education, Zygmunt Bauman (2005, p. 118) reminds us how, on entering liquid times, ancient wisdom has lost practical value and, people involved in education (that is so-called), have shifted their emphasis from a type of fixed informational learning to a 'learn as you go'[204] approach in preparation for, it seems, all eventualities. Bauman (2005, p. 124), in his discussion about the labour workforce suggests further that this shift has resulted in employers' inclination to 'subsidarise from their own on to their employees' shoulders responsibility[205] for all effects, but above all the negative ones, and more

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[204] According to Bauman (2005), in liquid modern times, learning must be continuous, never ending and life-long.

[205] Vecchi (2004, p. 3) states that Bauman is an individual who 'considers the principle of responsibility to be the first act of any involvement in public life'. Thus, sociology is not a discipline that is separate from other 'fields of knowledge but as providing the analytical tool to establish a lively interaction between it and philosophy, social psychology and narrative.'

generally, responsibility for 'failing to rise to the challenge.' In this instance, antenatal educators are faced with the impossibility of preparing each woman that attends classes for every eventuality and, if this fails, the ANE is unreasonably held accountable, as the extract below from P3 indicates. In this current system, antenatal classes are viewed unfairly as a safety net for anticipated informational needs that the woman does, should or could need.

While women need accurate information that considers the various phenomena that can occur during pregnancy, birth and motherhood (Gaskin 2011), it is unrealistic to expect that this can be offered within the confines of a setting that offers a policy determined programme for a limited time with various staff members. This is in the absence of continuity of relationship and space for women to self-identify what they really need and want to hear. Kirkham and Stapleton's (2004) research[206] revealed that a small number of midwives who openly confronted hospital policies feared chastisement from obstetric and midwifery colleagues, this is illustrated by the following extract explaining the repercussions for ANE co-researchers in the event of a complaint. In the Irish context, Mason (1998) has alluded to feelings of powerlessness and vulnerability for antenatal educators who fear reprisal.

> 'Even that look Vivienne, if you've a problem then, we get the call, this woman says she never heard about caesarean section and then we go back and look at her data, was she at that class? So we really have to be accountable as well for what we are covering. It's not like laissez faire, come on down for a cup of coffee if you'd like to talk about it, it's not like that in this setting. Now maybe it is set like that in other settings, maybe Cuidiú do all that, here it's business. And it's getting the information, getting them to ask questions, getting them to enjoy it as well obviously but actually, it's the very person who doesn't hear about caesarean sections will probably end up an emergency. And then we are being asked and she's never heard of it. We do get this.' **(ARC2 P3)**

[206] The qualitative aspect of this research explored the culture of the NHS maternity services that were studied.

Desire to engage with women is thwarted by the constraints of institutional practice, and this dichotomy results in a conflicted sense of professional self and vast concern that manifests in anxiety and perhaps a sense of personal liability when things go wrong.

> 'At the end of the day they will tell you that they are not encouraged to go and they'll tell you all that too.' **(ARC2 P3)**

There is a sense that the ANE co-researchers are weary and call for professional support but also, that women are responsible for their uptake of antenatal classes and the messages within. The narrative below reflects acknowledgement of the privilege of the adult learner to choose and identify self learning goals; however, this is not ultimately reflected in the style of class facilitation that time and resources permit, and the following exchange illustrates how the conversation segues back to self blame:

> 'But they have to be accountable for their own health as well. Because what is it 50%, 60% of first time mums come to classes. So what come back do the other people who just didn't bother coming have? If they didn't want to come it's their choice...' **(ARC2 P2)**

> 'It goes back to what you were saying about the expecting things to be done, like they nearly expect people to look after the babies in here you know.' **(ARC2 P4)**

> 'Like where are we going wrong? We must be going wrong somewhere....my mother had home deliveries, there was nobody, she put us to the breast and she fed us, she just got on with it get. Like there seems to be a lack of any sort of common sense.' **(ARC2 P3)**

In their analysis of the tensions and opposition to offering midwifery care in a small birth centre, Deery *et al.* (2010) identify the frustrations that maternity carers experience in providing a service set against contextual demands, for some, the solution lies in seeking reduced working hours or leaving the service.

7.7. Ways to Progress

The ANE co-researchers considered the women's feedback on the desire to engage with other women. One possible solution was the notion of providing longer classes less frequently. This was refuted on the agreed basis that most attendees, particularly partners, seemed keen to exit classes promptly. We decided to consider feedback from the next pregnant women's group, suggesting that the issue could also be debated with women at the Collaborative Inquiry Group meeting. On closing the meeting, I asked the ANE co-researchers to reflect on the transcripts and said that I should be grateful if they could share their thoughts and feelings with me. In addition, I offered my interpretation of the main messages that arose from our conversation.

7.8. The Action Research Cycle Two Pregnant Women's Group (Appendix 2)

Table Six outlines the characteristics of women co-researchers who participated in ARC2.

Table 6: Characteristics of the Women Co-researchers in ARC2

Code	Gestation (nearest week)	Age Group (Years)	Care	Heard about ANE classes	Live alone	Nationality	Main Support Person
W6	24	30-39	SPC	Midwife	No	Irish	Husband
W7	26	30-39	Midwifery led	Midwives clinic	No	Irish	Husband
W8	34	30-39	Midwives' Clinic	Waiting in Clinic	No	American and Irish	Husband
W9	21	20-29	Public	Hospital Brochure	No	Irish	Husband
W10	32	30-39	Public	Midwife	No	Irish	Husband

ARC2 involved meeting a new group of pregnant women to share their felt support needs for early motherhood. Again, the concept of 'normal'[207] emerged in conversation; particularly reassurance in normalcy of body changes; this knowledge need arose from grounded experience of 'problems' (W8 34/40) during pregnancy. Information needs were also specifically in relation to general knowledge about birth and breast feeding support. When birth knowledge was explored, ARC2 women co-researchers proffered that ANE should provide a forum for discussion of what to expect from labour and what one should be able to ask of professional carers; the essence of this is uncovered in Reading Four for society, culture and the institution.

> 'And even your rights during labour...that they won't do something and, I don't know, I mean they are not like terrorists or anything but that they won't do something that you don't want them to do...and even position in the bed and stuff.' **(ARC2 W8 28/40)**

Note here that the context that involves 'position in the bed' is accepted without question, according Oakley (2005, p. 123), 'this proper way to give birth may seem improper, but as a patient, it is not the reasoning behind the rule that matters, only the existence of the rule itself.' In 1978, an interpretation of modern obstetric practice was offered by psychotherapist Peter Lomas, who acknowledged serious doubts about the rationale of obstetric modern practice at that time. His doubts were influenced specifically through working with women with a diagnosis of postpartum depression. Now, thirty years later, we are confronted still with the many principles of the very obstetric regime that concerned Lomas (1978), of which preoccupation with techniques, as distinct from persons, is a feature. In Western society, childbirth is primarily a medical matter (ibid). According to Lomas (1978, p. 175), medicine while useful and beneficial to preserve life and treat disease, can also have harmful side effects and does not treat the person as a whole entity (ibid).

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[207] The concept of normal can be defined in psychological, biological and mathematical terms but for the purpose of this work, my interpretation is normal as a natural occurrence. Also, that the process of pregnancy and birth within the cultural context of Medicalisation becomes 'de-familiarised' (Hamilton 2002, p. 99) for the woman and family.

In keeping with Foucault's (1980) notion (discussed on pages 316-317) that acceptance of discipline's knowledge claims increases that particular discipline's power, Lomas (1978, p. 176) suggests that 'there is the effect of monopoly' which is increasingly controlled by uniform policy and impersonality. It is debatable whether the very personal experience of birth can be 'adequately managed' in such an impersonal setting (Lomas 1978, p. 176). This analysis of the practices of the modern obstetric regime reveals a pattern or trend in relation to how the mother and baby receive treatment, and thirty years later these trends are still relevant. One of the features, among other aspects, that emphasise control and passivity is 'the use of a passive position for birth and the treatment of the mother as ignorant and childlike' (Lomas, 1978 p. 176). This perpetuates the dominant ethos and the enforced passivity of the mother as recipient, the birth process is taken from the mother's control and her body is manipulated by strangers. Her baby is separated from her; 'the occasion is one of suffering as distinct from joy, spontaneity is replaced by control, there is a break in the continuity of the mother's life because birth does not take place where she is living and is instead replaced by an emphasis on structure and order'. According to Lomas (1978, p. 176) 'there is a formality which has something of the character of a public ritual' because birth is made public.

Women struggle to make sense of how they are situated as pregnant recipients of maternity services and how certain practices are anticipated and perhaps expected. Jo Murphy-Lawless (1998) suggests that, in her view, women convey strength that is associated with their aspirations and hopes for birth, while at the same time experience a sense of fragility and fear as a result of their reflections and concrete events but also because of the widely held link between obstetrics, life and death. This link needs a safe setting so that it may be explored and explicated; the space for this is currently not afforded in our existing system of care (Murphy-Lawless 1998, 2012). Notwithstanding this, women co-researchers articulated a need to openly discuss protocols of labour management and reasons for intervention and wished to know specifically if protocols differed depending on category of care, for example, public and private care. This question suggests awareness of the wider societal issues; nonetheless, there is acknowledgement of a system by which pregnant women have no option but to become subsumed, and perhaps a sense of programming that women have come to accept in late

modern society, concomitant with the midwife in the hospital system as the 'medical expert' (ARC2 W10 31/40).

> 'It's easier if you know what the system is because if you don't know what the system is, you don't know how to fit in to it' **(ARC2 W7 25/40)**

Simonds (2002, p. 564), suggests that 'hospital staff manage bodies in time and space by regulating them in ways that contribute to conducting the business of the institution efficiently as determined by the ''experts' who run it.' Women acknowledge that protocols exist; the following quotation demonstrates how one woman in particular perceives that protocols exist to discipline and control:

> 'And I suppose it's in the hospital's best interest too because their way of informing you is a way of *disciplining* you. Because it's a way of telling, teaching you how to behave when you come in here. So it's in their interest to inform you to behave in a certain way because I suppose with the labour thing it's moulding your expectations of what a hospital can do and what midwives do etc., etc.' **(ARC2 W9 21/40)**

Note how this woman, W9, realises that she is expected to conform. According to Kitzinger (2006),

> All 'total' institutions, such as the army, the prison system and large hospitals have ceremonies and protocols aimed at ensuring safety and develop strategies to keep everyone under control. The medical system manages women in childbirth through enacting rites of passage into motherhood that reinforce the authority of the institution in which birth takes place and that of the doctors and midwives who represent it. A woman is separated from 'normal' people going about their everyday lives (p. 22).

The idea of disciplining women to conform to institutional hierarchy is reflected by the use of the roll call in antenatal classes (this is mentioned at later meetings as a useful time for women to engage together during the roll call that is taken by the facilitator). The roll call is defensive practice in a litigious culture to insure against complaints; for example, if a topic is 'covered' in a particular class and the woman was present, it is not

the fault of the institution if something goes wrong, because the woman was given the information. This is consistent with a pedagogical approach to learning.

7.8.1. The Concept of 'Choice'

> 'I think you do have a choice, if we didn't want to be in this system we could have gone for a home birth so you know there are options there' **(ARC2 W67 26/40)**

Murphy-Lawless (2011b) reflects that in the absence of alternatives, a majority of women in Ireland have no experience against which to evaluate a medical model of maternity care, which limits conceptualisation for change. The current context of maternity services in Ireland means that less than 1% of women birth at home (Kennedy 2010). For those who do, the alternative to a generic medical package for birth that is dominant in Irish society is a path that is not navigated easily by women and is often fraught with obstacles. An illustration of the difficulty in unsupported decision making for women is provided below in an extract from the Irish Midwifery eGroup (2011). One woman shares her experiences of choosing home birth in Ireland as part of a discussion about midwifery led care:

> 'Speaking from my own experience as a mother who is going the home birth route for the second time, my personal feeling is that anyone considering going the HB (Home Birth) or MLU (Midwifery Led Unit) route would need to be extremely strong in her decision as would her husband and family and have done their research before hand, as depending on your HCP (Health Care Professional), there can be a lot of pressure to just be a good girl and go to the hospital. When I went for my own release appt (appointment) this time around I was told that I was doubling the risk of my baby or myself dying during the birth...there is so little faith given to women in their capability to birth without intervention and so little evidence based information given to mothers to be and their partners regarding birth choices. Combine that with our spiralling rates of intervention and the images of birth we are regularly exposed to in the media and it is no wonder that women are apprehensive about using these services, no matter how positive they may be.' (Extract from the Irish Midwifery eGroup 2011)

This personal account validates Michel Odent's (1984) assertion that 'the subtlest way to discredit home birth is to make it as dangerous as possible. It is made dangerous partly by creating an atmosphere of guilt. When a woman dares to think of having a home birth, the first thing she is asked is what she would do if there were complications' (Odent 1984, p. 133). Thus, 'choice' in birth is not supported and without support, the concept of 'choice'[208] in birth is beyond grasp because boundaries are so narrowly defined for women held within medicalised birth in order for the system of medicalisation to function. With such narrow definition and focus, women are without scope to explore beyond a superficial level, what birth can mean.[209]

7.8.2. Early Motherhood

Women identified a need to know how to care for their baby particularly in the first month after birth. Through our discussions, the prospect of taking a baby home became more immediate for women as, for many women co-researchers, the research conversation presented the initial forum in which to engage with other women with shared commonalities. Anticipated loneliness and isolation after birth is uncovered by reading for 'I' as W9 refers to 'the drudgery around child care'. For child-bearing women in Ireland, motherhood is unsupported quite cruelly in the early postnatal period, for women who are without fitting family help.

> 'I haven't a clue, and I kind of got a bit depressed you know...I would be over the moon if antenatal classes were things to do with coping with and being handed the child in the first month... just really practical stuff you know...I want them to able to give me really practical tools to handle a lot of the stuff that it

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[208] According to Pilley-Edwards and Murphy-Lawless (2006, p. 37), 'choice' is filtered through dominant social values of individualism and consumerism that have superseded the older social support system'. Pilley-Edwards and Murphy-Lawless (2006) refer to Bauman (1998) who suggests that the notion of 'choice' is in fact a decision that is compromised by the necessity of acceptance of complex circumstances in a society that is characterised by reduced support (Bauman 1998, Pilley-Edwards and Murphy-Lawless 2006).

[209] Rappaport (1995, p. 796) suggests that 'for many people, particularly those who lack social, political or economic power, the community neighbourhood or cultural narratives that are available are either negative, narrow, 'written' by others for them or all of the above'

takes...I'm thinking to myself 'oh if only I knew'...not that I'm very good at joining groups...I'd be more relaxed about it or something.' **(ARC2 W9 21/40)**

The prospect of psychological ill health after birth becomes real and this is coupled with concern about establishing the mother-baby relationship if postnatal depression becomes an issue.

'Will I even like this child, will I want to send her back or something (laughing)' **(ARC2 W8 28/40)**

Support from the healthcare professional and others is vital to establishing the mother-baby dyad and the concept of coping is coupled with 'being prepared' in terms of knowing what to do when bringing the baby home (ARC2 W7 25/40), with the view that being unprepared in terms of lacking knowledge could trigger stress and depression after birth. Postnatal depression (PND) is a complex health problem, which can have a number of subsequent consequences, for example, PND may compromise the mother baby relationship and affect the long term emotional, cognitive and behavioural development of the child (Buultjens and Liamputtong 2007). In-depth interviews to capture the feelings of women with severe PND (n=10) who were admitted to a large mother and baby unit in Australia, revealed that the women interviewed believed that mood after birth was not understood by the people who supported them or their health care professionals (Buultjens and Liamputtong 2007). Within the medical model, postnatal depression (PND) is regarded as an illness to be treated; however, Ann Oakley (2005) suggests that postnatal depression, though deeply unscientific in terms of aetiology, clear definition and treatment (Oakley 2005), provides a way for women to talk about responses to difficulty in birth and motherhood including lack of control over their birth experience (Oakley 2005). There are many suggested attributing factors to PND, such as the onset of stressful life events and personal and family history of PND; however, in keeping with Oakley's theory, Buultjens and Liamputtong (2007) suggest that attempts to satisfy the myth of 'maternal instinct' can create feelings of inadequacy in mothers who feel overwhelmed and are without what is described as instinctive or intuitive knowledge about motherhood.

7.8.3. Learning Motherhood

Women's views of becoming mothers are coloured by the demands of busy lives that are consumed with paid work and the competitiveness of modern society. Central to the concept of learning about motherhood for participating women is hearing about other women's stories and experiences of motherhood. For one woman, the concept of another mother or, indeed, midwife showing her what to do with her hands was very important, as was the concern that people possess higher order intellectual skills but lack basic psychomotor skills that are required to care for a newborn and, like any mechanical skill, need to be learned.

> '...people are so educated now to have all of this kind of, these skills that are all cognitive or mental skills but the actual practical, how you do this with your hands in a deft, kind of gentle manner. Because manual skills are so I suppose, not shown or not celebrated or not talked about. Just show us how to do it with our hands. And also the reassurance of really now you have to, well for me you would have to do a lot to actually injure the child you know, obviously you know.' **(ARC2 W9 21/40)**

There was the anticipation in this group that not all of the information could be addressed in classes, with acknowledgement of the time constraints that were imposed by large class attendance and the potential vastness of knowledge required in preparation for birth and motherhood. This segues back to the notion that knowledge in preparation for motherhood is embraced as procedural and must be learned as a schedule of facts. A potential solution offered by women co-researchers was that antenatal educators in classes could focus on 'the most common issues' **(ARC2 W9 21/40)**. Again, this reflects a generic approach to learning that the women adopt to fit in with the existing hospital structure and required learning of 'the official medical view' **(ARC2 W7 26/40)**

On naming knowledge needs, women required information on what to expect after birth and the growth, development and care of the baby. Statements reflect emphasis on the procedural aspects of knowledge as distinct from making room to consider various levels of support required, and the vulnerability, as a new mother of not knowing what

to do was evident. Bringing the baby home from hospital was considered a mammoth step, and easy accessibility of professional support in the community was considered crucial, in addition to knowledge about the level of support and assistance from the hospital midwife in the immediate period after birth (which was completely unknown in the lead up to birth):

> 'And how much time does a midwife give you after the birth? In the hospital like...If you are breastfeeding yeah, are they going to stay with you?' **(ARC2 W10 31/40)**

> 'And at what level, what level of help do they give you? Are they actually showing you how to change a nappy or stay with you when you are breastfeeding or what?' **(ARC2 W7 26/40)**

7.8.4. Birth

The idea that events surrounding birth are predetermined depict a sense of loss of control, and resignation is uncovered in the reading for the personal pronoun or 'I',

> 'I'm not concerned about the birth...I probably will when it's nearer the time but I just see that as a single event that is inevitable and it's going to happen the way it's going to happen and there's very little, I know this is probably all going to change my mind...a whole lot of it is already predetermined...I just see this Christmas day...I don't see as preparation for that day and I suppose I would be, because it's my first time to have a child and not a lot of people around me have children…' (**ARC2 W9 21/40)**

This woman co-researcher explained that her need to attend classes was motivated by her desire to learn about caring for her baby, as distinct from negotiating labour and birth because she viewed those events as pre-determined. I contacted the woman after our postnatal conversation to ensure that my interpretation of what she said was correct. When I asked her about what she meant about birth being inevitable and predetermined, she explained:

> 'So I guess what I was trying to say is that I believe there was a dimension to the birth that had already happened at that stage, and no hospital intervention could change that outcome. When I was being wheeled down to emergency caesarean surgery, I felt very calm (though not in a particularly good mood!), because I felt that all of it was already pre-programmed.' (**ARC2 PN W9)**

When I asked if her sense of calm was because she had belief or trust in her body to birth, she responded:

> 'Oh definitely not a belief or trust in the body! I would say it is more a belief in fate and I would not say that I thought all would necessarily be ok - just that it would be what it was destined to be, good or bad.' (**ARC2 W9)**

W9 had confirmed that this wasn't a religious belief; I considered that perhaps this was an expression of complete trust in the medical profession, despite this woman's views during our antenatal meeting that women were expected to conform to the hospital setting. Kirkham and Stapleton's (2004) research revealed that, set against a context of risk and blame, elements of trust between obstetrician or midwife, and woman were important to healthcare professionals, particularly in areas where they may be held accountable. This seems to extend only, however, to whether a woman could be trusted to conform to professionals' decisions if the unexpected arose. If trust is not forthcoming, discourse reverts to the language of risk, so ultimately, the woman feels compelled to comply. Risk and safety-related discourse is introduced on page 22 in relation to agency and also in discussion Chapter Ten.

7.9. The First Collaborative Inquiry Group Meeting

Please refer to Appendix 7 for ground rules and Appendices 4 and 5 for prompt schedules. Table Seven outlines the women and antenatal educators who participated in the first Collaborative Inquiry Group Meeting.

Table 7: Women and Antenatal Educators Attending the CIG1 ARC2

Antenatal Women	Postnatal Women	Antenatal Educators
ARC2 W6	ARC1 W1	P1
ARC2 W7	ARC1 W4	P2
ARC2 W9	-	P3
-	-	P4

My interpretations of the main themes from the meeting were sent to the women co-researchers and the ANE co-researchers for consideration prior to the Collaborative Inquiry Group Meeting (CIG)[210]. As suggested by Koch and Kralik (2006), the ANE co-researchers and women co-researchers collaboratively created meanings through the Collaborative Inquiry Group conversation, and these are recorded in the details of further meetings and in written correspondence from ANE co-researchers and women co-researchers. We analysed and worked towards developing a programme together and, in this way, we co-constructed knowledge through sharing and naming ideas.

[210] As previously discussed, The Collaborative Inquiry Group (CIG) consists of members of the local scientific community (Kemmis and McTaggart 2005), who are, in this case, a combination of women and antenatal educators (midwives/ physiotherapists and dietician) participating in the research. The specific aim of the CIG is planning and implementing change in practice, as distinct from gathering information. Group discussion is used to generate data through group interactions (Marchant and Kenny 2000). In this research, it is also about creating that space for women and health care professionals to meet.

Field note Entry from Reflective Diary 11th October 2010

In preparation for our conversation, I revisited Tina Koch and Debbie Kralik's (2006) work on participatory action research in healthcare and this prompted me to examine aspects of myself and my motivation to undertake this inquiry;

What am I Influenced by?

I am influenced by feminist thought and the co-construction of knowledge[211] through participatory research.

Has feminism shaped my way of being in the world?

Yes, (particularly since I became a mother) and in a way that hearing perceptions of truth and reality is important to me.[212]

What happens when we listen to others? What do I hear? Their story? Or my interpretation of it? (Koch and Kralik 2006).

This has been of concern to me since I began this work; I have endeavoured to find a method of data analysis to preserve the integrity of women's voices, particularly with my growing awareness of how women speak of themselves as living in connection with others (Brown and Gilligan 1992).

If this is the case, what does that mean? Is this hermeneutics?

I feel that this is why it is necessary for me to ask ANE co-researchers and women co-researchers to verify transcripts and my interpretation of main messages. I ask 'is this your story?' 'Is this what you meant?' This is vital because being heard promotes self-worth and personal power (Koch and Kralik 2006)

Group (CIG) and self reflection was encouraged to examine how internal and external factors may influence the agreement and implementation of action. The women and

[211] Co-construction of knowledge is widely discussed in feminist and action research texts; however, there is debate about the emancipatory nature of co-constructing knowledge when power relations in PAR are unequal (Koch and Kralik 2006)

[212] I am influenced by the work of Carol Gilligan (1993), whose questions are about our perceptions of reality and truth, how we know, hear, see and speak are about voice and relationship (Gilligan 1993).

ANEs came together and there was a sense that they were glad to be there, particularly the ANEs who really wanted to hear what the women had to say. Participating women voiced that they were glad to meet and to hear the perspectives of potential carers. Ground rules of how to behave in group settings, particularly in terms of confidentiality and respectful listening, were important in this instance (Appendix 7). ANE co-researchers had articulated their concerns about women, feeling their views could cause the ANEs to form judgments about their potential motherhood skills and additionally, that women co-researchers might judge the professional capacities of the ANEs. According to Koch and Kralik (2006), 'creating the space for voice involves a comfortable environment, safety (establishing group norms), authentic listening, allowing people time to talk and responsiveness without judgment' (Koch and Kralik 2006, p. 28-29).

To this end, women co-researchers and ANE co-researchers were mixed and disseminated equally and uniforms were not worn. Deery *et al.* (2010) note that uniforms symbolise the power of the dominant culture and identifies the wearer as belonging or loyal to the institution or organisation. Light refreshments were provided for all meetings and this brought some relief to the proceedings and settled everyone well (Barrett and Taylor 2002). As far as possible the environment was warm and comfortable with attention paid to seating arrangements conducive to engagement. I suggested that our meeting would last approximately one hour and that individuals were free to leave at any time; however, the CIG conversation continued for one hundred and two minutes in total despite my attempts to draw the meeting to a close on three separate occasions. Postnatal mothers were invited because they had experienced the current hospital-based programme and could potentially contribute to developing the antenatal education programme in light of their participation in the current antenatal education programme, and to share their experiences as new mothers.

Aside from ongoing analysis from previous meetings, my preparation involved highlighting the recurring commonalities and main messages of analysis of conversations. Due to my concerns about time restraints for the meetings, I felt compelled to compose and to offer a concise document outlining my interpretations in addition to the contemporaneous readings that I had sent the ANE co-researchers and women co-researchers. I offered a sheet of commonalities to all present and it was not

referred to again; in fact, everything that was documented re-emerged in conversation without prompt (Appendix 23). As Penelope Barrett (2006) suggests, our conversations provided a forum where we listened, learned and reflected together.

I knew that I wanted to discuss the issues that had surfaced in previous meetings but, in keeping with the PAR philosophy, the ANE co-researchers and women co-researchers led the agenda with some guidance only in terms of the principles of action research and our shared objectives. Broad themes included exploration of the women's reflections and discussions during and since our last meeting about their anticipated needs for motherhood, the ANE co-researchers' priorities in terms of information relating to imparting professional skills and knowledge, refining the class content and process based on previous discussion in relation to content, structure in terms of design, and process of antenatal education.

Again, Stringer's (2007) model of three basic action research phases of 'Look, Think and Act' were incorporated into the CIG conversation to prompt awareness and reflection about our current position and how we might progress. A broad framework inspired by my readings of Koch and Kralik (2006) supported our ongoing analysis.

What are the common assumptions about Antenatal Education? What are the common sense notions? What is it like? What matters? (Koch 1993). We began with the question,

Q Can we talk about what we think antenatal education is about?

Reading one for the main messages or plot of this meeting revealed re-emergence of issues raised in prior meetings, and these were revisited in addition to the co-generation of other themes described in the passages below.

7.9.1. Reassurance

Women spoke about the importance of reassurance and how this was found, particularly in relation to what is considered normal and what might 'go wrong'. When asked 'what is ANE about?' Reading Two for the personal pronoun or the voice of 'I' uncovers meaning in this:

> 'For me, I think it was about reassurance because it was my first time having a baby...I felt that was part of the role of the antenatal education, that you'd be reassured in learning first of all you know, from the start to finish...' **(CIG PN W6)**

On first reading of this section, my interpretation of 'reassured in learning' meant being able to ask questions to clarify meaning, but when I revisited the transcript in reading for the 'I', I questioned this and wrote to the woman to ask her to clarify what she meant, she responded:

> 'I think I was saying that I wanted to be reassured in learning that everything would be under control as my perception of the health service etc. is that it is very under-funded and hence understaffed and I was fearful of not having enough resources around me when the time came to giving birth' **(CIG PNW6)**

This concern is justifiable; qualitative descriptive research using five focus groups to explore women's (n= 25) experiences of childbirth in Ireland revealed that women felt isolated and unsupported after (hospital) birth, which was attributed to staff shortages (Larkin *et al.* 2012). In our earlier group meetings women were also concerned about accessibility of the midwife or carer in the immediate postnatal period. Length of hospital stay in maternity care in Ireland is determined by resources, including bed supply and demand, and private health care insurance in contrast to meeting individual need (Kennedy 2002). Other factors, significantly detrimental to quality maternity care provision, exist in the form of a reduction of staff since the implementation of a public services employment embargo in 2008, and the subsequent emigration of newly registered midwives educated to degree level. The aforementioned KPMG (2008) review of the three maternity hospitals in the Greater Dublin area confirmed that staff shortages exceed safety levels. The situation is intensified by a rising birth rate set against overcrowded facilities and the withdrawal of much needed services due to budgetary cutbacks, specifically DOMINO services and proposals to cut other midwifery-led initiatives (Murphy-Lawless 2011a).

The concept of reassurance was explored further, and it was clear that women segue back to their emotional needs time and time again. Reassurance in the form of platitudes and advice-giving does not confront reality, and, in doing this, does not provide emotional support (Kitzinger 1977).

Q: What's the reassurance about though?

> 'I think even being here though is reassurance isn't it?' **(CIG AN W6)**

> 'It's about building up their confidence, you say look you're well able to give birth to a baby, you're designed to have a baby, what's the fuss?' (All laughing) **(CIG P3)**

Reading two of the CIG for the voice of 'I' uncovered another aspect of fear in decision making that suggests that women are deeply unsupported in this process and are left with no option but to renege on personal autonomy and submit responsibility to the professional,

> 'I would still worry though that there are decisions that you actually have to make...' **(CIG AN W6)**

Lack of confidence in decision making in birth was discussed with the co-researchers and is created to some extent by conflicting sources of information in the media and other sources, and this manifests in occupation with hospital policy and apparent trust in the hospital system. Reading for relationship or the 'other' in the transcript of an earlier meeting with the pregnant women's group participating in this CIG meeting uncovered the primacy of the hospital stance above informational support from significant others, including close family members and maternal mother, combined with desire to connect with potential carers.

> '...I was expecting to get a hospital policy saying this is how the hospital policy is, the recommendations and stuff and I mean you can compare it to what your friends or your mum or whoever is saying but it's nice to know what the official medical view is, is the book out of date or you know has the person got out of

date information. I feel the hospital should have all that and be up to date (laughing)' **(ARC2 W6 31/40)**

ANE co-researchers confirmed that discussion about hospital policy was facilitated in the current programme to the extent of a specific regime and dominant ethos within the hospital,

'So what we're saying is this is what we do at (hospital), now if you don't like what we do, you tell us what you'd like and we'll try and meet your wishes, as long as you're well and your baby is well.' **(CIG P3)**

There is tight control on information sources; the suggestion of introducing other options for information outside of the hospital is opposed:

'And actually what you would do then is confuse people who are actually coming to this hospital I think...there'd be differences in the management of labour, when you come into the hospital, there'd be a lot of differences. I definitely wouldn't put them in touch with an English based school because I don't think it would do them any favours, because it would be, different to what they're talking, to what we're doing here' **(CIG P3)**

A request for information on national statistics for caesarean sections and assisted birth provoked lengthy discussion and it was agreed that perhaps online sources, such as the Association for the Improvement of Maternity Services in Ireland (AIMSI) and the Cuidiú website, could prove helpful for women, and links for these resources were offered to the women. According to Michael Hardey (1999), the use of online resources challenges the nature of the relationship based on unequal power distribution between medical expertise and recipients of care. Women co-researchers accessed the internet for potentially new ways of knowledge or knowing. Developments in alternative ways to access information destabilises the monopoly of medical expertise, with increasing scepticism from recipients of the health service, in a process called de-professionalization (Hardey 1999). Hardey (1999) refers to de-professionalisation as

demystifying the medical process by offering alternative knowledge; this poses a threat to dominant medical knowledge.

Dawn Hillier's (2003) analysis of power relations suggests that the call for empowerment of the public is generally designed to put people on equal status with experts, in terms of information gains that healthcare professionals have claimed traditionally for themselves. Hillier (2003) explains that, although women have increasingly accessed information from alternative sources (and she cites the internet), it is authoritative knowledge that remains powerful. She states, 'traditional midwives knowledge is not power- midwifery knowledge is not power - women's knowledge is not power because their knowledge has little status within the dominant scientific system and so they are not recognised as authentic creators or controllers of knowledge' (Hillier 2003, p. 146).

7.9.2. Restraining Factors

Problems identified by both groups were conflicting advice from midwives, lack of class interaction between women due to volume of attendance and a comparatively short time for class facilitation; classes were provided in a small space, which was also difficult to access. In an effort to encourage group participation and engagement in classes, it was suggested that light refreshments be provided; it emerged however, that environmental constraints made this difficult because of staff shortages and difficulty in accessing space for a refreshment trolley.

Efforts to promote interaction and space for women to explore and name needs are hampered by limited time to reconcile programmatic structure. ANE co-researchers voiced concern regarding the abundant nature of information to share that is underpinned by the hospital ethos and an occupation with ensuring that everything is 'covered'. When asked, ANEs confirmed that the programme structure must be adhered to rigidly.

> 'And I mean I think it came up the last time as well that, you said we're almost obligated to have said a certain number of things and like you know what you cover in each class so that if somebody comes back with some problem and they

say 'and nobody ever told me about this', that you're able to say 'well actually in class four we mention this every week'' **(CIG P4)**

This is followed by another woman's attempts to defend the ANE co-researchers' efforts and so the woman becomes a carapace for the ANE (Behar 1996).

'And you can see the tension immediately between the pressure to get everything across which disrupts interaction and then interaction, which disrupts the information given' **(CIG AN W11)**

7.9.3. Possible Solutions

One possible solution to providing information that is relevant to the needs of women was offered in the form of a 'Hopes and Fears' exercise; this involved class attendees recording anonymously their preferred issues for discussion on a piece of paper, which is shared with the group and facilitator. It was envisioned that this exercise may encourage women and partners to introduce for discussion questions and topics of relevance to them.

Reading Three, for significance in relationship or 'other', uncovered meaning about the importance of relationships with other women and how these could be fostered within the context of organisational constraint. The ANE co-researchers' views of the restraining factors for facilitating engagement between mothers was due to the issue of organisational constraint, these included class size, ratio of ANE to women, increased birth rate and lack of space for refreshments with a view to encouraging class women co-researchers to get together. A meaningful way to harness support that was already there was offered by one pregnant woman and it was agreed that one of the developments could be more focus on encouraging interaction between women and the provision of refreshments. Consequently, tea and coffee were arranged for couples attending the first class.

'And I suppose it was, just something about resources...if it was unlimited resources and you know, loads of midwives, obviously life would be great, but it's, how do you cope with a system that is under increasing pressure? And you,

so I mean there are some things you can change and some of the things you can't...but you see that thing about having a cup of tea at the end of a day or at the end of a session, that is really good because it, it's a really good idea because it leverages the, the support that is naturally there and it can be actually operationalised.' **(CIG AN W9)**

7.9.4. Antenatal Education as a Forum for Support and Connection

The women's stories indicate a sense of expectation that antenatal education provides an expert forum for information, yet efforts are offset with the struggle to 'cover' what is deemed relevant in the relatively short time period allocated to ANE. There appears to be so much confusion; women say they want 'information' when in fact, throughout the conversations, they frequently return to their emotional needs of support and confidence building as new mothers. This is uncovered in Reading Two or reading for the personal pronoun:

'...I had done a lot of research anyway...I think it was back to the reassurance thing and I think for me it was actually *physically* coming in here, and *physically* seeing somebody and I guess the things I really got out of it was, you know, for example, you saying oh 'call us whenever you want or whatever' **(CIG PN W6)**

The desire for support and connection is integral throughout the conversations, as is the apparent vulnerability of the women in embracing new motherhood. The potentially sensitive nature of birth and becoming a mother is revealed in a discussion of the appropriateness of timing in receiving information after birth and is uncovered by Reading Two, reading for the voice of 'I' which illuminates the importance of meaningful dialogue and relational autonomy.[213]

[213]I draw on Catriona Mackenzie and Natalie Stoljar's (2000, p. 21) analysis of relational autonomy that acknowledges the emotional and embodied agent who is 'psychically internally differentiated and socially differentiated from others' in addition to the way in which socialisation and social process inhibits or enhances the agent's capacity for autonomy (Mackenzie and Stoljar 2000).

> 'I think on the day after I had the baby and I just wanted to put a towel over my head...I couldn't concentrate...I think you need to go away...I mean my baby was in special care for three weeks...' **(CIG PN W7)**

7.9.5. A Discussion about Informed Choice

The concept of 'informed choice' had been highlighted in earlier meetings and this was re-introduced during the CIG2 meeting:

> 'To a degree I suppose is the right way to say that, I mean they are told about birth plans and that, you know that way, if they don't agree with what we're actually saying or if they have any issues about you know, the breaking of the waters or the oxytocin or things like that...and we kind of then would say to them that it is important that their issues are discussed beforehand because we mightn't be able to follow them through whenever they come in and they'd end up very disappointed' **(CIG P1)**

On reading this extract, it can be interpreted that informed 'choice' is argued within the boundaries and structure of a rigid hospital system. Real choice for women is limited under the current public maternity care as women are generally required to blend in with an existing service (Nolan 1999, Begley 2001). In a systematic review of the impact of ANE, Gagnon and Sandall (2007) note that the effect of antenatal education may be weakened by occurrences at birth and can incur disappointment for women who explore their birth preferences through the medium of antenatal education. Thus, there is a need to determine the independent effects of antenatal education (Gagnon and Sandall 2007).

> 'It's determined here by the situation...we keep our policies; really what we're doing is giving our birth plan for them. We're telling what our birth plan, and we also have a birth plan' **(CIG P3)**

My bias influences my interpretation of the above extracts as limiting women's capacity for choice. My further readings; however, enabled me to understand the ANE co-researchers' interpretation of birth as unpredictable in nature, through their instruction of the dominant medical view that birth is potentially pathological (Wagner 2001). Ann Oakley (1993, p. 76) asserts that the obstetric orientation towards controlling for

abnormal events ensures that women are treated by the 'as if' rule, therefore, the expectation that all women are potentially 'abnormal' is inclined to make them so. Uncovering of women's feelings about potential choices pertinent to labour and birth requires space for developing relationship for which there is little room when midwives are disempowered.

7.9.6. Pedagogy – Fear of Litigation

Fear of litigation resonated in the voices of the ANE co-researchers throughout our conversations, with and without women co-researchers. At this meeting, women co-researchers indicated their interest in having concise written documentation to support verbal information received in classes. Non-participant observation of antenatal consultations (n=886) combined with in-depth interviews with women (n=383) using maternity services in Wales were incorporated by Stapleton *et al.* (2002), to explore the value of evidence based maternity care information leaflets. Findings suggest that time restraint and lack of choice in the relevant maternity care setting limited discussion necessary to support written documentation. Consequently, in practice, women adhered to the restricted 'choices' that were outlined by professionals and ultimately complied with firmly established hospital procedure (Stapleton *et al.* 2002). Again, request for written documentation indicates a rote rehearsal approach to knowledge gain; however, women sought written documentation at the onset of the programme of five classes to aid learning and also, to plan ahead and to prepare questions for oncoming classes. This suggestion was refuted by the ANE co-researchers with the suggestion that women would not attend if information was provided at the commencement of the class programme; however, a 'handout' is currently offered at two of the classes with a brief outline of upcoming classes, and this was discussed during the operational plan meeting.

Over the course of the meetings we discussed how I could contribute to supporting documentation that was evidence based and that presented research in an accessible way. The ANE co-researchers were happy for me to format the documentation as per recommended font face and size; however, we agreed that any significant changes would have to be approved by the relevant hospital committee. Throughout the research process, I developed documentation on request which consisted of an evaluation questionnaire and information sheets explaining class content; ultimately, however, the

ANE co-researchers reverted to their original content with little change. I was disappointed with this development; over the process of the action research inquiry, I had remained very optimistic that we could pursue action that had arisen from our meetings and discussion together.

7.9.7. Intervention and Risk

Almost immediately, and at the onset of our conversation, the issue of intervention and concentration on risk and loss of control in the labour and birth process were highlighted for discussion by one of the pregnant women co-researchers:

> 'I suppose just knowing the different scenarios and why you might require certain interventions over other interventions and that you would be fully informed...that you don't feel that it's something that's just being sprung upon you and that you are losing control of the whole birth process or labour process' **(CIG AN W6)**

Control of the birth process is, in fact, an elusive and multifaceted concept. The very essence of a trusting relationship between midwife and mother as, potentially, in the case of home birth where continuity of carer as previously defined is facilitated, means that a women feels safe enough to relinquish this sense of 'control' and devote her energies to her birth and labour (Kitzinger 2006). The opposite to control in birth is loss of control or perhaps, surrender. In a discussion about surrender in childbirth, Sarah Buckley (2009) suggests that surrender in Western society is often perceived as weakness; women's difficulty with surrender in birth can reflect lack of confidence in the natural capacity of a woman's body. This perception is perpetuated by the obstetric model, which views birth as potentially dangerous and leans heavily on technology as a source of protection against birth as natural (Buckley 2009). Fear of surrender is exhibited by the women's need to separate from ownership and subjectivity of the birth experience, coupled with the plan to allocate responsibility to another. This is uncovered by the reading for the 'I'

> 'I wanted to know when you need to go to hospital and what do you do once the baby's born. The bit in the middle was kind of somebody's else's problem

because they are going to tell me, I knew there were enough people there to kind of help you out you know' **(CIG PNW7)**

Women had voiced concerns about intervention in previous meetings and the CIG presented an opportunity for exploration between ANE co-researchers and women co-researchers about birth that is marked by technology and intervention. When asked about types of interventions that are discussed in classes, ANE co-researchers offered:

'Well, we talk about breaking waters, why we do them, when we do them, we talk about oxytocin, why we give it, when we don't give it, continuous foetal monitoring, why we do it, when we do it, forceps, suctions, sections, when why, how...' **(CIG P3)**

Timing of labour and limiting labour was discussed with reference to the partogram. The partogram provides a rationale for increasingly strict definitions about how long labour should be, in addition to how time-intervals during labour should be allocated and for what purpose. According to Downe and Dykes (2010), birth is viewed as a linear process and over the years, parameters for what is increasingly accepted as 'normal' length of labour have decreased; further, they state that it is likely that many women if left alone would labour within the parameters of 'Friedman's curve.' There is also the probability that a substantial minority of women would not do so but would still be well and healthy. For this substantial minority of women, 'labour is deemed pathological in cultural settings where time and standard measurements are the arbiter of normal and abnormal' (Downe and Dykes 2010, p. 68)

'Well it depends how the mother is and how the baby is, so if the mother is well and the baby is well and making progress...you wouldn't see sixteen hour labours here on the labour ward...you wouldn't see them, there's only two percent go over twelve hours here in a year...but if the mother is well and the baby is well they will leave them be... and making progress... I mean if she stops making progress and then you have to look at what's going on, but as long as she's making progress and going on up the scale we will let her be as long as she's well, and the baby is well.' **(CIG P3)**

Q: And the scale is really the partogram?

'Yes, the nought to ten centimetres' **(CIG P3)**

Ideas that could be brought forward and developed for the antenatal class programme were discussed, and it was agreed that we should concentrate on five potential strategies to take forward because, in keeping with the gradual and incremental nature of change, a smaller number of targets may be more realistically achieved. Action research occurs in 'real-time' (Coghlan 2003, p. 459) and ANE co-researchers highlighted that implementing change would be a slow process, particularly in terms of organising structure and frequency of classes, because classes were arranged and booked months in advance. While we should be cognisant that change and therefore, PAR is often a slow process, it is necessary to remain open to opportunities for and timing for action (Grant *et al.* 2008). Table Eight overleaf outlines the changes that emerged from the first Collaborative Inquiry Group meeting. It was decided that the first five suggestions marked by the asterisk* below, although not in original chronological order, could be implemented.

Table 8: Ideas for Change that Emerged from CIG1

Ideas for Change that Emerged from CIG1
*Longer classes, maybe two hour classes, three times a week. The first hour with a midwife and the second with the physiotherapist or dietician and a break for refreshments in the middle.
*Maximise support that is already there- ways to meet and engage with other women. Tea is really the catalyst for bringing people together and, if this is not available, there was a suggestion for 'ice breakers'.
*More interaction and participation, prompted by questioning about learning goals for classes and the 'Hopes and Fears' exercise.
*A written handout to support information covered at each class, particularly on caring for a newborn, including pointers on baby care, for example, ten succinct points about 'what you need to know about caring for your baby'.
*Distribution of the antenatal and postnatal DVD as basic information and augment this with questions and discussion at the next class.
Smaller classes
Offer pre-reading prior to attending next class (postnatal mother)
Discuss essential practical requirements for infant care
Use different strategies for learning, for example, using dolls and inviting postnatal mothers and babies to classes
Guidance on what to read and obtaining evidence based information
Use of a folder for handouts
The hospital view and 'other options'
Information about other ways to support after birth 'Well even when you have your time here and your home you're like, how do I bath the baby and you could throw it on (DVD) or you have photos or something' (postnatal mother)
Postnatal women commented that they liked the hospital magazine and suggested making reference to the magazine in classes and highlighting relevant information pages
Specific information about 'what to do if you are concerned', 'who to contact after you have gone home' and maybe 'frequently asked questions by parents in the first few weeks at home'

Field note Entry from Reflective Diary post CIG 13th October 2010

There were many voices in the room and, despite my efforts one of the ANE co-researchers (P3) was the leading voice, although representation of women and professionals was equal in the numerical sense. A key observation of the group was the body language of women co-researchers in response to the charismatic nature of this ANE co-researcher, which indicated to me that they felt safe and connected with her. Women co-researchers laughed in response to her comments and they physically leaned towards her; I wondered if the success of antenatal education relies upon the skill and personality of the facilitator. According to Kitzinger (1977, p.6), 'the quality of the human relationship between teacher and taught may be difficult to measure, but it is this, rather than the subject taught or the teaching techniques employed, which is the essence of education'. Education requires taking into account the woman's physiological and psychological changes, dynamics of pregnancy and childbirth and being interested and open to discussion (ibid).

I felt uneasy following the meeting. First, I questioned if we were really communicating authentically with women co-researchers, as information that was offered is charged by the predominant hospital view and there appeared to be reluctance of ANE co-researchers for discussion of broader issues relating to the midwives' strict adherence to the hospital regime. I struggled with how the ANE co-researchers could be persuaded to this end without further compromising the inclusive nature of PAR. Secondly, I was anxious that our conversation had unearthed issues for pregnant women who had not yet the space or forum to explore them, and this was particularly evident in our conversation. An example of this was the postnatal women's accounts of conflicting advice offered in the period after birth; we dealt with this issue by inviting dialogue. While questions arose that undoubtedly need to be addressed, in terms of the adequacy of support and care afforded to women as new mothers, this discussion has raised awareness for the pregnant women who have signed up for the package of care offered in the hospital site. My anxiety was alleviated somewhat when I contacted women co-researchers by email subsequent to the meeting to thank them and to remind them that I was available should they need to discuss any concerns arising from our meeting; two of the pregnant and an additional two of the

postnatal women wrote to say that they were glad to be involved in the research. Below are extracts from the emails I received.

> 'I really enjoyed the meeting last night- it was great to meet the other Mums to be again and also to hear of the experiences of the new Mums. Also nice to know a few faces now of the Mid-Wifes and Physios' Looking forward to the next meeting- with a hopefully happy and healthy baby in tow!' **(ARC2 W7)**

> 'I was delighted to be part of the study. The last session was very interesting, with all stakeholders in the same room!' **(ARC1 W2)**

The remaining woman wrote at a later stage also. I also had the opportunity to raise my concerns with the ANE co-researchers at our next meeting, which was the operational plan meeting.

The ANE co-researchers remained with me to reflect on the conversation that had taken place and their immediate feedback suggested that they felt positive about hearing what the women had to share, with particular emphasis on the postnatal women's accounts of their experiences of the ANE programme and how this impacted their birth experiences. They were happy for me to approach the Director of Midwifery in the future, with their prior consent, in order to make housekeeping requests for refreshments and planning the environment; in fact, the classroom has been relocated subsequently due to fire and safety issues.

We agreed a provisional date for an operational plan meeting to discuss how we might progress proposed developments based on the CIG discussion; I felt it was unlikely that any change could be implemented immediately, particularly if change impinged upon organisational structure. Nonetheless, I was optimistic because the ANE co-researchers appeared to embrace the research and, with that, brought a sense of ownership and enthusiasm for what women co-researchers had to say. Analysis was an iterative process and on one of my occasions revisiting the transcript of this conversation, I became aware that, notwithstanding the individual voices, there were two distinct and dominant voices of ANE co-researchers and women co-researchers who were speaking

in parallel and diverse fashion (explained in Chapter Five). This realisation culminated in the development of Reading Five, reading for parallel and diverse discourses, depicting the emerging disparity between the dominant medical model and an alternative model of care that the women co-researchers had difficulty naming because, for the most part, they appeared unaware of birth beyond medical monopoly.

Following this meeting, thanks and verbatim transcripts were sent to the women and ANE co-researchers for comment and verification of accuracy in representing their views, in addition to a summary of my interpretations of the main messages. The summary scripts that were sent to the women for confirmation or review were originally formatted in Avedis Donabedian's (1980) quality indices model of 'structure', 'process' and 'outcome'; however, over time, presentation of the summaries evolved to be more continuous under subject headings, for example, 'Labour and Birth' and 'Postnatal Period', which perhaps is more reflective of Ann Oakley's (1984) notion of pregnancy, birth and motherhood as a continuous entity. I felt that, by imposing headings such as 'structure' 'process' and 'outcome', I was imposing structure and control that was consistent with a quantifiable and objective [214] paradigm.

7.10. Action Research Cycle Two Operational Plan

Following the CIG conversation, the ANE co-researchers and I came together for an operational plan meeting. The aim of the meeting was to share our experiences of meeting the women, the antenatal educators' experiences of facilitating the programme and ideas that women suggested were important, and to plan ways to implement strategies for change. The operational plan meeting was arranged three weeks after the CIG to suit the clinical demands of the ANE co-researchers and to afford some time for reflection. This also afforded time for transcription of the CIG conversation, summary of themes and receipt of feedback from the principal people involved.

[214] Concepts of 'Structure', 'Process' and 'Outcome' are consistent with Donabedian's (1980) analysis and indicators for the assessment of the quality related to medical care.

Field note Entry from Reflective Diary Preparation for Operational Plan Meeting 2nd November 2010

It was clear that the ANE co-researchers refuted offering women informational support on alternative options for care; however, as initiator of the research, I had a responsibility to guide and facilitate developing knowledge and the progress of the group's aims and objectives (Koch and Kralik 2006, Stringer 2007). To this end, and, in response to the women's identified need for informed choice, I tentatively offered ideas and supporting documentation for classes[215] during meetings with ANE co-researchers, while at the same time, acknowledging the value of their expertise. As a participatory action researcher, I am cognisant and respectful of the views of the ANEs; as a midwife, I find it difficult to stand back from the tensions that I feel exist between the dominant philosophy and what women appear to be asking for. It appears that the real issue is not so much about informational needs, although these are important, but rather the woman's relationship with the midwife or other and how this is nurtured, or neglected. It is also clear from the transcripts that ANEs welcome the opportunity to engage with women and to hear their views about the antenatal education that is available.

In relation to informed choice, raising the issue of uncertainty can bring about calm and there is the sense of 'enabling women to learn to trust that they will cope with whatever comes their way' (Leap 2010, p. 22). My initial reaction was to try to protect women from the tensions that exist between what women appear to want and the system that is available to them. On reflection, I realised that, in providing information about birth options that are not available them, women could possibly articulate the need for change and perhaps become active in their quest for alternative birth options. This changed perspective reflects Wheeler and Chinn's (1991) feminist concept of 'letting go'.

[215] Supporting documentation included a programme of MIDIRS informed Choice Booklets, information for partners, research articles and copies of the Association for the Improvements in Maternity Services in Ireland Survey, March 2010. According to Dickson and Green (2001), one of the advantageous of the external researcher is offering additional resources.

ANE co-researchers and women co-researchers were encouraged to reflect and record their thoughts and feelings between meetings; this approach had varying levels of success. Each reflection phase was used to reflect on data from the last action phase and to apply this thinking in planning the next action phase with due regard to whether the forthcoming actions of women co-researchers will be 'divergent or dissimilar and convergent or similar' (Heron and Reason 2006, p. 148).

The meeting began with an exercise to 'bring the mind home', inspired by John's (2004) Model for Structured Reflection 14th edition (Appendix 24), and the following questions were asked:

- How are you now and how have you been since the last (CIG) meeting?
- Did any of the discussion resonate?
- Have you had time to think about it since?
- How if at all has your practice changed as a result of engaging with the women in that way?
- What was it like being in that new space?

Overall, ANE co-researchers confirmed their commitment to the research and this was enhanced by their positive experiences of the CIG conversation,

> 'I mean we always want to make it better.' **(OP 1 P3)**

> 'I enjoyed that now I must say because I thought we, you get nice feedback from the women and they get to know what we felt and it was nice...' **(OP Plan 1P2)**

In order to gauge the level of authenticity of collaboration (Maiter *et al.* 2008) and, in keeping with the tenets of PAR, I asked the ANE co-researchers if they could suggest another way that they could engage more fully in the research if that was their wish. Engaging co-researchers in research through sharing control redefines knowledge production, process and outcomes in ways consistent with the quality standards of action research and its goals of democracy and participation (Reason and Bradbury

2006). We discussed our feelings, I explained that I keep a reflective diary and I suggested that they do the same, with a view to capturing the ideas, emotions, thoughts and feelings that could be provoked through engagement with the research (Heron and Reason 2006, p. 146). I shared my anxiety about the possible effect of the postnatal women's stories on the pregnant women in the group, and a brief discussion about the detrimental effects of mixing first-time and other mothers in classes ensued.

As in previous meetings, Stringer's (2007) broad and flexible framework of 'Look, Think, Act', was used and the discussion was influenced by the following questions,

- Can we discuss how we are now?
- What are your impressions of our discussion and how do we feel about what we heard?
- These are the main themes that were highlighted and brought forward from that meeting, can we look at them?
- What do you think?
- What can we do now?

Reading for the 'I' reflected the ANEs' experiences of the CIG, their thoughts following the meeting and reflections on how suggested change could be implemented. What emerged was the erratic nature of the physiotherapists' and dietician's involvement in facilitating the programme. This had obvious implications in terms of consistency and the ANEs' capacity to implement suggested change, and the potential sustainability of the research.

> '...I think I've only taught two classes...I tried out a few bits and pieces from the last time that we were talking, kind of changed a few different things to get people interacting with it...one class that I did it didn't work so well...I think the class that took to it more was actually couples (predominantly mixed couples' class)...' **(OP Plan 1P2)**

7.10.1. Needing Other Mothers –Ways for Women to Come Together for Postnatal Support

The ANEs acknowledged the women's desire for support from each other and their needs to establish informal networks in the absence of ongoing professional and peer or family support and this manifested in women, themselves, mobilising support for each other.

> 'Yeah, well a couple of weeks ago one lady asked me could she talk in the class, what she wanted to do was to start her own postnatal group...she stood up after the class and she said if anyone would like my email, I volunteer to have a support, herself...she asked at one class would it be accommodated in the hospital or would the hospital encourage that and I said well we'd encourage you to get to know other pregnant women but we don't have the room to accommodate a meeting afterwards, so then she came back at the last class and she said can I say something to the ladies here (The woman wished to talk about forming a mothers' support group).' **(OP Plan 1 P1)**

> 'We used to bring them back...we used to get them to fill out a questionnaire, it was a very good chance to get feedback for us, but what happened then, it kind of turned into a sort of a yakking between themselves and ah we all got busy...it changed to just bantering and talking between themselves...and you thought then well, let them off to the coffee shop. I have other things to do' **(OP Plan 1 P3).**

The above statement reflects the pressures that ANEs feel in trying to adhere to standardisation and task-centred care, consistent with institutionalised hierarchy that moves them further from the relational aspects of caring for women.

Introduction of possible strategies for change that were discussed at the CIG was met with some resistance. The difficulty in facilitating women in coming together through adapting longer classes (possibly two hour classes), the first class with midwife, the second hour with the physiotherapist or dietician, and a refreshment break in the middle was discussed. This was considered during our CIG meeting as a potential way to

progress; however, antenatal educators felt longer classes were not possible within the structure and organisation of the current programme.

> 'We have that with our multips but that having longer classes or having more smaller classes, it's not really possible' **(OP Plan 1 P2)**

7.10.2. Another Opportunity to Engage

Barriers to ideas that were offered in response to women's requests for practical skills and information in preparation for motherhood were presented in the form of the current programmatic structure. Specifically, ANEs commented on resources and timetable design. I suggested that the current curriculum be rearranged to address topics that women identified as meaningful, particularly, extra information about caring for a newborn, but antenatal educators stated that everything had to be 'covered'. We discussed the addition of an extra class to facilitate this information-giving, but ANE co-researchers felt that there was not sufficient space in the timetable. One suggestion was an optional class for women to attend if they wished, which would not impact on the current class programme and structure. The irony, of course, is that information about caring for a newborn is a core need identified by women yet, it is subordinated to an optional class in place of what to expect on admission and hospital policy related to labour and birth.

The optional class would include practical tips for caring for a newborn, Neonatal Resuscitation and First Aid and would also include valuable information offered by the dietician, which was currently under-subscribed. A restraining factor for implementation was lack of time for women to attend, as women already attended five, maybe six classes. To overcome this aspect, ANE co-researchers suggested a monthly arrangement and the possibility of an optional evening class was discussed but women would have to pay. Additionally, this could be facilitated by a neonatal nurse specialist and would help the ANE co-researchers by not adding too much to their already onerous clinical workload.

> 'I'm just saying it's hard to get it all in. The option would be good; it would give us another place to focus.' **(ARC2 OP Plan P3)**

It was suggested that, for some women, information on baby care during pregnancy might be tedious if not immediately relevant (Knowles 1984). This is in keeping with one of the postnatal women who had suggested that she was not ready for information about the baby until after birth, yet a repetitive theme in this research was women's desire for the provision of postnatal information during pregnancy.

> 'I think it was, I think that we're kind of I suppose saying that yeah it was about, I think that what they were maybe more anxious about *was* about having the baby, wasn't it? What they would be doing with the baby when they got it?' **(ARC2 OP Plan P2)**

The idea that information is available for women when it is relevant for them was discussed and the ANE co-researchers suggested promoting an informational DVD about pregnancy, birth and motherhood that was already in circulation. This was debated for some time and we came back again to the idea of an optional class on postnatal care and first aid, which could be offered to pregnant and postnatal women. Classes on baby care are currently offered after birth on the postnatal units but the postnatal women co-researchers confirmed that they were too tired to attend and retain information after birth.

> 'Because they often ask what happens if a baby chokes...' **(ARC2 OP Plan P4)**

Table 9: Suggested Content for Optional Class during Pregnancy

Suggested content for Optional Class during Pregnancy
Physiotherapist on providing care of self after birth
Dietician on nutritional support and weaning
Neonatal Resuscitation and Baby First Aid
General Practical Care of the Infant

7.10.3. Introducing Change

We discussed the issue of introducing more information on baby care during pregnancy as women had requested; however, from an organisational perspective, there was difficulty in changing timetables[216] to suit needs. This is influenced by the significant hospital birth rate and subsequent organisational constraints.

> 'Well now you see you have to be careful when you are moving things around in an establishment like this because then you have the postnatal lady coming for the introductory, it's hard, if you have something every Wednesday to stick with that, you'd have to bring it in another day.' **(OP Plan 1 P3)**

In the extract above, the ANE co-researcher is outlining the importance of rigid subject allocation in accordance with the timetable and previously allocated dates and times of classes.

> 'Maybe if one person did one thing (the suggestion here was to introduce change or meet demand by alternating the agenda for a particular session to address other issues once a week, offering an alternative)' **(OP Plan 1 P5)**

> 'It's very hard. Like, I had three people last Friday that came to the wrong things. If you have too many things at different times they are just all over the place.' **(OP Plan 1 P3)**

ANE co-researchers felt it was necessary to subscribe to the set content of classes; we debated how we could fit additional information around the existing structure. A safe option was to postpone decision-making until after the ARC2 pregnant women had birthed their babies.

Consistent with a programmatic approach to knowledge, there was a uniform approach to information-giving, which created a climate of fear if not strictly adhered to; notwithstanding this, since the onset of the research, there was evidence of change in the

[216] A Foucaudian perspective on the timetable as a means to control activity is presented in the discussion Chapter Ten.

developing programme which caused some discomfort and this is illustrated by the following exchange between two of the ANE co-researchers:

> 'I do a lot about babies in that class, I do about night feeds, I do about caring, I do about what clothes to buy.' **(OP Plan 1 P3)**
>
> '...I don't tell them what to buy.' **(OP Plan 1 P1)**
>
> 'I tell them buy cellular blankets, don't buy fluffies and woollies, you know all that stuff, you know post natal depression.' **(OP Plan 1 P3)**
>
> 'Yeah, well I talk about post natal depression.' **(OP Plan 1 P1)**
>
> 'I think I'm changing my class by the bit, I'm still running the video but I've changed it more to what it's like at home.' **(OP Plan 1 P3)**
>
> 'Then I need to talk to you about class X a little bit more...I don't talk about clothes, I don't have that.' **(OP Plan 1 P1)**

7.10.4. Documentation

Acknowledgement that participating women requested a handout of evidence based information provoked discussion about a review of documentation in terms of legibility and comprehensibility of information. Again, I offered my help, and it was agreed that I could format class documentation without changing content; we discussed learning needs consistent with adult learners. It was agreed that the midwives would meet to develop the additional information on baby care that the women requested.

> 'I think probably 5 simple things or 6 or 7, whatever *could* be done in the little handout after the class about the baby, because sometimes in the postnatal class we see the women that attended the classes antenatally and like they comment on the postnatal class and say I wish I'd known that beforehand and like I'd say to them did you think you were ready for it beforehand and they say no not really' **(OP Plan 1 P1)**

7.10.5. On Implementing Change as a Result of Collaborative Inquiry Group Meeting One

ANE co-researchers discussed their efforts to achieve and encourage more participation in classes in response to women's articulated needs during our CIG conversation. The various dynamics of different groups were highlighted. Co-researchers explained their growing awareness of how one strategy might work with one group, while another may not. An example of this was the 'Hopes and Fears' document which was deemed more successful with couples classes.[217]

Tea and coffee were arranged for one of the classes, despite the inaccessibility of the classroom and the obstacle that the building poses for women coming together; the tea is a metaphor for women coming together to share their experiences and to build support for each other. This was a real achievement and was instigated by the help of someone in the household department, who was willing to assist.

7.10.6. Fitting in to an Existing Structure

The suggestions for changes were small in the face of authoritative scientific knowledge and the issue of longer classes was problematic because of birth rate. The literature suggests that antenatal education is under resourced in favour of more acute settings. There is also the suggestion that the potential of antenatal education is compromised by lack of resources and educational opportunities for facilitators (Schott and Priest 2002).

The idea of working with smaller groups to encourage interaction was raised; however, and the ANE co-researchers agreed that they could possibly try some small group work in classes notwithstanding the fear that this could cut in to the time allowed for the existing programmatic structure and an occupation with time.

> 'My problem is that we've so much to cover, we're actually trying to get all this covered and you're looking up at the clock saying 'oh my God I'm over my time there's another class coming in', that's a good deal of pressure I think.' **(ARC2 OP Plan 1 P3)**

[217] Couples' classes is the term used in the hospital setting to describe male and female partners but also includes other relationship forms.

A review of class documentation reveals that current classes consist of information about the physiological manifestations of pregnancy and labour, and pharmacological and non-pharmacological methods of pain relief. Stages of labour and interventions are discussed in detail, in addition to information about practices that are specific to the hospital setting. A tour of the labour ward is offered, breast feeding is discussed, and there is a video of normal birth, for which attendance is optional.

Field note Entry from Reflective Diary 9th January 2011

Previous to this, my interpretation of the main messages was offered to the ANE co-researchers and women co-researchers in paraphrased form. In doing this, I feel that I am somehow drowning out their voices in my interpretation of what the women are saying, and this feels wrong. I have made more effort to include direct narrative with my interpretations of the messages that seem relevant and meaningful in our conversations. It is now easier to believe in the research process because of the women's interest and the increase in number of ANE co-researchers involved. This is now six and until recently, there were four. I feel this is because the research affords space and opportunity to come together and talk passionately about a subject that matters.

Table Ten overleaf outlines the actions that we agreed to bring forward from our first operational plan meeting.

Table 10: Agreed Actions to Bring Forward from Operational Plan Meeting I

Agreed Actions to bring forward from the First Operational Plan Meeting
Tea for class one
More interaction and smaller groups for discussion (e.g., hopes and fears exercise)
Tips for ice breakers (for example, turning the person on the right)
More discussion on what happens when the baby comes home in class 5
Adding pointers to the current handout on baby care, it was agreed that the midwives would meet to do this
There is also a possibility of an optional postnatal class; this will be considered again once the next group of women give feedback.
I will format the handouts as agreed for the recommended font face and size.
Distribution of the antenatal and postnatal DVD to each class participant

Field note Entry from Reflective Diary Post ARC2 Operation Plan Meeting

I have learned the value of immediate contact with the ANE co-researchers. There are many reasons for this, most importantly, to express my genuine thanks for giving of their time and themselves so generously and also to provide a prompt reminder of any agreed strategies. Following on from this meeting there was contact by email to discuss difficulties, progress and my feedback on documentation. The information and main themes that emerged from the operational plan meeting were also offered to the women co-researchers of the CIG, and the ideas and plans were well received.

7.11. Conclusion

In Chapter Seven, Action Research Cycle 2 is explored. The key findings from two ANE co-researcher meetings, one new pregnant women's group meeting and the CIG meeting with women co-researchers and ANE co-researchers are presented. The first meeting, with the antenatal educators only, revisited the ARC1 postnatal women's evaluation of the current programme and highlighted the ANEs' responses. The main themes that emerged in the second meeting (a women's only group meeting), with a new group of pregnant women, were the concept of choice, preparing for motherhood, and birth. The third meeting, the first CIG meeting, was composed of some members of the ARC2 group of pregnant women, some postnatal women from the ARC1 group and the antenatal educators. Issues discussed were: the concept of reassurance, restraining factors for change, possible solutions, antenatal education as a forum for support and connection, informed choice, fear of litigation and intervention and risk. In the fourth meeting (the first operational plan meeting with the antenatal educators), themes highlighted were: opportunities for connecting women, introducing and implementing change, documentation and how change might fit in to an existing structure. Chapter Eight describes the third Action Research Cycle (ARC3).

CHAPTER EIGHT PRESENTATION OF THE FINDINGS ACTION RESEARCH CYCLE THREE

8.1. Introduction

In Chapter Eight, the third Action Research Cycle process and findings are described. As with previous ARCs, the main messages emerging from analysis of the group meetings in ARC2 were shared and revisited. This gave opportunities to reflect on any changes that were implemented and their subsequent effects, and also generated further analysis and discussion for the ARC3 meetings. Two ANE co-researcher meetings, one new pregnant women's group meeting, a second CIG meeting with women co-researchers and ANE co-researchers, and one individual conversation with a woman who had completed the antenatal education programme but had yet to give birth, were included in the third Action Research Cycle. There is a large amount of data to consider and I offer selected findings from key meetings in this chapter.

8.2. Reconnecting

Approximately five weeks after the operational plan meeting, I sent an email to the ANE co-researchers to inquire about progress. Just three of the antenatal educators responded: P1, P2 and P4. (Please refer to Table One on page 89 for characteristics of antenatal educators). My questions are underlined with co-researchers' responses outlined below.

8.2.1. Are there any changes in place?

> 'Yes. Tea/coffee at 1st class, additional information on baby during the early days. I introduce this with baby's basic needs – warmth, food & love. I would expand on these points but I find each class can direct me to different subjects i.e. crying, bathing.' **P1**

> 'Couples encouraged & time allowed to reflect on information given at different time during the class' **P1**

> 'Yes, tea and coffee now in place for class one' **P2**

'I have started to add in more examples/anecdotes from real patients' **P2**

'We attempted to start the tea, coffee and biscuits as this came up a good few times in the meetings, but to be honest it hasn't really worked out. We had it in a fair few class ones and none of the mums or dads ever had any. I think in all the classes I taught maybe two mums had a cup, and after a while you just felt a bit silly offering it to them all the time. It also didn't seem to be adding anything towards the mums interacting with each other' **P4**

'In the first class while doing the registration we always ask the mums if they have any problems, anything they need to ask etc., but I have been more careful to let the parents know that it is an interactive class and that if they have questions in any of the classes to be sure and ask them as there are probably 15 other people in the room wondering the same thing' **P4**

'Stopping after each section of the class and making sure to ask if anyone is unsure about what I have spoken about or has any questions' **P4**

'I always make sure to leave the room for a minute or two towards the end of the class to get the leaflets and tell them they can take a minute to discuss what we've gone through with whoever is there and see if they have any questions at all' **P4**

'The hopes and fears sheets for the start and end of class four' **P4**

8.2.2. How easy or difficult was it to make a change?

'It took some time to sort type of information needed for baby during the early days' **P1**

'Not too hard, just have to ask the right people in the catering department, some are reluctant to provide given that they have to carry a trolley upstairs. Also,

disappointingly/surprisingly there is minimal uptake on the tea by the patients, so we have had a few 'Mrs. Doyle' type moments!' **P2**

'All the changes made above were easy to make but most of them were things I had been doing every now and again in my classes, now I just ensure that I am fitting them in every class, aside from the tea and coffee, which in fairness was mainly (secretary) organisation!' **P4**

8.2.3. If changes are in place, what's it like now?

'I find the classes can sometimes be a bit hit and miss, like sometimes the patients will take to the bit of extra interaction and when you ask questions they respond and they have plenty of questions of their own, but then you do get the odd class where they sit and look at you with blank faces and no matter what you do they don't seem to respond too well, but then it was like that before the changes too.' **P4**

'Reflection time allows more interaction' **P1**

'See above re: lack of interest in tea' **P2**

'The examples definitely seem to raise a laugh and you can see that patients are more interested.' **P2**

8.2.4. If there are no changes, why do you think this is?

'If it doesn't sound too arrogant, I think that we are actually already providing a service which is very close to what the women want. Based on the meeting we had with the group of pregnant and postnatal women, I think we do seem to be meeting their needs quite well.' **P2**

Q **'In relation to meeting the women's needs, do you have any ideas particularly on where the women's needs overlap with the antenatal educators' perception of those needs; do you mean specifically in terms on information?'**

'The overlap I think is in terms of class content/structure. As in the prenatal women wanted more info. on the babies etc. but then the post natal said that actually it was better to have that advice once baby was born, which is the way we currently do it.' **P2**

The 'overlap' of information was raised also in the ARC2 postnatal group by one of the women co-researchers,

'Yeah, I thought was it the first or second class were nearly the same apart from the physio came in' **(ARC2 PN W10)**

'I think a lot of the big changes that came up in the meetings were things that we don't have much control over, things like room size and class size. Unfortunately it is a busy hospital and there are only so many hours in the day for classes so they have to be big class sizes and there is no other facility or space for us to have the classes in. These were problems we were aware of, and as educators would all obviously prefer not to be squishing 50 or 60 people in to a small room as it doesn't make for the best forum for interaction. I teach a 'mums only' class which has generally around 20 mums in a class and I much prefer the smaller class size. People are more inclined to ask questions etc.' **P4**

'I also think a lot of the things these ladies said they wanted to hear in the classes were things which we already cover in our classes anyway. Most of the things they wanted to hear in terms of content were there already so no major changes as far as content go needed to be implemented, just a few minor tweaks I suppose' **P4**

The above statement illustrates the harmonious nature of the conversation between the women and antenatal educators in CIG1 and their avoidance of conflict in the interest of preserving relationship.

8.2.5. Are there any problems?

'I find that giving the group time to reflect on the information it can be difficult to get all information in on the class time frame.' **P1**

'Some of the things that we would like to change are impossible due to the size of the room and availability of same. That is, we cannot have smaller classes as the birth rate is up and we just don't have enough hours in the day or the man power to have any more' **P2**

'Aside from the reluctance on the uptake of tea and coffee and the issues with problems that are out of our control, no problems arose from the changes' **P4**

8.3. Action Research Cycle Three Women's Group Meeting

Table 11: Characteristics of the Women Co-researchers in ARC3

Code	Gestation (nearest week)	Age Group (Years)	Care	Heard about ANE Classes	Live alone	Nationality	Main Support Person
W11	26	39+	SPC	Midwife	No	British	Partner
W12	25	30-39	SPC	Advertisement	No	Irish	Husband
W13	29	30-39	Public	Website	No	Mexican American	Husband
W14	20	30-39	Private	Consultant	No	Irish	Husband
W15	20	20-29	Public	Midwife	No	Paraguayan	Husband
W16*	24	30-39	Private	Consultant	No	Irish	Husband
W17**	37	20-29	SPC	Midwife	No	Irish	Husband

*Individual meeting
** Individual meeting before birth and on completion of classes.

The first meeting of the third ARC was a pregnant women's-only group, and the key themes emerging from our conversations are described in the passages that follow. Overall, women welcomed the opportunity to attend classes to meet other women and to gain information. We discussed how learning is most effective and desirable when it takes place through discussion that is not structured and through hearing other women's experiences. Antenatal education was also described as

> '...a way of standardising information, filtering outside information and giving a balanced and standardised view of what women need to know' **(ARC3 W14 21/40)**

The above statement reflects prioritisation of medical knowledge and a move away from relational aspects, which has narrowed the concept of learning about becoming a mother to informational needs only, in the absence of an alternative model of care. This is also

consistent with the standardised approach to care that is characteristic of impersonal settings.

When asked, 'what do you think Antenatal Education (ANE) is about?' Women responded that they felt ANE is about birth, yet deeper analysis, particularly in reading for the voice of 'I', reveals that women have concerns beyond birth that need focus and attention. Reading Two uncovers a vulnerability and isolation that is not immediately apparent on first listening,

> 'I think in a sense you need more information for after the birth...I haven't. I know nothing...I'll been learning for the first time from books or from a midwife or from, from the internet...I've been researching things like what kind of pram I should buy or push chair, everything like that would be really, really helpful.' **(ARC3 AN W11 26/40)**

> 'I think your body has gone through so much and your hormones are all over the place...I think the after care would be an awful lot more important...I just think even getting groups of people and meeting up...I'm panicking...I just think that's going to be, for me that's going to be so important.' **(ARC3 AN W12 25/40)**

Women identified that being separated from the support of family and companions precipitates feelings of anxiety and insecurity. Discovering pregnancy can be a combination of relief and apprehension and having someone to talk to, particularly in the early stages, is very important. The role of antenatal education for one woman has the onerous responsibility of calming or terrifying her in the vacuum that is the short time and space that the women and ANEs have together. In addition, the isolation in the absence of statutory community midwifery support after birth is reflected,

> '...when the baby comes you're more or less left to your own devices.' **(ARC3 AN W12 25/40)**

When asked the question, 'what do you think you need to know?' Women responses reflected their need for specific information, grounded in real-life experiences, and this included learning from other mothers' stories, community supports and groups, such as,

La Leche League and Cuidiú. Dissemination of generic information was deemed irrelevant,

> 'And the Irish NCT, I never remember what they're called, stuff like that...rather than, I know I have to wash my hands you know, I know there's the hygiene you know, the flu or whatever they're written on, I don't need twenty leaflets.' **(ARC3 AN W11 26/40)**

Women welcomed information about introductory antenatal education from a professional source, for example, the general practitioner. They were unsure about the information that they needed, as has emerged in previous groups, but they named specifically information in early pregnancy on nutrition and vitamin supplementation and different options for care. They were also interested in information about 'natural' birth and hypno-birthing, routine tests during pregnancy, information on formal and informal support, and breast feeding support groups and sex[218] during pregnancy and after birth.

8.3.1. The Myth of Motherhood

A sense of fragmentation is initiated by a medical model of birth (Kennedy 2002). Analysis by Emily Martin (1987), suggests that, throughout their life course, women are expected to surrender their genitalia and reproductive organs for scrutiny by medical doctors. In her interviews with 165 women across three life stages, Martin (1987, p. 72) points out that the position required for such scrutiny by way of pelvic examination effectively separates the woman from the 'body parts' that the doctor is examining. Participating women in Martin's (1987) research also described uterine action as something that happened outside of the body; this was intensified by epidural analgesia. According to Martin (1987), women's beliefs about body image are framed by personal,

[218] Sheila Kitzinger (1977) suggests that 'the awareness of childbirth as part of a woman's whole psychosexual life – not simply as an isolated occurrence at one end on her body – must not only permeate all the teaching and affect the verbal imagery used and the way that it is put over but should involve sensitivity to difficulties that a woman may be confronting in her marriage, in the way she sees herself as a woman, in her attitude to motherhood, even in her relations with her own parents' (Kitzinger 1977, p.11)

cultural and social experience and are exhibited and re-enforced by everyday language culminating in pervasive imagery. This is evident in conversations with ARC3 women; undercurrent feelings about pregnancy are exposed by the voice of the 'I',

> 'I think it's really weird...I've got this lovely baby inside me...if I think about it too much I think Jesus I've got something parasitic in me and I really don't want a parasite inside me that I can do nothing about so I try not to think about it a lot' **(ARC3 AN W11 26/40)**

> '...I haven't really kind of made that connection yet that there's a baby coming, I haven't really. In my mind I'm like yeah I have to get ready for that...I thought it would be like flutters and something magical...I had to look it up on the internet...what am I feeling...I really still...butterflies in the stomach for me isn't what I feel...**(ARC3 AN W14 21/40)**

Miller (2005) suggests that by silencing ourselves as mothers and the inherent challenges and uncertainty, we perpetuate the myth that motherhood is instinctive and natural.

8.3.2. Societal Pressure

> 'Motherhood, I think that will happen as soon as the baby comes out…I haven't had a chance to think about it a lot because I'm doing, I'm obviously working full-time and I'm doing a masters…' **(ARC3 W17)**

Feelings about the birth were uncovered in reading for the 'I', which illustrates how previous experience can colour current perspective in the absence of a safe forum to explore feelings surrounding pregnancy and birth,

> 'Well I'm nervous about both (birth and becoming a mother)...I'm really nervous about the birth; I mean I'm just...I'm dreading the birth actually...because of what I had to go through...I had another friend who's lost a child as well...I'm just absolutely dreading the birth...I am dreading the birth...I've my mind set, I want a natural birth and you know, I want everybody

to do this hypno-birthing thing because it's going to help my mind' **(ARC3 AN W12 25/40)**

We shared email correspondence after this meeting to discuss hypno-birthing classes, books, CDs and relevant websites that might be of help and W12 was also attending pregnancy yoga with a midwife familiar with hypno-birthing methods.

8.3.3. Taking the Baby Home

'If antenatal education stops once you give birth, I would feel in this complete limbo of what the hell do I do now? I know it has to be fed; I know I have to do its nappy but how?' **(ARC 3 AN 11 26/40)**

Discussion focused on information needs in preparation for early motherhood and taking the baby home. As in other groups, the concept of what is normal in caring for the newborn was raised. The perceived fragility of the newborn and fear of unintentionally harming the baby is of real concern to women; this emerged in the ARC2 pregnant women's group discussion also. Concern for the psychological development of the newborn is also evident, in addition to the role that other carers play.

'In the first weeks, I would say when to involve your partner or whoever is helping you, how can they, what is the best way to get them involved you know, in such a way that is welcoming for the baby. I don't know because I don't know the psychology of the baby at that stage you know, when you have to put, like him or her in somebody else's arms, how to handle the baby and also, what else, I don't know.' **(ARC3 AN W13 28/40)**

8.3.4. The Context of Maternity Care

Fear about care in labour and birth emerged as the overarching theme in the ARC3 pregnant group women's conversation. This was augmented by the mounting dissatisfaction of two women co-researchers and their felt disrespect from professional midwives in their experiences of the services. Women co-researchers' perceptions of

the historical, cultural and religious influences on the organisation of maternity care in Ireland were discussed in the context of the United Kingdom. This was in addition to the value of having relationship continuity (Hatem *et al.* 2008), and midwifery care at home or in the community.

> 'I've heard so many horror stories about the Irish medical system and not particularly about the birth but a horror story about a consultant that a colleague of mine had...I don't understand it because Ireland seems to be so pro-children and people seem to have such large families compared to the U.K. and yet from what I've heard and what I've read, the whole giving birth system seems to be so much backward than in other countries.' **(ARC3 AN W11 26/40)**

> '...there doesn't seem to be enough midwives...there aren't enough maternity hospitals and I'm really concerned that I'm just going to be on a production line, and if I don't give birth within a certain length of time, I'm sorry the consultant is going to have to move on to the next woman and you're going to have to have a caesarean or we're going to have to pull it out with a ventouse or whatever and I, I suppose I just don't trust the system here...I would much rather be giving birth in my own midwifery centre in the U.K. But they don't really even, no, there's two here in Ireland I think.' **(ARC3 AN W11 26/40)**

The debate about valuing professional and 'expert' advice over opinion and coexistent distrust and suspicion of the system, stemming from experiences of care, culminates in a perception that one has to navigate the system and it means that women are located very tenuously.

> 'And then she moves you around and she gives you a number and okay, and after you've been there once, you know the system...but the first time you have not a clue...it's just, wandering around like sheep, you have no idea.' **(ARC3 AN W11 26/40)**

Some women co-researchers stated their feelings of disappointment about the way they were treated as recipients of the services, particularly in antenatal clinics. These women felt that the services were anonymous and impersonal in nature. The idea that healing

could occur through their sharing of their grievances came about because many women co-researchers expressed the therapeutic nature of discussion that was afforded through participating in the research and in meeting other women in similar circumstances to air their views.

> 'And you're treated like crap.' **(ARC3 AN W12 25/40)**

> '...all the advice I can give you from what I've gone through is come in and pretend you're the only person in the hospital and pretend you're the most special person in the whole hospital and pretend that you're, it is your health, so you aim the best for your health and if you have to, if your voice has to go louder and louder and if you have to act like a bitch in front of somebody you do that...and that is the only way, and you could walk out of the hospital and say well at least my bloods are OK, and things are okay, and somebody is listening to me' **(ARC3 AN W12 25/40)**

This was shocking to hear. The woman is referring to her experiences of maternity care in this pregnancy and her previous (first pregnancy), which culminated in her baby's diagnosis with a condition that was incompatible with life. She was dissatisfied with the services of the (same) hospital at the time and travelled to England to have her baby, where she felt she was treated with respect and kindness. The ethical dilemma that this woman's story presented for me is discussed on page 100.

8.3.5. The Role of Other Mothers

As with the other women co-researchers, women value other mothers as a source of information and discussed the merit of joining local community groups in pregnancy with a view to establishing postnatal support and to access information about baby equipment, in an attempt to manage the vast array of merchandise marketed towards families and women as new mothers. In her discussion of conceptual choices,[219] Davis-Floyd (2003) suggests that many pregnant women rely on peer support and the

[219] Davis-Floyd's discussion about 'conceptual choices' extends to models of care and the ideal of childbirth. In Irish maternity care, the technocratic medical model dominates; thus, conceptual choice in this instance refers to the ideal of what childbirth should be like that as defined narrowly within the parameters of the medical expert (Davis-Floyd 2003, p.33).

reassurance of another mother's grounded experience. Throughout history, the vital role that other mothers play has been longstanding.[220] This emerges repeatedly throughout the conversations with women in this research in discovering pregnancy and navigating and making sense of early pregnancy. In considering options for care, women relied on their colleagues and friends for guidance in choosing a care pathway:

> 'I just did what she did' **(ARC3 AN W14 21/40)**

In the absence of family and friends, as in the case of this woman co-researcher who has moved recently to Ireland, loneliness and isolation are tangible when there is no support system or network in place

> 'I'm not going to cry (laughs)...I don't really know anybody here, I've never really felt central to here...I've never really made any friendships...I won't have anybody to give me advice...' **(ARC3 AN W12 25/40)**

Victor Turner (1969), as cited by Davis-Floyd (2003, p. 34), propounds the particular shared sense of unity between those who navigate ritual processes together. This sense of unity or bond is expressed through the CIG2 postnatal woman's account of mutual support that she fortuitously uncovered in her community,

> 'What's been fantastic is the resources in the local community where you walk to each other's houses every Thursday and the kids in the mums' houses and you get phenomenal support, I never even knew that existed...there's still people in the community who wouldn't know about it and you meet them and they've no idea...' **(CIG2 PNW4)**

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[220] An early example of mother-to-mother support during pregnancy is recorded in the Bible in Luke's Chapter 1. When Mary is told she is expecting a child she responds intellectually - 'I am willing to accept whatever [God] wants' (verse 38); however, when she visits her pregnant cousin Elizabeth, Mary responds emotionally and wholeheartedly, bursting into song (verse 46) with The Magnificat and stayed with Elizabeth for three months. I am grateful to Professor Sandy Oliver (2011, Personal Communication) for this insight.

8.3.6. On Finding Information

Participating ARC3 women viewed with suspicion popular internet discussion forums as sources of valid information and requested alternative websites for information. I offered online informational sites that I had viewed and felt were potentially useful. The first two were based in Ireland, but the third one was an 'informed choice' website based in the U.K. with evidence based information booklets written in professional and lay (non medical) language available for purchase. The limitation of the provision of a U.K. website was that options for women such as water birth are not currently available under the auspices of the Health Service Executive (Murphy-Lawless 2011a). Women spoke about their perceived shortcomings of the current system and its failure to provide information that they felt was meaningful and relevant to their needs

> 'Plus the system doesn't tell you (what you need to know)' **(ARC3 AN W12 25/40)**

This woman had not yet attended classes and was speaking, not only from her experience of this current pregnancy, but also her first previous pregnancy that culminated in an intra-uterine death. Women identified the difficulty in addressing informational gaps without knowing what they needed to know.

> 'But that comes back to, at least if you know what you want then you can start to ask for it but if you don't even know, for example that the alternatives exist, you wouldn't even know what to ask for and put pressure on.' **(ARC3 AN W11 26/40)**

> 'Yes completely, if you listen to your friends who have given birth at the hospital you just continue on the same kind of cycle.' **(ARC3 AN W14 21/40)**

The women above welcomed the idea of meeting postnatal women at the next meeting (CIG) because they had been recipients of maternity care in the relevant setting and they had birthed and brought their babies home; in addition, they had attended classes and, most vitally, they were willing to share their experiences.

As with previous meetings, verbatim transcripts were sent to all women co-researchers following this conversation to ensure accuracy in presenting our conversation and my interpretation of the main messages also; confirmation and feedback were received. Messages that seemed significant were also sent to the ANE co-researchers in the interests of transparency and to promote reflection about how to progress the development of the programme in preparation for our next CIG meeting. ANE co-researchers and women co-researchers were invited to comment on these and agree, refute or add to each reflection. Participating women were also offered the main messages that emerged from the ANE co-researcher group meetings.

During the time between the ARC3 pregnant women's group meeting and the upcoming CIG2, I liaised through email correspondence with the ANEs to ascertain any developments in place and also to enquire about how they were managing implementation of the agreed changes. Always, I suggested that they keep in touch with me and share their views and concerns. In fact, I found that our correspondence was inconsistent and almost always initiated by me, but I felt that this improved over time, particularly as trust developed between us (Maiter *et al.* 2008).

8.4. Action Research Cycle Three Collaborative Inquiry Group

I felt that, by saying less and being less active during this conversation, I may encourage the other women co-researchers to say more. I asked one of the ANE co-researchers to facilitate the flip chart, which meant that I could observe more, and I hoped that this would result in less focus on me. As with the first CIG, to save time and to allow some focus, I collated the main themes from previous meetings in the lead up to the CIG2 conversation. I had forwarded my first reading of the ARC3 pregnant women's group conversation and I had found their dissatisfaction with their heretofore experiences of care particularly striking.

The second Collaborative Inquiry Group (CIG) meeting was scheduled to take place on the 8th December 2010. The meeting was cancelled due to inclement weather conditions and was rescheduled for the 13th January 2011, because of this there was a fall in the rate of participation, as women were unable to travel. This meant also that some women attending the CIG (W11 and W13) had already attended approximately half of the existing programme with the revised changes from ARC1 and 2 meetings.

Table Twelve presents the numbers of women and antenatal educators who participated in the ARC3 CIG2 meeting.

Table 12: Women and Antenatal Educators Attending the ARC3 CIG2

Antenatal Women	Postnatal Women	Antenatal Educators
ARC3 W11	ARC1 W4	P1
ARC3 W13	-	P2
ARC2 W14	-	P3
-	-	P4
-	-	P5
-	-	P6

Please refer to Table Three (page 106) in Chapter Four for characteristics of the ANE co-researchers. As in previous meetings, Stringer's (2007) broad flexible framework of 'Look, Think, Act', was used. ANE co-researchers (n=6) and women co-researchers (n=4) met together with a with a view to developing and progressing antenatal education. Once we had settled down, we discussed ground rules which, as previously stated, are particularly important in groups where power is unequally distributed. According to Brown and Gilligan (1992), it is important to ask whether open and genuine dialogue can occur when a meeting has different significance for those involved, especially when one person has the power over format and structure of the meeting. Conversations as part of interviews are different to the conversations we have in everyday life, they are 'both private and public, informal and formal, lived in the present but preserved for the future' (Brown and Gilligan 1992, p. 25). In an attempt to share the power balance, I felt it was important to ask the questions and hear the response to 'How are you feeling?' 'What is going on at the moment for you?' It was also important that I share something of myself in relation to how I felt about the

research. We revisited the main messages that had emerged from the ARC3 pregnant women's group. The women confirmed that I had provided accurate representation of their views:

> 'You really captured everything we discussed.'**(CIG2 AN W14)**

This was followed by general agreement. Affirmation from women co-researchers is an important part of the analysis and confirms that my interpretations of the messages were congruent with their views. The CIG2 inquiry began with the question:

8.4.1. How Can We Develop Antenatal Education?

One pregnant woman (W14) proposed that classes be reduced in size,[221] as large groups prevent ANEs from engaging in meaningful discussion with time to answer questions. This suggestion was countered quickly by explanation from ANE co-researchers of the difficulty pertaining to reducing class size set in a large institution:

> 'I would just like to say when you look in context of what we are doing at this hospital there's nearly X deliveries last year so you can see why the classes are so big, we would actually prefer it if they weren't so big...there's too many people but you see we have X courses a week running... people don't like being turned away...we used to have a limit on our classes what numbers we have but now we can't really because everybody wants to get in' **(CIG2 P3)**

KPMG (2008) reports that capacity of the three maternity hospitals in the Greater Dublin Area is not adequate to support the increasing number of births, which is currently one third of all births nationally and increasing; in addition, KPMG (2008)

[221] At the point of the CIG2, W4 was one of two women who had attended two sessions of a programme of classes with approximately 40 people attending each class. The initial goal was to have the CIG before the women attended the classes so they could experience the modified programme they had contributed to, so initially this was perceived as a limitation. On reflection, their input added to the richness of the dialogue and made insights on class size and intervention (see below discussion about episiotomy) possible. Changes to the research design as a result of the participative nature of the inquiry are in keeping with the emergent nature of action research (Stringer 2007).

indicates that hospitals are understaffed. According to Patricia Kennedy (2010), maternity care in Ireland continues to be obstetric-led and is tantamount with active management of labour ensuring that care is highly medicalised.[222]

The postnatal woman (W4) described her personal anxiety in potentially being unable to book a place in hospital-based antenatal classes. For her, the notion of group support and the opportunity to meet other women with similar interests provided motivation for class attendance, when this did not materialise, the void she experienced was filled by lay postnatal community support. She presented possible solutions of offering information about local supports in the community and encouraging women to interact with each other in classes. There ensued a discussion about interaction in classes; however, for the ANE co-researchers, time is an issue, which forces a programmatic approach to information giving within the context and constraints of the organisation. Thus, we can see how engagement and dialogue between the woman and carer is influenced and shaped by the antenatal educator's impossible task to somehow balance meeting the needs of the institution with the woman's needs (Edwards 2008, Kirkham and Stapleton 2004, Murphy-Black 1995, Murphy-Lawless 1991).

ANE co-researchers explained the difficulty in meeting women's needs and balancing the needs of the institution in terms of catering for large groups. According to Anderson (2004), by perpetuating the message of the institution, midwives become agents of oppression and control. Anderson (2004, p. 263) cautions that a generation of midwives have been damaged in this way and, unless this 'ruling hegemony' is addressed, the individual needs of women cannot be met.

> 'I think once you get people to start talking to one another and taking their time to get going and by the time they have got going you think there's 10 minutes gone. You know, time is time you know. You've got so much time to give information and you want to try to give them time at the end if they want to ask questions so there is a time element I think that kind of restricts us. Sometimes people are very, very slow to talk to strangers you know' **(CIG2 P1)**

[222] This has been discussed in Chapter Two with the medicalisation of motherhood and antenatal education.

Alternative sources of antenatal education were discussed, and the message was clear: that for women who are attending a particular hospital for care, there is the expectation that they attend classes held in the institution to learn about the dominant ethos of care offered.

> 'I suppose also looking back at the management of this hospital and the way that the hospital works it always, it comes down from the master[223] right down, filters through that they actually want the people who are having their babies here to attend classes here in the hospital where possible. They are not encouraging you go to out to Cuidiú and neither are we because we are giving them a message probably and we don't want that diluted.' **(CIG2 P3)**

This statement is presented truthfully and without ambiguity and reflects the antenatal educator's staunch belief in the dominant ethos of care which permeates throughout classes and therefore shapes the messages that women receive. For women attending the hospital, there is no doubt about the agenda and ethos of the institutional setting. The women co-researchers were momentarily silent and the conversation returned to emotional support needs and potential mechanisms to meet other women. The antenatal educators confirmed that women are encouraged to seek information about local community support during pregnancy but agreed that this could also be added to the documentation that was offered as part of the hospital information pack. We discussed the value of written information without supportive dialogue and it was agreed that we could add discussion supporting this written information to the current class format. There followed a discussion about group dynamics and difference. Antenatal educators explained how conversation was encouraged within the tight constraints of the hospital regime and its emphasis on programmatic structure and there was positive affirmation provided by the postnatal mother. The difficulty for women in speaking in large groups was acknowledged, and it was suggested that silence was intensified by the complexity of knowing and articulating need.

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[223] 'Master' is the long standing title afforded the obstetric lead in each of the three Dublin maternity hospitals.

8.4.2. About Antenatal Education Classes

> 'I thought they were fantastic. At the time I was probably like 'oh what do I need to know, I don't know what I need' you know that but looking back, going through the labour they were absolutely what I needed for the birth, they were fantastic. For knowing what's going on in the hospital, for knowing my options, for factual they were absolutely spot on (baby talking...) the physio was fantastic, the dietician was fantastic. Sorry yeah they were very factual (all talking)...maybe that's where the problem is. They are factual and they give you the information but they are not going to be your new friends.' **(CIG2 PNW4)**

In response to this postnatal woman's comment about the factual nature of the information presented in classes, one of the pregnant women stated her feelings that classes were biased towards giving information that favours intervention; for example, episiotomy, with a view to putting the needs of the institution first. This is reflected by the following exchange between the woman and P3:

> 'I actually disagree with the factual, I do think they are biased and I think they should provide all the information instead of favouring intervention. I think they should put it up front and leave it up to you to decide.' **(CIG2 AN W13 32/40)**

> 'Well, that's what we do really, we tell you what we do, if you like it that's good and if you don't like it, let us know and we try and meet your wishes' **(CIG2 P3)**

> 'But you are just trying to persuade people to say like 'oh, the episiotomy, like it is all good, it's not that big of a deal.' Well it doesn't seem that way when you look at the research; there is a debate about it. I think that you guys should be more realistic instead of promoting it, I know it speeds things up, we know that, we know that it's going to be good for the hospital' **(CIG2 AN W13 32/40)**

> 'No, that's not true. I'm sorry I'm going to have to disagree with you there now, I'm sorry; it's not to speed things up unless your baby is stressed. The only we

time we would have to do that. It's not for the convenience of the hospital and I do think episiotomy is very useful in the right place' **(CIG2 P3)**

A charged debate about intervention and episiotomy ensued in relation to indications for episiotomy, hospital rates of episiotomy, likelihood and effects. Discussion related also to women's perception about 'blasé' or 'over confident' attitudes of carers in relation to aspects of care such as episiotomy that may be routine events for professionals, despite the profoundness of the event for women. According to Davis-Floyd (2003), routines and rituals in birth intervention such as episiotomy are justified long after they are required because of the safety that ritual brings in the face of 'birth's inherent danger' (Davis-Floyd 2003, p. 64), and this is characteristic of the technocratic model of care which obstetric nurses[224]perpetuate. Indeed, Davis-Floyd (2003) suggests that antenatal educators[225]can potentially foster independent thinking[226]or can alternatively, and most pervasively, socialise a woman into the hospital system as distinct from examining real choice, depending on their personal philosophy.

Women co-researchers suggested that women need to hear more specific discussion in classes about details and context for interventions in order to allay anxiety and to promote informed decision-making. This is consistent with Oakley's (2005) assertion that women need to know about desirable and undesirable information. The point 'if you don't know, you don't ask' was raised by women co-researchers along with the need for a platform or medium between and/or during classes to provide space to question and address topics that potentially cause concern. There followed a debate about offering information without frightening women versus the right to make informed decisions and the ethics, or lack thereof, of withholding information for the comfort of others, which is ultimately a form of social control (Mason 1998).

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[224] Davis-Floyd uses the term 'obstetric nurse' to describe midwife, with reference to the obstetric nurse in the United States.

[225] Davis-Floyd (2003) refers to antenatal educators as 'childbirth educators'.

[226] In keeping with Bauman's (1998), discussions about choice, it may be argued that 'independent thinking' is culturally dependent and is also reliant on the concept of real 'choices' available to women.

'Yeah, yeah. So I think there's an element of within a large group, you want to give enough information without frightening people as well is important and again it comes back to the large groups and the group dynamics that there are always going to be people in the group who want to know more and want to know more and then there are other people who don't want to hear all that detail and they are just hopeful, they just approach things in a different way and I think as a group educators we have to be very mindful of that, that we are not frightening the life out of somebody with information that they may never need to know about. That's the other thing, it's only a third of people that might need to know.' **(CIG2 P2)**

'Yeah and when you think about it you don't want to say to some people, if you go like that at them they could go home and not sleep for a week, they cry themselves to sleep at night...some people maybe they are not able for all the gruesome details like.' **(CIG2 P3)**

There was the suggestion from the postnatal mother that the role of medical staff is to distil information because of the potentially questionable validity of other sources:

'...there has to be an element of giving a selection or the best evidence and they may not give absolutely all the details because a lot of studies out there have been very questionable so it's their role and when you choose to have a baby in a hospital environment you have to trust to a certain extent that the medical team are giving the best care that they can. There's something else and you have to trust the medical team to be able to take those decisions for us.' **(CIG2 PNW4)**

These views illustrate absolute trust and faith in the medical profession and authoritative scientific knowledge. In this research, women co-researchers appeared to place value on intellectual knowledge over 'intuitive, emotional, or bodily knowledge'[227] (Davis-Floyd 2003, p. 31). According to Oakley (2005), where social order is regulated by men, the threat of women controlling natural reproduction must be

[227] Ways of knowing are discussed in Chapter Ten.

managed. This is achieved in two ways: through 'separation'[228] or 'incorporation' where the woman relinquishes personal autonomy over birth, which is then 'mastered' by medical male dominance (Oakley 2005, p. 151-152). Thus, medical messages shape women's experiences and processes in the context of childbirth.

8.4.3. Meeting Need

Women articulated that individual needs were sometimes complicated by communication difficulties; thus, there was the challenge of presenting information in accordance with best evidence within the time frame allowed by the institutional setting and in relating with large numbers of people. Notwithstanding the shortcomings of written documentation, without adequate and meaningful explanation, and the awareness that one in four people have difficulty reading and writing in Ireland (National Adult Literacy Agency 2007),[229] one pregnant woman laboured the importance of choosing information that is relevant and meaningful to the individual,

> 'I think some people don't actually want to know, you know, if you give people an information pack with all the detail they go 'hmm'. That way they are not going to have any misinterpretation and those who want to know will read it and those who don't will go 'well I'm going to the hospital so they'll look after me' **(CIG2 AN W14 25/40)**

Again, the role of antenatal education as a panacea to all ends was debated and the importance of developing relationships with other carers was acknowledged. The following statement from an antenatal educator echoes the views of a pregnant participant in earlier conversations:

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[228] According to Oakley (2005), in the case of separation, reproductive matters are exclusively women's domain.

[229] According to the National Adult Literacy Agency (2007), the most recently available published report in Ireland by the Department of Education and Science (2007) has outlined the results of an International Adult Literacy Survey (1995), which was published by the Organisation for Economic Co-operation and Development (OECD) in 1997. The research reveals that of those who responded, one in four adults in Ireland have problems with everyday literacy tasks such as reading instructions for medication use.

'Is there also potential that the classes are only going to do so much...it's extremely difficult and as the numbers are higher in classes, it's even more difficult to get a sense of where everybody is at...every woman attending will have other interactions with other members of the staff in the hospital and perhaps that's the opportunity on an individual basis to get more information and more detailed information on things about episiotomies, to discuss it...maybe that's a further opportunity to build on what you are doing in the classes which by, at some level need to be a bit more generic' **(CIG2 P5)**

8.4.4. Potential Strategies for Change

In keeping with the challenge to promote information-giving that is relevant and meaningful to women, possible solutions raised were that classes be a forum for primary or general information with an option for a longer class or optional class at the end of the core group of five if more detail or discussion was required by the individual. In response to the previous suggestion of two-hour classes, the ANEs felt that women become too tired for longer classes; this had been attempted unsuccessfully in the past. There was the suggestion that classes be commenced promptly to avoid wasting time and having to recap information when people join the class late, which was considered unfair to other class attendees. Women register their attendance for classes and, to save time, it was suggested that women register online; however, it was argued that a personal encounter encourages women to confide concerns or anxieties with the class facilitator.

Pregnant women who have access are bombarded with a vast array of online information and chat forums related to pregnancy, birth and motherhood.[230] Women co-researchers, however, stated that they would have more confidence if this information was provided by a trusted hospital source with a view to making the hospital website a 'centre of excellence.' The website could provide primary basic but evidenced based, information, a 'what to expect when you are expecting'[231] (W14)

[230] Particular websites of interest according to women participating in the research are Rollercoater.ie, eumom and the VHI discussion forum.

[231] This is in reference to the title of a publication about pregnancy and birth by Irish consultant obstetrician Peter Boylan.

equivalent in one central forum online. In this way, women would have the choice to come to classes if they wished, subsequently, it was anticipated that classes would be smaller and could be a forum for human connection and clarification of issues. This would free some time for women who needed to meet class facilitators on an individual basis or in small groups.

There was also the suggestion that women are too tired for longer classes and sometimes cannot travel. Thus, a podcast would work well, as women could access information at a time that was appropriate for them, and, in addition, a DVD that was currently in use could be updated and used as a basis for podcasting information; therefore, cost would not be a huge issue. The concept of a podcast and online information was embraced cautiously by the ANE co-researchers because they felt that online strategies would compromise their personal engagement with women. This is a contradiction in terms, as there are far too many people attending classes to achieve personal engagement. Women would like to meet the midwife caring for them in labour but this is difficult because of the fragmented nature and lack of continuity in care; there is no guarantee that the midwife the woman meets will be caring for her in labour. For those who do want online information, ANE co-researchers suggested that a podcast of each of the classes could be augmented by actual, as distinct from virtual, discussion in classes. Women could obtain an access code to link in once they had registered with the hospital. Podcast would also be helpful to women with literacy issues, obviously, more so than written online content alone. The information provided could be specifically related to disseminating the information related to the dominant hospital ethos and would provide women with more choice in terms of discussing information relevant to their needs. Other suggestions for online content were a 'list of things to bring' and 'frequently asked questions'.

> 'This actually might be a very good solution in that there are people who don't want to ask questions, who don't want to participate and they do just want the information but they want it from us, so if they have it online and they saw the general flow, the standard issue, this is all the information, yes they'd miss a lot but they didn't want that in the first place. Whereas you guys want the interaction, you want to ask more questions you want to know more, you've done the background reading, you want extra. So, if there's people who don't

want all that they don't come anymore, so the classes are small...the classes would be a better size and we would get more out of each class that we did and the other people would still get the potential for information' **(CIG2 P2)**

There are issues for women who don't have access to online learning, and provision of website information in addition to other support systems requires careful consideration of the challenges presented by customising website information for educational support purposes. This was considered a good alternative by members of the group because it seemed like a potential solution when having vast information to report on in a short time and may facilitate smaller classes through the provision of choice of educational medium.

'Well there you go, if it's online you don't have to worry about running out of time and it's covered' **(CIG2 AN W14 25/40)**

'Just on that like myself and the other dietician just changed our minds on that regards how much information to put up because it was a thing that we were producing information and we felt it needed to be directed, that you needed to see somebody individually but in actual fact we don't have a lot of quality time with people anyway and an awful lot of things that would be answered in the information leaflets are very simple questions, that would save an appointment for somebody who needs that face to face time that little bit more.' **(CIG2 P5)**

There was also the suggestion that the hospital should provide an online forum for chatting; however, some co-researchers refuted this, stating that there are difficulties associated with monitoring content and liability issues, and there was the view offered by women and antenatal educators that the hospital should 'behave as a hospital' **(CIG2 W11 30/40)**. This reflects a medical orientation to pregnancy, which is supported by the ANE co-researchers' view that the hospital should not be a 'community forum' **(CIG2 P5).** Sally McIntyre (1981, p. 2) suggests that conceptualisations of pregnancy may be derived from the woman's relationship with her 'medical attendants' and their interpretation of pregnancy; either a condition that is similar to illness or that lies within the broader relational social context.

Field note Entry from Reflective Diary Meeting 13th January 2011

One ANE co-researcher was upset after the meeting because of the discussion we had in relation to the evidence based information and truth in information giving. There was a lot of tension in the room. The ANE co-researchers and I spoke briefly after the meeting; they have embraced this research but naturally felt deflated following this conversation. Despite her upset, P3 felt it was a good meeting and she was glad to hear the woman's point of view. There was the suggestion that women may be hard to satisfy. According to Anderson (2004) if a woman decides to diverge from the plan of care that is set out for her, she is then considered a 'trouble-maker' and, unless she conforms, may be excluded from mainstream services. The suggestion of a pod cast of information has had mixed responses, however, pod-cast and website information to support the classes could facilitate evidenced-based informational support. This research is creating a space with women for frank discussion, which according to the ANEs has not happened before now. The challenge in this research is ensure that dialogue and resulting action is sustainable.

8.5. Supporting Co-researchers

I had the opportunity to meet with two of the ANE co-researchers after the meeting and they emphasised the importance of being able to discuss events in an informal way immediately afterwards. They also shared their interpretations of the conversation, their disappointment in the woman's dissatisfaction and their perceptions of aggression towards them. Unfortunately, the opportunity to discuss events immediately was not available to all because they had to undertake another class, so they were left to deal with this alone in the absence of formal supervision or peer support[232]

I was anxious that they contact me for support and had offered this throughout the entire research process as a way of helping to reflect on the developments in the work but also

[232] There is scant literature on the needs of antenatal educators in the Irish context; however, an unpublished report of a research project conducted in the South East region, to identify the training needs of antenatal education facilitators outlined the following recommendations: development of national standards of practice, the appointment of a national co-ordinator, development of an accredited programme of education, and development of a specialist practitioner role (Haughney 2005)

with a view to making sense of their thoughts and feelings. I had also explained on several occasions that their sharing would help me analyse the material. I was anxious that they share their thoughts and feelings so that they could be documented because I was aware that my interpretation is mine alone and I was concerned about how best to represent their voices. My emails from then on were less formal in an effort to break down tensions but also to encourage them to write to me. Less than a week after the meeting, I received an email from one of the ANE co-researchers (P1) stating that she had mixed feelings after the meeting and she articulated the following

> 'Some women have so many questions that it is not possible to address them all in the classes'
>
> 'Can the classes/hospital possibly meet the expectations of some of these women?'
>
> 'Is it possible to have more than one postnatal lady at the meetings – 3:1 ratio may be a little imbalanced.'

These statements reflect the difficulty in facilitating learning within the confines of the institution, the dichotomy between what women want and what they are left with and the struggles for ANE co-researchers to mediate two very different frames of reference. I had initially invited three new mothers from the earlier research groups to be part of the CIG2 conversation, but it was difficult for them to come back to the hospital with their small babies and other demands. We talked about this back and forth, and the suggestion from P1 was that the way to support the women who have lot of questions is to see them individually if time allows.

Women also wrote to me after the meeting:

> 'P3 mentioned that there are (number of) teams of midwives at (hospital) and I realised that this was something I hadn't known before. So I would suggest that at the first class, the midwife gives a brief introduction to the unit - in my class we had a brief run through of what would happen to us when we came in (wait in reception, go to (unit) etc.) but I don't remember being told anything about the

staff structure (e.g., how many teams there are, how many midwives in each team, whether you have the same midwife throughout your entire labour etc.). Perhaps I'm one of these people who want more than the average amount of information, but I find this kind of thing reassuring, so perhaps others would feel the same way too' **(ARC3 W14).**

8.6. Action Research Cycle Three Operational Plan Meeting

While all action meetings may be regarded as critical events (Argyris 1984), CIG2 is particularly so due to our frank exchange on the subject of intervention and the consequent unveiling of a truth that I had not seen before. I perceived at that point, that as co-researchers, we had heretofore engaged in a scripted performance that dissipated abruptly at the CIG2 meeting and, the impact for me was visceral. Immediately, I was aware of the very influential nature of obstetric thinking on my orientation and 'training' as a midwife. The focus and discussions of the meetings with antenatal educators (including the CIG1 meeting) had until now reflected what Chris Argyris (2006) describes as single-loop learning. Single-loop learning works on the basis that errors are detected and corrected without changing the values that oversee the existing organisational defensive routines or 'theory-in-use' (Argyris 2006, p. 10). In other words, the status quo remains unchallenged and unchanged. In engaging in single-loop learning, we had skirted issues of power and powerlessness; relationships between woman and professionals, between medicine and midwifery, and, between other disciplines.[233] We did not challenge the socio-political nature of the woman's position in the maternity services and the subsequent effects on pregnancy and birth experience. Until CIG 2, our co-researcher conversations were system-focused, in contrast to being woman-focused (Hunter *et al.* 2008, Kirkham 2010b). To combat single-loop learning, Argyris (2006) suggests that we incorporate a method of double-loop learning. The governing values for this are: producing valid information, informed choice and, vigilant monitoring of the effectiveness of the implemented actions (Argyris 2006). CIG 2 afforded awareness and insight into this learning, but also, challenged the relationship between woman and antenatal educator as information giver. According to Thomas (2002), there is potential for conflict in any relationship and recognising this helps us to grow. In doing so, we define and redefine our needs (ibid). The women co-

[233] I refer specifically to the disciplines of physiotherapy and dietetics in this instance.

researchers and ANE co-researchers in this research touched on conflict but this was not negotiated in any way and was avoided.

As was typical of our conversations, the meetings with the antenatal educators began with reviewing where we were and our individual senses of what was happening in the group and the themes that were emerging. We discussed our perceptions of the CIG2 at length. They had mixed feelings and felt that the conversation had been thought-provoking but were disappointed. This is uncovered by reading for the 'I',

> 'I don't think they are representative of a lot of people...I suppose it's maybe thought provoking. I think a lot of us felt a bit deflated after the meeting...I think that sounds a bit negative... I think maybe less so, maybe, maybe I think it was worse for maybe the midwife component was a bit more, I don't want this, and I don't like this... I think if you listen to the ladies that gave their opinions in the meeting the last day, you'd think you were doing an awful job' **(ARC3 OP Plan P2)**

I confided that I felt something had shifted; that we were having a different conversation and, for the first time throughout the course of the research, I felt that I had seen their authentic selves, their disappointments and their need for positive re-enforcement and motivation. For me, the second operational plan meeting was very much about sustaining connection and ensuring individual and group integrity of the ANE co-researchers; they assured me that they each had personal mechanisms to deal with challenge. Nevertheless, I was concerned that just one ANE co-researcher had written to me in the interim between meetings, and I was anxious to support them in any way that I could. For me, this highlighted the difficulties in sustaining the antenatal educators and women during and after the research 'project' when reflection begins and the thoughts come, even sometime after the conversation and how this is recaptured (Taylor 2010).

We discussed the salient questions that emerged from the CIG2 meeting and the potential personal strategies that could be used to manage anxiety and sustain the self through periods of stress. It seemed clear to me that achieving clarity in addressing professional issues required confidence in self-awareness, and a key way to encourage

this was through the process of personal reflection (Bulman and Schutz 2004). According to Taylor (2010), reflection, though not a panacea for everything that can go wrong, provides a systematic way through which constraints on practice issues can be named. With this in mind, I presented a reflective journal to each of the ANE co-researchers with a view to confidential recording of critical incidents and personal reflections, for the purpose of attempting to make sense of experiences that caused personal conflict. We considered potential skills that were required to do this; reflection was not a new concept for the co-researchers, as from the beginning, this had formed an integral part of our work together.

My personal reflections following the CIG2 uncovered my keen awareness of a lack of professional support[234] for the ANE co-researchers, by this I mean, an enabling relationship to support and guide professional development and learning. Indeed, several times the ANE co-researchers had celebrated that the process of inquiry had facilitated their coming together to explore issues that were practice-related. In some ways, our group times embodied the support that we needed, not just as co-researchers, but as workers and as women. I hoped that the process of empowerment had begun with the ANE co-researchers through our conversations about the problematic practice issues that faced them; I also hoped that their evident resolve to support each other would sustain them in their endeavours to empower women. Reading for the voice of the 'I' demonstrates their vulnerability and isolation as they struggle with their attempts to balance the tensions of the service and environment through the concomitant needs of being 'with woman'[235] versus being an employee (Kirkham 2010a).

> 'I think we're catering for large numbers...I think we do our best, but maybe our best isn't good enough, like that's what I was thinking after that when I went into the office, I thought well maybe our best isn't good enough you know...I'm trying so hard.' **(ARC3 OP Plan2 P2)**

[234] ANE co-researchers confirmed that our group work together afforded space for reflection, discussion and support.

[235] A discussion about being 'with woman' is presented in Chapter Ten.

There was concern about whether the women co-researchers provided adequate and valid representation of pregnant and postnatal women attending the hospital for maternity care and the possible impact of challenging personality and perceived aggressive nature of the participant. The struggles in meeting various needs within hospital constraints is illustrated by the Reading for the voice of 'I'

> 'I don't know is it possible here to fulfil all those views...I think their expectations were very, very different you know...I don't know if it's possible to meet that. I mean, the only suggestion would be kind of, sit down and talk to them, maybe on a one to one but time I suppose may not allow that you know...I suppose we could try, I did meet her after; I remember I did move the class around, but I was hoping to get to talk to her after the class but I didn't have time to do so.' **(ARC3 OP Plan P1)**

> 'What can you do, stand on your head? Sometimes it's hard because you're really telling them the facts and the truth but they're looking at you like where did they find her? Where did they get that one?' **(ARC3 OP Plan P3)**

It was argued that evaluation forms are usually completed anonymously; thus, ANE co-researchers found it unusual to receive verbal feedback and evaluation of classes in person, possibly to a degree that it was a relief when their particular area of interest was not discussed overtly.

> 'Normally people fill out evaluation forms and go away and you can absorb that but yeah, it's difficult to, to sort of receive that and we're again fortunate that they don't seem to have any interest in physiotherapy at all you know, even though they're listed information topics that they wanted to know about. Nothing that we are involved with unfortunately is listed.'**(ARC3 OP Plan P6)**

8.6.1. Potential Strategies to Bring Forward

As discussed in the CIG2 meeting, a podcast offering information on the more procedural aspects of maternity care would overcome literacy challenges and would save time to concentrate on more meaningful class discussion and interaction. In addition, women co-researchers felt that people benefit from different learning

strategies and information could be selected according to need. Barriers to change on the introduction of podcasts were evident however,

> That's a very big task...and we don't have the people power or the time **(ARC3 OP Plan 2 P4)**

> 'You'd need somebody to update it and spend the time on it.' **(ARC3 OP Plan 2 P3)**

There is also evidence of frustration with the current system and structure,

> 'And I think one of the things that, we would all be in agreement with some of the criticisms. We know the classes are too big but the, our ability to do anything about it, is what's frustrating. I think that's what leaves you feeling more criticised, because you're kind of going we know these and yet we can't, we do our best within those constraints but the people you know, it's very difficult then to explain why the hospital can't or doesn't or you know, why the institution doesn't *change* those things or you know, it's a difficult thing to defend because we don't particularly want to stand over it I don't think. It's not the ideal way.' (**ARC3 OP Plan P6)**

> 'Nobody is pushed into anything if they don't want it, but at least we're telling the truth, what is going on. But if you don't like it then you don't, and I think (hospital) doesn't always get credited with that...the sort of, that we just give them and say this is the way you have to do it, which we're not really. We're saying this is what we think is good for you...' **(ARC3OP Plan2 P3)**

> 'I think people know at the heart of it, they know, but I mean you're more prepared for eventualities if somebody has been straight with you, even though at the time it might seem like you're being told that you're on a conveyor belt, it might feel like that. But if you have the truth of the situation as opposed to suddenly 'ah yes, it's not what we want'...not telling people the truth isn't going to make you feel better in ante natal classes and it's not going to help ultimately when they're in the labour ward' **(ARC3 OP Plan 2 P5)**

We agreed that the hospital website could be updated, as suggested from the previous CIG meeting; however, it was clear that any changes to the website would require approval by the hospital management and heads of department. The ANE co-researchers were asked if they felt that there was anything positive about the interaction of the CIG2; they found the postnatal mother's accounts of her experiences reassuring. Specific challenges that ANE co-researchers highlighted in this meeting were finding balance between what women want to know and ideas that ANE co-researchers had about women's needs.

> 'I was saying, I was kind of interested in what she was saying because she'd been through the whole process and she'd kind of come out and said you know, okay I might have thought that I needed to know that, but actually in reality it would have been too soon to take that on board, and sometimes that's been hardest, to find the balance between what they want to know...and what they can actually absorb, you know, or what they need' **(ARC3 OP Plan 2 P4)**

8.6.2. What Antenatal Education is About?

> 'See what we're really doing is giving our birth plan to them but then they can turn around and say I really don't want my waters broken, and that's fine, you just need to write it down, show it to somebody, a midwife or that a couple of weeks before delivery and we'll try and meet their wishes, but that message goes across as well but I think maybe for that other lady, I think she was reading so many books from different countries. Like I'd say she was reading English and American.' **(ARC3 OP Plan2 P3)**

For the women, antenatal education is about interaction and information to make informed choices. It is also a medium to meet other women in similar circumstances to share thoughts and experiences, and yet perpetuation of the dominant ethos persists. The statement below confirms this antenatal educator's belief in the system of care.

> 'To do classes here in this setting you actually have to believe in (dominant ethos of the hospital)' **(ARC3 OP Plan2 P3)**

We discussed documentation; one challenge was that information about hospital procedure and protocol was shared between departments in a uniform fashion; this meant that ANE co-researchers could not amend current written records to support verbal information without consulting other departmental personnel. It was suggested that there may be some conflict about changing existing documentation. A possible solution to overcome this was by proposing to other departments sharing the documentation, that we had decided to review current ANE documentation, and that any change would be subject to hospital approval. I felt that shared documentation between departments, while useful for consistency of information also ensured that the hospital's dominant ethos was the overriding message that women received. I suggested that the documentation could be used to offer factual information so that time could be afforded for the relational aspects of ANE that women identified as necessary.

8.6.3. Strategies to Bring Forward to Classes

Table thirteen overleaf describes the changes that emerged from the second Collaborative Inquiry Group Meeting.

Table 13: Changes that Emerged from CIG 2

Ideas for Change that Emerged from CIG2
We agreed to circulate a piece of paper at the end of each class to record a list of questions and queries, with a view to addressing queries in the following classes, week to week. There were some operational issues and it was suggested that the list could be held with the list of class attendees and this would make for better continuity between members in terms of discussion.
Women received information in classes on making use of postnatal community support and this information was also available in the Bounty pack and the postnatal discharge pack. It was agreed that sources of this information will be highlighted at each class and that a list of local health centres would be compiled also.
We agreed that there was scope for an optional class during pregnancy on baby care, baby resuscitation, First Aid for infants and weaning. This could be facilitated by a neonatal nurse specialist on site. ANE co-researchers intended to collaborate on information that could included in the optional class.
I had brought written documentation related to class content that the antenatal educators had asked me to review. It was agreed that any written information must be vetted by the relevant hospital committee.
While we all felt that hospital-based website information is a valuable resource, which could be developed in a more meaningful way and relevant to women, ANE co-researchers suggested that was a large undertaking. I confirmed that I was happy to work on this, with the ANE co-researchers' guidance on the scope of what they wanted to include and any work would be reviewed by the relevant hospital committee.

8.7. Conclusion

The first part of Chapter Eight describes the antenatal educators' responses to my inquiries about the progress of changes that were implemented from our previous

meetings. The first meeting of the third ARC was a pregnant women's-only group. The key themes emerging from our conversations were: women welcomed the opportunity to attend classes, to meet other women and, to gain information. We discussed loneliness, and coping after birth, and the need for knowledge grounded in the real-life experiences of other mothers. We also discussed feelings about pregnancy, birth and taking their babies home, and fear about the quality of care received in maternity settings. The third meeting was the CIG2, which involved three members from the pregnant women's group, one postnatal woman from ARC2 (PNW4), and all of the participating antenatal educators. The key themes highlighted were: ways to develop ANE, meeting women's needs and potential strategies for change. We also debated and discussed a practice issue (episiotomy). The fourth meeting was the second operational plan meeting with the antenatal educators only. We discussed barriers to change and we discussed, and agreed, potential strategies to bring forward. The fourth Action Research Cycle is not allocated a separate chapter, but salient issues and events, arising from the ARC4 meetings have been included in Chapter Five and are discussed also in Chapter Ten. Chapter Nine introduces a theoretical model of antenatal education, which is cognisant of context and that has emerged from the findings.

CHAPTER NINE TOWARDS A THEORETICAL MODEL OF ANTENATAL EDUCATION

9.1. Introduction

The core research question is revisited in this Chapter, that of,

> 'How can knowledge created in collaboration with mothers to be, mothers and antenatal educators inform hospital-based antenatal education programmes to prepare women for birth and motherhood?'

Throughout our joint and individual reflections and discussions, we have moved towards learning about the nature of knowing about pregnancy, birth and motherhood, through creating space for potential awareness and respect for all voices. We have witnessed how genuine engagement through antenatal education has been hampered by the restrictions of a dominant medical model of care that endorses a very linear and prescriptive approach to pregnancy, birth and preparation for motherhood. This is coupled with constraints on facilitators to directly challenge institutional practice. Challenging dominant practices requires courage and commitment, which calls for the antenatal educator to decide whether, through a process of consciousness-raising (Freire 1993) she is with-woman[236] or 'with institution'. To clarify, the term 'with institution' refers to Billie Hunter's (2004, p. 261) description of hospital based midwifery which is dominated by meeting service needs, via a universalistic and medicalised approach to care; the ideology [is], by necessity, 'with institution''.

[236]Other terms used to describe 'with woman' are 'woman centred' and 'in partnership with women'. Carolan and Hodnett (2007) state that the concept of being 'with woman' emerged with Australian midwives, as a solution to medicalisation of pregnancy and birth in an attempt to reconnect women with their capacity to birth without intervention. Being 'with woman' is also a central component of the New Zealand *Midwifery Partnership Model* (Guilliland and Pairman 1995/2010).

9.2. Being 'With Woman' and Challenges Therein

All relationships are context bound (Kirkham 2010a). The findings of this research support the belief that maternity services in Ireland are informed predominantly by the doctrine that birth is pathological and requires intervention. Midwives view their role as ill-defined[237] and women are not afforded continuity of care or carer[238] due to the fragmented structure and organisation of maternity services in Ireland (Kennedy 2002). For these reasons, the notion of being 'with woman' as it was originally envisaged, (that is, in a singular one-to-one relationship), cannot apply to the current dominant system of maternity care that is occupied with rapid through-put. As noted by Hunter *et al.* (2008), the organisation of care reflects the value that is placed on relationship and this is an important issue, which affects the woman's experience and those who provide care for her.

In this setting, it has been suggested that hospital-based ANEs, in accordance with how programmes are structured and arranged, are ideally positioned to offer information and support, because ANE affords women the opportunity to meet members of the same team on more than one occasion (Mason 1998). The potentially positive effects of continuity, though limited are mediated; however, by the definition of the role and function of the antenatal educator by the powerful other (medicine), that is, to provide instruction congruent with the dominant institutional ethos. Indeed, the survival of the dominant message depends upon the capacity of the ANE to disseminate it. ANEs who aspire to practices that emulate a 'with woman' philosophy, distinct from a 'with institution' philosophy are situated very tenuously. If the ANE decides to be 'with

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[237] In the research presented here, two of the most experienced and key facilitators of ANE were midwives. Although the Scope of Midwifery Practice (An Bord Altranais 2000) is outlined within the EEC Council Directive of 1980 (80/155/EEC), the definition of a midwife in accordance with the World Health Organisation/International Confederation of Midwives/International Federation of Gynaecology and Obstetrics (1992), consultative processes with practising midwives reveal their views that midwifery care in the current context is bound by a pervasive medical model and is in contrast to midwives' defined role and function (Kinder 2001, Government of Ireland 1998).

[238] I refer to continuity of relationship, which according to Hatem *et al* (2008, p. 3) is 'a therapeutic relationship of the service user with one or more health professionals over time.'

woman', she faces conflict with colleagues and other disciplines (Kirkham and Stapleton 2004). If she decides to be 'with institution', she risks alienating the woman through lack of genuine engagement. Thus, the role of being 'with woman' requires that the ANE has courage and commitment for change, in addition to finding a way to work in harmony with other healthcare professional disciplines, where appropriate. In her analysis of emotion work[239] in midwifery practice, Billie Hunter (2011) observes that balancing dissonance between conflicting ideologies of practice culminates in significant emotion work for midwives, most notably midwives who are hospital-based (Hunter 2004, 2011).

9.3. Finding Common Ground

The distinct nature of the voices of the antenatal educators and women that emerged from the process of Reading Five highlights the disparity of their separate discourses, or, what Oakley (1986, p. 308) refers to as 'the gap between mother and expert'. The prospect of reconciling the gap between mother and expert has culminated in the concept of 'Finding Common Ground'[240] (Figure 2). The title, 'Finding Common Ground' is inspired by Marvin Weisbord's (1992) edited book, *Discovering Common Ground*. Weisbord (1992) suggests that we already know what we need to know[241] and when we work together on common ground, we are stronger as 'we tap deep into the wells of creativity and commitment' (Weisbord 1992, p.6). This concept was re-enforced by the ANE co-researchers' group analysis of the critical event in the (CIG2) transcript. We read for the plot or story, the personal 'I' and explored briefly the

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[239] Billie Hunter (2011) cites Arlie Russell Hochschild's (1979, 1983), concept of emotion work, or, managing regulation of emotion to ensure the effective working of organizations.

[240] The term 'finding common ground' is also used by Tina Koch and Debbie Kralik (2006) in their discussion about the importance of working collaboratively with others for whom the research is important.

[241] Belenky *et al.* (1986, p. 19-20) in relation to the knowledge uncovered throughout their research, state 'we realise this knowledge was not new but had been, for us, underground, unarticulated intuited or ignored...the stories of the women drew us back into a kind of knowing that had too often been silenced by the institutions in which we grew up and of which we were a part. In the end we found that, in our attempt to bring forward the ordinary voice, that voice had educated us.'

concept of 'other' or, what Carol Gilligan more recently refers to as contrapuntal voices (Gilligan 2011a). This afforded recognition of women's perspectives and is discussed in Chapter Five. Finding common ground is about the quality of the interpersonal relationship characterised by meeting the woman as, not 'you' but 'thou'[242] (Buber 1958, as cited by Kitzinger 2006), or what Martin Buber (1958) refers to as our 'natural combination'[243] (Buber 1958 p. 26). The use of 'I-you' (Kitzinger 2006) or 'it' (Buber 1958), refers to the 'other'[244] in the everyday where a person is labelled and perceived as an object; 'I-thou' on the other hand is mediated through open dialogue, which is not solely about talking, but can be about silence (Kirschenbaum and Henderson 1990). Similarly, an extract from our research conversations illustrates the very important nature of human connection, which manifests as love in the midwife-mother relationship and which Ann Oakley (1993) reminds us is an essential component of maternity care.

> 'I knew everything about her and she knew everything about me. And the next day she came in, even though she wasn't working to see if I was okay...I just could not believe it. And hugging you and kissing you and like just so, so professional and so caring. The combination of the two that you really needed. I felt sorry for anyone who didn't have her as their midwife.' **(ARC 2 PN W9)**

As we can see, finding common ground is integral to, but also extends beyond, the forum of structured hospital-based antenatal education, as all carers are invited to 'maximise the potential for women to take up the power that will enable them to lead

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[242] Sheila Kitzinger (2006) makes reference to philosopher Martin Buber's (1958) text where he considers that 'all real living is meeting' (p.17) and 'relation is mutual...we live our lives inscrutably included within the steaming mutual life of the universe' (Buber 1958, p. 15). Buber (1958, p. 98) states also that the teacher must appreciate entirely the learner's 'wholeness' and can only do this through fostering an ethos of partnership.

[243] Buber (1958) in his writings is in fact referring to his relationship with God. God, as 'Thou', is without boundaries; a genuine and authentic encounter between people could also be an 'I-Thou' relationship, as the other person is connected to everything.

[244] The concept of 'othering' is discussed on pages 102-103 and 124-125.

fulfilling lives as individuals and as mothers' (Leap 2010, p. 19). Thus, the woman should be central and active throughout her maternity care experience (Gray 2000). Key aims of preparation for motherhood emerging from the findings of this research are:

- Creating space for women to identify and name their needs in preparation for birth and motherhood.
- Creating space to hear women's needs through human connection that is authentic, responsive, meaningful and based on trust.
- Working towards having articulated needs met through initiating learner-facilitator relationships.
- Encouraging and promoting informal support systems for women as new mothers by creating space for mothers to meet[245]

9.4. Finding Common Ground in Antenatal Education

In relation to hospital-based education, finding common ground is supported by the voices of women participating in this research, which call for a learning philosophy that requires the antenatal educator to view the woman as a whole entity, that is, a person with value systems and beliefs who is engaged in obtaining knowledge that is fitting for her informational and other needs. Women have called for support in the form of an online database of information (including information on the hospital system). In this way, a woman can choose to access information she believes is of personal relevance and meaning. The antenatal educator, therefore, becomes a point of reference for clarification and discussion. This requires the ANE to develop reflective and self-awareness skills and other ways of knowing, to facilitate connected knowing[246] to the self and other. The following extract from the research depicts the power of connected

[245] Women co-researchers have suggested that meetings would work best if facilitated by a midwife and initiated within the hospital. This has been successful elsewhere; see (Barrett 2006).

[246] According to Sara Ruddick (1996) connected knowing is an activity, which cannot be separated from emotion or feeling. Knowing involves capacity to appreciate and an attendance to persons and relationships or objects.

knowing that is facilitated by a midwife providing care in the postnatal ward to one of the women after birth (discussed also on page 174):

> 'I remember saying to the midwife no one has showed me how to give her a bath...she kind of just dedicated about half an hour to me and showed me a few things...I just felt then I was leaving the hospital kind of equipped, I knew if I wanted to give her a bath how to do it...I knew I was going home and I had some clue about what to do with her when we got home, which is nice.' **(ARC2 PN2 W7)**

Connected knowing that has manifested through awareness is also expressed by Adrienne Rich (1995, p. 176) in her moving account of her 'gratitude and amazement' in her experience of connected caring demonstrated by a student nurse holding her hand when she awoke from anaesthesia following the birth of her third son. Essential principles of finding common ground for human connection, therefore, are:

- Learning the art of communication – to listen and wait, as the process of the conversation affects the range and quality of information that the woman receives (Kitzinger 1977). I interpret 'quality' in this instance to mean, relevance and meaning to the woman's particular situational context.
- Believing in truth, trust and relationship. In this instance, I refer to truth that is not limited, as distinct from 'truth' (or package of care) offered in the 'best interests' of the woman and family. Offering truth has implications for the continuing professional development of antenatal educators in sharing information that is factually correct, evidence based and requires moral imperative that limitations in facilitator knowledge and learning are identified and addressed.
- The ability to articulate and promote discussion on issues that are relevant and meaningful to women
- Success lies in the interaction between the mother and midwife that is characterised by presence, compassion (synonymous with caring), concern, deep feeling and empathy for the woman and the life events she is experiencing, and empowerment (Siddiqui 1999).

- The facilitator/ woman relationship is characterised by principles of truth, self awareness and reflection, positive regard, empathy, and mindfulness.[247]

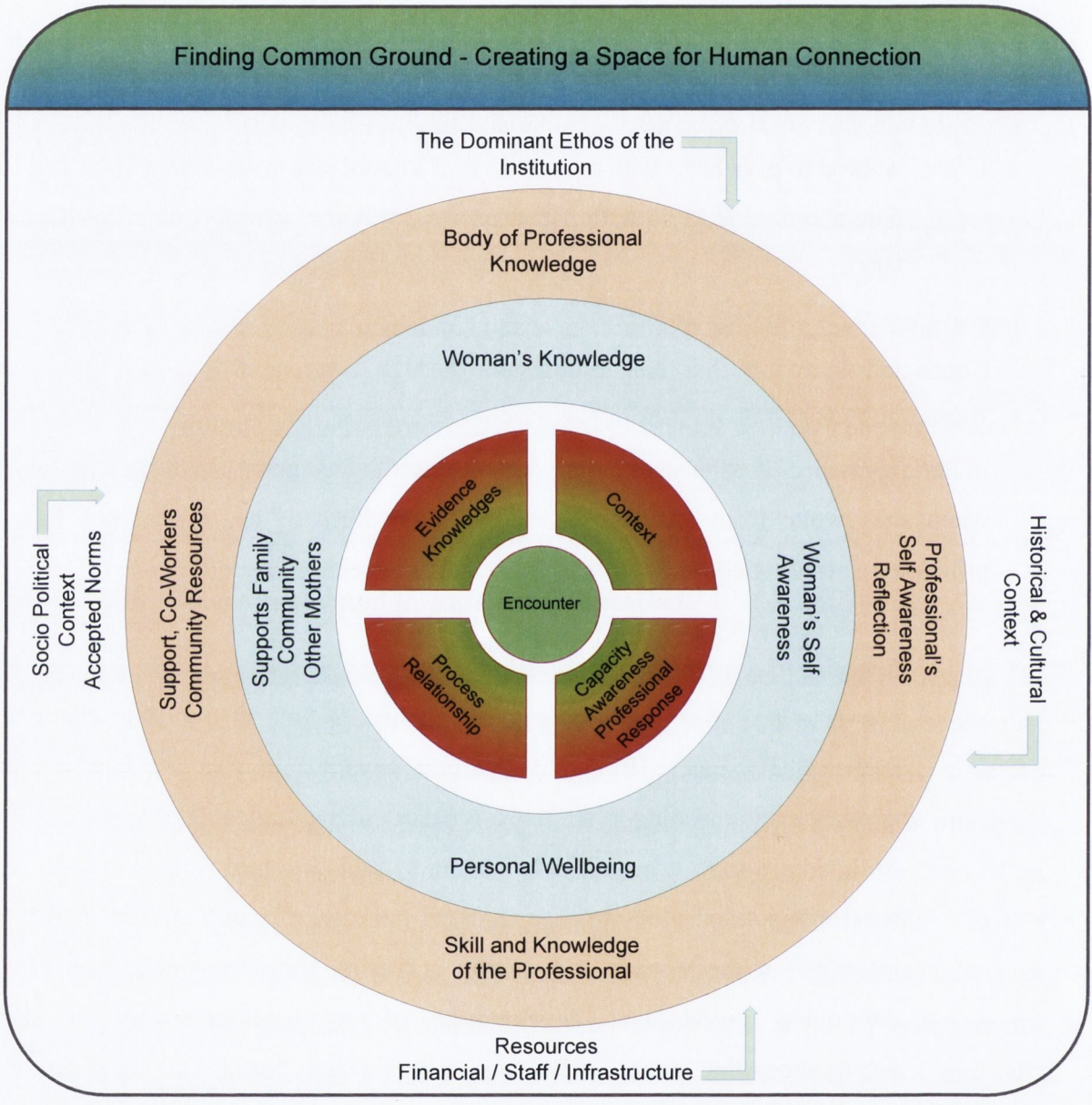


Figure 2: Finding Common Ground

[247] These principles reflect Carl Rogers (1994) conditions of the therapeutic relationship that are necessary for human growth.

9.5. Explaining the Model of Finding Common Ground – Creating a Space for Human Connection

A model of 'Finding Common Ground' has emerged as a result of our research inquiry, which depicted the encounter between woman and ANE as situated within the context of an institutional setting characterised by a culturally and historically privileged medical ethos in which high rates of medical intervention, coupled with stretched resources have become the norm. Practice is informed by a body of professional regulations and guidelines developed locally and reflected in debates at international level, in addition to the personal skill of the antenatal educator, and the ANE's colleagues, other disciplines and community resources that are available to assist her in her support of women. This research has demonstrated however, that practice is contingent upon the dominant rulings of the institution, and these conditions also determine the behaviours of those working within it. Thus, the ANE's ability to find common ground and to articulate and promote discussion about issues that are relevant and meaningful to women, in addition to her professional skills and knowledge,[248] relies upon her level of personal awareness of the differing tensions that ensue at institutional level and her ability, courage and commitment to challenge them. Common ground can only be achieved; therefore, if the ANE has the personal and professional resources to address the points of vulnerability at the level where intersections meet (the concept of intersectionality was introduced on page 75 and is discussed further in the Discussion Chapter Ten).

The woman brings her knowledge to the space, the knowledge she has gained through her life course, and her personal knowing and resources, that is, what she knows about herself, that no-one else can know fully. This could be, for example, awareness of her feelings, how she copes with anxiety or sustains herself in times of struggle. The woman's capacity to engage in and to challenge the learner-facilitator encounter depends upon her level of personal well-being (the notion of personal well being is discussed in more detail on page 317). This is influenced by the supports available to her and the degree to which she is invited and enabled to share her needs and desires.

[248] By this I am referring to the total knowledge that a practitioner uses in her practice: the empirical, historical, political and autobiographical experience (Johns 1998).

The encounter between the woman and ANE therefore, is influenced by context, knowledge and ways of knowing, the nature of their relationship (influenced by the quality of the time and space they share) and the awareness and capacity of the professional to respond to the woman in a meaningful way.

9.6. Essential Components of a Model of Antenatal Education Named by Women

In creating space, women and antenatal educators have co-constructed essential components of a model of learning for pregnancy, birth and motherhood. In keeping with the theme of authentic representation[249] of voices, elements of the model emerged under the terms of 'Who?', 'What?', 'How?' and 'Why?' and reflect a continuous entity that may be offered at every opportunity for engagement between woman and healthcare professional. Adopting a participatory approach including many voices has added richness and 'interpretive complexity' to knowledge construction (Ospina *et al.* 2008, p. 431). Throughout this research, women have named these concepts through 'ordinary talk' (Maguire 2006, p. 64). Titles of 'Who?', 'What?', 'How?' and 'Why?' possibly reflect the complex cyclical rhythms of feminine experience (Lefebvre 1961, as cited by Felski 2000), as distinct from that of the structured and perhaps masculine approach of a more traditional format. Mary Nolan (2010) suggests that conversations develop in response to the needs of those involved when discussions are fluid, as distinct from a more prescriptive mode of information giving. The words used in the research presented here illustrate a wide variety of needs from pregnant and postnatal women, which reflect their experiences of classes and are the learning objectives that the women have named for themselves, in addition to the ANE co-researchers' responses. Hence, the components of 'Who?', 'What?', 'How?' and 'Why?' do not make an exhaustive list but a framework from which to begin and a reminder that as 'ordinary talk' has illustrated, each woman is unique in her need. These findings, in addition to the cyclical nature of the Action Research Processes, are presented in Chapters Six, Seven and Eight; however a summary, which serves as a reminder, is offered in the paragraphs below.

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[249] Representation in this sense refers to what Maguire (2006) refers to as ordinary talk, voices are presented as heard and are maintained throughout the writing to avoid writing over or voicing over another person's voice (Gilligan 1994, p. 411).

The concept of 'who' refers to the personnel women identified as important facilitators of information giving. Women named the midwife, physiotherapist, family doctor and hospital doctor, as 'experts in their field' (W10). The emphasis on the professional and 'other' as expert, often to the detriment of the woman's confidence in herself, is also described in a grounded theory study of the support needs of first time mothers (n = 8) in the UK (Wilkins 2006). Wilkins (2006, p. 174) suggests that the influence of the apparent expertise of others, whether positive or negative, depends largely upon the relationship between so-called experts and self defined novice mothers, in addition to the woman's personality and previous experiences. In the current research, lack of confidence in ability to birth is portrayed by a postnatal mother in her response below when asked about the level of involvement and control that hospital personnel exercised in relation to her labour and birth process:

> '...I am not an expert in birth...there was somebody who knew about what was the best way to have a baby. I could insist that no, I didn't want to have a caesarean or I wanted to keep pushing and keep going at my rate. But there was a recommended way of, the hospital standard is after ten hours of doing this then, 'yes we would recommend this, you still have control but we recommend it'' **(ARC 3PN W14)**

Strikingly, women co-researchers emphasised the significance of family members, friends and other mothers, in sharing information and support with the view that experiential knowledge of pregnancy, birth and motherhood is more meaningful than 'expert' knowledge:

> '...what I found in this woman (a postnatal woman who visited the antenatal class to share her experiences of birth and breastfeeding) was that she'd been through that experience; she'd been through the (hospital) experience and (pause) in a sense what she had to say was so much more valid than anything a midwife could say' **(ARC 3PN W11)**

Women co-researchers' desire to hear mothers' stories of labour, birth and motherhood is a recurring theme in the findings of this research and is supported by the conclusions

of others (Leap *et al.* 2010, Olafsdottir and Kirkham 2010, Svensson *et al.* 2006, Wilkins 2006, Kitzinger 2005, 1977, Davis-Floyd 2004, Gaskin 2003).

'What' refers to the content of the information that women felt they needed in preparation for the pregnancy, birth and motherhood continuum. Again, the knowledge needs that women identified when they were afforded space to explore their feelings about birth and motherhood emphasised the experiential knowledge of other mothers. This was illustrated by expressed interest in 'practical things' including for example, where and what type of baby equipment to obtain, some women discussed the requirement to borrow from family and friends, perhaps out of economic necessity. There was interest also in the nature of birth and other women's experiences and interpretations of birth, breastfeeding, and if breastfeeding, whether this was perceived as difficult, and if not perceived as difficult, the issues that made breast feeding manageable. Women were interested in coping with life after birth and life changes, particularly after the birth of a first baby as was relevant to women participants of this research, and the return to paid work where applicable. Encouragement from other mothers about managing periods of stress and coping in the early postnatal period was desired. Women were interested also in support after birth, in terms of caring for themselves and for their babies and in managing illness, tiredness and sleepless nights.

Overall, women sought information about several issues, which may be organised under the following themes below.

Self care during pregnancy

Women co-researchers expressed interest in knowledge about nutrition, vitamin supplementation and general well being, including physical and psychological changes in pregnancy. They shared concern for emotional wellbeing and courses of action to take in the event of complications in pregnancy, such as miscarriage, and how previous miscarriage could potentially affect a current pregnancy. Women co-researchers expressed concern about 'safe pregnancy' and managing symptoms in a 'safe way', this was coupled with queries about tests, specifically blood tests during pregnancy, and timing and appropriateness of sexual activity during pregnancy and after birth. In the current research and in support of the findings of Svensson *et al.* (2006), the concept of 'normal' emerged throughout discussions with women with respect to safe pregnancy,

for example, normalcy in body changes, and birth and after birth. This was also translated to desire for knowledge regarding 'normal practices' (Svensson *et al.* 2006, p. 23), which is evident in women co-researchers' questions about 'what to look out for' (W3), what is considered 'normal' (W1), in addition to requests for clarification about the nature of items women were expected to bring to hospital.

Self care after birth

Occupation with normal process (practices) and outcomes persisted in the weeks after birth, when women sought information about coping skills, tiredness and the assurance that feelings of confusion and anxiety after birth were 'normal'. Women co-researchers wanted information about postnatal depression and psychological health after birth, which was connected to perceptions of the mother and baby relationship and fears about unsuccessful attachment. According to Rogan *et al.* (1997) and later Leahy-Warren (2005), these fears are mitigated when women learn the practical skills required to care for their babies. Self care after birth extended to relationships and coping with partners' families, specifically the paternal mother. This was coupled with anxieties about ensuring involvement of the baby's other parent in practical baby care and paying attention to maintaining the relationship between parents.

Information needs about labour and birth

The nature of information needs varied from 'rights during labour' **(ARC2 AN W8)** regarding positions for labour and birth and information about self help skills, yoga, breathing techniques in labour, strategies to remain calm, hypno-birthing and alternative ways of dealing with pain in labour. 'Natural birth' was described as birth without pain relief and without intervention; there was interest in water birth, which was not available to women co-researchers in the research setting. Postnatal women co-researchers reported a lack of awareness of the physicality of birth, specifically in terms of the unexpected sheer effort required for pushing in the second stage of labour. Women co-researchers expressed comfort in familiarity with the birth environment; this is supported by the results of a descriptive survey set in a Dublin Maternity hospital (Brady 2009) and in an online parenting survey in the UK (Nolan 2008). Women also sought clarity for medical terminology used routinely, for example, 'the C.T.G' and information about the predetermined nature of labour and hospital birth and the use of an action line (Walsh 2007), measured by the partogram. Some women observed that it

was comforting to have knowledge of the institutional philosophy of labour as being limited, with a beginning and an end, and this is portrayed by the following words of a postnatal woman:

> 'That there was an end. That yellow page, you know, the birth notes that the midwife uses (partogram)[250] we were taught that through the class and for me that really brought home that there was a start and an end to this...and that if you progress over eight hours and nothing is happening, you will have a caesarean section, you know, that there was a definite plan in place and that, this is what we do in (hospital). This is what we do if this happens. You are reassured to know that you won't be in labour for how many number of hours (baby talking)' **(ARC 3PN W14).**

The concept that interest in the partogram as being connected to broader cultural anxieties about time and pain, as highlighted by Dykes and Downe (2010) is acknowledged on pages 223 and 307 of the thesis. The focus on normal practices re-emerges with desire to know about hospital policy, protocol and intervention and effects on the mother and baby, and what could be 'expected' from the time of admission to the labour ward until birth. Women co-researchers also wanted to know about 'choice' with the view that although there may be options available, choice was limited; this is demonstrated by the question, 'Is everyone going to have a fit if I say 'I don't want that?' **(ARC2 AN W7)**. Women wanted to know about complications in labour, for example, the indications for birth by caesarean section; they were also interested in whether category of care, that is, public, private consultant care, or semi-private attendance, affected the process and conduct of labour and birth.

Supports

Women co-researchers sought information about the level of support after birth, notably from midwives, in learning practical skills, particularly in relation to infant care and breast feeding, and voiced their needs for reassurance that a midwife would remain with

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[250] According to birth anthropologist Sheila Kitzinger (2005, p. 34), the obstetrician Emmanuel Friedman introduced the 'labour curve' in 1954 and this has remained the norm by which to measure labour ever since.

them after birth. Acknowledgement of short hospital stays and the sense of urgency about 'bringing the baby home' prompted questions also about other sources of support in the community and local groups for new mothers. Results of questionnaires distributed to first-time mothers whose babies were born in a large maternity unit in the Republic of Ireland (n=512) revealed that women who received social support, that is informational, instrumental, emotional and/or appraisal support after birth, were less likely to experience post natal depression when asked six weeks after birth (Leahy-Warren *et al.* 2011). Further, when women received social, and in particular, emotional support, rates in prevalence of post natal depression decreased when measured 12 weeks after birth (Leahy-Warren *et al.* 2011). According to Leahy-Warren *et al.* (2011), rationale for the reduction in prevalence of postnatal depression 12 weeks after birth may be the woman's increasing adjustment to motherhood over time. Comparisons by the researchers revealed no disparity between responders and non-responders to their study, with regard length of stay in hospital, gender of baby, type of birth and level of maternal education. There was evidence however, that women who breast or partially breast fed their babies had a higher follow up response rate to the research (80%) at 12 weeks than women who were bottle feeding alone (70%)(Leahy-Warren *et al.* 2011).

Baby care

As a mother, I appreciated the women co-researchers' information needs about baby care but as a midwife, I was astonished by the profoundly fundamental nature of their questions. Women wanted information about practical manual skills and mastering dexterity in handling and caring for their babies. They expressed fear about holding infants without hurting them; they asked questions about how to avoid 'hurting the baby's neck when holding the baby'. There was concern particularly about nappy changing, bathing and bringing a new baby outside and what happens 'if you do something really wrong, like drop the baby.' Our conversations involved basic baby care prompted by questions such as, 'do you bath them in the first month?' Several topics emerged throughout our discussions, for example, positions for sleeping, feeding, how to feed and how often, according to hospital regime and practice.

As previously described, our conversations reflected a level of uncertainty and lack of trust and self confidence as new mothers, which was the driving force behind requests for information during pregnancy about coping after birth. Women co-researchers

asked about what to expect in the first days and weeks after birth, specifically in terms of managing colic, evidence about Vitamin D supplementation, common problems, nappy rash and indeed other rashes, care of the umbilical cord, how to ensure that their baby was healthy, signs of thriving, sustainable alternatives to nappies and equipment required at home. There was also significant interest in the psychological health of the infant with requests for clarification about how much the baby should be 'educated' and 'entertained'. There was occupation with and anxiety about how to care for infants who were unwell and how to recognise illness, and confirmation of the considerable benefits of First Aid instruction in ANE classes.

'How' refers to the process and media through which information and support is offered and this incorporates various known visual and auditory learning strategies, in addition to suggestions for podcasts and an upgraded and dedicated hospital website. Another suggestion was the use of descriptive flow charts illustrating labour and birth events and alternative plans if experiences do not proceed as intended. This requires departure from the fixed message of procedure to allow for discussion about alternatives to the currently offered dominant hospital message (Nolan 2010). Women enjoyed handling practical equipment, for example, dolls and pelvises and reflected that some had not held or cared for a new baby. For many, this new found responsibility was an entirely new concept that they had no prior experience or knowledge of, 'I know nothing...' **(ARC3 AN W11 26/40)**. In this way, there was emphasis on procedural knowledge, or familiarising themselves with procedure, skills and techniques (Belenky *et al.*1986). This is conveyed by the words that women used to explain their needs in terms of acquiring and processing new information, for example, 'say 'this is what you do...just show us how to do it with our hands' **(ARC2 AN W9 21/40)** and 'anything that increases your awareness and makes you aware' **(ARC1 AN W4 23/40)**. Women welcomed practical demonstrations for breastfeeding and useful positions to adopt for labour and birth, and in this way appreciated the skills of the physiotherapist, illustrated by the words, 'she was down on the ground and literally showing us how' **(ARC3 AN W17 37/40)**. The importance of gauging individual need was discussed, in the words of one woman, 'maybe for antenatal education the education part is withholding as much as saying' **(ARC2 PN W9)**. This statement is in reference to a discussion about the very personal nature of the experience of pain in labour and is possibly illustrated best by the exchange below:

'And I just thought that was good, that you don't tell them; don't tell them about the pain (laughing)... I had no idea of how painful it was going to be. And in relation to the antenatal classes I am *so glad* they didn't say it (this is said with emphasis and relief – and is almost sighed out), it was like, it's a *massive secret* (with emphasis) and no one tells you until you go in and I know it is a very personal thing but I've a very high pain threshold and I have never ever experienced pain like it before. And I'm so glad that in antenatal education they don't concentrate on pain or tell you anything about it. They just completely bypass it because the terror of thinking of that pain again makes me not want to have children again' (**ARC 2PN W9)**

Q Is there anything that could have prepared you for that?

'I don't think there's anything, and you shouldn't be prepared for it, I think.' **(ARC 2PN W10)**

'No, that's what's so weird, like it made me think because I was thinking about this today, maybe for antenatal education the education part is withholding as much as saying, do you know what I mean? It's a judgment call as to how much you tell someone. And I just thought that that was good, that you don't tell them; don't tell them about the pain (laughing)' (**ARC 2PN W9)**

Women valued group and individual discussion, and expressed desire to meet other women and to 'have a good time' at classes. The skills of the facilitator in promoting humour, good dialogue and a non-judgemental approach, with open mindedness and consistency in information giving emerged throughout our conversations. Overall, women participating in this research indicated a preference for a flexible approach to learning; and what they described as 'unstructured' discussion that incorporated a variety of techniques and cited hypnobirthing, 'learning visualisation and focus' for labour and birth and 'making it interesting' as examples. In the research presented here, women commented about the overwhelming surge of information offered about pregnancy, birth and motherhood, and appeared to embrace the role of the health care professional in filtering information from what they described as 'outside sources' and wishes for a 'balanced' view. These findings are supported by the results of an online

survey by a parenting website in the UK (n=1,826), which showed that both first time and other mothers valued the opportunity to interact directly with maternity carers (Nolan 2008). Women co-researchers also expressed a preference for written notes to take home with a view to consolidating learning that had occurred during classes.

'Why' refers to the desired outcomes of learning to prepare for motherhood and identifies the physical, psychological and emotional aspects of becoming a mother Women acknowledged informational support as an important component of antenatal classes, and discussed the value of making 'informed decisions', specifically in terms of procedural aspects of managing labour and birth; when to come in to hospital, ways to ameliorate pain in labour, and when to adopt certain behaviours and potential positions for labour and birth. Uncertainty about how to voice needs and desires is expressed by a comment that is perhaps more indicative of how women are situated in maternity services in Ireland as passive recipients of care and that is, 'you need to know what to expect from labour or what you should be able to ask' **(ARC2 AN W10)**. Women co-researchers embraced their encounters with antenatal educators as a medium for encouragement and confidence building as new mothers and in terms of what could be expected after birth. Nonetheless, there was frank recognition that not all knowledge needs could be addressed by ANE. This acknowledgment echoes the findings of Australian research incorporating focus groups and interviews with health care professionals, pregnant women and mothers attending a large maternity hospital in Sydney (Renkert and Nutbeam 2001). Most strikingly in the research presented here, women sought opportunity and space through antenatal classes to rebuild a sense of traditional communities with other women and they found comfort and solace knowing another woman might experience similar concerns while navigating the journey to becoming a mother.

9.7. Conclusion

In chapter nine, we have examined the conflicting ideologies of being 'with woman' and being 'with institution'. We have discussed the inherent challenges for antenatal educators in adopting a 'with woman' stance within the dominant and hierarchal ethos of an institution and of which they are an integral part. We have discussed the concept of 'Finding Common Ground' and its relevance for hospital based antenatal education in Ireland. We have also explored the essential components of a model of antenatal

education under the titles of 'Who?', 'What?', 'How?' and 'Why?' that are named by women as critical in preparation for pregnancy, birth and motherhood. The salient aspects of this research are discussed in the following and final Chapter Ten, with occasional extracts from ARC2 and ARC4 meetings that highlight the messages in women's voices.

CHAPTER TEN DISCUSSION

10.1. Introduction

In the research presented here, two models of antenatal education have emerged. The concept of 'Finding Common Ground' describes hospital based ANE as it exists currently, in the absence of consistent and genuine relationship between a woman and her known midwife. Common ground cannot be achieved unless the intersections where hierarchy and subordination meet are identified and addressed. A second model of care has emerged and is composed of the essential components of 'Who?', 'What?', 'How?' and 'Why? Women have named these components, which reflect a continuous entity to be offered at every opportunity for engagement between woman and healthcare professional, as essential in preparation for motherhood.

In this chapter, I will discuss aspects of this research that emerge as being particularly significant. These are: how women in Ireland currently know birth and motherhood, concepts of power and fear, and the relevance of PAR in maternity care settings. From the outset, motivation for this work was underpinned by a participatory world-view influenced by thinking that reality is subjective-objective[251] (Reason and Bradbury 2006). This is coupled with a feminist gaze (Felski 2000) that privileges the agency[252] and complexities encountered, in this instance, by women in everyday life (Smith 1987), specifically through the processes of pregnancy, birth and motherhood. As previously stated, there are many feminist epistemologies[253]; however, a central theme

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[251] The concept and meaning of subjective-objective is explained in Chapter Three; 'we draw on diverse forms of knowing as we encounter and act our world' (Reason and Bradbury 2006, p. 9), while we may rely on certain types of scientific knowledge and skills, orientation is framed within human context, which in this research, requires working collaboratively with women co-researchers and ANE co-researchers.

[252] Anthony Giddens (1984, p. 14) refers to agency as 'to be able to deploy (chronically, in the flow of daily life) a range of causal powers, including that of influencing those deployed by others.'

[253] According to Debold *et al.* (1996), understanding of feminist epistemology requires first engaging with how 'authorised' knowledge has been produced. The rational dualism of mind and body, intrinsic to the Enlightenment, still features as a cultural practice that defines what is normal and how we become

of this work, which is relevant to standpoint theory,[254] is the concept of women 'speaking their truth', thus creating new knowledge that is grounded in women's experiences (Ramazanoglu and Holland 2002, p. 64). Both feminism and PAR dissect conventional distinctions between academic and lay knowledge (Ramazanoglu 1989). The premise of PAR, that knowledge is co-constructed with others through ongoing dialogue (Reason and Bradbury 2006, Maguire 2006) is in harmony with feminist values that knowledge is created through dialogic engagement (Tarule 1996, DeVault 1999, Edwards 2005, Maguire 2006). In support of feminist knowing, Edwards (2005) suggests that feminist epistemologies acknowledge post-modern awareness of the necessity of drawing diverse voices together and an appreciation of differences and similarities between groups and individuals.[255] Knowing, therefore, is an 'active verb' (Vella 2001, p. 44, Reason and Bradbury 2006) that is influenced by dialogue contextualised by personal and cultural understanding and meaning (Debold *et al.* 1996, Goldberger 1996). In adopting a participatory worldview (Reason and Bradbury 2006)

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subjects/subjected (Debold *et al.* 1996, p. 101). According to Oakley (1993), childbirth is not consistent with the mind-body divide and cites the link between social stress and difficulty in birth.

[254] A critique of standpoint theory by Susan Hekman (1997) and responses to this critique by others (Harding 1987, Smith 1987, Collins 1994) suggest that standpoint theory explores and seeks connections between knowledge and power, deconstructs the knowing feminist (that is, acknowledges that a feminist researcher 'knows' from a specific and partial social location (Ramazanoglu and Holland 2002, p. 65) and so the knowing self is socially constituted), that a feminist standpoint is grounded in women's experience, emotions and embodiment. This is not always an agreed or simplistic notion; rather there is variation in how experience is conceived and how knowledge, knowing and experiences are connected (Ramazanoglu and Holland 2002). Feminist stand point also considers diversity in women's experiences and interconnecting power relations and acknowledges that knowledge is always partial (Ramazanoglu and Holland 2002).

[255] Anthony Giddens (2003, p.2) suggests 'the condition of post-modernity is distinguished by an evaporating of the 'grand narrative' – the overarching 'storyline' by means of which we are placed in history as beings having a definite past and a predictable future. The postmodern outlook sees a plurality of heterogeneous claims to knowledge, in which science does not have a privileged place.' Feminist epistemology acknowledges plurality as distinct from the patriarchal codified stance of rationality, objectivity, and reason (Edwards 2005).

and consistent with the centrality of plural ways of knowing, a discussion about women's ways of knowing is necessary.

10.2. Ways of Knowing

Drawing on discussions of radical[256] feminist perspectives, Alison Jagger (1983) suggests that women's understanding of the world contrasts with patriarchal ways of knowing.[257] Characteristic of patriarchy is the conceptual separation of 'aspects of reality that are in fact inseparable...it [patriarchy] imposes dualisms[258] within which one side of the dual is superior to the other side', thus imposing hierarchies in nature[259] (Jagger 1983, p. 96). The relationship between Jagger's (1983) description of patriarchal knowledge and a technocratic model of birth is the imposition of hierarchy and the assumption that 'expert' knowledge is superior to the knowledge of pregnant and birthing women (Edwards 2005, Davis-Floyd 2003, Murphy-Lawless 1998).

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[256] According to radical feminists, patriarchy is identified as the primary source of women's oppression; thus, radical feminism focuses solely on oppression of women as women, as distinct from workers. Issues of sexuality, marriage, motherhood and aspects of women's intimate experiences in the private domain are of key concern, and the commonalities of women are celebrated (Janes 2003).

[257] Mary Belenky *et al* (1986, p. 5) suggest that 'drawing on their own perspectives and visions, men have constructed the prevailing theories, written history, and set values that have become the guiding principles for men and women alike.' In support, Nancy Rule Goldberger (1996) citing Ortner (1974) and Sampson (1978) makes the point that the association of man with reason and mind and of women with nature and body began with the patriarchally-fuelled emergence of the Enlightenment. Women, thus, are concerned with daily existence and bodily function and men with 'higher levels of thought' (Goldberger 1996, p. 353)

[258] In fact, in terms of knowledge, William Perry (1970) refers to dualism in which there is only one answer, as the simplest way of knowing.

[259] Distinct from patriarchal hierarchies of nature, Alison Jagger (1983, p. 96) suggests that women recognise that they are part of nature and, consequently, 'trust in their direct and intuitive mode of knowing which perceives the wholeness and oneness of the universe in the way in which everything is connected with everything else.'

In his analysis of 'hundreds' of interviews with women as a psychiatrist, coupled with clinical observation of the mother- baby relationship over a period that spanned thirty years, Daniel Stern suggested that women as mothers become central players in the vast unfolding of earth's history (Stern *et al.* 1997) and are integral to teaching the next generation (Stern *et al.* 1997, Belenky *et al.* 1986). Despite this, women's intuitive[260] knowledge is considered more primitive,[261] less legitimate, and indeed, less relevant than objective reasoning (de Beauvoir 1949/1997, Jagger 1983, Harding 1987, Belenky *et al.* 1986, Debold *et al.* 1996, Ruddick 1996). As Adrienne Rich (1995, p. 43) proclaims, 'patriarchy would seem to require, not only that women shall assume the major burden of pain and self denial for the furtherance of the species, but that a majority of that species - women - shall remain essentially unquestioning and unenlightened.' In contrast to patriarchy, feminist epistemology recognises that 'women are knowledgeable...that knowledge comes from their intellects, emotions,

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[260] Belenky *et al* (1986, p. 62), refer to intuitive knowing as subjective knowledge, the belief that truth resides within the self; discovery of personal authority relies upon situation, context and life course. Subjective knowing also values 'maternal authority', that is, turning to other women to make sense of experiences. Other women's ways of knowing identified by Belenky *et al.* (1986) in their research on women as knowers and learners were: knowing or not knowing through silence (women in extreme self-denial and depending on others for direction), received knowledge (where women depend on 'the authorities' for knowledge), procedural knowledge (where the woman listens and values the voice of reason) and, finally, constructed knowledge, in which truth is understood to be contextual and situated that the knower is part of (ibid). Despite the suggestion by Belenky *et al.* (1986) that ways of knowing are not sequential, several aspects of women's ways of knowing (Belenky *et al* 1986) have been critiqued in later essays; further, whether the ways of knowing follow a developmental sequence is something that the original authors cannot agree on (see Goldberger *et al.* 1996), specifically, and of relevance here, the notion that 'progress' is relevant to epistemology and how women's ways of knowing as described by Belenky *et al.* (1986) potentially mirror dominant educational ideology (Ruddick 1996). Consistent with this, Debold *et al.* (1996), state that the 'various uses of self and voice...are created by dialogue within varying power relations' and therefore, women's ways of knowing do not exist in a vacuum and are not developmental or progressive.

[261] According to Jagger (1983, p. 96), historically, 'women have been seen as closer to animals both because they lacked reason and because the functioning of their bodies have been thought to commit them to the repetitive biological reproduction of the species', just as men are pre-occupied with creation of culture (Jagger 1983).

bodily[262] sensations, imaginations, past experiences and other attributes that create who we are and what we know' (Edwards 2005, p. 52). Thus, feminist epistemology is in keeping with a social ideology of birth, which requires the midwife to use her midwifery knowledge and skills and to turn to obstetric support if complications arise (Edwards 2005). Oakley (1980, p. 298) reflects '...the traditional occupation of female midwifery has always placed a belief in nature - which amounts to a belief in women as their own deliverers...' When social order is ruled by men, 'women become the embodiment of an alternative government,[263] which must be avoided at all costs' (Oakley 1980, p. 8). In keeping with this line of thought and according to Davis-Floyd (2004), midwifery knowledge and skills, which recognise and value women's different views of the world (Guilliland and Pairman 2010), are under attack worldwide due to the growth, power and influence of technocratic birth.[264] A feminist perspective holds that reality is concealed by false hierarchies that are imposed by patriarchal culture (Jagger 1983); however, in matters related to birth and motherhood, 'feminism stands helpless at the entrance to the maternity hospital: the oppression of women continues unchecked inside' (Anderson 2004, p. 259).

Women's surrender of their reproductive autonomy to the control of male-dominated medicine legitimises the ideology and cultural representation that reproduction is a medical matter (Oakley 1980). In this research, it is evident from the accounts presented in the findings chapters that a dominant technocratic ideology that privileges medical expert knowledge and patriarchal knowing has saturated our research

[262] Nancy Rule Goldberger (1996, p. 353) refers to 'embodied' as being 'tied to bodily orientations, experience, and interaction in and with our environment.' Of significance to this work, Lois McNay (2000, p. 25) suggests that the idea of embodiment ties to the concept of gender as a lived set of 'embodied potentialities', as distinct from external imposition of confining norms; embodiment is held partially to overcome mind and body dualisms.

[263] In response to criticisms of feminist knowledge, Caroline Ramazanoglu (1992) makes the interesting point that the 'validity' or truth of feminism is rejected by criteria designed by a standpoint that uncritically and historically defends and privileges non-feminist or masculinist thinking. Feminism, on the other hand, empowers women by problematising power relations and what is meant by knowledge, objectivity and reason, where social divisions and difference exist (Ramazanoglu 1992).

[264] Technocratic birth is first introduced on page 19.

discussions, despite efforts to engage in participatory dialogue. Knowledge is dictated in accordance with the rules and regulations required to maintain strict functioning of the relevant institution. The diversity of each woman's way of knowing and women's ways of knowing[265] means that it is unlikely that every woman will know in the same way in response to various contexts all of the time (Ruddick 1996, Goldberger 1996). In acknowledging this, however, Sara Ruddick (1996) notes that prolonged focus on a particular way of knowing can shift epistemological emphasis, and, may well produce similar cognitive thinking and attitudes that occur in varying degrees. In this research, there is scant evidence of women co-researchers' belief in the value of their personal intuitive or bodily knowing; rather, there are predominant suggestions of dependence on external knowledge, with very occasional exceptions.

According to Stern *et al.* (1997), as mothers, women need to accept and become comfortable with their intuition in responding to, and in developing ways to care for their babies because, as distinct from paid work, tight, rational control is not a feature of motherhood (Stern *et al.* 1997). In Nadine Edwards' (2005) research exploring birth autonomy in Scotland, the importance of caring midwifery in supporting women to develop strengths as mothers is evident. Edwards (2005, p. 255) states:

> These women [interviewees] explained that being encouraged to become strong, competent and caring mothers helps them to protect their babies, and keep them safe, before, during and after birth. Their abilities to do this depends on being encouraged to develop their autonomy skills, by being listened to, trusted, respected, and treated as capable individuals. This enables them to make good decisions.

In the research presented here, data suggest that pregnant women appeared to lack the supportive self-assurance needed for confident motherhood and depend on guidance from external authority. Becoming a mother requires space and time to articulate need and to develop confidence. Further, and as noted by Edwards (2005), Tarule (1996) and Belenky *et al.* (1986), the environment in which dialogue and engagement occur impacts forcefully on knowledge development (Ketler 2000), where 'the kind of thinking possible is constrained or enhanced by the nature of the community' (Tarule

[265] To explain, each woman has different ways of knowing and equally, women's ways of knowing are different and, therefore, ways of knowing cannot be categorised.

1996, p. 285). In a medical model of care, knowledge development is dictated in accordance with the rules and regulations required to maintain strict functioning of the relevant institution. Ina May Gaskin (1996) shares this view by stating that as childbirth moves into hospitals, midwives are accountable to institutions and not communities; furthermore, we risk losing traditional cultural wisdom about pregnancy and childbirth (ibid). In women's ways of knowing, midwives draw out women's knowledge; the focus of the midwife is the woman's knowledge and not that of the midwife (Belenky *et al.* 1996). Therein is the distinction between technocratic and social models of care.

ANE co-researchers observe a lack of confidence in motherhood that is evident on the hospital postnatal units after birth, and this was generally perceived as lack of 'natural instinct' (ARC2 P3). It is ironic that women who are situated as passive recipients of maternity care in pregnancy and birth (Murphy-Lawless and Quin 2004), with the overriding message that decision-making is beyond them, are suddenly expected to get on with caring and rearing their infants without the authoritative knowledge that has dictated the conduct of their pregnancy, labour and birth at every turn. Following rigid instruction for labour and birth, women co-researchers describe a sense of feeling lost after birth (this is discussed on pages 186 and 187). Enforced dependence on professional and authoritative knowledge without recognition of other ways of knowing render women co-researchers vulnerable.[266] This apparent vulnerability and emphasis for women on relational[267] knowing also meant that women co-researchers and ANE co-researchers, for the most part throughout the research, have been careful not to engage in conflict. Pat Thomas (2002, p. 35) suggests there is potential for conflict in all relationships; it is only through 'negotiating conflict that we define and refine our

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[266] One of the ways to counter this and to hear women's voices clearly was to meet with women co-researcher groups and ANE co-researchers separately and before the CIG; this is outlined in the methodology Chapter and explained in full in the findings Chapters Six, Seven and Eight.

[267] According to Sara Ruddick (1996, p. 263), 'knowing is always a relationship with the known as well as with other knowers.' A knowing self is created within relationships (Ruddick 1996). Ruddick (1996, p. 264) makes comparisons between relational knowing and Belenky *et al* (1986) connected knowers stating that ideas are embodied and embedded in someone's personal history and present psychological life.'

needs.' In the absence of space for authentic relationship, conflict was avoided during our earlier research meetings as it appeared that neither group felt safe to challenge and debate. As time passed, debate slowly grew. We arrived at a turning point during the ARC3 CIG2 discussion when women questioned antenatal educators about the accuracy of evidence they offered in relation to episiotomy. This discussion is introduced on pages 260 and 261 and pertinent ethical issues of relevance are also highlighted on page 100.

10.2.1. The Health Care Professional (Medical) as Expert

Seminal research based on interviews with 135 women from diverse backgrounds explored women's ways of knowing and how previous experience influenced concepts of self and relationship (Belenky *et al.* 1986). Findings identified 'received knowers' (Belenky *et al.* 1986, p. 42) as women who placed emphasis on, or valued external and authoritative knowledge, or, knowledge, which is associated with more power (Jordan 1993, Ketler 2000) as absolute truth, often defining themselves according to the expectations of others (Belenky *et al.* 1986). Later, Nancy Goldberger (1996) suggested that received knowing is culturally contingent and determined by situation and context and that ways of knowing are drawn out in response to particular settings and circumstances. The belief that truth comes from external authority or others is characteristic of 'received knowers' and this is compounded by lack of confidence in the ability of the self to speak. The dependence for direction, as well as for information, continues unchallenged without realisation that powerful authorities have capacity to construct knowledge (Belenky *et al.* 1986). Consequently, there is the illusion of only one answer, one truth, which is a manifestation of dichotomous or dualistic thinking.[268] According to Belenky *et al.* (1986), women co-researchers embodied characteristics of 'received knowers' by expressing their need and desire to be instructed about what they were expected to do.

[268] Belenky *et al.* (1986) refer to a dualistic perspective on dualistic thinking as 'either/or' or dichotomous thinking – Belenky *et al* (1996) and Kirkham (2010c).

In the research presented here, this manifested in intense preoccupation with hospital policy, which reflects women's awareness of the medicalised[269] nature of birth; however, in the absence of a feasible alternative,[270] women co-researchers were forced to valorise medical knowledge as the dominant way of knowing that is communicated through antenatal education. It has been argued that some women desire, and indeed, find comfort in maternity care that is infiltrated by dominant medical knowledge and practices (Nolan 2008, Ketler 2000, Davis-Floyd 2003 and McHugh 2003) and this is discussed on pages 155-158 of the thesis in relation to the concept of choice for women in birth. The problem with acceptance of a dominant medical model; however, is articulated by McHugh (2003, p. 73) in her analysis of empowerment of women as recipients of maternity services:

> ...the removal [of woman] from the decision making process, is a removal from self-determination and responsibility. This then transcends the concept of expertise and fosters a different set of power relations, which is inherently imbalanced and unhealthy. Client participation at whatever level that individual is able, is paramount to self-determination and a crucial part of birth and the passage to parenthood.

Rosemary Mander (2002) suggests medical activity undermines women's confidence in themselves and their confidence in those who care for them. In her analysis of the relationship between midwife and medical practitioner, Mander (2002) proposes that activities which were originally the remit of the medical doctor have become routinised and are accepted as a normal part of labour, and as such, become subsumed under the responsibility of the midwife. Discussion regarding normal labour and birth, therefore, becomes coloured by the medical view that birth requires intervention, as distinct from the midwifery philosophy of birth as a normal life event and physiological process (An

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[269] According to Murphy-Lawless (2006) medical science has made substantial contributions to safe birth, including the provision of antibiotics, improved techniques in surgical procedure and perinatology; however, the message that improved maternal health and good midwifery care contributed significantly to safe birth was not communicated to the same degree.

[270] An independent review of the maternity and gynaecological services in the Greater Dublin Area emphasises lack of choice in maternity care for pregnant women, prominence of a hospital-based medical model of care with underdeveloped community care and primary services in terms of 'access, choice, equity and information' (KMPG 2008, p. 81).

Bord Altranais 2000, 2010). Such emphasis on technocratic birth requires dependency on the medical model to see women through birth (Davis-Floyd 2003, Buckley 2009). In the technocratic model of birth, the female body is a defective machine that could perform better if attached to another more perfect machine, as the female body alone is considered deficient (Davis-Floyd 2003). Thus, power and kudos are attributed to those who are knowledgeable about machines and how to use them. In the research presented here, postnatal women co-researchers expressed comfort that there were 'standards and procedures' **(ARC3 PN W14)**. In the absence of scope during pregnancy to explore new feelings associated with pregnancy and oncoming motherhood, there is evidence in the women co-researchers' accounts of disassociation from birth. Disassociation in this sense can perhaps be attributed to a cultural and social schooling that birth is dangerous and layered with risk and is not achievable without medical intervention (Davis-Floyd 2003, Murphy-Lawless 1998).

Women come to birth ill-supported, and subject to strong cultural and societal messages of risk and the ideology that technology keeps women and babies safe (Murphy-Lawless 1998, Davis-Floyd 2003, Davis-Floyd and Davis 1996). Perceptions of risk compel women to seek expert guidance in birth and motherhood (Miller 2005). Thus, according to Davis-Floyd and Davis (1996, p. 238), 'a reassuring cultural order is imposed on the otherwise frightening and potentially out-of-control chaos of nature.' In our research, there is evidence that women co-researchers unquestioningly accept the package or process of care that is offered to them as a way of making birth possible, in the absence of space and opportunity to unearth and to explore their fears, anxieties and feelings about pregnancy, birth and motherhood. Unquestioning acceptance of the dominant package of hospital care was also observed by one of the antenatal educators; however, this was motivated by her belief that women in general, lack physical awareness or bodily knowledge and display eagerness to relinquish personal responsibility for birth with the assumption that birth will be straightforward and trouble free if managed by someone else. Downe and Dykes (2010, p. 62) refer to this position as a by-product of consumerism (the notion of consumerism in maternity care is discussed on page 72) with emphasis on the individual and 'quick fix' or getting what one wants with as little risk or effort as possible. They suggest that this ideology is perpetuated by professionals and women alike and is:

...epitomised by the emphasis on a view that pregnancy and birth can and should be as short as possible while insisting on guarantees of safety, on increased epidural analgesia usage and caesarean section, and on litigation, if and when things deviate from what was expected or demanded' (Downe and Dykes, 2010, p. 62).

10.2.2. Knowledge as a Set Approach to Procedure

Women co-researchers' views of knowledge related to pregnancy, birth and motherhood as procedural[271], or as a set of facts to be memorised is characteristic of personal meaning[272] compounded by the influence of authoritative scientific knowledge. Features of procedural knowing, according to Ruddick (1996), are continual separation of the knower and the known, and knowing of the mind, from bodily, social and emotional life. Ruddick (1996) observes that impersonal procedural knowing is a necessary requirement for project management. When asked to identify their reasons for attending antenatal classes, responses revealed that women co-researchers denied personal knowledge and self-trust and refrained from sharing emotional or personal insights, with firm emphasis on tasks and procedure. There was evidence of a programmatic and fixed managed approach to birth in a situation where midwives and ANEs on the one hand, were bound by procedure and on the other hand, women were dealing with unfamiliar territory, had no prior birth experience or perceived control of events, and expressed vulnerability and fear. This accurately reflects the consistent findings about the impact of the dominant models of care on women in the work of Kennedy (2002, 2004), Hillier (2003), Davis-Floyd (2003) Edwards (2005, 2008), Dahlen (2010), and on midwives in the work of Mander (2002) and Kirkham (2010a). According to Hillier (2003), when birth takes place in modern obstetric care, women

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[271] By procedural knowledge, I refer to the Belenky *et al.* (1986, p. 95) definition of 'knowing how' as women who are 'absorbed in the business of acquiring and applying procedures for obtaining and communicating knowledge' with emphasis on procedure, skills and techniques.

[272] Michael Polanyi (1962, p. 252) refers to personal mode of meaning thus, 'I started as a person intellectually fashioned by a particular idiom, acquired through my affiliation to a civilisation that prevailed in the places where I have grown up, at this particular period of history...all my amendments will remain embedded in the system of my previous beliefs. Worse still, I cannot precisely say what these beliefs are.' The relevance of Polanyi's assertion here is that the power of social or community conceptions of birth communicated through pervasive discourse invades the consciousness.

find birth harder because their confidence is diminished and the support that they need is lacking.

In keeping with information needs, I asked women co-researchers to share a piece of information that they had received in classes, which they felt had sustained and supported them in birth. Their responses reflect their feelings of satisfaction with a philosophy of an expected and set approach to labour and birth, incorporating the use of the partogram to convey the message that labour had a beginning and end. This is resonant with Downe and Dykes' (2010) aforementioned assertion that women and health professionals have come to view birth as a linear process with a defined start and conclusion. According to women co-researchers, anticipation of an expected approach to labour and birth offered feelings of control. Control however, as previously discussed, is a multifaceted concept and the notion of control in labour and connotations between truth and control has been acknowledged on page 155.

Within the context of maternity care in Ireland, birthing women have no alternative[273] but to align themselves with the dominant model of care once they enlist in a particular package, unless they are forced to disengage from the services. Control at a very basic level therefore, amounts to whether to enrol or 'register' with a particular institution for care or not, and this decision is compounded, at the very least, by lack of availability and accessibility of maternity services. Once a woman enlists with a particular package of care, choosing another maternity hospital is not a straightforward alternative because of the lack of resources and sheer inaccessibility of services. This is evidenced by the findings of the *Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area Final Report* by KPMG (2008), which confirmed that the birth rate for the Greater Dublin Area[274] (GDA) was in excess of 26 000 births per annum that year. This was expected to increase over the next eight to ten years (KPMG 2008). Maternity services in the GDA are provided by three stand-alone Dublin maternity hospitals and one private facility with a birth rate of approximately 1,400

[273] Almost all maternity care in the Greater Dublin Area takes place in the three Dublin Maternity hospitals (KPMG 2008)

[274] According to KPMG (2008, p. 38), for the purpose of the review, GDA refers to Dublin City, Dun Laoghaire-Rathdown, South Dublin and Fingal as the Dublin Area (DA). This review was commissioned by the Health Service Executive in 2007.

babies per year (KPMG 2008). According to the Central Statistics Office (2012), the number of births nationally in 2009 was 74,728. In addition, the growing trend towards centralisation of maternity services in large maternity hospitals in Ireland has resulted in more closures of smaller local maternity units, limiting further the concept of choice and availability of care (DOHC 2003, Devane *et al.* 2007).

10.2.3. Knowledge of Body and Self as Defined by Someone Else or Working against Another's Parameters.

The extract below from an ANE co-researcher illustrates how powerlessness is communicated and sustained through encounters with healthcare professionals. Dominant discourse in the form of the medical health professional as 'expert' shapes and influences how women know in the messages that they receive about their bodies and babies.

> 'What if the baby has to be delivered...say the baby is distressed, and the mother still doesn't want to be monitored continuously or say she's previous section and doesn't want to be monitored continuously. So then we pass it by (name of Labour Ward Manager)...If (labour ward manager) is not happy we go further than that, to the master...but it doesn't happen that much...usually it's resolved before that...it's actually to give a woman a chance just to think she's in control sometimes. That's all they want to feel sometimes. But they find it too difficult, or like we [women] want you to decide for the moment...' **(ARC 4 ANE P3)**

Thus, a woman learns that birth is potentially dangerous and that she is not equipped to make decisions because her decision-making is contingent upon and complicated by the prevailing social and relational context[275] (Murphy-Lawless 1998). This is consistent with Ivan Illich's (1975) suggestion that whatever prior capacity that we have to look after ourselves is threatened by the tendency to rely on experts. The communication of

[275] Jo Murphy-Lawless (1998) suggests that decision making is complicated further by fragmentation of the woman's body in addition to how she sees herself, the role technology plays, and the deep seated culture of patriarchy within maternity care.

risk[276] is consistent with the medical model approach to birth and the assumption of control and intervention in the birth process (Mander 2002). According to Mander (2002), this has the effect of not only undermining the woman's confidence in the midwife but also her belief in her own abilities to birth without intervention. Thus, ANE co-researchers' perceptions that women find it difficult to make decisions is perhaps unsurprising, given the lack of engagement permitted to foster ownership of power through genuine dialogue (Kirkham 2010c). Nessa McHugh (2003) considers that for women to be empowered, someone must be an agent of empowerment, but as midwifery is a highly gendered profession, issues that affect women also affect midwives (ibid). The effect of having an all-female group of ANEs, therefore, in terms of balancing gendered power differentials is very relevant. Results of a cross-sectional, descriptive, national survey to elicit the conditions important in facilitating midwives' empowerment in maternity services in Ireland reveal four imperative conditions for empowerment. These are: having control over practice, which included having access to adequate resources, support from colleagues and managers, recognition of the role of the midwife by medical colleagues and having adequate skills to perform the role of the midwife in accordance with scope of practice (Matthews *et al.* 2006). In the research presented here, the antenatal educator seeks permission from another to give a woman information and support and thereby she is deeply disempowered by her position. According to McHugh (2003),

> The relationship between midwives and the dominant medical culture around them would potentially indicate that midwifery struggles with its own identity, fighting its own disempowerment...the disempowerment of the advocate may leave her in a position to understand and unite with the woman as client, but why have an advocate who is unable/unwilling to speak? (p. 71)

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[276] According to Nadine Edwards (2005), in her analysis of risk, in western contemporary society, while there is always uncertainty, birth is less dangerous than other parts of world, yet this decrease in danger is paradoxically countered by pervasive discourse about risk and danger and the safety related to obstetric led birth. Further, according to Edwards, (2008, p.463), 'while women strive to exert (necessarily limited) activity during the childbearing period, due to the impact of current risk society, standardised practices, and a relentless reduction in the welfare state due to neoliberal health care policies, their efforts and those of midwives are severely restricted even in a relatively affluent context'.

In the current context and with the institutional preoccupation with throughput, it is apparent that antenatal education cannot facilitate a situation where women can begin to explore decision-making. When subject to power relations, the concept of self is challenged, reorganised and redefined in response to negotiating rigid and inflexible structures (Edwards 2001, Debold *et al.* 1996). According to Edwards (2005, p. 56), if, by attending institutionalised care, women are prevented from 'questioning, revisiting and revising' their decisions during pregnancies, they become dependent on 'expert' ideology, and this prohibits their ability to make decisions autonomously as mothers. Knowledge dependence from sources of authority is accepted even if the woman is aware of context and organisational structure, but within the current system of care there is no alternative option.

10.2.4. Knowledge from Other Mothers

In the absence of what Stern *et al.* (1997) refer to as an 'affirming matrix'[277] in the form of a sustaining and continuous professional embrace, due to the fragmented nature of services, women, as conveyed by the voices of women co-researchers in listening/reading three, desire and turn to each other for relational[278] ways of knowing and of being mothers. Throughout this research, women identified the support for birth and motherhood that they needed, and did not have, and, reference was made to the lack of opportunity to meet other mothers in antenatal education classes. The relevance and meaning of knowledge grounded in women's experiences that are shared through the very necessary informal networks between women (Gaskin 2003, Davis-Floyd 2004) are evident in the women co- researchers' accounts. The need for other mothers support and approval of their decisions as new mothers and the salience and significance of other women's experiences provides insight into the knowledge needs that women identify when they are afforded space to explore their feelings about birth and motherhood. On occasion, women co-researchers spoke about other mothers as potential information support, in a respectful and reverent way, with emphasis on the mother's experiential knowledge. Ketler (2000, p.143) refers to this as 'exclusive

[277] Stern *et al.* (1997) describe the affirming matrix as a special psychological environment, in which a mother can feel secure, trusted and encouraged to explore parental skills...at the centre of the affirming matrix is a wish for a mother figure, whether real or idealised to aid and support and be with.

[278] A description of relational knowing is offered on page 62.

motherhood', which is characterised by a woman's unique experience of birth and motherhood and which cannot be understood by another unless they have encountered the process themselves. Ketler (2000) suggests that younger women who witness exclusive motherhood in an institutional context often speak about it in spiritual terms. Sharing experiential knowledge offers a woman security of both knowledge itself and also intimacy with another (ibid).

10.2.5. Messages from Society and the Institution: Mothers are what Women are Supposed to be

For some women co-researchers, the social construct that mothers are what women are supposed to be (Oakley 1979, Chodorow 1999) is perpetuated by societal and institutional/professional expectation and this was elicited through Readings Four and reflected in the voice of this pregnant woman co-researcher:

> 'I don't know like I suppose it's a question that people only ask women...I didn't particularly want children and my partner really, really wanted children... sometimes the male is more maternal than the female and yet you are expected, I went for the scan and the midwife was doing the thing and saying 'oh look at the little finger', I think she was a bit aghast that I wasn't cooing over this kind of CT image and so I'm just going 'ahh isn't it amazing?' (laughing) but it was to comfort her' **(ARC2 AN W9 21/40)**

Technocratic ideology of birth that is rooted in the organisation and structure of maternity services extends beyond the institution and into the community. This is demonstrated by routine attendance of women co-researchers with their general practitioners for confirmation of pregnancy[279] and for unquestioning acceptance of systems of care available. Thus, hospital birth is normalised and accepted from the onset of pregnancy so that it is difficult for women to distinguish birth that is natural[280]

[279] Barbara Katz Rothman (1996) suggests that the requirement for medical confirmation of pregnancy destabilises and systematically challenges the woman's own knowledge.

[280] I use the word natural here as distinct from 'normal.' According to Walker (1976, p. 131) normality is difficult to define because it is influenced by various factors that include geographic, cultural and obstetric guidelines.

and birth that is complicated and requires obstetric assistance. Women co-researchers' anticipated lack of ownership in birth was reflected in their responses to their sudden awareness they could choose a hospital to attend for maternity care following prior expectation that this was fundamentally a decision to be taken by their General Practitioners. According to the Association for the Improvement of Maternity Services in Ireland, AIMS Ireland (2010), the culture and organisation of maternity services in Ireland will evolve only when women, as service users, and GPs, as primary healthcare professionals, are versed about the benefits of a social model of care in normal pregnancy and birth versus the current authoritative medical model[281] (Kane 2010). The voices of women co-researchers suggest the ideology that birth is complicated and requires medical attention is perpetuated throughout media discourse, where birth is depicted as chaotic event to be feared.

10.2.6. How Antenatal Educators Know?

Ann Oakley (1993) argues that in the contemporary industrialised world, medical science and related disciplines have claimed expert authority over all aspects of reproduction. This has become the pervasive discourse in how childbirth is socially and culturally constructed, specifically for women as passive objects of clinical attention. These views stem from her interviews in the 1970s with women having babies in a London hospital. This, she states, is in addition to assumptions apparent in the medical literature about women as patients, at the time of her research. Thus, the pervasive discourse of medical science has found a way to permeate into societal views of birth by assuming a taken-for-granted approach (Edwards 2008). For recipients of care and care givers, this means that a whole population is dependent upon expertise and hierarchal structures that 'constitute the largely unaccountable bureaucracies dominating our health provision' (Sang 2003, p. 56).

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[281] AIMS Ireland made this statement in response to the publication of results of a randomised controlled trial (MiDU Study), undertaken to evaluate a pilot Midwifery-Led Service in the North East. AIMS Ireland emphasised the importance of broad dissemination of the results to the public, in addition to academics, clinicians and policy makers. AIMS Ireland's mission is to highlight and campaign for normal birth and mother-friendly birth practices, which are supported by evidence-based research and international best practice (AIMSI 2012).

Robbie Davis-Floyd's (2004) analysis of open and closed systems[282] of thinking illustrates how proponents of a medical or technocratic model of birth can be socialized to incorporate only new information that fits their current knowledge system (she refers to this as Stage Two Thinking). If information does not fit with their existing framework of knowing, Stage Two thinkers tend to ignore new information resulting in very rigidly codified systems of information. According to Downe and Dykes (2010), birth that takes place in a technocratic, consumerist, risk-averse setting that is characterised by surveillance influences all professionals operating within it. The notion that healthcare professionals have the propensity to assume each others' behaviours is articulated further by Mavis Kirkham (2010c) who suggests that working so closely with doctors has caused midwives to adopt many of their customs. Sara Ruddick (1996) asserts that knowing is connected to practice; thus, people engaged intensively in particular practices acquire distinctive ways of associated thinking. This is to the point where practice determines the salience and relevance of questions, the chosen methods of inquiry, and, the answers to questions, with criteria to decipher the appropriateness of solutions (Ruddick 1996). The influence of practice on associated thinking is illustrated by ANE co-researchers' responses and orientations that are influenced by their backgrounds in obstetric-led care that is defined predominantly by risk. One of the ANE co-researchers argued that if women have expectations of a healthy outcome that they should be aware that they may have to compromise in terms of satisfaction with birth experience.

While there is, at times, an obvious requirement for biomedical care (and to ignore this fact would be, at minimum, irresponsible), the implication from the extract above is that women cannot birth without risk and should be willing to compromise experience to achieve an outcome that is considered satisfactory. According to Dahlen (2010, p. 157), promotion of scientific evidence over women's choices and midwives' clinical skills and judgments, demonstrates a 'deluded' trust in science, which is augmented by

[282] See Davis-Floyd's (2004) discussion about various stages of knowing in open and closed systems from Stage One to Four, from very rigid closed systems of thinking and knowing, to flexible humanist approaches.

learning about fear, as we witness increasing birth intervention. Gaskin (1996) shares a powerful insight relating to how practice influences her ways of knowing,

> It seems that the kind of intuitive flashes I have described develop from being with many women continuously during labour...the doctor, nurse, or midwife who has been with labouring mothers only intermittently is likely to have very different ideas (more mechanistic, usually) about how labour works (p. 296)

This is suggestive of what Davis-Floyd (2004, p. 15) refers to as Stage Four Thinking that is open to new information and midwifery knowledge from multiple systems, as distinct from Stage One Thinkers who make decisions based on the only knowledge they have and Stage Two Thinkers (she cites the example of 'biomedical practitioners'), who may be exposed to new information but incorporate only aspects that fit within their pre-existing knowledge systems.

10.2.7. Knowing Birth – Birth as Unpleasant and to Be Feared

Edwards (2008) suggests that the concept of risk stems from rationalism, science and neo-liberalism, and it is perpetuated by fear, in the case of birth, that women might harm themselves or their babies and that they can be saved by experts and science. Edwards (2008, p. 465) states poignantly 'we (the public) do not define the risks, but avoiding them becomes a moral imperative, for our own good.' This view is supported by Hannah Dahlen (2010, p. 158) who suggests that maternity carers are 'undone' by their fear of adverse events related to childbirth and this incites fear of birth in the women they care for.

In the research presented in my thesis, the assumption that birth should be feared filtered through our conversations. In her analysis of pregnancy, childbirth and motherhood, the poet Adrienne Rich (1995) acknowledged that for the first time mother, fear may be precipitated by the unknown, coupled with what the woman has heard and witnessed, in addition to fear of suffering and even death. Ina May Gaskin (2011) suggests that fear of birth is compounded by not knowing. Accumulation of, or indeed recognition of inherent knowledge is empowering because it provides an essential way to negotiate fear of birth (Gaskin 2011). This knowledge involves

recognition of the mind and body as connected[283] (Gaskin 2011), as distinct from linear notions of patriarchal dualism. The move from home to hospital birth is attributed to fragmentation of maternity care and loss of continuity with one woman and an associated deskilling of carers to realise the impact of their practices, positive or negative (Gaskin 2011). Our findings suggest that women look for ways in antenatal education classes to negate fear and are disappointed with the current format that militates against companionship and support. According to the women co-researchers strategies to deal with fear are often found in the company of other mothers and are connected to sharing experiential knowledge.

Fear is also illustrated by a woman co-researcher's account of choosing a particular maternity unit because of 'the safety perspective' and her evident preoccupation with birth related statistics. For this woman, the concept of safety is defined by physical outcome coloured by orientation with risk, as distinct from process, which contributes to safe outcomes for mother and baby.[284] While statistical analysis can be useful, and was certainly of interest to women in our research, interpretation must be contextualised and combined with other knowledge and women's concerns (Edwards 2005).

10.2.8. Birth as Truth- On Telling the Truth or Not

These accounts reflect the findings of Ann Oakley's (1980) research focusing on women's reactions to birth in her '*Transition to Motherhood Study*.' Oakley (1980) found that women felt misled by unreal expectations of birth on two accounts. The first was related to the intensity of pain in childbirth (that birth was more painful than they were led to believe) and the second related to the level of medical activity and intervention in birth. Oakley (1980) at the time, called for a review of antenatal education practices in terms of content and goals. The interventions that Ann Oakley

[283] In her practice as a midwife, Ina May Gaskin (2011) shares concrete examples of how women's emotions connect with their bodies' abilities to give birth. She also cites how sudden fear, a painful vaginal examination or a person entering the room can cause the cervix of a labouring woman to close. Gaskin (2011, p. 30) refers to the opening and closing of the cervix in response to emotion as 'sphincter law.' In keeping with this, according to Sara Ruddick (1996), the notion of connectedness refers to having a voice of one's own.

[284] Edwards (2005, p. 136) refers to how the women in her research 'were convinced that feeling positive, confident and above all relaxed during pregnancy and labour would contribute significantly to how birth unfolded.'

(1980) referred to specifically were: episiotomy, forceps birth, artificial rupture of the membranes, and the use of oxytocin to induce or accelerate labour. These interventions were not expected by the research participants involved in Oakley's (1980) study. Thirty years later, women co-researchers in our current research, were instructed about these methods as part of the rigid adherence to services that are engaged to the detriment of natural physiological approaches to childbirth.

10.2.9. Ways of Knowing and Power

Interestingly, Oakley (1980, p. 283) analysed how medical control colonized natural birth to the point where the cultural treatment of reproductive pain is construed as 'women's difficulties.' Adrienne Rich (1995, p. 157) suggested that the majority of women, 'literate or illiterate, come to childbirth as a charged, discrete happening, mysterious, sometimes polluted, often magical as torture rack or as peak experience.' Fear drives women to seek pain control in the form of epidural analgesia which, according to Martin (1987) and Rich (1995, p. 158), 'is a dangerous mechanism' that causes women to disconnect not only from painful sensations but also from ourselves. In relations of power, the self is divided and internal conflict is reflected through multiple voices (Gilligan 1993); women co-researchers in this research were situated tenuously in response to dominant power relations and ways of knowing. Debold *et al.* (1996, p. 93) state that 'a subject tends to align with - that is, be internally persuaded by- one voice over another in ways that then typically align her selves with normalising discourses about gender, power, and morality'. In our research, women co-researchers altered their voices with occasional exceptions, to fit with the dominant voice of the antenatal educator and tended to avoid conflict by repositioning themselves and their views.

10.3. Power

Leading from a discussion about knowledge and knowing, it has been argued that power and knowledge are inextricably linked (Ramazanoglu 1992). Foucault (1991) declares that acceptance by the public of a particular discipline's knowledge claims effectively increases that discipline's power which, in turn, legitimises further the discipline's assertion of knowledge. In this way, the power of the discipline is all pervasive in that it shapes expert knowledge claims but also dominates social relations. The dissemination of medical knowledge via a strict hierarchal order has placed doctors in

control, followed by nurses [midwives] and finally clients [women and families] (Fleming 1992). Kathleen Fahy (2002) suggests that privileging medical knowledge has also ensured that midwives have handed over their decision-making responsibilities in a quest for freedom from responsibility, to the point where some resist midwifery models of care.

The centrality and reference afforded to the antenatal education class time-table provides a classic example of what Michel Foucault (1991) refers to as control of activity. The time-table ensures that no time is wasted and is characterised by three objectives: to establish rhythms of activity, to impose particular occupations and to regulate cycles of repetition (ibid). The quality of the time that is used is ensured by constant supervision and pressure from supervisors (this is reminiscent of pressure placed on ANE co-researchers to have everything 'covered') and the elimination of distraction (Foucault 1991). Power of a discipline is marked by detailed control and regular intervention[285] in every moment and is marked by linear progress, one moment upon another, which is oriented towards a 'terminal, stable point' (Foucault 1991, p. 160).

According to Fahy (2002), Foucault's analysis of legal power operates openly in the form of disciplinary procedure; however, she suggests that, from a woman's perspective, legal power is in the form of self-determination in spite of medical disciplinary power. It is important to note that a woman's ability to face disciplinary confrontation is much more likely to be successful when she is not physically vulnerable (that is, healthy and not in labour) (Fahy 2002). There are occasions when obstetric intervention is clearly necessary; notwithstanding this, the following extract from this research illustrates the utter powerlessness experienced by a woman when she is physically and emotionally vulnerable in labour and fears for her baby's wellbeing.

> 'But I think procedurally it's very, it was very clear to me what was going on, and it was just so frustrating that it wasn't happening. And then when the doctor came in and then decided there was meconium on the baby and it happened

[285] 'Intervention' in this sense refers to differentiation, correction, punishment and elimination (Foucault 1991, p. 160)

very, very quickly and he just said no, no, no, absolutely no way and I still remember *begging* him saying no please just let me try one more hour and he was having, he just didn't even look at me. You know, just no, he just knew it wasn't...you are just very tired and you just, you are very terrified of what's wrong with your baby' **(ARC 2 PN W9)**

Q Yes. When you heard those words 'absolutely no way' and he didn't look at you, what did that do to you?

'(Sigh) I suppose it just made me defer to his expertise, I didn't, I was probably a bit sick of begging you know...so I just deferred to their expertise because you are in such a vulnerable position, there's literally the struggle inside you to get out and you just have to, I was extremely fatalistic about it...I just, I suppose you reach a point where you just give up...you don't want the control...you just say no, someone else do it now...so when he just didn't look I just knew that there was probably little point in asking what was going to happen, it just was going to happen' **(ARC 2 PN W9)**

The woman's account of events that led to her baby's caesarean birth illustrates her vulnerability and powerlessness and the doctor's apparent lack of response to her concerns. In her chapter on 'Self and Body Image', Emily Martin (1987) discusses how birth by caesarean section affects women more negatively than vaginal birth and the feelings of powerlessness that women describe as intense experiences of fragmentation. This feeling is intensified by epidural analgesia. Friedman (1982, p. 173), as cited by Martin (1987, p. 83) recalls this emotion, 'they talked over me and to each other, but not to me. I felt like an object and not a human.' The woman co-researcher's narrative also illustrates the notion of being grateful to be saved despite how difficult or traumatic the experience (Davis-Floyd 2003, Kitzinger 2006, Buckley 2009).

In their proposed theory about birth territory,[286] Fahy and Parratt (2006) identify relationships between the environment where birth takes place and experiences of

[286] The authors suggest that there are limitations to this theory; relevant to this work is the focus of the theory on the individual birth room only, and this has not been tested sufficiently to guide practice, and

power and control, and the way in which women potentially experience labour and birth physiologically and emotionally. They identify the term 'disintegrative power' as power that is motivated by the user's self-serving goals, which disintegrates other forms of power including that of the recipient. Fahy and Parratt (2006, p. 47) suggest that 'midwifery [or medical] domination' interferes with the woman's labour by effectively silencing her. The woman becomes 'docile' and she is required to follow the midwife's instructions, thereby relinquishing her own power and embodied knowledge.

10.4. Empowering through Participatory Action Research

Mavis Kirkham (2010c) has acknowledged the tensions that result for midwives, who strive to develop relationships that are consistent with a social model of maternity care in institutions that do not value relationship. This can lead to frustration and alienation on the part of the healthcare professional. In order to address this, Murphy-Lawless (2006) suggests that we look to the writing of sociologist Zygmunt Bauman (2005). In his discussion about lifelong learning and the limited capacities of the citizen to procure 'planning for life' against the context of 'the free play of market forces', Bauman (2005), suggests that empowerment (or enablement)

> ...is achieved when people acquire the ability to control or at least significantly influence the personal, political, economic and social forces by which their life trajectory would otherwise be buffeted (p. 124)

Empowerment, according to Bauman (2005), requires that one can make choices and act effectively on the choices made. Prerequisite to this is our ability to influence the range of choices available and the social settings in which they are held. This is not a feature of current maternity services in Ireland, which require restructuring at governmental and national policy level. Genuine empowerment requires personal and social skills to navigate a system that is designed and enforced by others (Bauman 2005, p. 124); in

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the structure and function of the maternity services. Birth Territory refers to the features of the birth room, called the 'terrain', and the use of power within the room, called 'jurisdiction' (Fahy and Parratt 2006, p. 42)

this way, the personal becomes political.[287] Dominique Simone Rychen (2004), as cited by Bauman (2005) suggests that in meeting others who speak a different language (actual and metaphorically) to ours, we need space to interact, to dialogue, to negotiate and to gain mutual understanding in an attempt to resolve the inevitable conflict encountered in sharing human life. Through using a PAR approach, this research has focused on creating space to interact, to dialogue, to negotiate and to gain mutual understanding and knowledge. It is helpful to remember that groups and individuals are not innately powerless; rather their ability to exercise power, whether personal or collective is constrained by structural and institutional inequalities (Grant *et al.* 2008). According to Grant *et al.* (2008), while we document these inequalities, we must resist reinforcing or reproducing them within the research relationship. Awareness of the unequal status of health carer, recipient, and researcher prompted attempts to equalise power differentials in the research with varying success. This included efforts to achieve equal numbers of healthcare professionals and women participating in the Collaborative Inquiry Groups, opportunities for ANEs to enhance their own knowledge and skills and share ideas through engagement with other disciplines (midwives, physiotherapists and dietician). The involvement of women and antenatal educators in research dissemination was promoted (but has yet to take place). All co-researchers were valued as team members, and assurance was given that their expertise, commitment and contributions to the research would potentially yield more relevant and meaningful findings for women in addition to developing practice (Maiter *et al.* 2008).

10.5. Reflecting about Participatory Action Research in Practice

There is a need to argue and protect what is needed to support women in birth and early motherhood (Murphy-Lawless 2006). With this in mind, the research presented here has attempted to focus on one aspect of maternity care by working with women and antenatal educators. Participatory Action Research is founded on the belief that action and collective reflection on action, constitutes a valid form of generating knowledge and

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[287] By this, I refer to the relationship between the personal or private and political from a structural inequality perspective, as distinct from Linda Janes' (2003, p. 120) account of the 1960s Women's Liberation Movement (WLM) slogan of 'the personal is political'. This conveyed the consciousness-raising efforts of women's sharing of their personal experiences across the public/private divide and roused a new 'politicized collective consciousness' (Janes 2003, p. 120).

its success is judged, in part, on its ability to address community concerns (Brydon-Miller *et al.* 2004). This research has highlighted the conflicting views of women as recipients of maternity care and of antenatal educators as facilitators of learning, and, as gatekeepers. From a PAR perspective, we attempted collectively to analyse our discussions and to co-construct knowledge, while trying to navigate the unrelenting personal, organisational and structural barriers characteristic of the chosen research setting. This was coupled with my awareness of my responsibilities as researcher in initiating and guiding the process (Karnieli-Miller *et al.* 2009, Koch and Kralik 2006). The goals of PAR have been identified as achieving emancipation and empowerment for oppressed groups and highlighting social problems through cyclical processes of research, learning and action (Grant *et al.* 2008). At the outset of this work, it was anticipated that all co-researchers could work towards commitment to authentic dialogue, combined with reflection and action in the interests of working collaboratively together. It is doubtful however, whether this research has proved emancipatory against the very rigid setting and unequal status of participants. According to Chris Argyris (2006, p. 5), an apparent 'systematic blindness' to practice problems exist because of the early adoption by researchers and practitioners of the cultural and social traits of another group. This culminates in the development of defensive routines and reasoning and effective action, which is a requirement of human and organisational performance (ibid). Argyris (2006) suggests that action is considered effective by the organisation when it is consistent with organisational objectives and when action does not harm the organisation.

In terms of empowerment, the therapeutic nature of our discussions appears to have strengthened participating pregnant and postnatal women's awareness and desire to reflect, to consider and at times, to question their experiences of maternity care. According to Kesby (2005, p. 2052) however, and of relevance to this particular point, 'empowered agency' is another effect of powerful discourse and practices, such as participation and/or feminism and is therefore, 'partial, situated, and subject to future challenge and transformation.' As such, the discourses that promote empowerment need to be performed repeatedly to be accepted (Kesby 2005). We are reminded that consciousness, agency and resulting actions are context-bound or related to space and time (ibid). We have highlighted the social problems of the maternity services through our cyclical processes of research, learning and attempting change through action.

During our time together, I was convinced that we were engaging authentically in the participatory principles of action research. I knew that our inquiry and plans for proposed change presented difficulties for ANE co-researchers. They consistently explained the constraints they were working against, namely, the large number of couples attending classes and organisational and structural barriers to meeting women's needs that have been identified in this research.

10.6. The Personal is Political

At this juncture, it is necessary to revisit the notion of intersectionality and to emphasise that characteristics of oppression and privilege are not discrete entities and therefore, affect the activities of the everyday (Smith 1987) in very concrete and complex ways. Thus, the boundaries between the personal and private, and the professional and political, are inevitably blurred (Hulko 2009). According to Wendy Hulko (2009), intersectionality is best viewed as a theoretical insight to describe the practical implications of one's social location and the corresponding degree of historically and culturally situated privilege and vulnerability. In the research presented here, the level of privilege and vulnerability that we[288] experienced (individually and as a group) was time and 'context-contingent'[289] (Hulko 2009, p. 52) and was moderated by the characteristics that defined us, specifically those of gender, position and occupation. These features rendered us vulnerable and prevented us from feeling powerful enough to address and confront the causes of our oppressions at the intersections where they were most evident (Hulko 2009).

The experience of intersectionality is greater than the experience of divisions themselves (Nash 2008); in my case, as a researcher and midwife, I struggled with my allegiance to the antenatal educators and my consequent anxiety about overt criticism of their positions and actions (I have discussed my intersectionality and positionality on page 117). With regard to the antenatal educators, I perceive their vulnerabilities to be most pronounced at their intersections with medical hierarchy. This point of

[288] I refer to the participating women, antenatal educators and I.

[289] What I mean is that inequality is configured in different ways in accordance with various contexts (McCall 2005).

intersection highlighted their multiple subordinate locations (McCall 2005), which as previously stated, undercut each other, as women, as workers and as 'non-doctor', imbued by knowledge that is typically less valued. These intersections were marked by the ANEs' continued responses to obstetric censure and their deference as employees to a powerful hospital ethos and management (Kirkham 2010a). I had the opportunity to speak with the midwives immediately following the ARC4 meeting between the postnatal mothers and ANEs. I stated very clearly my belief that in order to make effective change in ANE, we would have to challenge and confront the system's inherent routines and practices. While their responses reflected a desire to 'improve' antenatal education, the preservation of intra- and inter-disciplinary relationships in doing so, was stated. In challenging long established, entrenched practices and consequent fear about unsettling relationships, I am reminded of Paulo Freire's (1993 p. 30) suggestion that, 'the oppressed suffer from the duality which has established itself in their innermost being. They discover that without freedom they cannot exist authentically. Yet although they desire authentic existence, they fear it'.

Although our positions of power and vulnerability are actual and concrete, they are also a response to the various ways that we are frequently addressed and perceived (Buitelaar 2006). Antenatal educators have been allocated the unenviable position of transmitting a dominant medical message to women, coupled with expectations of how women are expected to conform during pregnancy and birth. If the discourse or message that the ANEs embody is not welcomed by women in the spaces where women and antenatal educator intersect, the vulnerability experienced by the ANE is augmented. This is evidenced by ANE co-researchers' obvious discomfort when challenged in this research by participating women's evaluation of their classes, with reference specifically to our discussion about episiotomy. It is also visible in their apparent weariness at having to carry a system that endorses a culture of blame and reprimand if actions interfere with the efficient running of the institution (this is discussed on page 197). Notwithstanding this, it is worth considering that difficulties experienced by antenatal educators in exercising agency must be intensified for women who do not have equal status in maternity care. It is important to be aware of the diversity and level of difference within a group and inherent degrees of subordination and inequality (McCall 2005, Yuval-Davis 2006, Nash 2008). Regarding our discussion about episiotomy, those most affected by the women's challenges were the

participating midwives. The dietician and physiotherapists expressed their consolation that they were not directly involved with information-giving of this nature (indeed, they had comparably less combined input to the programme in general) and thus felt that they were absolved from reproach. When I queried this with the physiotherapists and suggested that care of the pelvic floor is within their scope of practice, they agreed, but said that their discussion about episiotomy is with relevance to care of the pelvic floor after birth.

10.7. Contribution to Practice

In his analysis of insider action research,[290] Coghlan (2003) refers to mechanistic-action research in AR or PAR, which focuses on practical outcomes and is distinct from organistic-oriented action research, which is characterised by the inside researcher's personal learning as an essential component of the research inquiry. Mechanistic- and organistic-oriented forms of action research are not mutually exclusive and may be complimentary (Coghlan 2003). Organistic-oriented action can be more difficult to achieve; however, as the nature of learning and reflection tends to expose any underlying assumptions or inherent defensive practice routines (Coghlan 2003). The practical or mechanistic orientated changes that have been achieved as a result of our co-researching efforts are presented below:

- We have altered class format to encompass discussion about practical help and support for women in caring for a new baby. We have also identified resources in communities for women as helpful and include information about community support in classes.
- We have recognised that mothers both experienced and new, provide a vital support system for each other and accordingly, we have brought first-time and other mothers together, for the first time in the history of the research setting, to share their experiences and learning.
- By bringing women and antenatal educators together to analyse antenatal education, we have shared a space that until this research inquiry, had not been achieved in the research setting.

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[290] Insider action research is characterised by researchers undertaking research in the organization in which they work while being a 'complete permanent member' (Coghlan 2003, p. 456).

- We have identified women's needs for developing a podcast of information and optional postnatal class for infant First Aid and resuscitation and we have commenced discussion about how to progress these areas.
- ANE co-researchers have found new ways to reflect, analyse and evaluate their classes and how information and support is offered.
- We have examined and evaluated the written documentation incorporated into classes that prior to our research inquiry was not questioned.
- We have identified and tested ways to increase women's and their partners' participation in class.
- We have explored and tested new strategies to facilitate learning.
- Women have identified the very therapeutic nature of the women's group discussions to share their experiences and the opportunities that this has brought them in developing support and networks of other mothers.
- We have developed a forum where women can question and think through aspects of care.
- We have started the journey towards a theoretical model of antenatal education in preparation for motherhood.

The dominant message of the institution continued to be a prominent feature of classes when I disengaged from fieldwork in November 2011. At that point, we had not successfully challenged the medicalised nature of birth within the institution but had faced it, albeit indirectly. Organistic-oriented action research is characterised by the insider action researcher engaging in a process of personal and professional reflection. To this end, antenatal educators have confirmed that the process of engaging in our inquiry has caused them to examine practice and this has been encouraged also by their use of a personal reflective diary. For the ANE co-researchers, this has resulted albeit briefly, in what I like to consider a changed conceptual perspective, or, another way of seeing, which has caused the antenatal educators to pause, to examine their practices, and to reflect about their activities.

10.8. Contribution to Knowledge

This inquiry demonstrates the complexity of the process of action and change that is set within the confines of a rigidly codified system of maternity care. It illustrates how

change is obstructed or enabled by context, in addition to the ability of those involved to challenge directly organisational constraints. We have illuminated how antenatal educators as active organisational members and insider action researchers, engage with, and refute or subscribe to the dominant working ethos of the institution. Acceptance of change occurs where there is total participation, as distinct from representative participation.[291] In the research presented here, the antenatal educators lacked total participation in the setting because although the research was welcomed, true participation was not facilitated. In other words, any discussions we had were not supported by the organisation; without this support, change could not be implemented. According to Koch and Kralik (2006), PAR offers an outstanding orientation to change; however, this relies on the ability of participants to embrace another way of seeing. Key ANE co-researchers' allegiance to the staunch model of care has made this difficult. Of relevance to researchers and the action research community, discussion and exploration of working through field work and the challenges encountered in incorporating PAR in midwifery and healthcare settings, as an orientation and methodology may be helpful.

10.9. Sustainability of Awareness and Change

In this process, I have found space to observe and to develop awareness of myself as mother, midwife, researcher, and as woman, and where applicable, co-researchers have been invited to do the same. It was anticipated that this research could develop a greater sense of self-awareness of how position and perspective can shape, or be affected by, power relations and generally accepted cultural norms (Taylor and Pettit 2007). Whether changes are sustained beyond the life of this project depend ultimately on the ANE co-researchers' commitment to change, challenge and reflective thinking. According to Maiter *et al.* (2008) reciprocity embodied (manifested through the efforts described to address issues of democracy and participation) throughout the research inquiry has a ripple effect, thereby linking individual and community empowerment. Real change will not come about however, until the ANEs challenge their

[291] Coch and French (1948), as cited by Coghlan (2003, p. 453) describe two relevant approaches in the implementation of change: representative participation and total participation. The research by Coch and French (1948) explored the introduction of change in an institution where there was strong resistance and total participation of group members yielded faster and higher rates of productivity than representative participation (Coghlan 2003).

intersectionality or points of subordination where obstetric hierarchy and ANE meet, to reposition as central, the expressed needs of women, as distinct from the needs of the institution. According to McCall (2005 p. 1791), 'the point is not to assume this outcome a priori but to explore the nature and extent of such differences and inequalities'. This research therefore, attempted to create a space to initiate and sustain open dialogue, which is requisite to acknowledgment of the influence of intersections (Reid and Frisby 2008). Throughout our project, I was working on the basis that co-researchers were co-operating with an understanding and a real sense of dialogic engagement. The distance afforded to me in writing this thesis has increased my awareness of the unequal value placed on the epistemological standpoints of women, and professionals, in a hierarchical medicalised setting. It has also confirmed that the difficulties we experienced were reflective of trying to fit elements of a social model of care into a system embodying an unwavering medical model and how the two are so thoroughly incompatible. I had experienced previously through clinical practice, the effects and constraints of providing services concerned with 'throughput', but I was convinced that the co-researchers and I had developed meaningful and authentic relationships. As it transpired; however, one ANE co-researcher emigrated during the research process without telling me! Now it seems that time and future reports about the research project will reveal the true extent of the sustainability of practical changes beyond my engagement in the field (Koch and Kralik 2006, Maiter *et al.* 2008).

10.10. Implications coming from the Findings of this Research

The findings of this research show that women require the constancy and intensity of a one to one relationship between mother and midwife to protect space for respectful and autonomous discovery in preparation for motherhood. In the absence of continuity of relationship from within the current structure and organisation of maternity services in Ireland, characterised by a fragmented biomedical model of care, antenatal education requires restructuring at all levels to ensure that all carers take full advantage of any opportunity to enable women to be confident mothers. The implications arising from this research therefore, are presented in terms of practice, local and national policy legislation, guidelines and education, and for further research.

10.10.1. Implications for Practice

The findings of this research indicate a requirement for the appointment of a national co-ordinator, specialist practitioner and advocate of ANE, who is passionate about preparation for motherhood and who will co-ordinate innovative learning for facilitators and women. Learning should focus specifically on communication skills and learning to listen, the ability to encourage conversation of relevance and meaning to the woman's particular situational context and an emphasis on truth and transparency in relation to care and care systems. This appointment should be supported and approved by the Minister and Department of Health and Children.

Our research indicates that ANE programmes should be evaluated in the months after birth to ascertain women's degree of confidence in birthing and becoming mothers, and their satisfaction with the learning process and the perceived efficacy of information offered to them in preparation for motherhood.

10.10.2. Implications for policy

A national audit of ANE practices and services is required, as currently, there is no national data base of this sort in Ireland. This research has identified local criteria for an audit of ANE; however, ANE audit should continue on a national scale with the development of working groups characterised by clear aims and focus to identify meaningful criteria for national audit of ANE. Pertinent questions related to an audit of antenatal education practices may be how the aims, goals and processes of ANE are influenced, specifically by local and national context, in addition to the impact of the personal and professional philosophy and orientation of each class facilitator. An example of criteria for audit of the diverse aims of ANE may be identification of whether ANE is biased towards transferring factual information about hospital policy, as distinct from enabling women's practical and decision making skills, with a view to developing confidence in preparation for motherhood. Other questions should focus on the level of training/education and clinical experience of each ANE and how this impacts upon class facilitation and performance. On completion of a national audit, the development and implementation of national guidelines for ANE, fully supported by the Department of Health and Children, are required to assist ANE facilitators in preparing

women for motherhood, with regular review to assess their value. Results of the review should be shared with the national co-ordinator and used to influence the development of guidelines and ANE programmes.

Regulation by Bord Altranais agus Cnáimhseachais na hÉireann (the Nursing and Midwifery Board of Ireland) for Continuing Professional Development for antenatal educators to ensure that information that is shared is evidence based is required, on the premise that limitations in facilitator knowledge and learning be identified and addressed promptly. Education in antenatal class facilitation and the principles of group and adult learning, specifically in terms of self-direction, goal orientation and the effect of life experiences on the learner (Knowles 1984) should be mandatory. A programme of education for facilitators should be accredited with university status; ideally ANE assessment should take place through peer supervision and support, and service user and peer review, in addition to the development and submission of a professional portfolio.

10.10.3. Implications for research:

The aim of this research was to develop antenatal education in preparation for motherhood, based on knowledge created in collaboration with mothers to be, mothers and antenatal educators. The model of ANE discussed in this research should be implemented in the research setting and evaluated by service users and facilitators.

Further research with Antenatal Educators is required to uncover the relationship between practice, local policy and evidence, with a view to building robust and evidenced based programmes of ANE.

Findings of this research are fitting for local context; however, more research is required to explore the influence of antenatal education on women's birthing experiences and preparation for motherhood on a wider, national scale in other hospital and private settings.

Finally, the established term 'Antenatal Education' should be renamed to accrue less emphasis on didactic connotations and replaced with an expression that reflects respect

for women's knowledge and ways of knowing, perhaps that of 'Preparing for Motherhood.'[292]

10.11. Conclusion and Plans for the Future

This thesis has presented the trajectory of an emergent action research design encapsulating intrinsic difficulties and subsequent impact on knowledge that is created in collaboration with mothers to be, mothers and antenatal educators and the extent to which this knowledge can be realised. My concern for the emotional welfare of all co-researchers following exit from fieldwork that has raised this awareness, is moderated by our plans to come together as an entire group (all participating women and antenatal educators). Our aim is to reflect on the research process and to revisit the theoretical model of antenatal education to assess whether, or how, it is feasible to implement the components of Who, What, Why and How, identified as desirable by participating women. And so, our action research cycle continues.

10.12. Epilogue

In this research, women and ANE co-researchers shared their knowledge separately and collectively with a view to developing a framework for antenatal education. Approximately three months following submission of the thesis for examination, I met with three of the Antenatal Educators (two midwives and one physiotherapist) to plan a conversation involving all co-researchers. The ANE co-researchers confirmed that the mechanistic changes that had taken place as described on pages 324-325 of the thesis were still in progress. In addition, ANE co-researchers reported that they had found new ways to reflect, analyse and evaluate their practices, specifically in relation to how they offered information and supported women and their partners. According to the ANEs, participating in this research highlighted areas for practice development and regular team meetings now took place to discuss areas for potential change. ANEs were disseminating questionnaires to class attendees to seek information about satisfaction with classes, timing, frequency, length and process, and content, in addition to questions inviting comment about whether classes were enjoyable, interesting or helpful. This was with a view to analysing and evaluating their professional performances and identifying suggestions for progress. According to the ANEs, results of their surveys to

[292] Preparing for Parenthood could include male partners

date reflected an aspect of the findings of our research together, that women need more information during pregnancy about life after birth. Class documentation had been amended in response to women's requests about baby care.

Overall, the ANEs described being 'more mindful' about the impact on women of taking their babies home. This mindfulness was reflected in their orientations and actions and evidenced by their restructuring of a class that was timetabled traditionally to convey the institutional philosophy of managing labour and birth, to allow for more satisfying discussions for women about motherhood. Pregnant women continue to join postnatal mothers in the postnatal class and the impact of the support of other mothers is acknowledged by engaging postnatal women in ANE to share their experiences as new mothers. Discussion about the development of a hospital based podcast of information relevant to pregnancy, birth and motherhood and the introduction of an optional postnatal class for infant First Aid and Neonatal Resuscitation has commenced.

My experience of this visit prompted me to reflect about sustainability, in terms of the capacity for change to continue, and how in this instance, conceptual change progressed when I, in my role of outsider/ researcher, left the field. It occurred to me that perhaps the ANE co-researchers needed space from the research and my influence, to develop their knowledge and ways of knowing, in order to experience real ownership.

We plan to progress our action research inquiry by meeting with the Director of Midwifery to share our research findings, with a view to the continuing development of antenatal education in the research setting. We also plan to meet with the women co-researchers again in hope that we can continue our conversations.

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APPENDICES

Appendix 1

A Typology of Participation: How People Participate in Development Programs and Projects

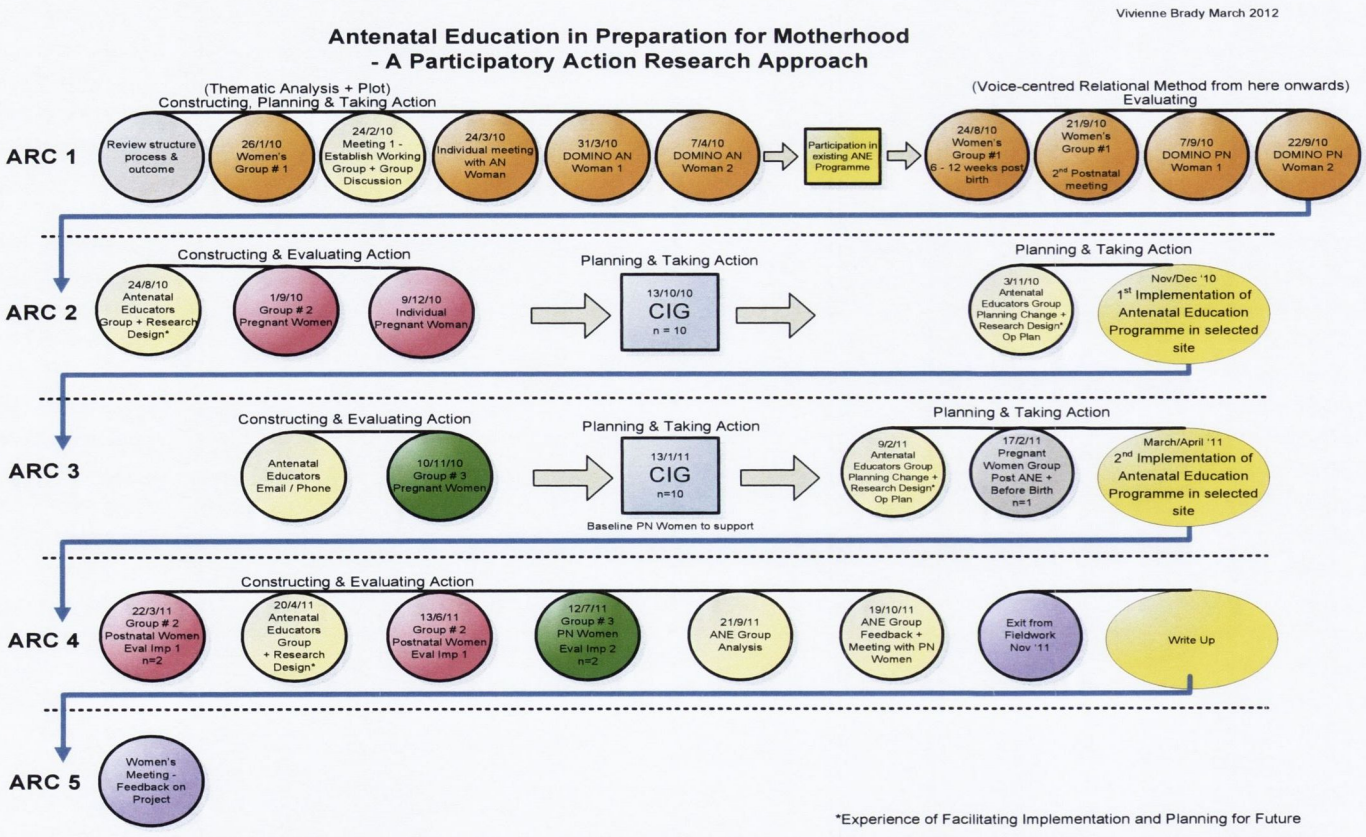
Typology	Characteristics of each type
1) Manipulative Participation	Participation is simply a pretence, with "people's" representatives on official boards but who are unelected and have no power.
2) Passive participation	People participate by being told what has been decided or has already happened. It involves unilateral announcements by an administration or project management without any listening to people's responses.
3) Participation by Consultation	The information being shared belongs only to external professionals. People participate by being consulted or by answering questions. External agents define problems and information gathering processes, and so control analysis. Such a consultative process does not concede any share in decision making, and professionals are under no obligation to take on board people's views.
4) Participation for material incentives	People participate by contributing resources, for example, labor, in return for food, cash or other material incentives. Farmers may provide the fields and labor, but are involved in neither experimentation nor the process of learning. It is very common to see this called participation, yet people have no stake in prolonging technologies or practices when the incentives end.

5) Functional Participation	Participation seen by external agencies as a means to achieve project goals, especially reduced costs. People may participate by forming groups to meet predetermined objectives related to the project. Such involvement may be interactive and involve shared decision making, but tends to arise only after major decisions have already been made by external agents. At worst, local people may still only be co-opted to serve external goals.
6) Interactive Participation	People participate in joint analysis, development of action plans and formation or strengthening of local institutions. Participation is seen as a right, not just the means to achieve project goals. The process involves interdisciplinary methodologies that seek multiple perspectives and make use of systemic and structured learning processes. As groups take control over local decisions and determine how available resources are used, so they have a stake in maintaining structures or practices
7) Self-mobilization	People participate by taking initiatives independently of external institutions to change systems. They develop contacts with external institutions for resources and technical advice they need, but retain control over how resources are used. Self-mobilization can spread if governments and NGOs provide an enabling framework of support. Such self-initiated mobilization may or may not challenge existing distributions of wealth and power.

Source: adapted from Pretty (1995), Sattetthwaite (1995), Adnan, Alam and Brustnow (1992) and Hart (1992), in Pretty (1995).

Appendix 2

The Action Research Cycle



Adapted from Coghlan, D. and Brannick, T. (2010) *Doing Action Research in Your Own Organisation*. 3rd edn. London: Sage Publications

Appendix 3

Demographic Questionnaire to Ascertain the Characteristics of Women Co-Researchers

Antenatal Education in Preparation for Motherhood–An Action Research Approach
Thank you for agreeing to take part in this study and for completing this short questionnaire.

Please do not write your name on the page.

The questions can be answered by putting a tick in the box next to the answer that applies to you.

Q 1	How many weeks pregnant are you? Write the number of weeks in the box ☐ Don't know ☐
Q 2	What is your age group? *(Please tick <u>one</u> box only)* Less than 20 years ☐ 20 - 29 years ☐ 30 - 39 years ☐ 39 years + ☐
Q 3	Which clinic do you attend? *(Please tick <u>one</u> box only)* Public ☐ Private ☐ Semi private ☐ Midwives' clinic ☐ Domino ☐ Home birth ☐

Antenatal Education in Preparation for Motherhood – An Action Research Approach

Thank you for agreeing to take part in this study and for completing this short questionnaire.

Please do not write your name on the page.

The questions can be answered by putting a tick in the box next to the answer that applies to you.

Q 4 Where did you hear about antenatal classes?

(Please tick all that apply)

Midwife	☐
Family doctor / GP	☐
Friend	☐
Family	☐
Public Health Nurse	☐
Advertising	☐
Other	☐→ (please describe below)

.....

Q 5 Do you live alone?

(Please tick yes or no)

Yes	☐
No	☐

Q 6 What is your nationality?

(Please state below)

.....

Antenatal Education in Preparation for Motherhood–An Action Research Approach

Thank you for agreeing to take part in this study and for completing this short questionnaire.

Please do not write your name on the page.

The questions can be answered by putting a tick in the box next to the answer that applies to you.

Q7 Who is your main support person?

(Please tick all that apply)

- Partner ☐
- Mother ☐
- Sister ☐
- Friend ☐
- Other family member ☐
- Other ☐→ (please describe below)

.....

Q8 How often would you see your main support person?

(Please tick <u>one</u> box only)

- Daily ☐
- 2 - 3 times weekly ☐
- Once a week ☐
- Once a month ☐
- Other ☐→ (please describe below)

.....

Q9 Are you?

(Please tick <u>one</u> box only)

- Married ☐
- Single ☐
- Separated ☐
- Divorced ☐
- Widowed ☐
- Other ☐→ (please describe below)

.....

Appendix 4

Flexible Prompt Guide for Pregnant Women's Conversation

ARC 3 First Antenatal Group Meeting with Women

One very important thing that I would really like to say is that there is no right or wrong answer. This is really a conversation about thoughts and impressions. As you know, I am gathering information about preparation for first time motherhood and I am interested in your needs and expectations. There are areas that I would like to explore; however, I'd really like to understand your views and feelings so please add anything you wish at any time.

- Can you recall your thoughts when you found out you were pregnant?
- Did you/ do you have any expectations about pregnancy, birth or motherhood?
- How would you describe the experience of being pregnant?
- Have you tried to find out about the pregnancy? What do you need to know?
- Do you have any idea how your closest friends and relatives found information about pregnancy, birth and labour?
- What have you tried to learn thus far and how?
- What do you think antenatal education is about?
- Why choose classes here in the hospital?
- What do you think birth will be like?
- Have you ever held or cared for a new born baby?
- Do you think having a baby will make a difference to your life?
- Have you thought about becoming a mother?
- Is there anything else that you would like to add?
- How does it feel to talk through these issues now?

Appendix 5

Flexible Prompt Guide for Postnatal Women's Conversation

ARC 1 First Postnatal Group Meeting with Women

Congratulations on becoming a mother!

One very important thing that I would really like to say is that there is no right or wrong answer. This is really a conversation about thoughts and impressions. As you know, I am gathering information about preparation for first time motherhood and I am interested in your needs and expectations. There are areas that I would like to explore; however, I'd really like to understand your views and feelings so please add anything you wish at any time. The last time we met, you were expecting your babies. Is there anything that you would like to say about that meeting or would you like to share any thoughts or reflections you have had since then? (Transcripts also)

- How have you felt since the birth?
- Can you describe how you felt in the early days after the birth of your baby?
- Can you describe your day now?
- What things are different about your life now than before your baby was born?
- What, if anything, is different about yourself since you became a mother? Do you see yourself differently?
- How would you describe your feelings as you look ahead?
- Who do you turn to for help and support?
- Can you tell me about your experiences of antenatal classes?
- Looking back, now that your baby is born, what aspect(s) of classes did you find most useful to help you prepare for pregnancy, birth and motherhood?
- What aspect(s) did you find least useful?
- Looking back over the time since you found out you were to become a mother, what is the most significant change that has taken place in your life?
- How does it feel to talk through these issues now?

Appendix 6

Consent Form for Transcription

Developing an Antenatal Education Model in Preparation for Motherhood – A Participatory Action Research Approach

Re: Transcription

The group meetings will be audio taped and transcribed in full. You can get a copy of the transcript if you wish. ***Transcripts will be distributed only with written permission from all group participants.***

Declaration

I have read and understood the above. I freely give permission for distribution of transcripts of the meeting to members of the group.

Your signature: _____ **Date:** _____

Contact details

Phone: _____ E-mail: _____

Researcher's Signature: _____**Date:**_____

Appendix 7

Plan for Collaborative Inquiry Group Meetings

Plan for CIG2 13th January 2011

Ground Rules (relevant specifically to CIGs when antenatal educators and women mix)

- Be good listeners without judging others
- Support and inclusion of everyone in the group is very important
- One person speaks at a time
- Be mindful that other people who want to speak should have the opportunity to do so
- Ensure privacy of group members (what is said in the group stays in the group)

(Koch and Kralik 2006, p.106)

Plan:

Look, Think, Act Model (Stringer 2007).

LOOK

Distribute summaries/ original readings from women's group ARC3.

THINK

What can we do about this?

ACT

How can we move forward?

What do we agree on?

Prompts

What are the common assumptions about Antenatal Education?

What are the common sense notions?

What is it like? (Koch 1993)

What matters? (Koch 1993)

(Koch and Kralik 2006, p. 148)

What has the experience of participating in this discussion been like for you?

Appendix 8

Contribution of Women Co-researchers and ANE Co-researchers to the Research Design

- At each meeting, participating women were invited to comment on the research process and design.

- Women co-researchers were invited to share their experiences of participating in conversations. In doing this, I requested also that they make suggestions for a more meaningful or relevant way to elicit their views, with the exception of one woman who suggested an online survey, all agreed that the research conversations afforded space to articulate their needs and experiences, which they confirmed were intensely valuable and therapeutic.

- At the request of ANE co-researchers, the ARC3 PN women co-researchers were invited to meet ANE co-researchers for a second conversation when their babies were older. This request emerged from our discussions about the CIG2 conversations in the ARC3 operational plan meeting on the 9th February 2011. Of the five women, four were contacted because one woman was not available and two women; W1 (baby 8 months) and W4 (baby 6 months) participated.[293]

- ANE co-researchers requested that I meet women who had completed classes and before birth. This request emerged from concerns of inadequate representation of women participating in the research. Thirty packs were distributed and one woman participated in an individual research conversation. My interpretation of the main messages of that meeting was shared with the woman co-researcher (in addition to the transcript) and the ANE co-researchers.

- Women co-researchers and ANE co-researchers prioritised issues of concern and relevance related to ANE and preparation for birth and motherhood. Apart from

[293] Of the remaining ARC3 PN women, one woman had emigrated, another woman had relocated and the third shared that she had postnatal depression.

the use of a prompt guide where necessary, there was no preconceived agenda for meetings.

- ANE co-researchers participated in group analysis of a section of transcript using VCRM.

Appendix 9

Letter to Director of Midwifery Requesting Access to Conduct Research in Hospital B

Ms.
Director of Midwifery

Ms. Vivienne Brady
School of Nursing and Midwifery
Trinity College Dublin
24, D'Olier Street
Dublin 1
Tel: (01) 896 4076
Email: vibrady@tcd.ie

4th July 2008

RE: Developing an Antenatal Education Model in Preparation for Motherhood – A Participatory Action Research Approach.

Dear,

Further to our meeting last week, I am writing with regard to the above research study I am undertaking to fulfil a PhD with the School of Nursing and Midwifery, Trinity College, Dublin.

The aim of this research is to develop a hospital-based programme of antenatal education that is informed by collaboration with women and antenatal educators, in order to promote public involvement in, and ownership of the process.

I have been awarded a Clinical Research Training Fellowship in Midwifery with the Health Research Board, commencing in October 2008, which will enable me to undertake this work in a full time capacity. In addition, this research has been approved by the Faculty of Health Sciences, Trinity College Dublin.

I am seeking your support to invite your team of antenatal educators (midwives, physiotherapists and dieticians) and women attending the (Name) Hospital, to participate in this research. The research will be conducted concurrently at a second maternity hospital in Ireland also.

I enclose my research proposal for your information and I would be delighted to meet with you at any time to discuss this further. As we discussed, it is my intention to apply to the July meeting of the (hospital) Research and Ethics Committee.

Many thanks for your anticipated support in this regard.

With best wishes,

Yours sincerely,

_____

Vivienne Brady

PhD. Student/ Research Assistant.

Appendix 10

Consent Form for ANE Co-Researchers to Participate in the Research

Consent Form

To take part in a study to develop a programme of antenatal education[294]

We wish to conduct a research study to develop a programme of antenatal education. The programme will be based on collaboration between women and antenatal educators in your hospital and you are invited to take part.

Taking part in the study

1. You should be willing to discuss your views about antenatal classes.
2. You should have experience in the area of antenatal education in a maternity hospital in the Republic of Ireland.
3. You and the antenatal education team will need to participate in three group meetings with women who plan to attend/have attended classes at your hospital.

- The first meeting will take place before classes start so that you can share your views of the aims and desired outcomes of antenatal education.
- The second group meeting will take place with a group of pregnant women prior to classes and some new mothers who have attended classes at your hospital. Together you can develop ideas for antenatal education, which will influence the antenatal education programme that is developed.
- The third group meeting will focus on your experiences of facilitating a programme of antenatal education.
- You should be willing to be involved in facilitating the antenatal education programme that develops as a result of the discussions that you take part in.

[294] REforM: (Researching Education for Motherhood)

Benefits

This research will provide a unique opportunity for women and antenatal educators to develop antenatal education together to prepare women for motherhood.

Risks

We do not anticipate any physical risks in taking part in this study.

Your information and confidentiality

The group meetings will be audio taped and transcribed in full. You can get a copy of the transcript if you wish. ***Transcripts will be distributed only with written permission from all group participants.***
No one, other than the transcriber and the researcher will hear the audiotape. The research supervisor will see the transcript only.

The information you give will be used for research only. The information will be held on a laptop that is password protected. The research may be published or presented at conferences in the future, but at all times we will protect your confidentiality. We will not reveal your name to anyone outside the study group or allow it to appear in any documents. Nor will we reveal any information that could give away your identity. The study involves the participants working closely with the researcher; therefore, it is likely that staff in the hospital in which you work will be aware of the fact that a study is underway in your department. Your name will not be released; however, you are free to discuss your involvement in the research with colleagues if you wish.

Joining or leaving the study

You have volunteered to participate in this study. You may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and you will not have to give up any benefits that you had before entering the study.

If you wish to take part, please sign and complete the details in this consent form when you have read it carefully and return it to me in the stamped addressed envelope provided. Please also sign and keep a copy for yourself.

Further information

If you have any questions or concerns about taking part in this research, please feel free to contact me, Vivienne Brady, at **086 222 9674**.

Thank you for agreeing to participate in this research.

Declaration

I have read and understood this consent form. I freely agree to be part of this research study.

Your signature: _____ **Date:**_____

Contact details

Phone: _____ E-mail: _____

Researcher's Signature: _____**Date:**_____

Appendix 11

Information Sheet for ANE Co-Researchers to Participate in the Research

Information Sheet

A study to develop a programme of antenatal education

What we are doing

We are currently carrying out a study to develop an antenatal education programme.[295] The aim of the study is

- To develop a programme of antenatal education by consulting with women and antenatal educators (midwives, physiotherapists and dieticians).
- To ensure that maternity services meet the needs of women as they prepare for motherhood.

The study is taking place in this maternity hospital and one other maternity hospital in Ireland.

What we are asking you to do

We would like you to take part in six group discussions with other antenatal educators in the hospital and with women in order to share your views and to contribute to developing antenatal classes. You will also be invited to take part in one final group discussion with me. Discussions will take place over a period of approximately 22 months.

1. The first focus group discussion will take place with the antenatal education team to discuss your views on the aims and desired outcomes of antenatal education.
2. The second focus group discussion will take place with pregnant and postnatal women to work together to develop ideas for an antenatal education programme.
3. You and the antenatal education team will have the opportunity to implement any agreed changes/ideas to the antenatal education programme in your maternity hospital. This will require motivation and support, which will be provided by the researcher and the hospital.

---

[295] The full name of the study is: Developing an Antenatal Education Model in Preparation for Motherhood – A Participatory Action Research Approach

4. The third focus group will provide an opportunity for you, with the antenatal education team, to evaluate the revised antenatal education programme by discussing your views of facilitating the programme.

To develop a programme of antenatal education, this entire process will be repeated three times.

Benefits

This research will provide a unique opportunity for women and antenatal educators to work together to develop antenatal education to prepare women for motherhood.

Risks

We do not anticipate any risks in taking part in this study.

Exclusion from the study

You cannot take part in this study if you:

- Are not willing to share your views and experiences in relation to antenatal education.
- Are not a midwife with a minimum of 6 months experience in the area of antenatal education in a public maternity care hospital in the Republic of Ireland.
- Are not a physiotherapist or dietician involved in the provision of antenatal education in a public maternity care hospital in the Republic of Ireland.

Your information and confidentiality

If you take part in the study, the information you give will be used for research only. The research may be published or presented at conferences in the future, but at all times we will protect your confidentiality. We will not reveal your name to anyone outside the study group or allow it to appear in any documents. Nor will we reveal any information that could give away your identity. ***Only coded information will be held on a laptop, your personal details will not be held.*** The study involves the participants working closely with the researcher; therefore, it is likely that staff in the hospital will be aware of the fact that a study is underway in your department. Access and ethical approval to conduct the study has been received from the Faculty of Health Sciences Research Ethics Group, Trinity College Dublin and the Research and Ethics Committee of (hospital).

Joining or leaving the study

It is your choice to take part in this study and you can change your mind at any time. If you would like to take part in this study, please keep this information sheet. Please also sign the attached consent form and return it to me with your contact details in the stamped addressed envelope provided.

If you do not want to take part for any reason you can withdraw at any time. If you decide not to participate, or you withdraw, you will not be penalised and you will not have to give up any benefits that you had before entering the study.

Further information

If you have any questions or concerns, please feel free to contact me, Vivienne Brady, at **086 222 9674**.

Thank you.

Appendix 12

Consent Form for Women Co-Researchers to Participate in the Research

Consent Form

To take part in a study to develop antenatal education classes

We wish to conduct a research study to develop antenatal education classes. You can take part by sharing your views about antenatal education classes with other women and with antenatal educators (midwives, physiotherapists and dieticians).

Taking part in the study

1. You should be willing to discuss your views about antenatal classes and be interested in attending antenatal classes at this hospital.
2. You will need to take part in two group meetings with other women who also plan to attend hospital classes.
    - The first meeting will take place during your pregnancy before the classes start; you will be able to share your expectations of antenatal classes and any of your needs in preparation for motherhood.
    - The second group meeting, when your baby is about 12 weeks old, will focus on becoming a mother and the possible impact of antenatal classes on your experience.
3. If you enjoy taking part in the study and you would like to contribute to developing antenatal education, you will be invited to take part in a third discussion with the hospital team and another group of pregnant women. This will take place within three months of the second group meeting.

Benefits

This research will provide a unique opportunity for women and antenatal educators to develop antenatal education together to prepare women for motherhood.

Risks

We do not anticipate any risks in taking part in this study.

Your information and confidentiality

The group meetings will be audio taped and transcribed in full. You can get a copy of the transcript if you wish. No one, other than the transcriber and the researcher will hear the audiotape. The research supervisor will see the transcript only.

The information you give will be used for research only. The research may be published or presented at conferences in the future, but at all times we will protect your confidentiality. We will not reveal your name to anyone outside the study group or allow it to appear in any documents. Nor will we reveal any other personal information that could give away your identity.

Joining or leaving the study

You have volunteered to take part in this study. You can withdraw at any time. If you decide not to take part, or if you withdraw, you will not be penalised and you will not have to give up any benefits that you had before entering the study.

If you wish to take part, please sign and complete the details in this consent form when you have read it carefully, and contact the researcher, Vivienne Brady at **086 222 9674**. Please also sign and keep a copy of the form for yourself.

Further information

If you have any questions or concerns about participating in this research, please feel free to contact me, Vivienne Brady, at **086 222 9674.**

Thank you for agreeing to participate in this research.

P.T.O.

Declaration:

I have read and understood this consent form. I freely agree to be part of this research study.

Your signature: _____ **Date:** _____

Contact details

Phone: _____ E-mail: _____

Appendix 13

Information Sheet for Women Co-Researchers to Participate in the Research

Information Sheet

A study to develop antenatal education classes

What we are doing

We are currently carrying out a study to develop antenatal education classes.

The study is taking place in this maternity hospital and one other maternity hospital in Ireland.

What we are asking you to do

To help with the study, we would like you to take part in the antenatal classes that are offered at this maternity hospital as part of your maternity care. We would also like you to take part in two discussions with other women, to share your views about the appropriate content of antenatal classes and how the classes should be facilitated.

- The first group discussion will take place here in the hospital with other pregnant women, before you start ante-natal classes during your pregnancy.
- The second discussion will take place with the same women about 12 weeks after the birth of your baby.

Each group discussion will take about one hour, and the two discussions will take place over a period of about seven months. We will provide light refreshments. You are welcome to bring your baby with you to the post-natal discussion.

If you enjoy taking part in the study and would like to contribute to developing antenatal education with other women, we will invite you to take part in a third discussion with the hospital team and another group of pregnant women. This discussion will take place within three months of the second group meeting.

Benefits

This research will provide a unique opportunity for women and antenatal educators to develop antenatal education together to prepare women for motherhood.

Risks

We do not anticipate any risks in taking part in this study.

Excluding certain women from the study

You cannot take part in this study if:

- You do not speak English,
- You are less than 18 years of age.

Your information and confidentiality

If you take part in the study, the information you give will be used for research only. The research may be published or presented at conferences in the future, but at all times we will protect your confidentiality. We will not reveal your name to anyone outside the study group or allow it to appear in any documents. Nor will we reveal any information that could give away your identity.

Joining or leaving the study

It is your choice to take part in this study and you can change your mind at any time. If you would like to take part in this study, please keep this information sheet. Please also sign the attached consent form and contact the researcher, Vivienne Brady on **086 222 9674**.

If you do not want to take part for any reason you can withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and you will not have to give up any benefits that you had before entering the study.

Further information

If you have any questions or concerns, please feel free to contact me, Vivienne Brady, at **086 222 9674**. Thank you.

Appendix 14 Overview of Women Co-researchers, their Characteristics and their Levels of Participation

ARC	Code	Gestation (to nearest week)	Age Group (Years)	Care	Heard about ANE	Live alone	Nationality	Main Support Person	AN	CIG	PN
I	W1	21	30-39	SPC	Nurse	No	Irish	Husband	√	-	√
I	W2	18	30-39	SPC	Early Pregnancy Class	No	Irish	Husband	√	-	√(2)
I	W3	34	30-39	Public	Midwife	No	Irish	Partner	√	-	-
I	W4	23	30-39	Private	Hospital Information Evening	No	Irish	Husband	√	-	√
I	W5*	25	30-39	Public	Midwife	No	Irish	Partner	√	-	-
I	D1*	32	30-39	DOMINO	Midwife	No	Irish	Partner	√	-	√
I	D2*	30	30-39	DOMINO	Midwife, Friend, PHN	No	Irish	Partner	√	-	√
II	W6	24	30-39	SPC	Midwife	No	Irish	Husband	√	√	√
II	W7	26	30-39	DOMINO	Midwives Clinic	No	Irish	Husband	√	√	√
II	W8	34	30-39	Midwife	Waiting in Clinic	No	American/ Irish	Husband	√	-	-
II	W9	21	20-29	Public	Hospital Brochure	No	Irish	Husband	√	√	√
II	W10	32	30-39	Public	Midwife	No	Irish	Husband	√	-	√
III	W11	26	39+	SPC	Midwife	No	British	Partner	√	√	√
III	W12	25	30-39	SPC	Advertisement	No	Irish	Husband	√	-	-
III	W13	29	30-39	Public	Website	No	Mexican/American	Husband	√	√	-
III	W14	20	30-39	Private	Consultant	No	Irish	Husband	√	√	√
III	W15	20	20-29	Public	Midwife	No	Paraguayan	Husband	√	-	-
III	W16*	24	30-39	Private	Consultant	No	Irish	Husband	√	-	-
III	W17**	37	20-29	SPC	Midwife	No	Irish	Husband	√	-	-

*Individual meeting**Individual meeting before birth and on completion of classes.

Appendix 15

Consent for Women Co-Researchers to Participate in the Research (ARC2 Onwards)

Consent Form

To take part in a study to develop antenatal education[296]

We wish to conduct a research study to develop antenatal education classes. You can take part by sharing your views about antenatal education classes with other women and with antenatal educators (midwives and physiotherapists).

Taking part in the study

1. You should be willing to discuss your views about antenatal classes and to take part in a new programme of classes at this hospital that are developed from your participation in the group discussions.
2. You will need to participate in three group meetings with other pregnant women who also plan to attend hospital classes.
   - The first meeting, before the classes start, will take place during your pregnancy so you can share your expectations of antenatal classes and any of your needs in preparation for motherhood.
   - The second group meeting will take place approximately one month after the first meeting. The hospital antenatal education team will join your group, as will some new mothers. Together you can develop ideas for antenatal education, which will influence the programme you attend.
   - The third group meeting, which will take place when your baby is approximately 12 weeks old, will focus on becoming a mother and the possible impact of antenatal classes on your experience.
3. If you enjoy taking part in the study and would like to contribute to developing antenatal education with other women, you will be invited to participate in one further discussion with the hospital team and other mothers. This will take place within three months of the third group meeting.

[296] The full name of the study is: Developing an Antenatal Education Model in Preparation for Motherhood – A Participatory Action Research Approach

Benefits

This research will provide a unique opportunity for women and antenatal educators to develop antenatal education together to prepare women for motherhood.

Risks

We do not anticipate any physical risks in taking part in this study.

Your information and confidentiality

The group meetings will be audio taped and transcribed in full. You can get a copy of the transcript if you wish. Transcripts will not be distributed without your written permission. No one, other than the transcriber and the researcher will hear the audiotape. The research supervisor will see the transcript only.

The information you give will be used for research only. The research may be published or presented at conferences in the future, but at all times we will protect your confidentiality. We will not reveal your name to anyone outside the study group or allow it to appear in any documents. Nor will we reveal any information that could give away your identity.

Joining or leaving the study

You have volunteered to participate in this study. You may withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and you will not have to give up any benefits that you had before entering the study.

If you wish to take part, please read the consent form carefully and contact the researcher, Vivienne Brady at 086 222 9674.

Further information

If you have any questions or concerns about taking part in this research, please feel free to contact me, Vivienne Brady, at **086 222 9674**.

Thank you for agreeing to participate in this research.

Declaration

I have read and understood this consent form. I freely agree to be part of this research study.

Your signature: _____ **Date**_____

Contact details

Phone: _____ E-mail: _____

Researcher's Signature: _____ **Date:** _____

Appendix 16

Information Sheet for ANE Co-Researchers to participate in the Research (ARC2 onwards)

Information sheet

A study to develop antenatal education

What we are doing

We are currently carrying out a study to develop antenatal education classes[297]. The aim of the study is

- To develop antenatal education by consulting with antenatal educators (midwives and physiotherapists) and women like you, and
- To ensure that maternity services meet the needs of women as they prepare for motherhood.

The study is taking place in this maternity hospital and one other maternity hospital in Ireland.

What we are asking you to do

We would like you to take part in three group discussions with other pregnant women and hospital staff to share your views and to help us to develop antenatal classes.

- The first group discussion will take place here in the hospital during your pregnancy with other pregnant women.
- The second discussion will take place in the hospital with the same women approximately one month after the first meeting. The hospital antenatal education team and some new mothers will join you for this group discussion.
- The third discussion will take place with the same group of women about 12 weeks after the birth of your baby.
- You may be invited to meet with the antenatal educators and other mothers after birth

[297] The full name of the study is: Developing an Antenatal Education Model in Preparation for Motherhood – A Participatory Action Research Approach

Each group discussion will take approximately one hour and we will provide light refreshments. You are welcome to bring your baby to the post-natal (after birth) discussion if you wish.

You will have the opportunity during your pregnancy to take part in the antenatal education classes that develop as a result of your participation in the group discussions. You can share your experiences of the classes and whether they helped you to adjust to motherhood at the final group discussion after your baby is born.

Benefits

This research will provide a unique opportunity for women and antenatal educators to work together to develop antenatal education to prepare women for motherhood.

Risks

We do not anticipate any risks in taking part in this study.

Excluding certain women from the study

You cannot take part in this study if:

- You do not speak English,
- You are less than 18 years of age

Your information and confidentiality

If you take part in the study, the information you give will be used for research only. The information will be held on a laptop that is password protected. The research may be published or presented at conferences in the future, but at all times we will protect your confidentiality. We will not reveal your name to anyone outside the study group or allow it to appear in any documents. Nor will we reveal any information that could give away your identity.

Joining or leaving the study

It is your choice to take part in this study and you can change your mind at any time. **If you would like to take part in this study, please keep this information sheet and contact the researcher, Vivienne Brady at 086 222 9674**.

If you do not want to take part for any reason you can withdraw at any time. If you decide not to participate, or if you withdraw, you will not be penalised and you will not have to give up any benefits that you had before entering the study.

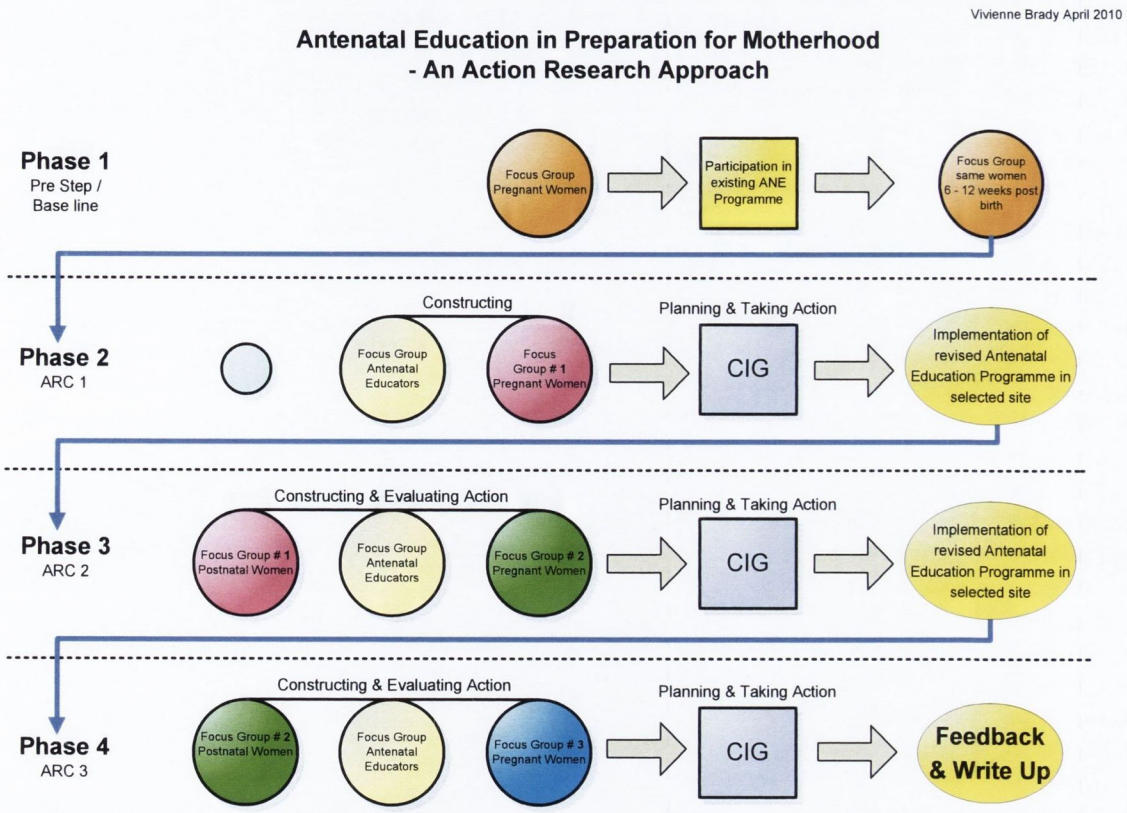
Further information

If you have any questions or concerns, please feel free to contact me, the researcher, Vivienne Brady, at **086 222 9674**.

Thank you.

Appendix 17

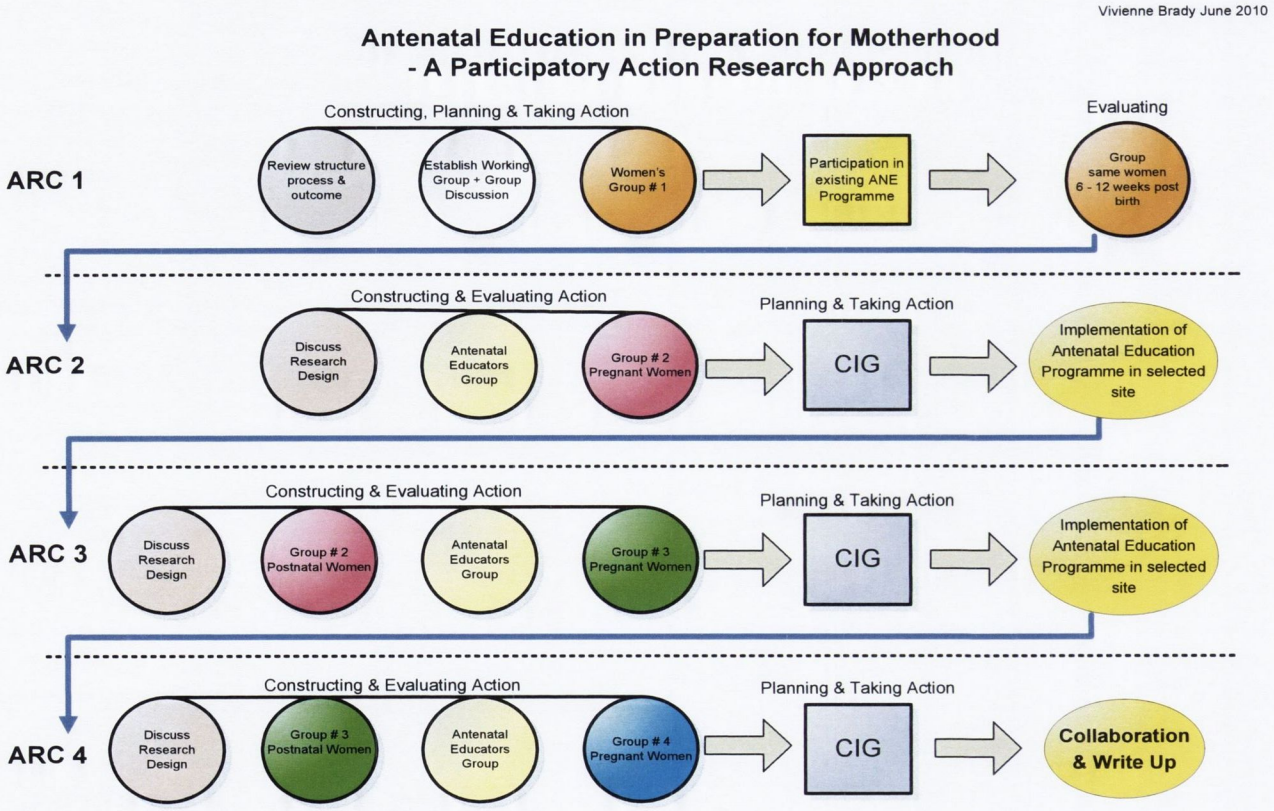
Action Research Cycle April 2010



Adapted from Coghlan, D. and Brannick, T. (2010) Doing Action Research in Your Own Organisation. 3rd edn. London: Sage Publications

Appendix 18

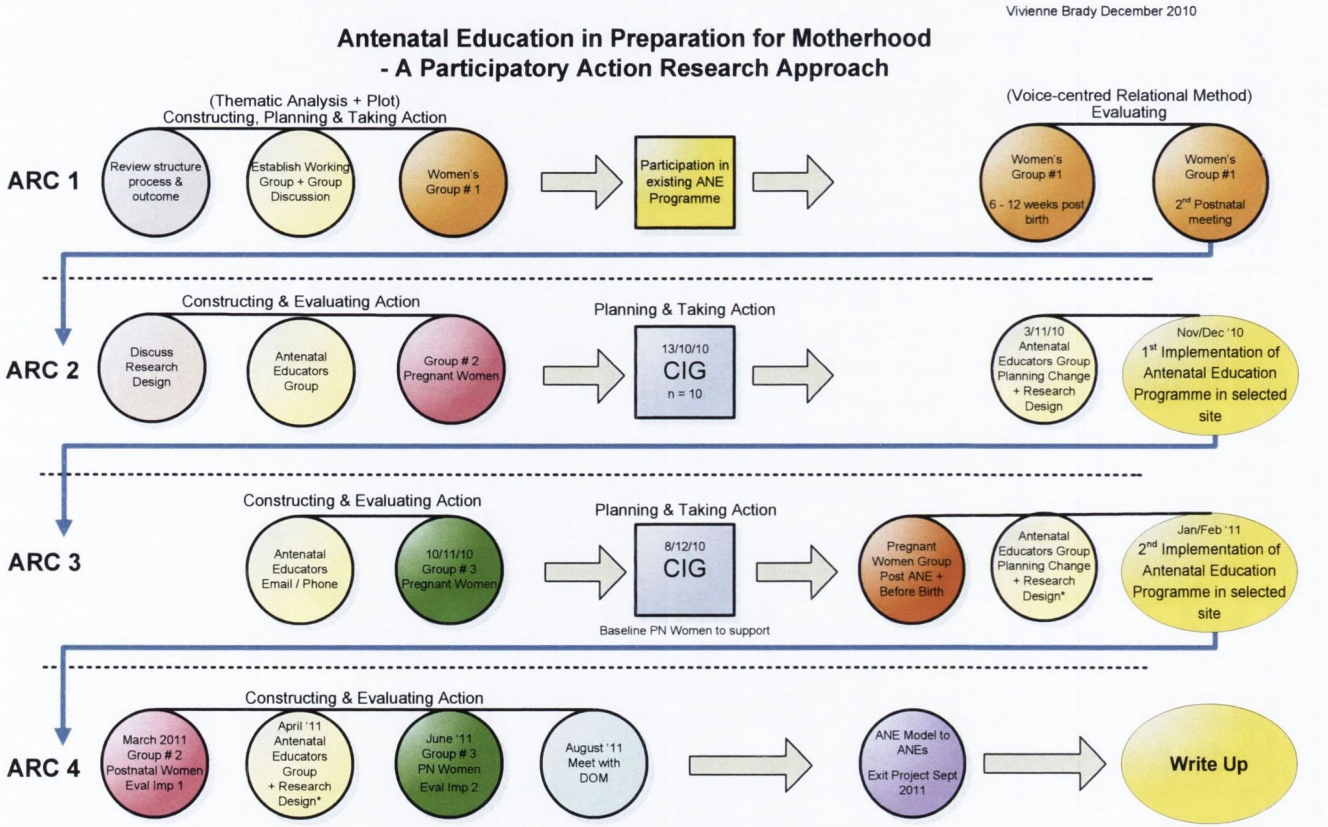
Action Research Cycle June 2010



Adapted from Coghlan, D. and Brannick, T. (2010) Doing Action Research in Your Own Organisation. 3rd edn. London: Sage Publications

Appendix 19

Action Research Cycle December 2010

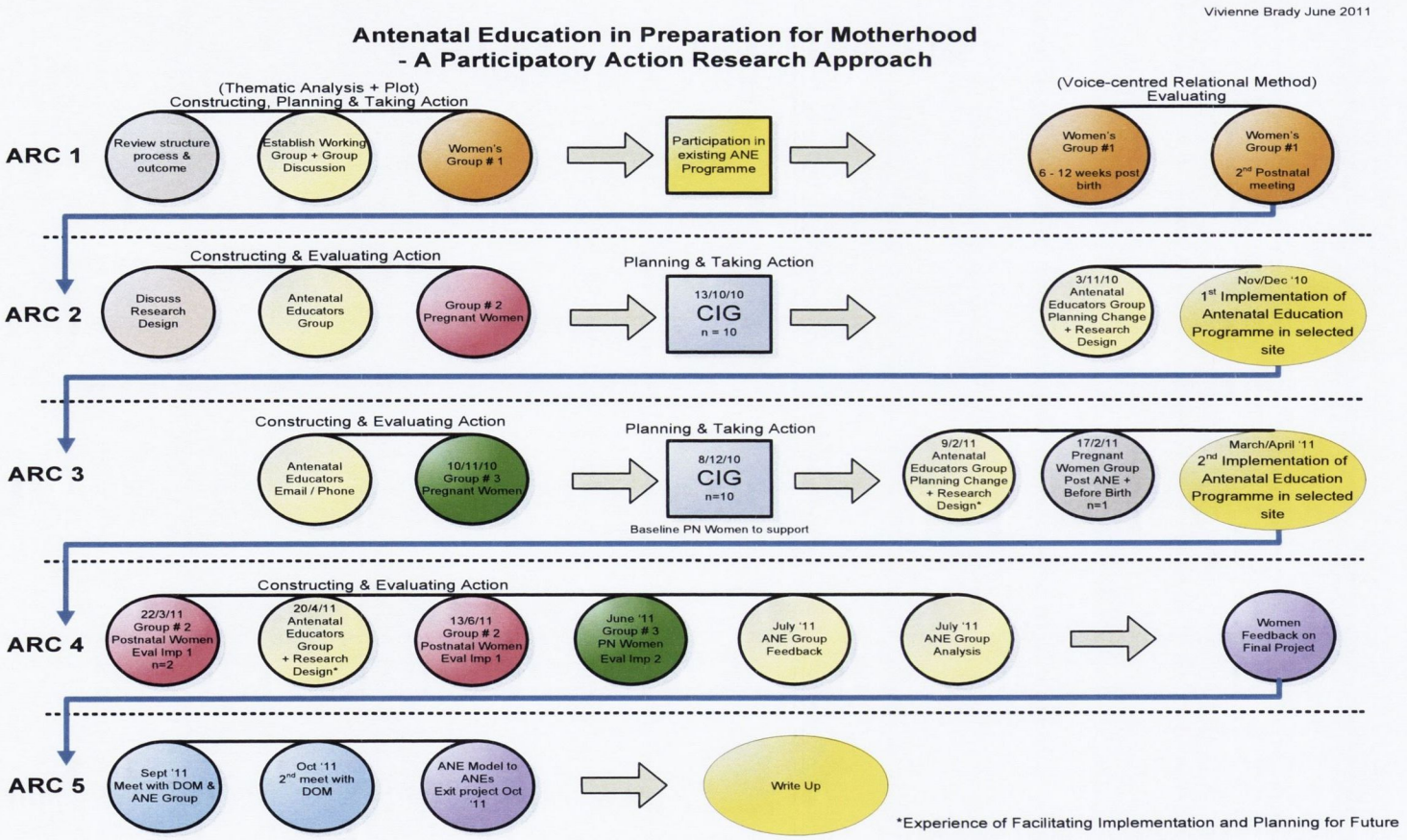


*Experience of Facilitating Implementation and Planning for Future

Adapted from Coghlan, D. and Brannick, T. (2010) Doing Action Research in Your Own Organisation. 3rd edn. London: Sage Publications

Appendix 20

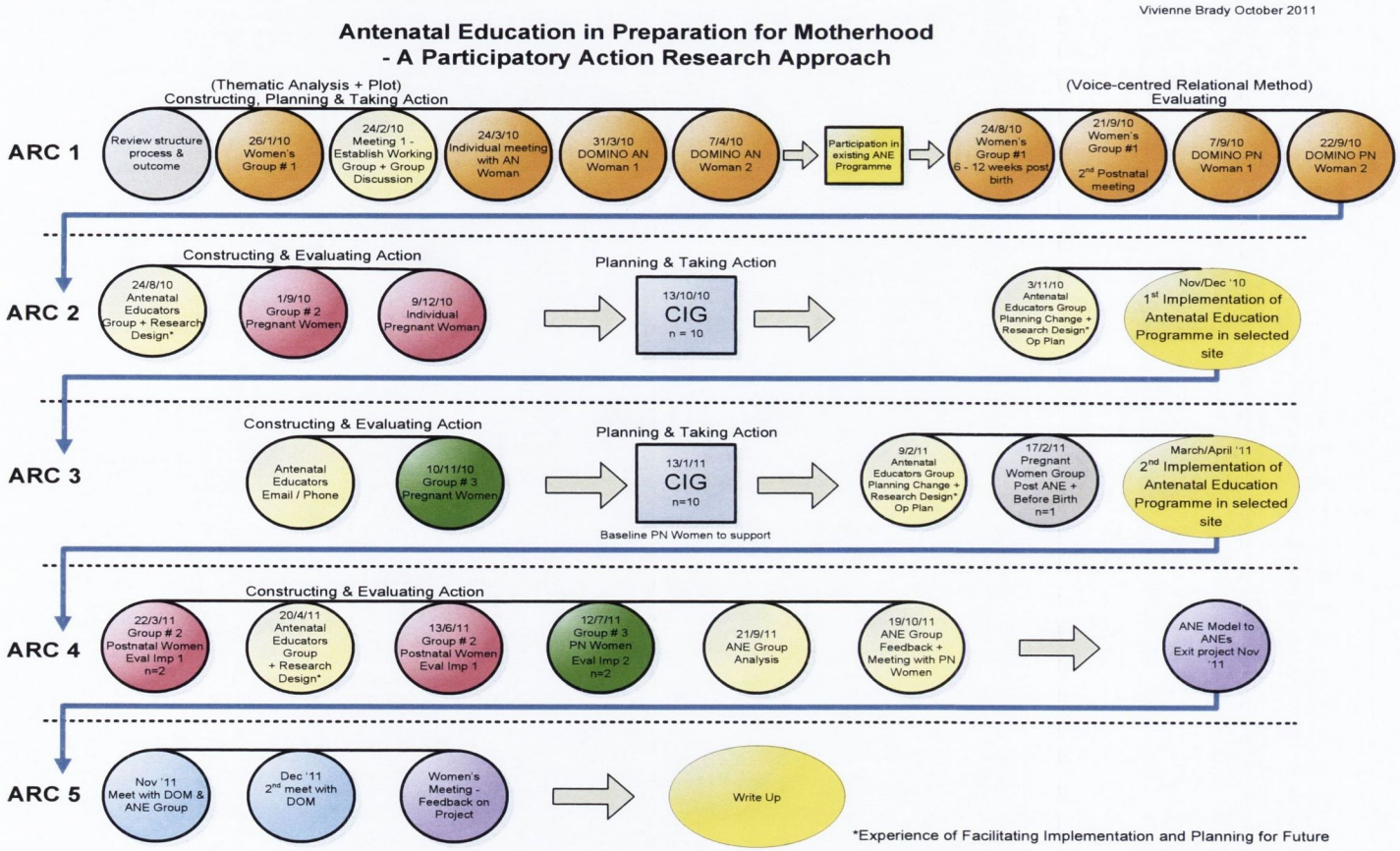
Action Research Cycle June 2011



Adapted from Coghlan, D. and Brannick, T. (2010) *Doing Action Research in Your Own Organisation*. 3rd edn. London: Sage Publications

Appendix 21

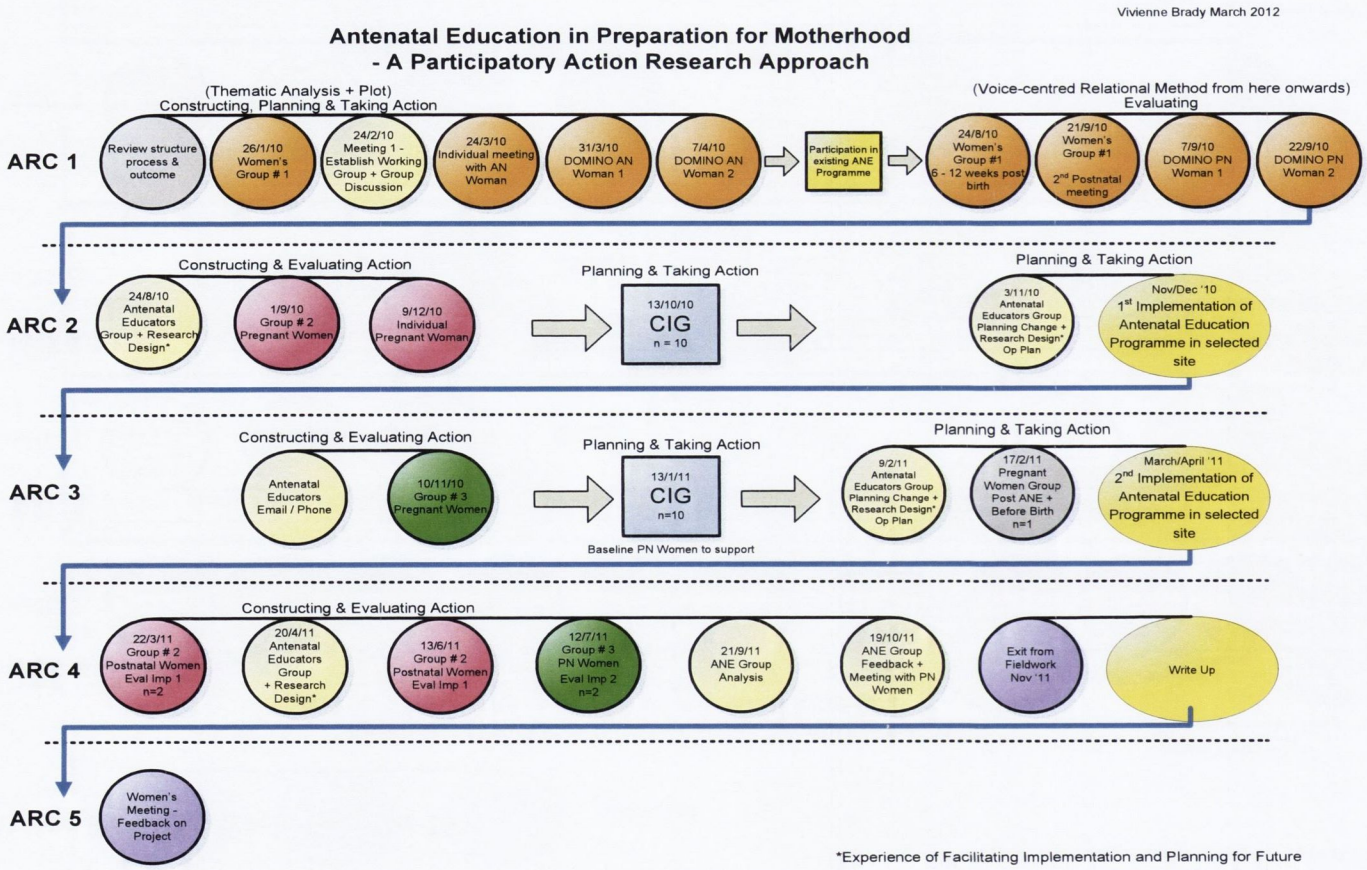
Action Research Cycle October 2011



Adapted from Coghlan, D. and Brannick, T. (2010) *Doing Action Research in Your Own Organisation*. 3rd edn. London: Sage Publications

Appendix 22

Action Research Cycle March 2012



Adapted from Coghlan, D. and Brannick, T. (2010) *Doing Action Research in Your Own Organisation*. 3rd edn. London: Sage Publications

Appendix 23

Summary of the Main Themes from ARC2 Antenatal Educators' Meeting 2

What Women Want from Antenatal Classes

- Women need help from antenatal educators because they don't know what it's going to be like (first birth).
- Difference - women who want natural birth versus hospital culture, 'some people who are very much into natural birth and natural delivery and they may be a lot more informed and a bit more involved... a lot of women in this generation do seem to want to come in and have it done for them.' There is possibly generational difference for example, culture of formula feeding and breastfeeding.
- Women have to be accountable for their own health as well yet there is the feeling that they are reluctant to embrace responsibility for giving birth??? Example: 'my group of friends ... they are very detached even from body awareness and that's what I mean about going back to the medical thing, 'I'm going to go in and have my baby in the hospital so somebody is going to do it for me, ah sure I'll go in and come out with a baby.' And this naivety and maybe as well, denial that it could go wrong or it could be sore or this or that, and there's something of not wanting to hear about the sections and whatever'

Other Sources

- The influence of friends, websites and people's experiences really has an effect on women
- The importance of using valid information sources.
- Other women – women all over the world talk to each other

The Process of Antenatal Education

- Every woman is different
- Women share their anxieties and their worries and bond and sometimes make friends through groups at antenatal classes and this is very important (particularly evident in the 'women only' group).
- 'We think what they might want to hear but actually, they might want to hear something else'

- 'In classes we are moving from one topic to the other, in classes you have to deal with everyone in the room who all have different experiences and try to do as much as possible. You can't just get one persons experience'
- There is too much to do in such a short time. 'Maybe with two hour classes you would have more time for the chat, but then you see on the other hand I think particularly when the guys are here that they want in and out'
- Every group is different but the large group size makes it difficult for women to form relationships
- There is too much medical, or too much information in a short period of time.
- The setting reflects the content covered in classes – 'we really have to be accountable as well for what we are covering... here its business'
- The importance of group belonging, body image and sense of identity in terms of contribution to self worth.
- We are practising obstetric medicine.
- Uniform advice is very important (confusing if different things are said)
- Hospital structure takes away from building relationships (flight of stairs, women tired and cannot bring trolleys for tea)
- Embracing change 'we've gone round in circles here and we've tried all sorts of things... we have tried different things'
- Where are we going wrong? (motherhood now)

Women's Information Needs

- Some women want to know about the use of forceps etc. and some women don't and that is difficult –'some of them don't really want to hear.'
- 'Couples have actually come up and asked me after class if there's a class beforehand to teach them how to hold the baby and change the baby and wash the baby *before* the baby is born'
- Going home from hospital early means that women are going home with very little information on how to look after a baby.
- 'The problem there is that the pregnant woman isn't actually able to concentrate on thinking about the baby until she actually has it'

This Research

- It's important to gain an understanding of the varying responses and levels of engagement with women and antenatal education – 'I think it's important in this study that we *do* have a cross section of people'

- 'We need to hear it (seeking feedback)'

Appendix 24

A Model of Structured Reflection (Johns 2004)

Box 1.1 Model for structured reflection – 14th edition (Johns 2004a)

Reflective cue	Way of knowing
• Bring the mind home	
• Focus on a description of an experience that seems significant in some way	Aesthetics
• What particular issues seem significant enough to demand attention?	Aesthetics
• How were others feeling and what made them feel that way?	Aesthetics
• How was I feeling and what made me feel that way?	Personal
• What was I trying to achieve, and did I respond effectively?	Aesthetics
• What were the consequences of my actions on the patient, others and myself?	Aesthetics
• What factors influenced the way I was feeling, thinking or responding?	Personal
• What knowledge informed or might have informed me?	Empirics
• To what extent did I act for the best and in tune with my values?	Ethics
• How does this situation connect with previous experiences?	Reflexivity
• How might I respond more effectively given this situation again?	Reflexivity
• What would be the consequences of alternative actions for the patient, others and myself?	Reflexivity
• How do I NOW feel about this experience?	Reflexivity
• Am I more able to support myself and others as a consequence?	Reflexivity
• Am I more able to realise desirable practice monitored using appropriate frameworks such as framing perspectives, Carper's fundamental ways of knowing, other maps?	Reflexivity

From Johns. C (2005) Expanding the gates of perception. In *Transforming Nursing through Reflective Practice*. 2nd edn. (Johns C. and Freshwater D., eds.), Blackwell, Oxford. pp. 1-12.