Manufacturing Childbirth: The Sociocultural Context of Induction in Ireland

How fear-mongering, coercion and blind trust in the administrative powers of the elite manifests in the medicalization of maternity care, from the perspective of women who have dedicated their lives to advocating for the sector's reform.

"We cannot get past this monster at this point."

"Whatever happens to a woman, whatever is happening to women– it is always a woman's fault."

Beloved lecturer, sociologist, author and activist Dr. Jo Murphy-Lawless, with whom I was immensely lucky to be able to arrange an interview with, opens our conversation on the prevalence of induced labour in Irish maternity hospitals with one simple statement: "We have lost the war on this one."

This remark was made in light of a study conducted by the Association for Improvement of Maternity Services Ireland, which I had referenced at the beginning of our call. Published in an article by The Irish Times in June, it demonstrated a severe growth in rates of induced pregnancies across the country, with the highest identified being 71% in Portiuncula Hospital, Galway[1]. In a world where medical intervention in birth is increasingly normalized, natural birth advocates' hopes for reform are at an all-time low.

[1] Lynch, Krysia, "Induction Of Labour: Clinically Necessary or Routine Intervention?", *AIMSI,* (2020), <https://aimsireland.ie/induction-of-labour-clinically-necessary-or-routine-intervention/> [accessed 14 Dec 2024]

Induction of labour is defined by the World Health Organisation as "the process of artificially stimulating the uterus to start labour." This procedure is "usually performed by administering oxytocin or prostaglandins to the pregnant women or by manually rupturing the amniotic membranes." In other words, it refers to the manipulation of the woman's body by physical, manual and hormonal means to produce contractions, thus instigating labour. WHO's 2010 Global Survey on Maternal and Perinatal Health[2], which included 373 health-care facilities in 24 countries and nearly 300, 000 deliveries, recorded induction rates of 9.6%. Data varied across Western, African, Asian and Latin American countries, with the lowest recorded in the Republic of Niger with 1.4% and highest in Sri Lanka with 35.5%.

Current figures in Ireland show that at least half of first-time mothers have their labour induced. [3] Chair of Maternity Advocacy group AIMS Ireland, Dr. Krysia Lynch, says "Induction is a sociocultural as well as physical process. People have to be socioculturally accepting of induction."

Lynch references The ARRIVE trial as the most salient study shaping the conversation of induction today. Incredibly contested and yet widely considered to be single-handedly responsible for induced labour's risk-averting reputation, the study randomly assigned 6.100 healthy first-time mothers to either induction at 39 weeks, or to "expected management", spontaneously onset of labour, eventually inducing, or undergoing planned cesarean. Findings claimed to demonstrate that routine induction at 39 weeks is better for healthy women than allowing the pregnancy to continue, because induction reduces the odds of adverse outcomes for mother and baby, specifically with regards to cesarean section.[4] Lynch affords the recent shift in narrative to the study's release in 2019, detailing that this paved the way for the normalization of induction within both the medical and public sphere. "This is the first piece of research that was ever produced that suggested that induction might be a good thing. Because prior to that point, everyone viewed induction as being a necessary evil."

Additional studies have been conducted since the ARRIVE trial and were subject to similar critique based on the medical approach used. A trial conducted in the Rotunda Hospital in November of 2020 recruited 86 healthy first-time mothers, also proceeding with induction at 39 weeks. Funded by private Pharmaceutical company Medicem Technologies, the trial operated with the Master of the Rotunda Hospital, Professor Fergal Malone, as its principal investigator.[5] A midwife employed by the Rotunda Hospital at the time, preferring to remain anonymous, said that concerns regarding the trial stemmed not only from the way in which research was conducted, but also with regards to the nature of the information leaflets and phone calls that circulated in advance of the study. In their words, "Information provided on the leaflets were comprehensive but overwhelming. Women I spoke to who were contacted about the

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[2] World Health Organization, 'Global survey on maternal and Perinatal Health: Induction of labour data', *WHO,* (2010) <http://www.who.int/reproductivehealth/topics/ best_practices/global_survey> [accessed 14 Dec 2024]

[3] Krysia Lynch, "Induction Of Labour: Clinically Necessary or Routine Intervention?", *AIMSI,* (2020), <https://aimsireland.ie/induction-of-labour-clinically-necessary-or-routine-intervention/> [accessed 14 Dec 2024]

[4] William A. Grobman Et al., 'Labour Induction Versus Expectant Management in Low-Risk Nulliparous Women, *The New England Journal Of Medicine,* (2018), <https://www.nejm.org/doi/full/10.1056/NEJMoa1800566>

[5] Sarah M. Nicholson Et al., Outpatient elective induction of labour at 39 weeks' gestation, *The Lancet,* Volume 74 (2024)

study reported receiving information that leaned more in favor of the advantages of induction than the risks involved." Supported by data gathered by the original ARRIVE trial, healthy, first-time mothers with no complications were being offered medical intervention as a means to - they quoted directly from the original leaflet - "decrease the risk of complications for you and your baby."

The risk-aversion narrative surrounding induction appeals to women for a reason. According to Rotunda Midwife and Hypnobirth practitioner Natalia Arden, our perception of pregnancy and labour is dominated by fear. This is shaped by women's personal recollection of events - which are oftentimes originally experienced within incredibly overwhelmed environments, elaborated on below - but also by the way in which discussions surrounding labour can be approached within maternity care. "Negative stories stick with us 6 times longer than positive ones… It's an Irish thing." says Arden, stating that the pre-existing societal association between birth and tragedy allows for induction to be "kind of thrown at [women], dangled at them like a carrot when they're vulnerable and feeling big and tired." Arden appreciates many cases of induction are for perfectly valid reasons, be it that some women simply don't want to deliver on Christmas day, or are prioritizing their consultants - who are often incredibly expensive - being available, or, of course, if their health is genuinely in jeopardy, but affirms that it is important for women to make that decision on their own accord. "I don't want women to fear [interventions]," says Arden, "but I do want them to question them."

Dr. Lynch shares Natalia's perspective surrounding the coercive means through which women can be convinced to induce, stating that women are oftentimes relayed the possibility that their babies could die. "Once you start attributing the emotion of fear, that there might be something wrong with your baby if you don't have an induction, it's very easy to get people to commit." In discussing natural birth activist Sheila Kitzchinger's work, Murphy-Lawless referred to this as 'shroud-waving', the strategy of

highlighting potential negatives in order to influence public opinion.[6] Lawless gives the example of providing statistics in relative rather than absolute form. To demonstrate, she performs her own weather report, telling me that if I remain on the northside of Dublin tonight, there's a 0.01% chance of snow. Whereas if I come to the southside, the potential is upped to 0.02%. Although I double my chances, "It's not going to f*cking snow, is it?"

Lynch's belief is that efforts to convince women in favour of induction are deliberate, with staff shortages and the demand put on hospitals playing a major role in the capacity for each individual pregnancy and labour to be given the attention it deserves, "I don't think care providers have the time to sit there and talk with women." As a midwife operating on the ground, Arden knows this to be true, stating that severe shortages - not only in staff, but in beds and hospitals across the country - ultimately dictate the degree to which women can be taken care of. "You've got all these women, 6- 70,00 women coming through a delivery suite where-in, you know, there's only 10 beds… It becomes a real bottleneck." This simultaneous lack of support and increase in demand has resulted in an approach to maternity care that Lynch disdainfully refers to as akin to "moving units of production through your birth factory."

"Traditionally, birth was managed in the home," says Rotunda Clinical Midwife Specialist Lisa Carroll. "Hospitals took over birth and funeral homes took over death." The institutionalization of these two processes called for a system that could function under the demand of these inevitable aspects of life. The process of managing labour exists in an effort to manage that "bottleneck" system referred to by Arthurs. This is echoed by Carroll. "If you were to allow - I don't like the word allow - women to go into spontaneous labour, the hospitals could become overwhelmed." says Carroll, admitting that the reality is, they already are; "1000 years ago, birthing was an individual introspective event," says Dr. Lynch, "We made it a social event. And now we're collapsing under the demands of making it that event."

Maternity care advocates attribute this in part to the centralization of Maternity hospitals. "In the old days, there were maternity homes all over the country. They were scattered everywhere; they'd be called little birthing centers." says Lynch, stating that the role the closure of these units played in laying the foundation for the rise in induction is undeniable. "In Cork, for example, you're driving to Cork University Maternity Hospital. From West Cork, it's nearly 3 hours in a car. If this is your third baby, you're probably going to have had that baby by the time you arrive." Lynch says women in the countryside are offered induction when faced with the idea of a road-side birth by way of perceived necessity, instead of advising they contact a community midwife to either assist them in home labour or accompany them on the journey. "Induction is the technocratic alternative to having community based maternity services."

Jo Murphy-Lawless' vast research as a sociologist affords her an insight into the broader structures at play within the issue of maternity care. For Murphy-Lawless, this is a conversation of class, power and corruption. The modern tug-of-war between women's lives as mothers, professionals, and citizens existing at the mercy of higher political powers has introduced a way of living Murphy-Lawless believes is inherently unsustainable. "It became kind of accepted that women would have working lives into which somehow or not maternity was squashed." says Murphy-Lawless, staunch in the belief that poverty plays

[6] Sheila Kitzinger, '*Birth Crisis' (London: Routledge, 2006) p.34*

an inexcusable role in how these employment advances affected women and devastated at the overwhelming lack of consideration for this reality. She references the 1973 marriage ban; “Once you’re married, for example, you had to leave the public service– of course, it never applied to women scrubbing the steps of the public service building, did it?”

Murphy-Lawless takes the example of gestational diabetes, a form of diabetes that develops in a woman’s body during pregnancy due to a lack of insulin, currently affecting one in six pregnancies in Ireland [7]. Murphy-Lawless frames the conversation within the lens of the cost of living, contributing women’s inability to meet nutritional guidelines to the social and finacial instability inherent to life in Ireland today. “If you take the rates of homelessness, women living in temporary accommodation where they can't even cook proper meals, women who are trying to put together 2 or 3 jobs to pay rent of 16, 17, 1800 a month … Let me tell you, they are not coming home to home-cooked meals of proper nutritional value.”

Ignorance from within legislators is systemic; “The problem with the TD’s and the neglect of the maternity service is, of course, because all the TD’s go private.” Murphy-Lawless grants the possibility of the exception of one or two policy-makers, but affirms that the ignorance this breeds does incomparable damage to maternity services’ prioritization in the eyes of the government. “They have never even begun to think about the distinction between public and private care.” On a basic-level, the sector is defined by this legislative neglect; “Women are going into services which we all know to be understaffed. They can’t operate.” Murphy-Lawless says this has been of inconceivable detriment to the capacity to care for women. “What we’ve learned going through all the maternal death inquests are the failures of these maternity services again and again and again.”

As pioneers in the road to reform, Lynch and Murphy-Lawless agree that women’s individual agency is rended null by a system that is rigged against them. “It’s not an issue of education. People shouldn’t have to be educated to receive a high quality of care.” says Lynch. Murphy-Lawless’ elaboration on women’s attempts to exercise power over their birthing process through expanding their knowledge is grim, stating that not only that “women are trying to make strategic decisions for themselves when they have absolutely no power to make any other”, but that those who are oftentimes most vulnerable to this subversion are already collapsing under the strain of day-to-day life. “We’ve tried to do birth-education in so many settings, and it hasn’t been possible to sustain because women are under too much pressure.”

Murphy-Lawless refers to this disintegration within women-centered healthcare practices as a symptom of the “unutterable” levels of misogyny which define the social and administrative navigation of women’s issues in the 21st century. “Whatever happens to a woman, whatever is happening to women– it is always a woman’s fault.”

[7] Diabetes Ireland, ‘inclusion of Women With Gestational Diabetes to the LTI Scheme’, (2022), <inclusion-of-women-with-gestational-diabetes-to-the-lti-scheme> [accessed 16 Dec 2024]

BIBLIOGRAPHY.

1. Lynch, Krysia, 'Induction of Labour: Clinically Necessary or Routine Intervention?', AIMSI, (2020), https://aimsireland.ie/induction-of-labour-clinically-necessary-or-routine-intervention/ [accessed 14 December 2024]
2. World Health Organization, 'Global Survey on Maternal and Perinatal Health: Induction of Labour Data', WHO, (2010), http://www.who.int/reproductivehealth/topics/best_practices/global_survey [accessed 14 December 2024].
3. Lynch, Krysia, 'Induction of Labour: Clinically Necessary or Routine Intervention?', AIMSI, (2020), https://aimsireland.ie/induction-of-labour-clinically-necessary-or-routine-intervention/ [accessed 14 December 2024].
4. Grobman, William A. et al., 'Labour Induction Versus Expectant Management in Low-Risk Nulliparous Women', The New England Journal of Medicine, (2018).
5. Nicholson, Sarah M. et al., 'Outpatient Elective Induction of Labour at 39 Weeks' Gestation', The Lancet, 74 (2024). http://www.who.int/reproductivehealth/topics/best_practices/global_survey [accessed 14 December 2024].
6. Kitzinger, Sheila, Birth Crisis (London: Routledge, 2006), p. 34.
7. Diabetes Ireland, 'Inclusion of Women with Gestational Diabetes to the LTI Scheme', (2022), <inclusion-of-women-with-gestational-diabetes-to-the-lti-scheme> [accessed 16 December 2024].