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**Discontented Midwives:
The Politics of Care Work in Iceland**

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Submitted for the Degree of
Doctor of Philosophy in Social Anthropology
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Declaration

I hereby declare that this thesis has not been, and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature: Rebecca Ashley

Date: 30th April 2021

Abstract

This thesis explores the work of Icelandic midwives in addressing a deficit of care, through protest and industrial action. Based on eighteen months of ethnographic fieldwork in Reykjavík, south-west Iceland, among midwives, doulas, hospital staff, and protestors, I examine the ways in which midwives experienced and contested the politics of their care work, in the aftermath of financialised crisis. This thesis focuses on the events of the midwives' *kjarabarátt*, the 'wage and working-conditions struggle', in which midwives protested inadequate salaries, inadequate working conditions, enacted strikes and resigned from their jobs, protesting the many lacks in which they felt embroiled. I argue that the event of the *kjarabarátt* can be understood as a moment when a refusal of these deficits is erupting. The breakdown in a social consensus about how people should be able to afford and enjoy a similar standard of living was, for midwives, about a breakdown in their ability to care, and be cared for, at work. The sense of value of the work they did did not square up with the material conditions of their work and the compensation they received for their time. I argue that midwifery protest and dispute is about a negotiation of a deficit of care, in which it had become untenable to live in a way that felt cared-for, adequate, and enjoyable.

This thesis contributes to the anthropologies of midwifery, care, and work, by highlighting the ways in which midwives' experience of their work, and of the politics of this, is absent in the literature. Through my ethnographic material, I show how midwives were protesting not only a wage deficit, but a deficit of care. This was a way of articulating a sense of anxiety about the future: of midwifery as a profession, and the ways in which midwifery could be expected as a form of care. Through focusing in on the event of a midwifery conference, I show how midwives are engaged in different forms of work in order to reproduce themselves as a profession. I examine the ways in which midwives experienced their work within an economy of affect, and contested specific framings of a work ethic. The final ethnographic chapter explores the emergence of doula work as a way of mediating a care deficit, and creating a market for care.

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The care, time and company of many people is written through this project. I am deeply grateful to the midwives, doulas and students in Iceland who shared their stories and ideas with me over the course of my fieldwork. Thank you so very much for welcoming me and being generous with your time. While I cannot name individual participants in these acknowledgements, I hope those reading it will feel listened to and their politics engaged with through the stories I tell here.

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University library to apprentice myself to Ólöf Ólafsdóttir's PhD thesis. I spent a whole, wonderful day reading it, and her reflections and insight into Icelandic midwifery and narratives of work and care sewed ideas that have stayed with me ever since.

In the UK, I am extremely thankful to the midwives and birth workers I've met over the years at the Birth Gathering; so much of what I've thought and written about in this thesis has its roots in the workshops and conversations shared at those weekends. In Iceland, the company and activism of the many folk I met through Andrými helped me learn and think critically about Icelandic politics, and helped me feel my way through participating in a commons of care and solidarity.

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During fieldwork, on a late-summer hiking trip in West Iceland, some friends and I took a detour down several miles of dirt track into a farming valley. Some weeks before there had been a massive landslide from the northern lip of the valley, and we set out to find it. We drove along a pot-holed track, passing a cave and several sheep-pens, the dog in our car barking at the scent. The road ended abruptly at a wall of mud and rock intersecting the track at a precise right-angle. Stopping the car, we pulled on waterproofs and scrambled up the side of it. Atop the uneven mound of dirt, the outpour from the mountain was vast. It had obliterated almost everything we could see: the river, vegetation, the road. It felt bleak and empty, and quiet. When I think of my friendships I come home to this moment in this valley. I think of the group of us venturing out into the mud together. I think of watching them climb over the sprawled rocky mass, off to find the river the mountain has intersected. Returning to find Jamie's pockets crammed with quartz, we pile in the car as the rain begins, unearthing the rocks in the seats, holding them up to the bright light through the windscreen. I think of the reassurance of company, the acceptance of mess and the promise of brighter days. The friends on this journey, Jamie McQuilkin, Plume and Ragnheiður Freya Kristínardóttir, helped me lift myself out of some very challenging times and also marked my happiest. For those gestures of honest, unflinching care, I cannot thank them enough.

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Chapter 1

Introduction: discontented midwives



1.1: A group of midwives and supporters hold a solidarity vigil during the *kjarabarátta*, outside the municipal offices in Reykjavík, 2018.¹

1.1. Thesis statement: midwifery and the care deficit

This thesis is about midwifery work and care, and it explores a specific politics of care in an ethnographic context of midwifery, financialised crisis, industrial action and protest. I use the

¹ The text on the placards feature statements supporting the midwives' protest, including: '*I stand with midwives*'; '*Did midwives save your life?*'; '*Salary = poverty-line earnings and education.*'

concept of a ‘care deficit’ to explore the work midwives do to reproduce themselves and their work at a time when they are required to live with and within different kinds of deficits. In Iceland, people have been living with deficits in the aftermath of the 2008 financial crisis. For midwives in Iceland, tensions between work and care, different kinds of lacks and absences including living with inadequate forms of care, created fissures in the ways in which they understood and experienced the effort they put into both making a living and making a life.

Through an ethnographic exploration of the midwives’ *kjarabarátta*, the ‘wage and working-conditions struggle’ which unfolded during the course of fieldwork, I explore how midwives resisted a deficit of care. Midwives enacted strikes and resigned from their jobs, protesting inadequate salaries, inadequate working conditions, and the many absences and lacks they lived with. Midwives experienced a breakdown in the social consensus of what a liveable life in contemporary Iceland should be. For midwives, this breakdown was a sense of the unavoidability of rising inequality, and indignance that an inability to afford to live existed: the numbers, wage packets, payslips, stipends and the sense of value of work and time did not add up for these women. I argue that midwives were breaking out of a political imaginary in which living within these multiple deficits was no longer sustainable, or permissible. The *kjarabarátta*, as a particular moment of protest and discontent, is one instance where a refusal of these deficits erupted.

By understanding the economy as the ‘effort to make life’ (Narotzky and Besnier 2014: S14), I argue that midwives’ protests and discontent, was a way of contesting the exploitative normativity of living within a capitalist economy. Through strikes, mass resignations, protests and a discourse of crisis within midwifery, people contested the economic circumstances—not only of inadequate wages for labour, but of their reproductive efforts, affects, and desires within and for midwifery—in which their lives were embroiled. I use the concept of a ‘care deficit’ as a lens through which to focus on the political economy of midwifery, explore maternity care in the

context of neoliberalism, and focus on midwives as workers. I suggest that the ways in which midwives experience shifts in subjectivities, and come to understand, and feel, a specific economic framing of their work, is an area of research in need of anthropological attention.

One of the central contextual tensions underpinning this research is that between Iceland's reputation and celebration as a 'feminist utopia', and midwifery discontent. Popular assumptions of economic well-being and the provision of an adequate, well-functioning welfare state in Iceland are refracted through reports on Iceland's economic recovery (O'Brien 2015), its reputation for excellent gender equity (World Economic Forum 2021), and on its well resourced, equitable and fair health care system (Pálsson and Durrenberger 2015), and underscore this ethnography. In a country purportedly an excellent place to live and work as a woman, why were there historical and current protests around wages and working conditions within an entirely feminised healthcare profession? Preceding my own period of fieldwork between 2016 and 2018, there had been a period of industrial action, including protests, strikes and resignations among nurses and midwives during 2015. These events struck me as pointing to some fascinating tensions between work and care. In parallel, I was also interested in how the financial crisis of 2008 had impacted midwives, and how Iceland's celebrated and swift 'recovery' from this crisis might mask some more complicated politics around the work of women, the politics of midwifery work, and a set of austerity policies that had seen funding for public services, including maternity services, decline. This thesis explores this boiling over of discontent among midwives, reproductive work in the context of a wage dispute, that unfolded in midwifery in Iceland during the course of my fieldwork.

In this thesis, I draw on Hochschild's (1995) concept of a 'care deficit', a concept used to describe arrangements of care in which shrinkages in the availability of care occur alongside expansions in the requirements for it. The concept of a care deficit therefore refers to a context of welfare state shrinkage, including reductions in services available, lacks in staff, shortages of time,

alongside increasing workloads. The care practiced as a central part of work done by midwives, and other healthcare professionals, within this context is shaped and marked by these deficits. I draw on this concept to examine midwifery work and care at a time when deficits are felt and experienced throughout multiple, intersecting parts of people's lives, and explore the ways in which midwives, through learning 'to live without much care' (Hunter 2010: 258), articulate and negotiate the politics of their work. Drawing on the concept of the care deficit helps an ethnographic thinking-through of the politics of care, and focuses analytical attention on how midwives reproduced, protested, and resisted their labours. It opens up space to consider the ways in which the work of care might deplete midwives, in ways that are not adequately remedied. This, I suggest, seems antithetical to common framings of midwifery, and care work in general, in which this work is framed as something fulfilling to providers of care. Requirements to love one's job, and find fulfilment in the value of it, can obscure the ways in which one's work might be extractive of affect, and exploitative of feeling. I draw on anthropological understandings of care needing to be something that is 'troubled' (Duclos and Criado 2019) in order to open questions and explore the ways in which midwives experienced care as a deficit. This speaks to uncomfortable and disjointed tensions in arguments for care: for the work, feeling, time, and resources drawn on in order to tend to people and things, and create the conditions of a life worth living. A deficit brings to the surface metaphors of extraction; what resources are being taken from people in order to remedy deficits?

The notion of deficit is tightly bound to austerity, and understood as a problematic gap in public finances; a requirement for urgent belt-tightening in ways that are set at a level of national policy, and reverberate throughout the material conditions of people's everyday lives (Fraser 2017). A deficit points to holes, absences and lacks in public finance requiring remedying through extraction of other resources; the way this works out in lived, working life, and bodies, a visceral extraction. A deficit might be understood through anthropological attention to contexts of precarity and austerity as a widening gap and inadequacy in the resources needed to reproduce

one's own life. Talk of a financial deficit is not solely about abstract absences in macrofinance, but the everyday experiences of absence and loss resulting from the creation, maintenance and remedying of financialised deficit: inadequate resources with which to live a secure life, such as food, utilities, housing, as well as those affective resources necessary to a liveable life, including care, desire and hope. Neoliberalism creates and maintains specific deficits, not only of the components thought to comprise what we understand as the economy—time, resources, labour, wages—but also deficits of care, of feeling and affects. In the tradition of feminist scholars writing about work and care (Federici 2012, Hochschild 2003b, Narotzky 2018, Weeks 2011), I suggest that we can think of the economy in terms of the ways in which people balance relationships, emotion and care as central components of the economy, and that these aspects of human experience are deserving of scholarly attention. They are not irrelevant aspects of people's lives, but central to work, to capitalist economies and integral to the effort people exercise to create and maintain futures. Making a living, and making a life worth living, can be thought of not only in terms of the exchange of labour for wages, but the work, care, longing and hope people experience and practice for the possibility of a future.

Exploring a care deficit is therefore about exploring neoliberalised maternity care, asking questions about the ways in which structure, institutions and political economy shape midwifery work, as well as midwifery identities, subjectivities and affects. In professional-facing midwifery literature and discourse, there is little work exploring neoliberalism as the context and condition of midwifery work and care (Kirkham 2019). This thesis seeks to shift that. While this is an anthropological thesis, I also hope it will speak to work within midwifery and participate in a broader conversation on the political economy of midwifery work. I suggest we can understand midwifery, and explore midwifery in the context of financialised crisis and neoliberalism as an example of this refusal of deficit we see in multiple contexts of precarity and resistance (Muehlebach 2016). There is a lack of anthropological attention to how midwives navigate their

role as workers, and this project will provide a timely and necessary portrait of how midwives cope through varying intersections of deficit.

This research is guided by central questions of care and work, in which a focus on a care deficit opens up questions about labour, professional subjectivities, gender and neoliberalism in midwifery. How might a focus on a deficit help us ask questions of how midwives experience work? What lacks at work do they compensate with their own bodies and subjectivities? What is extracted from midwives? How might a concept of a deficit complicate our assumptions of the experience of being a midwife? How might it speak to the politics of contemporary, post-financialised crisis maternity services? How might it complicate normative assumptions about care, what it means to care, and the value of this? What are the institutional politics of midwifery work in Iceland? What is caring in a deficit for midwives in contemporary Iceland? What happens when maternity staff resist deficit?

In this chapter, I introduce the thesis, outlining the argument, context and scope of the ethnography. In the following sections, I outline the specific context of midwifery work in Iceland, detailing who midwives, the protagonists of this thesis, are. The fieldwork context, including the central issues of financialised crisis and gender in Iceland are also outlined. I then go on to explore the literature in order to outline the scope and place of this thesis within relevant debates. I draw on three key literatures: anthropological approaches to care, midwifery, and work in order to demonstrate a gap where there is little focus on midwifery work in the context of neoliberalism. I demonstrate how an overlapping focus on care, midwifery, work and economic anthropologies frames my ethnographic research. I introduce the concept of a 'care deficit' in detail and show where and how it has emerged in the literature. Finally, in the last section of this chapter, I provide an outline of the thesis and an overview of the subsequent chapters.

1.2. Midwifery in context

1.2.1. Midwives and midwifery in Iceland

A *ljósmóðir* ('mother of light') is a midwife, a trained professional belonging to midwifery as a specific occupational group with university training to hold expertise in providing skilled advice and care in pregnancy, labour and birth. The role of a midwife is broadly to provide care during this time and the postnatal period of 6 weeks following birth, and midwives are the lead care providers for antenatal, intrapartum and postnatal care in low-risk pregnancies. The model of midwifery service provision in Iceland is, broadly, not dissimilar to that of the UK and neighbouring Nordic countries, in which midwifery is not only a legitimate occupation, but a core component of primary health care provided by the state. Iceland has a unique occupational history (Einarsdóttir 1984, Gottfreðsdóttir and Karlsdóttir 2009, Ólafsdóttir 2006), and unlike other contexts of midwifery work elsewhere in the world, contemporary midwifery is an entirely feminised occupation.

Iceland provides universal health care; this is funded primarily through taxation, and residents access subsidised or free health care services through Icelandic Health Insurance, with many health services requiring co-payment by service users. Maternity care is free for all those eligible to receive state insurance, requiring service users to have been registered as resident in Iceland for a minimum of six months. Additional support services in maternity, such as some antenatal workshops and lactation consultancy may be purchased from private providers for a fee. Clinical guidelines on the schedule and content of maternity care are set by Embætti Landlæknis (the Directorate of Health), based on and adapted from NICE clinical guidance published in the UK, for example, setting out the evidence for and clinical parameters of routine screening. Providers of maternal health care include primary health care clinics, outpatient clinics, university and teaching hospitals; in the greater Reykjavík area, Landspítali (the National University Hospital of

Iceland) and Heilsugæslan (health clinics) are the two locations for state healthcare. The geographical centralisation of maternity services into these municipal institutions has been a key policy and organisational change in Icelandic health care services over the past twenty years, in which neoliberal shifts prioritising efficiency and productivity (see, for example, McKinsey & Company 2016). Antenatal care is provided for low-risk pregnancies through midwife-led clinics at primary healthcare clinics; high-risk pregnancies are cared for by either the Obstetric and Gynaecology Department at Landspítalí, or the obstetric-led maternity ward at Akureyri Hospital. Antenatal care typically begins at eight to ten weeks of pregnancy, and involves a scheduled series of regular clinical appointments, including routine ultrasound at twenty weeks, as well as specialist referrals if required; most first-time mothers have ten antenatal visits in pregnancy. A recent trial of group antenatal care provision has been conducted in Iceland, with evidence suggesting that this was more effective than routine individual antenatal visits in reducing fear of birth (Swift *et al.* 2021). Intrapartum care and birth may happen at either an obstetric-led maternity ward, a midwife-led birth centre, or at home. In 2016, 74% of births took place at Landspítalí, 2.1% of births were planned home births, and the remainder of births occurred in hospital units or birth centres elsewhere in the country (Statistics Iceland 2021). Postnatal care may be provided for in hospital if there is a requirement for an inpatient stay, and continues with postnatal home visits, often conducted by the midwives working at antenatal clinics.

Health and wellbeing indicators point to a health and social care context in which maternal healthcare is comprehensive, equitable, and effective. Iceland is ranked 4th in the UN's Human Development Index (UNDP 2020), with particular significance placed on its low rate of maternal mortality (a current ratio of 2 deaths per 100,000 live births), and high levels of gender equality, including ratios on political empowerment, economic participation, and educational attainment, ranking it first out of 156 countries in the Global Gender Gap Index for the twelfth year running (World Economic Forum 2021). Though these rankings celebrate Iceland's achievements in

gender equality, this ethnography demonstrates how many of the assumptions contained in blunt rankings shy away from a more complicated social context (Benoit, Wrede and Einarsdóttir 2011, Henriksson, Wrede and Bureau 2006, Símonardóttir 2016). In 2020, a total of 4,512 births were recorded in Iceland, within a population totalling 368,590; this marks a current fertility rate of 1.7 (Statistics Iceland 2021). Data on maternity care outcomes and obstetric intervention over the past twenty years demonstrate that Iceland features a relatively stable and low prevalence of caesarean section birth: 14.3% of women having a first birth, and 7.3% of women who had previously birthed experienced an emergency caesarean section in 2014 (Swift *et al.* 2018: 372). Instrumental delivery rates in Iceland are also low and constant, with 9.1% of both first and subsequent births involving instrumental assistance (*Ibid.*: 373). This is in sharp comparison with other maternity health care contexts in Europe and North America in which the past twenty years has marked a rise in caesarean section birth, induction of labour, and use of epidural anaesthesia (*Ibid.*: 374). Iceland is however experiencing a considerable rise in rates of induction of labour and epidural anaesthesia, and this recent trend is a point of focus in Icelandic midwifery research, in which neither an increase in the diagnosis of hypertension and diabetes, or sociodemographic factors among service users, explains this change (Swift *et al.* 2018). This is a topic of concern for midwives; at professional research conferences such as the Nordic Midwifery Congress, midwives sought to explore the ways in which shifts in midwifery work and care might have contributed to these significant changes in routines of clinical intervention.

The majority of midwives are employed directly by the state to work within the hospitals in Reykjavík and Akureyri and primary health centres across the country, and other midwives are self-employed, but paid by state insurance to provide out-of-hospital birth services, or home visits. They have the professional autonomy to work without the guidance of any other health professional so long as a woman's pregnancy remains 'normal' and low-risk. Midwives work in clinics, hospitals, and homes. They are experts in 'normal', physiological birth, referring to obstetric colleagues when complications arise and practice care framed as 'woman-centred', a

preference to the clinical language of ‘patient’. Midwives are present at most births; these births may be supported within a hospital delivery suite, a midwife-led birth centre, or within women’s homes. For women experiencing a labour interpreted as ‘high risk’, midwives collaborate with obstetric colleagues during the labour, and may, in cases of instrumental or surgical birth, provide assistance to obstetric and paediatric doctors during the birth. The parameters of midwifery expertise and work are continually shifting, and midwives in Iceland, unlike those working in the UK, for example, now participate in cervical cancer screening as a recent development in clinical practice. Alongside the hands-on work of attending to people’s bodies, medical tools and pharmacological substances, midwives are employed in a variety of tasks folded into the life of clinical midwifery, such as cleaning, medication management, clinical and service audits, administration, correspondence, housekeeping and driving.

There are approximately 260 registered midwives in Iceland, and at the time of my research, only 1-2% of those midwives were women of foreign origin (Mangindin 2018), having completed their training in either Iceland or abroad. Midwives require a license to practice, and these are issued by the Medical Director of Health; the right to use the professional title of midwife, and to practice midwifery, is limited to those granted a licence. The total number of registered midwives is complicated by the fact that many of these registered midwives work part time, and one third of these midwives are due to retire within the next decade. This statistical issue was central to the midwifery dispute, as will be explored. The training, provided through the University of Iceland, takes six years, and midwives must first take a four-year degree in adult nursing, before taking a two-year post-graduate course in midwifery. This is important to mention for two reasons here: firstly, that in the way their education is organised, midwives struggle to identify themselves as a distinct, autonomous professional group, rather than a speciality of nursing. In some countries such as the UK, midwifery is a direct-entry degree, so there is no requirement to qualify as a nurse before being permitted to ‘specialise’ in midwifery; in Iceland, this alternative training route has been discussed but the direct entry route has not found approval at Ministry level. The second

reason to mention this training is that one of the issues central to the union dispute was that the salary midwives received once they qualified as midwives was less than they received on graduating as nurses: midwives effectively received a pay cut for pursuing midwifery training. Because the course is over-subscribed, with only 8-10 students being accepted onto the midwifery course every year, there was a sense that the privilege of the role trumped any issue with the very real fact that this training involved a salary drop. This pay gap varied depending on experience, so for women who were going on to 'retrain' as midwives after several years working as nurses, rather than those women who completed the full 6 years back to back, the pay gap would be larger. The pay itself was too small to live on: women could not support themselves alone, or with a family, to live in Reykjavik. Midwives wanted this pay discrepancy rectified, and in engaging in a series of public protests, strikes, media engagement and mass resignations, the dispute became a significant public conversation about the role of care and feminised work within post-crisis Iceland.

This context of occupational precarity can be examined by looking at the routes midwives take into the profession in Iceland. Whether women first work as nurses prior to postgraduate training as midwives, or transfer directly into the midwifery training varies. Some midwives will have worked for several years within nursing, specialising within a particular area of nursing, before choosing to train as a midwife. Other midwives spend a shorter period of time, between one to two years, working as a nurse, consolidating specific nursing skills and earning a secure salary, before beginning midwifery. Additionally, some midwives transfer into midwifery training directly from nursing. Many students begin nursing with the plan that they will continue straight into midwifery, and that this is the end goal, with the teaching team recognising that they 'get the best students' from the nursing degree. Midwifery faculty in Iceland recognise that midwifery is a long-haul training programme, and a commitment to seeing through several years of work and insecurity until reaching qualification, status and remunerated work. The six-year project can be intimidating to consider and an exceptionally long chapter in one's life before completing the training part of the journey to becoming a midwife, and moving past this period of insufficient

salary. Another central pillar to the midwifery dispute was this issue of training length and income, when cast in comparison with the few other, better-paid professions requiring the same length and degree of education. As I will explore through the ethnography, midwives sought recognition of the ways in which their occupational training and status was undervalued and inadequate.

Though there is a limited scholarship on Icelandic midwifery, its professional history is long and unique, specific to its historical geography and the practicalities facing people who historically survived in isolated, mountain-scaped settlements (Einarsdóttir 1984, Hastrup 2008, Ólafsdóttir 2006). While contemporary professional rhetoric can mask the messiness of occupational history in midwifery (Borsay and Hunter 2012), Ólafsdóttir's (2006) thesis captures some of the changes in midwifery work through documentation of midwifery narratives, including the movement of midwives across the Danish empire for formal midwifery schooling during the eighteenth century, which instated midwifery as a respectable, middle-class occupation, and the development of medical institutions during the nineteenth century, which shifted midwifery towards a predominantly clinical, hospital-based role. During the twentieth century, Icelandic midwifery underwent a profound relocation from remote community settings to clinical and hospital locations, resulting in the concentration of the majority of maternity procedures within a small number of hospitals (Benoit *et al.* 2011). The broader socio-historical context of this change is important to consider: hospital-based midwifery came into being through requirements for equitable care and public health provision for large numbers of women and babies (Hunter 2004), forming the basis for a comprehensive healthcare system in addressing broader epidemiological requirements (Wrede, Benoit and Einarsdóttir 2008).

1.2.2. Ideals of good care in midwifery: being ‘with women’

During the late 1980s, Icelandic midwives began to develop a critical view of institutional care as fragmented and often unsatisfactory for women working in and using maternity services (Ólafsdóttir 2006), in parallel to cultural shifts in midwifery in other Euro-American contexts (Bourgealt, Benoit and Davis-Floyd 2004, Davis-Floyd and Sargent 1997, Davis-Floyd, Pigg and Cosminsky 2001). For example, midwives identifying the ‘cascade of intervention’ occurring within hospital-based birth, in which routineised clinical procedures were found to often necessitate more invasive clinical interventions to bring about a healthy birth. As will be examined in the literature review, authors have focused on the ways in which midwifery care is insufficient for both midwives and families (Hunter 2010). The organisation of midwifery through hospitals, as specific institutions prescribing requirements for how birth should proceed, unsettles midwives’ expertise in facilitating physiological birth, a midwifery term used to describe a labour that proceeds healthily, at its own momentum, and with little clinical intervention. Efforts to open out occupational territory for midwives beyond the confines of the hospital are topical in midwifery research (Coxon *et al.* 2016), and a current focus of evidence-based policy and practice is on challenging discourses of clinical safety associated with hospital birth, relocating birth into people’s homes, and asserting midwives’ expertise (Sandall 2013). Within midwifery, the view that hospitalisation for childbirth is a ‘retrograde’ step (Hunt and Symonds 1995: 16) gained credence in the development of midwifery research, and midwifery as a professional, and academic, discipline. Hunt and Symonds (1995) explore how midwives’ discontent around hospitalisation as a particular form of medicalised institutionalisation of pregnancy and birth this involved, became widely expressed through the ‘clichéd’ analogy of the hospital as a factory, and hospital birth as resembling the assembly line of a factory (1995: 16). A ‘crisis of practice’ (Wrede *et al.* 2008), in which midwives struggle with feelings of professional dissatisfaction, and experience a complicated mismatch between professional values, employment requirements,

collegial need and institutional demand, is common to a diversity of contexts of midwifery work (Crowther *et al.* 2016, Hunter 2010), and historically underscores this ethnography.

This critical view was indicative of a shift towards promoting the use of research evidence to standardise low-risk birth, the importance of interpersonal relationships, and ‘woman-centred care’ as principles of good midwifery practice (Page and McCandlish 2006, Hunter *et al.* 2008). Authors note how physiological, or ‘normal’ birth has become ‘an organising principle’ for midwifery and the parameters of midwifery expertise, knowledge and training (Hunt and Symonds 1995: 10). Midwives organise professionally to promote the status of midwives as primary care providers in pregnancy, and to reclaim and develop ‘real’ midwifery skills (Hunter 2004, Mansfield 2008). The development of midwifery as an academic discipline in its own right, with its own body of research, and own unique history and skills, forms an important component of midwifery work, and is reproduced through professional publications and events, such as conferences, as will be explored through the ethnography in Chapter 4.

One of the ways in which midwifery has been shaped and reproduced as a profession, with its own unique set of values, norms and practices, is through the language and work of ‘woman-centred care’, and being ‘with women’, as markers of good midwifery work (Borsay and Hunter 2012). Emphasis is placed on the centrality of relational care as foundational to good midwifery care; there is a specific, ‘midwife-mother relationship’ that defines the encounter between a midwife and the woman cared for, differentiated from other forms of professional caring (Kirkham 2010). For midwives, this unique healthcare relationship has the potential be reciprocal, based on continuity, solidarity, intimacy, and ‘skilled companionship’ (Walsh 2007: 225), however, researchers point to the difficulties of realising these forms of relational care in services that are ‘fragmented’ and within organisational structures that midwives ‘feel oppressed by’ (Walsh 2007: 225). These tensions are further complicated by occupational values predicated on a culture of ‘service and sacrifice’ (Kirkham 1999), in which a gendered work ethic historically

the professional identities of midwives and notions of care (Hunter 2010, Weeks 2011). Framings of ideals of midwifery work as being ‘women-centered’ bring up interesting questions about the ways in which different forms of care and labour are in focus, and other forms are obscured for midwives, as I will explore through the ethnography.

1.2.3. The changing work of ‘sitting over’ a birth

While *ljósmóðir* is in contemporary use as the term for midwife, an older word predates this in Icelandic. Until the early twentieth century, *yfirsetukona*, ‘the sitting-over woman’, was in use as the word for midwife. In 1924, the professional name for midwife was registered as *ljósmóðir*, and the name of the school became Ljósmæðraskóli Íslands, ‘the Mother of Light School of Iceland’, marking a shift in professionalisation (Ólafsdóttir 2006). This shift maps out alongside changes in status and a rise in professionalism across European midwifery contexts, in which late nineteenth-century campaigning to create midwifery and nursing registration was made along the lines of creating new professional identities for midwives (Borsay and Hunter 2012, Leap and Hunter 1993). Middle-class, reformist campaigners for this professionalisation sought to align nurse and midwifery identities with those of a health missionary, encouraging the midwife in ‘making herself a little centre of light and knowledge amidst the ignorance and misery she longs to mitigate’ (*Nursing Notes* 1906: 173, cited in Hannam 1997: 82), demonstrating a particular moral framing of ‘light’. There are records, however, of a handful of ‘light-fathers’ who have worked in the country (Einarsdóttir 1984). This figure of *ljósmóðir* is celebrated and valorised, with a public vote deeming it the most beautiful word in Icelandic (Háskóli Íslands 2013), and is, as will be explored, attached to a framing of maternal altruism midwives sought to challenge.

The act of *yfirseta*, 'sitting over', or the practice of 'being with' is an integral part of midwifery, and is a practice associated with the development and continuation of midwifery knowledge (Ólafsdóttir 2006). It references both an older Icelandic name for midwife, *yfirsetukona*, the 'sitting-over woman', as well as a practice specific to midwifery: the act of being-with, or sitting-over a woman's labour. This 'art' of midwifery work is referenced within midwifery as a key skill that develops with time and experience (Gottfreðsdóttir and Karlsdóttir 2009). In a physiological, uninterrupted labour and birth, the gold-standard midwifery role is one of 'watchful waiting' in which there is minimal intervention. The term *yfirseta* describes this role and activity well, framing the labour of midwifery as being one of unfussed presence and a skilful watching of the labour unfold. It is interesting to consider how this framing of work becomes folded into moral descriptors of idleness and time-wasting (Latimer 2000, Marlow 1979). This maps out alongside enduring, popular tropes of midwives as 'gossips', stereotyped by the character Sarah Gamp in Dicken's *Martin Chuzzlewit*, who remains a caricature of lazy midwifery and incompetent care (Dickens 1982). Attention to this language raises questions about shifts in the moral framing of midwifery and of proper midwifery work, and what the practice of labouring as a midwife should be constituted by, as I explore later in the thesis.

Across a variety of European contexts, the localised impact of health service reforms under neoliberalism have shifted the content of day-to-day midwifery work (Sandall *et al.* 2009). While the content and inheritance of this work may be presented as the timeless routine of attending pregnancy and birth, this thesis examines contemporary midwifery work as shaped and reproduced within and through neoliberal economies. Paying attention to the ways in which service provision changes, as the result of neoliberal policy making, cause effects in the ways in which workers experience their labours as subjective and professionalised experience, is important to pay attention to (Ganti 2014). For example, the changing geographical centralisation of maternity services shifting midwifery work into large, regional hospitals has been a key policy and organisational change in Icelandic health care services, and runs parallel to the organisation of

services in other neoliberalised economies, including the Nordic region. In Reykjavík, the construction of a new *sjúkrahótel* ('hospital hotel') over the course of my fieldwork symbolised this centralisation move. Watching the construction of this large, multi-story building develop outside the hospital maternity unit was a reminder of the story of midwifery service change unfolding in the country. Attached to the National Hospital, and adjacent to the Women's health department, the *sjúkrahótel* was built to accommodate people visiting the hospital from outside the capital region for services, and who would otherwise need to stay in privately-rented accommodation in the city. It could be used by families using the maternity services in the hospital. It was staffed by clinical staff, and with the Women's health department next door, provided easy access to a range of facilities. This hotel was being specifically targeted at maternity service-using families who would be travelling in from outside Reykjavík. It was specifically about adapting to and normalising the centralisation of maternity services. At the same time, protests about the closure of smaller maternity units erupted elsewhere, and a stand-alone, midwife-led birth centre opened in the capital.

1.2.4. Financialised crisis and the fieldwork context

The period of my fieldwork was bracketed by two general elections, and protests following the Panama Papers scandal marked my arrival in Reykjavík; the largest protests ever seen in the country unfolded, with the public contesting financial inequality and parliamentary corruption. Over the course of fieldwork, public anxieties about the Icelandic economy marked media discourse and everyday life (Loftsdóttir 2018, Maraj Grahame 2016), in conjunction with the recent history of financialised crisis, and a volatile public trust in public finance and political structure (Thorsteinsson 2016, Wade and Sigurgeirsdóttir 2010). Anthropological literature voicing Icelanders' experiences of growing disparity and inequality, arising from the separation of a 'global elite' from 'ordinary' Icelanders and the repercussions of the financial crash (Loftsdóttir

2014, Pálsson and Durrenberger 2015), formed the research context I stepped into. Understandings of this disparity have been explored by ethnographers through the juxtaposition of the brazen, risk-taking international investment banker, the ‘Business Viking’, with the tax-paying, risk-averse Icelandic citizen in public discourse (Loftsdóttir 2015), as my ethnography will further explore in the context of midwifery.

The global financial crisis of 2008 had significant implications for the Icelandic economy and everyday life (Durrenberger and Pálsson 2015), and is referred to colloquially as the *kreppa* (the ‘crash’). In the early 2000s, the lifting of regulations on privatised Icelandic banks encouraged these financial institutions to borrow from foreign lenders and depositors, creating, for several years, a normative culture in which Icelandic banks kept minimal cash reserves, and Icelanders drew heavily on credit for household expenditure, borrowing foreign currency from foreign banks with low interest rates, and repaying these debts with Icelandic krónur. Between 2001-2007, the Icelandic stock market had risen in value an average of 44% per year, creating ‘a bubble that simply had to burst’ (Durrenberger and Pálsson 2015: xvii). When the financial crisis in the United States began unfolding, it became apparent that Icelandic banks were deeply in debt to foreign lenders, and lacked cash reserves to shore up the debt; the three largest banks, *Kaupthing*, *Landsbankinn* and *Glitnir*, owed debts of over ten times Iceland’s GDP. Lenders ceased lending to these banks, and in 2008, the krona crashed; Icelanders’ wages halved in value against the foreign currencies they had been borrowing from, and the price of all imported consumer products doubled (*Ibid.*). In October 2008, the Icelandic government nationalised the banks, froze the stock market, and accepted a \$2 billion IMF loan, in order to secure the economy. The structural adjustments demanded by the terms of this loan negated the Icelandic social contract underpinning civic life, and the resulting public insecurity and anger led to wide-spread protests in Iceland, known as the ‘Pots and Pans Revolution’. This sociohistorical context, therefore, underpinned the period of this research; in 2018, the anniversary of the *kreppa* was marked by public conversation, talks and events to process the social change Icelanders had

experienced as a result of the boom and bust years and the lived experience of financialised crisis. I note here that in using the term ‘financialised crisis,’ I follow Durrenberger and Pálsson’s (2016: xi) suggestion that discussions of ‘financial crisis’ can too narrowly focus on economic issues, rather than considering crisis as multiple, complex, and intersectional. Rather than use ‘financial crisis’ as a catch-all descriptive holder to describe a complex socio-historical context, in discussing different forms of crisis in the context of Icelandic midwifery, and in referring to a specific context in which Icelanders experienced multiple forms of crisis, I have chosen to refer to ‘financialised crisis’ in order to express a particular lived experience of crisis that can be described as financialised.

Social changes brought about by the *kreppa*, the 2008 financial crisis, such as healthcare reform, and growing class divisions, shaped the sociopolitical landscape of my research. Anthropologists have documented changing social relationships and healthcare worker subjectivities as effects of neoliberal reform in Iceland (Árnason and Hafsteinsson 2018). Changing arrangements of midwifery work (Wrede *et al.* 2008) were compounded by the banking crisis, which caused an intensification of social insecurities within Iceland (Willson 2015). One of the central repercussions for midwives following the crash was the experience of unemployment, an unprecedented trend in which newly qualified midwives were unable to find work in the immediate years following the crisis (Magnusdóttir 2010), and in parallel to a broader unemployment peak of 9.2% in 2010 (IMF 2013). A group of these graduating midwives went on to establish a private, stand-alone birth centre, in response to difficulties in attaining secure work at the National Hospital. Pressures of staff and resource shortages, resulting from the impact of neoliberal reforms within Icelandic healthcare, preceded the period of my fieldwork (Benoit *et al.* 2011). The Minister of Finance, named as a beneficiary in the leaked Panama Papers, was reinstated to public office, and was one of the main politicians the midwifery union fought with during the *kjarabaráttta*. In following these threads through the particularities of Icelandic midwifery, I demonstrate that ethnographic focus on this North Atlantic island can

speak to other contexts of midwifery, and that the politics of this specific set of work crises, disputes and tensions this thesis describes are not exclusive to Iceland, but reverberate across many different contexts of midwifery work. Midwifery protests, disputes, and negotiations have and are occurring across a range of industrialised countries, in the Nordic region and beyond (Hunter *et al.* 2019), and it matters that we pay ethnographic attention to them.

1.3. Literature review

In this thesis, I use the concept of a ‘care deficit’ to explore the politics of care experienced by protesting midwives. In this section, I turn to explore the literature in which this thesis is grounded, drawing on the anthropological literatures of care, work, and midwifery. This concept of the care deficit draws together ethnographies of health care, political economy, anthropologies of midwifery, and of work. I trace the work relevant to this thesis in the following sections. I examine intersecting, thematic pools of literature on the anthropologies of work, care, and midwifery, as well as ethnographic and qualitative research within midwifery. I demonstrate how drawing on anthropological literature on the economy in order to frame questions about midwifery work and protest is productive. This section addresses questions of how neoliberal contexts of midwifery work have been represented in the literature; how an ethnographic focus on emotional labour is useful for considering affects such as discontent as part of a politics of care.

In this section, I introduce the care deficit and how it has been used in the literature. I then explore anthropological work on the economy in order to define an anthropological understanding of neoliberalism and establish how ethnographic approaches to the effects of neoliberal change help ask questions of midwifery; I also show how literature on social

reproduction is useful for examining midwifery work. I examine ethnographies of midwifery work to show how a politics of work and political economy in midwifery has been addressed. I next explore writing on the work ethic, and the ways in which this speaks to midwifery literature exploring a specific ethic of work within midwifery. Finally, I address anthropological literature on care to understand it as something requiring troubling, and in order to use these messier ideas of trouble, deficit, extraction and economy in order to understand the midwives' *kjarabarátta*.

1.3.1. The origins of the 'care deficit' in the literature

While this thesis mobilises the concept of a 'care deficit' in order to explore the work and protest of midwives, it is important to trace the genealogy of this concept. The 'care deficit' was first introduced by Hochschild (1995) as a way of describing a structural lack of care under late capitalism. Hochschild argues that a 'deficit', or gap in care provision occurs when there is a simultaneous contraction in the supply of care, alongside an expansion in the requirement for it; the care deficit is therefore a way of describing a social context of a lack of care. Hochschild explores this in the context of the United States, where work arrangements, gendered divisions in work and care, and political administration and policy create a particular economy of caring. Hochschild suggests that while care is necessary and needed, our very *idea* of care has become privatised, in that the provision of care has come to be seen as the responsibility of individuals, and contained family units, rather than being seen a collective responsibility, a public good or resource, or something provided for by the state. Hochschild's concept of the care deficit asks us to consider the ways in which understandings of care, the economy, work and gender subjectivities are split between the realm of private and public under late-stage capitalism. Authors have used Hochschild's idea of deficit to explore the structural ways in which a care deficit maps out in the unequal organisation of work and care through people's homes, workplaces, across geographic borders, and through categories of gender, race and class

(Hochschild 2003b, Nadasen 2017, Zadoroznyj, Benoit and Berry 2012). A care deficit expresses the tangible ‘gaps’ created by financialised capitalism, and these gaps express a ‘crisis of care’ in which the reproduction of a life lived with adequate care is impossible (Fraser 2017).

Hochschild’s concept of a care deficit has had some traction in anthropological work and has been used to frame a particular politics of care, including in ethnographies of health care. Using Hochschild’s framing, Bone (2002, 2009) has explored the ways in which a care deficit impacts the work of maternity nurses in the United States, within a context where midwifery is absent as a distinct profession, and the work of intrapartum care is provided by obstetric nurses within hospital wards. Bone traces the effects of neoliberalised restructuring and financing of health care services, showing how managerial strategies, such the restructuring of healthcare service and clinical mergers, and cost-efficiency measures, such as shrinkages in the time available between nurses and patients, have impacted upon the labour of nurses (Bone 2002). Nurses she interviewed reported experiencing lower staffing numbers and an increase in their workload as consequences of managerial restructuring, a reduction in the time available for them to conduct their work, including emotional labour. Bone shows how nurses’ emotional labour is being practiced in the context of a care deficit where the demand for this labour, the provision of care, exceeds the supply of it; she argues that emotional labour has become displaced through neoliberalised changes in the way care is organised and provided. Due to an increasing structural lack of care, shifts in occupational subjectivities were reported, with nurses experiencing a sense of loss of professional identity around caring. Bone demonstrates how the resources and support available to nurses are becoming increasingly ‘problematic’, requiring shifts in the ways in which nurses understand, perform, and identify with their work.

This ethnographic work on the care deficit, and its implications for maternity staff, raises questions about other areas of the literature. I suggest that Hochschild’s concept of a care deficit opens up ways of thinking about economies of care, labour, and the ways in which care is

practiced and experienced in particular sociopolitical contexts. This focus on the ways in which a care deficit, as a structural condition within which maternity staff work, opens questions about the ways in which maternity nurses and midwives experience healthcare reform as something that impacts their work, bodies, feelings, and social relationships. I turn now to explore anthropological work on the economy.

1.3.2. Making a life: anthropological approaches to 'the economy'

'A life worth living', and what constitutes well being is a theme explored by Narotzky and Besnier (2014) in examining anthropological approaches to the economy, and exploring the ways in which the economy can be approached in order to work against neoliberal doctrine. How people construct, negotiate and reproduce a liveable life is a central question for anthropologists of the economy, labour and work. In approaching 'the economy' and economic life anthropologically, I draw Narotzky and Besnier's (2014) understanding of the economy as the 'effort to make life' (2014: S14), grounding economic processes and practices in the everyday activities of people. Unsettling dominant economic paradigms and normative assumptions about what constitutes 'the economy' or 'the market' is a central project for anthropologists of the economy (Wærness 2005). Rather than understanding contemporary capitalism as an abstract model and separate domain of economic life, anthropologists challenge this orthodoxy by approaching economic life as something embedded in the everyday lives of people (Ganti 2014, Loftsdóttir et al. 2018, Narotzky 2018). Economic life is constituted by the practices, experiences and affects of waged labour, social relations, care and provisioning; forms of social practice often considered marginal to normative economic models (Ortner 2011). Economic life under late-capitalism is shaped by particular imaginaries (Fisher 2009, Fisher and Gilbert 2013). These authors suggest that making a liveable life is about not only the exchange of labour for wages, but

the work, care, longing and hope people negotiate in order to create a secure and possible future for themselves.

In terms of phrasing, I follow Ganti's (2014) suggestion that 'late capitalism' be used as a descriptive concept referring to shifts in the relationships between states, capital and labour, and the ways in which the structures of production are organised. 'Neoliberalism' is instead a 'prescriptive concept' referring to a 'normative vision of the proper relationship between the state, capital, property and individuals' (Ganti 2014: 93). For anthropologists, neoliberalism is used to critique the social conditions of informants' lives, and refers to 'a darker, bleaker narrative' (Ortner 2011). Anthropologists of neoliberalism have explored the ways in which ethnography can focus on two broad, interconnected layers of neoliberal effect: structure and subjectivities. It is understood in ethnographic analysis to be both a structural and ideological 'force' which impacts the way in which people experience their lives, social relationships, and their sense of belonging in the world (Ganti 2014: 94). The anthropology of neoliberalism therefore helps us focus on the ways in which people not only experience neoliberalism, but develop strategies to cope with the material, structural and subjective effects of neoliberal policies. It also aids focus on the effects of neoliberal policies on workers: ethnography demonstrates that neoliberalism is interlaced with experiences of increased uncertainty, precarious employment, temporary contacts, and casualisation, in which these experiences are normalised and embodied (Molé 2010). Effects are about both the changes in structural, material conditions of workers (Harvey and Krohn-Hansen 2018), and changes in the kinds of subjectivities that workers are expected to embody, such as flexibility and resilience (Freeman 1998), as well as the emergence of new worker subjectivities in the form of the 'precariat' (Millar 2014, Muehlebach 2013, Prentice 2020). Anthropological literature also helps us understand how shifts in employment, the 'dismantling of full-time, stable [employment]... has eroded many people's sense of security and faith in a predictable future' (Harvey and Krohn-Hansen 2018: 13). This sense of insecurity and precariousness can involve a sense of lived fragmentation; 'working lives' are, for most people, not

concurrent with ‘the relatively secure income-generating environments of stable wage employment, which appear as a short-lived historical exception’ (Narotzky 2018: 39). Narotzky (2018) notes that on the one hand, neoliberal policy has degraded secure waged labour, involving a rise in flexible work, temporary and part time jobs. On the other hand, she notes that ‘self-employment and petty entrepreneurialism as recourses against the failing of secure wage employment opportunities have been actively promoted as a way to enhance individual autonomy and escape the shame of depending on state benefits’ (Narotzky 2018: 39). Both these things are forms of precarious labour, documented by anthropologists discussing the rise of the ‘precariat’ (Muehlebach 2013).

Rather than exchange being thought of as the main form of economic activity, the continuity, change, and reproduction of life can be seen as the centre of economic activity (Narotzky and Besnier 2014). Literature shows how the economy is about practices and work people do in order to reproduce lives and provision the future (Narotzky 1997, 2018), a practice I examine in detail through an ethnography of midwifery conferences in Chapter 4. People project their hopes and aspirations into the future, and express this through projects organised around making a better life. The work of autonomist feminist theorists such as Federici (2012), draws attention to the ways in which ‘care’ obfuscates work (Bhattacharya 2017). This literature demonstrates how gendered caring roles have historically often been seen as above or below work; the Wages for Housework campaign challenged the ways in which time and tasks are framed, how they are made meaningful, and the role they play in capitalism (Dalla Costa and James 1975, Federici 2012). Marxist feminist work on unwaged care work shows how this work encompassed both scholarship on ‘emotional labour’ or ‘affective labour’, and ‘social reproduction’; this work was exploited labour which capitalism required, but did not provide remuneration for. Marxist feminist scholars argued that unwaged care labour has been historically, politically devalued (Murphy 2015). At the same time, another branch of feminist scholarship examined care politics from a different angle, looking at how waged emotional labour within service industries was

deeply gendered, in which affective labour is required, and a part of paid work (Murphy 2015, Hochschild 2003[1983]). The way in which work is organised involves specific, gendered values which support divisions of labour and care, with women encouraged to find purpose and meaning in the work of tending to the care of others (Navarro 1976), and unpaid reproductive work has often been framed as ‘female’, and private (Benoit and Hallgrímsdóttir 2011). This literature shows that the ways in which people might be cast as making a life through work is value-laden, and deeply politicised, in terms of what such a life might look like, and what the work one might do to obtain it looks like.

Authors point to the ways in which the politics of care might be thought through in terms of promising a future, and reproducing a liveable life (Duclos and Criado 2019, Haraway 2016). For example, Verdugo-Paiva’s (2020) ethnographic research on the paid and unpaid work of working-class mothers in Chile demonstrates how the desires of women and their daughters to transcend the reproduction of class and gender challenges us to think about how reproductive labour can be disruptive. Rather than being about the maintenance of a particular set of social relations, reproductive labour—such as acts of care—is about challenging the social reproduction of capitalist structures. For example, daughters hope that by creating and inhabiting different futures they might themselves become financially independent of men, and help their mothers shift their lives beyond ‘machista relationships’ and poverty (Verdugo-Paiva 2020). The ways in which people go about reproducing their lives, entangled with others, is about resisting and shifting the patterns and structures that reproduce conditions of poverty and gendered dependence.

Bringing together literature on the anthropology of the economy, neoliberalism, and work with midwifery is useful because it frames questions about midwifery care and work as being about economic practices. Economic anthropology turns our attention to this question emerging from Bone’s research: how do maternity staff live within and experience neoliberalism? While it is

commonplace to think about midwifery's involvement in the physiological reproduction of life, and of midwives having the skills and expertise to practice this, I suggest here that using ideas around social reproduction in order to think about the reproduction *of* midwives and midwifery is useful. What about if we approached labour, within scholarship on childbirth and the work to facilitate this, as also being about the labour of midwives, and the reproductive work they do to secure their own future? What forms of material, affective, and imaginative work does this involve? How do midwives reproduce their professional lives within capitalism?

1.3.3. Midwifery and the politics of work

A focus on economic life in maternity care opens up themes such as the way in which maternity and reproductive services are imagined organised according to market principles, consumer rights and rhetorics of choice (Craven 2007, Unnithan and de Zordo 2018), as well as how the transformation of health care into something marketed and commodified is part of a process of biomedicalisation (Clarke et al. 2003, McCabe 2016), involving shifts in work towards measurement of outcomes, focus on institutional protocol and policies, as things which determine midwifery work, rather than the commitment to providing women-centred care (Fitzgerald 2012). The privatisation of state services, such as healthcare, has led to new work configurations in which requirements for affective labour find reliance on care work, often volunteer and unpaid positions (Harvey and Krohn-Hansen 2018, Muehlebach 2011). Healthcare staff experience work speedup and time constraints due to healthcare reform, restructuring, and restrictions on resources (Bone 2002, Hochschild 2003a, McCourt 2009). The anthropology of work raises questions about people's experiences of dispossession (Narotzky 2018).

Ethnographies of midwifery raise questions about the absence of work and political economy of midwifery. Ethnography provides a rich, critical literature on childbirth and reproductive experience across a diversity of clinical contexts (Davis-Floyd and Sargent 1997, Jordan 1993, Rapp 1999). Within this literature, midwives have a limited visibility as workers. In resource-rich contexts, the labour of midwives is often framed in terms of their complicity in biomedical, obstetric regimes of care (Benoit *et al.* 2005, DeVries and Barroso 1997, Hyde and Roche-Reid 2004, Lane and Reiger 2013, Sandall *et al.* 2009), and frequently in their incapacity to respond to broader inequities of maternal health in resource-poor contexts (Cosminsky 2012, Pigg 1997, Pinto 2008). On the other hand, in analyses of resource-rich contexts, midwives are often collapsed into an edifice of ‘biomedical’ practice, portraying contexts of obstetric work taking place within institutional settings which are inadequate, or devastating for women (Davis-Floyd *et al.* 2009). The ways in which midwives experience shifts in subjectivities, such as individualisation, entrepreneurialism, and come to understand a specific economic framing of their work is an under-researched area of the literature (Lanlehin 2018, Sandall *et al.* 2009).

One of the ways in which these shifts occur is through the use of pain relief during intrapartum care. As salaried providers of care, labour ward nurses experience a ‘squeeze’ in which they were expected to work more with less, and patients were expected to cope with less care (Bone 2009). Bone (2009) argues that nurses’ use of epidural anaesthesia as an intervention in labour is a way for these workers to plug the gaps in care. Employing the use of epidurals remedies the care deficit maternity nurses experience in their own bodies, and addresses the limits of their capacity to provide emotionally intensive care. Bone argues that the prevalence of epidural anaesthesia is a way of understanding how the care deficit maps out within North American maternity care. Using a pharmacological reduction of pain represents a shift in the kind of care work being conducted by maternity staff: it requires a different type of emotional labour, and care becomes something about technical expertise, pharmacological and time management, and control (McCourt 2009). Work becomes something procedural, as the management of

epidural anaesthesia requires an intensification of task-based, routineised work. Bone's research opens up questions about the ways in which a care deficit is experienced by maternity staff, how it shapes working conditions, and how we might understand the strategies maternity staff deploy in order to cope with these changes (Hunter 2010).

This research helps us focus on how the effects of neoliberal policy in clinical work contexts, emerges in the affective dimensions of healthcare work. The politics of care—the social relations and practices constituting care, an ability to care and be cared for in maternity work—are intimately tied to contexts of managerial change brought about by neoliberal policy (Benoit *et al.* 2005, Sandall *et al.* 2009, Wrede 2001). Ethnographies of midwifery work points us towards how some of these strategies to accommodate managerial protocol, time management, and resource scarcity can be subversive in contexts of midwifery work (Fordyce and Maraesa 2012, Hunt and Symonds 1995, McCourt 2009 Scamell and Stewart 2014). In an ethnography exploring midwives' use of vaginal examination and partograms to monitor labour progress, Scamell and Stewart (2014) find the work of midwives in subverting clinical protocol to be about the mitigation of unnecessary and damaging categories of 'risk'. I read this research as opening a fascinating set of questions about how midwives negotiate their own well-being and capacity to care. A concept of 'well-being' here underscores an anthropological approach to economic life, where people are able to accomplish 'socially reasonable expectations of material and emotional comfort', with the sufficient, diverse, and accessible resources available to them (Narotzky and Besnier 2014: S4). This work opens up questions about how midwives experience a care deficit; how midwives might experience care being something extracted from them, and how they might strategise to resist it. Ethnography suggests that maternity nurses and midwives resort to work that involves less bodily and affective depletion, where opting for protocol-based and technical forms of care in the day-to-day work on a maternity ward might be the safest way for midwives to negotiate a care deficit, and to 'learn to live without much care' (Bone 2009: 57).

Some research finds maternity units comparable to factories, in which an industrial model of care is the organising principle for midwifery work, and the hospital as a site in which reproduction is understood as a form of production (Hyde and Roche-Reid 2004, Martin 1989). Hunt and Symonds (1995) note the significance of ‘labour’, as something which is both the activity of birth, and the organisation of work. This vernacular, and the ways in which the work of gestation is also a form of labour, is explored by Lewis (2019).

Two hospital ethnographies of contrasting clinical environments – a midwife-led birth centre (Walsh 2009) and an obstetric-led labour ward (Hunt and Symonds 1995) – stand out as examples of analysis focusing on midwifery work. In a comparative ethnography of two hospital labour wards, Hunt and Symonds (1995) examine the work of midwives and what it means to be a midwife ‘at work’ on a high-risk, acute clinical setting. This ethnography allows us to reflect on midwifery as work; we have ethnographies of midwifery work in institutions, and clinical ethnographers exploring the work and routines that exist in clinical midwifery.

Their research examines how the occupational identity of midwives is constructed through everyday work practices, disentangling the procedures and activities that are ordered within rhetorics of ‘real’ work. For midwives in this study, ‘proper’ midwifery was associated with processes that were efficient and standardised; delay, procrastination, slow labours and chatter on the ward could not be tolerated as ‘work’ due to the potential for disruption to the system, and to professional image. ‘Care’ is shown to consist of routines of work, rather than specifically ‘biomedical’ orderings, and these routines are organised within clinical environments along both temporal and gendered lines (Hunt and Symonds 1995, McCourt 2009). Walsh (2009: 128) notes that hospital-based midwifery is often ‘steeped in a culture of busy-ness’, and it is organisational and employment imperatives that drive the unfolding of women’s labours, and the midwifery work organised around managing them. Within these ethnographies, work is spoken of in terms of Fordist management, involving factory metaphor such as ‘assembly-line’ and

‘conveyor-belt institution’ in order to explore and expose midwifery as work (Hunt and Symonds 1995, Rothman 2014, Walsh 2009). The use of factory metaphor remains a dominant way of discussing and presenting women’s working lives, making the politics, architecture, and feeling of labouring within clinical spaces legible to those who have not encountered working life there.

Walsh (2009) provides an unusual ethnographic portrait of a free-standing birth centre, examining the day-to-day work of midwives employed within territory of a district hospital. The birth centre provides an interesting example of clinical place and ‘hospital midwifery’; it is not an obstetric ward, but is a small building staffed by midwives and maternity care assistants, located at a distance to the nearest consultant-led maternity unit. Walsh’s chapter foregrounds the work that midwives do in this particular clinical place, examining how this work is organised, and the ways in which some forms of work conducted by midwives are made invisible. Within the birth-centre, ‘care’ is ‘typified by an absence of task orientation and time-defined routines’ (Walsh 2009: 133). The work enacted by midwives transgressed ‘traditional’ boundaries between being on or off duty, as well as rhetorics of ‘proper’ midwifery work: midwives called in on their days off, and the centre’s communication book was as full with building-related issues as those considered clinical, ‘yet hospitality and upkeep were seldom mentioned in the staff interviews’ (Walsh 2009: 137). By capturing the variety of day-to-day work – such as labour support, answering phones, cleaning floors, making drinks, managing engineering problems – this ethnography emphasises how midwifery work consists of multiple material and emotional orderings as part of a ‘lived experience’ of work.

1.3.4. Ethic of work

A specific ethic of work (Weeks 2011) is prevalent in midwifery, and within professional literature the culture of midwifery has been framed as being predicated on an ethic of service (Kirkham 1999), in which gendered constructs of ‘service, self-sacrifice and conformity’ historically underpin framings of midwifery work (Hunter 2010: 261). In the literature, the concept of a ‘service ethic’ raises broader questions of what it means to care and to forge a professional identity around the occupational activities of caring (Benoit 1994, Benoit and Hallgrimsdottir 2008, Stacey 1981). Labour can be important for people’s sense of worth (Muehlebach 2011, 2016). Midwives’ experiences of emotional reward at work occur in a context in which there are occupational standards for emotional labour (Cronk 2010, Fitzgerald 2008, Hunter 2004). The performance of affect can be necessary in providing ‘good care’, whether or not the feelings communicated are actually felt. This raises questions about midwives’ experiences of care as an extractable resource, as well as experiences of alienation (Ong 1988).

The literature raises questions about the ways we might consider discontent as an affect tied to the experience of work. Other literature points more closely to the ways in which emotional lacks and absences are linked to political economic context; for example, Powers and Rakopoulos (2019) explore how ethnographic attention to the affects of austerity ‘mines the senses and experiences of indignation, frustration, and general discontent’ (2019: 5). Ethnographic research points to the ‘anxieties and strategies’ that the experience of neoliberal policy produces (Narotzky 2018: 40). Anthropological literature on work suggests we can think about specific affects, such as ‘discontent’, as an affective language tied to labour history, industrial action and strikes (Harvey and Krohn-Hansen 2018).

Midwifery research on emotion work in midwifery raises interesting questions about the ways in which midwives go about negotiating wellbeing at work, exploring the ways in which

midwives experience emotion and how this links to attrition, satisfaction, and fulfilment (Hunter and Deery 2008). Emotional labour constitutes the structure and content of much of what we see as midwifery work, and is mobilised as an occupational resource (Wharton 2009). Within maternity care, the way in which not only women's experience of birth, pain and mothering are affected, but the experience of the labour in facilitating this is affected too (Bone 2009, Hunter 2010). Hunter's extensive work on emotions in midwifery (Hunter 2010, 2018) points to the ways in which an inadequacy of time and resources to create and maintain emotional relationships, and the absence of these emotional relationships, can be alienating for both families and midwives caring for them. Hunter notes "a labour ward of women who are all attached to epidurals and electronic monitors can be 'managed' by technicians, often operating at a distance from a central surveillance station. As a result, the emotion work skills of childbirth attendants become devalued and eroded, and the focus of work becomes task related rather than relational. This is clearly a desolate situation for both women and their carers" (Hunter 2010: 258). How midwives experience a sense of loss and depletion in care and work provides an interesting background to questions of lacks in care. The literature suggests that emotional labour involves suppressing discontent, and that experiences of 'emotional dissonance' point to the difficulties of squaring difficult feelings of loss and insecurity arising from organisational restructuring, alongside requirements to perform particular affects as part of a midwifery role (Bone 2002). Hochschild (2003a) argues that part of the emotional labour of nurses involves the suppression of disappointment or exasperation—negative feelings elicited, for example, by the absence of recognition for work done, such as an absence of feedback. Hochschild calls this 'appreciation starvation' (2003a: 69). Hochschild's reflections on how employees resort to using feeling as a transactable resource in the context of an absence of emotional reciprocity is an interesting framing of a sense of a deficit of feeling.

In her provocation of the valorisation of work, Weeks (2011) seeks to unsettle and defamiliarise the work ethic, in which we find the concept of a sense of vocation, where people

feel ‘called’ to a particular form of work. She finds neoliberal restructuring to be part of a new ethic of work, in which people are encouraged to devote themselves to work, not just in terms of time and the development of specific, technical skills in one’s body, but a devotion that involves ‘the labours of the head and heart’ (Weeks 2011: 69). This is not just an orientation to work involving the development of affective skills, such as competency in emotional labour (Hochschild 2003, Fitzgerald 2008), but the requirement to have a complete physical, emotional, subjective embodiment and orientation to a profession. This sides with anthropological reflections on how one of the significant effects of neoliberal policy are the changes people experience in their subjectivities; neoliberalism represents a ‘force’ that impacts on the ways in which people form and align their subjectivities in relation to specific values of work (Ganti 2004). Weeks picks up Weber’s (2001[1930]) work on the protestant work ethic to explore how a sense of moral contingency around work, and a subjective sense of calling has developed in conjunction with capitalism. The experience of work as vocation, and of having a ‘calling’ to occupy a specific professional identity and enact specific forms of work (Weeks 2011), have been explored ethnographically (Fitzgerald 2004, Hull 2020, Vacchiano and Afailal 2021). As I will explore in Chapter 5, this work has salience with discussions about how midwifery work is orientated around an ethic of service and sacrifice, a sense of duty, and how it is that midwives experience this.

Tensions around healthcare workers’ motivations to go to work, and embody a particular professional role, are explored in Fitzgerald’s (2004) ethnography of nurses. Care is framed by moral framings of work, in which motivations to earn a wage through care work are viewed as problematic. Nurses are expected to embody a vocational ethic of service, rather than attend work in order to earn a living and reproduce the material conditions for their lives. This is highlighted in interview data, where a clinical manager comments on the trope of ‘appliance nurses’, saying ‘Not everybody necessarily comes to work to provide a high-quality service everyday. They come to work for a variety of other reasons and I remember years ago (name deleted) used to say there

were nurses who really cared and there were appliance nurses. These were nurses who came to work to get enough money to buy the new appliance—whiteware!’ (Fitzgerald 2004: 337). In this extract, the manager equates a ‘high-quality service’ with a framing of authentic care in which nurses should be motivated to work primarily out of a compulsion to care, rather than in order to attain the material conditions needed for a liveable life. This ethnography foregrounds tensions discussed by social reproduction theorists, that authentic care is both an act as well as an embodied feeling; it is right that healthcare workers should desire care of another, and this orientation towards care as service towards another is gendered, as feminised occupations such as nursing and midwifery contain moral understandings of care and caring understood as a ‘natural’ aspect of how the labour of health care and professional roles are divided (Henriksson *et al.* 2006). Women’s health care roles are understood as being ‘confined to care’; women are cast as emotional labourers and care is understood to be a natural attribute feminised quality, rather than as work (Henriksson *et al.* 2006: 177, Hochschild 2003b). In this framing, caring for a wage is seen as inappropriate and contradictory to the ideal of care work. Scholars have shown how this framing leads to a ‘fetishisation of sacrifice’, in which care workers are required to desire and find pleasure in working for free (Muehlebach 2011: 75). The desire to attain a secure life, perhaps through the purchase of domestic appliances that might make the variety of gendered reproductive labours they need to engage with more bearable, as well as desires for a pleasurable life, perhaps through aesthetic aspirations for appliances that feel good to live with, is relevant to contemporary framings of midwifery work, care and vocation, as I will explore in the coming ethnographic chapters.

1.3.5. Troubling care in the literature

In anthropology, the subject of ‘care’ has proliferated, and captures a broad, diffuse range of practices, affects, and conditions (Alber and Drotbohm 2015, Black 2018, Han 2018).

Ethnographers have explored the messiness of it as a subject, complicating framings of ideal care: care's meaning in terms of affect is multiplicitous and expansive, designating emotional attachment, the desire to look after, the state of feeling concerned, as well as pointing to meanings that are about being troubled, worried, or unsettled (Duclos and Criado 2019, Haraway 2016, Murphy 2015, Park and Fitzgerald 2011).

Care is imagined to sit at an awkward intersection between work and non-work, and feminist scholars have sought to trouble this division by showing how care is both undervalued work as well a valuable, affective practice of connecting with others (Federici 2012, Fraser 2017, Hochschild 2003b). Scholars critical of this work, such as the Wages for Housework Campaign, have suggested that calls to remunerate care as a form of affective labour were also subsumed into a particular stage of capitalism (Murphy 2015). For Hochschild, care signifies an emotional bond and responsibility towards another's wellbeing, requiring emotional work that is seen to be so intimate and personal, and 'so involved with feeling, that we rarely imagine it to be work' (2003a: 214). This framing has historically, and still, obscures the *work* of care, the thought, time, skills, affects and presence put into practices of care, as I will explore in this thesis. Understanding the economy as the effort to reproduce life recenters our ideas about what economic processes are around the 'human need of mutual support' (Narotzky and Besnier 2014: S7). In this recentring, care is understood as both central to economic practices and contemporary capitalism, as well as a practice to be foregrounded which works against the grain of the self-interested individual promoted in neoliberal theory (Navarro 1976). Feminist approaches to the economy importantly demonstrate the centrality of relationships—of mutuality, solidarity, and dependency—and of emotion; an approach running in parallel in midwifery literature, in which intersubjectivity, relationships, and emotion are understood as foundational to good midwifery care (Hunter *et al.* 2008, Kirkham 2010, Martin *et al.* 2015, Page and McCandlish 2006).

Care is about labour and it is a core part of the work of healthcare workers; further, it is not only about affective labour but other forms of work (Fitzgerald 2004). Care has a history in feminist works of conveying the centrality of undervalued and invisible work done to ensure the reproduction of everyday life, as well as the necessity of emotion (Bhattacharya 2017, Federici 2012). Care is understood as both a series of affects and emotional experiences, as well as a practice involving skill and responsibility (Park and Fitzgerald 2011, Wærness 1984); it is both procedure and a felt concern (Williamson 2020). There is a multitude of ways in which care might be carried out as work, in which care is performed as both a professional project and commoditised activity (Alber and Drotbohm 2015). Care is something communicated, embodied, and performed, and is not only to do with interpersonal interaction in contexts of healthcare provision, but also a ‘tinkering’ between people and machines (Mol, Moser and Pols 2010). Practices of care are about the tending to, negotiation and reproduction of relationships, and these practices are shaped by broader social conditions, including policy, such as during the time of the COVID-19 pandemic (Bear et al. 2020). In clinical contexts, “care” is mobilised to signify an emotional orientation, a personal investment of self towards the wellbeing of someone or something else (Fitzgerald 2004). Care can also involve detachment and boundaries (Duclos and Criado 2019), finding appropriate distance and tone (Puig de la Bellacasa 2017). Care is often associated with physical presence and practices occurring among people in direct contact, with ‘a subjective presence, moral sensibilities, and reciprocity’ (Duclos and Criado 2019: 156).

However, “care” also signifies an impersonal, bureaucratic relationship relating to the obligations of performing work within a specific occupational identity (Fitzgerald 2004), and care practices might be thought of in terms of technological or bureaucratic, rather than ‘hands-on’ practices. For example, care is also about the ‘invisible’ organisational skills of healthcare staff, such as administrative competency (Allen 2015). Furthermore, workers may experience the accomplishment of these ideals and standards of care as meaningful (Hull 2012, Latimer 2014, Park and Fitzgerald 2011). Park and Fitzgerald (2011) examine the entanglement of care with

biotechnology, focussing on the work of diagnostic radiographers and examine the ways in which their experiences of providing good care to patients squared with a view of their work emphasising business, efficiency, time management and the closure of intimate talk. Pride in ‘good care’ was in fact, for these radiographers, about their ability and competence in running an efficient service. Affective care was ‘rerouted’ through minimising the time patients spent in clinics, returning them to the care of their families faster. The pressure of time was ‘resolved’ through this ‘re-routing of affect towards the patient via the technologist’s tension to their imaging equipment... These silent acts of mechanised kindness and moral practice are part of that unspoken logic of care which Mol (2008) suggests require more study by anthropologists’ (Park and Fitzgerald 2011: 435). Much of this ‘care’ work was hidden from patients, who did not see the work clinicians did in creating a more efficient experience of moving through the system for them. Unrecognised care was a point of contention for midwives and expressing it was about expressing a neglect of recognition of the actual care they conducted. These ethnographies trouble our assumptions about what might constitute experiences of good care work from the perspective of midwives, as I go on to explore in this ethnography.

Ethnography disrupts taken for granted assumptions about care as something inherently, or necessarily benevolent, involving ‘good’ feeling and positive affect, and care is often conflated with nurture and affection (Murphy 2015). Histories and practices of care, such as gynaecological routines, are deeply entangled with histories of racism, colonialism, imperialism and class privilege, and ‘affects’, as emotions, often conceal the social relations and historical structures that generate them (Martin *et al.* 2015, Murphy 2015). Care may be marked not by the practice of caring activity but by absences (Hyde and Denyer Willis 2020). Anthropological literature shows us how care may be a problem, and that care must not be sentimentalised; anthropology has a history of unsettling expectations of familial affect (Han 2018, Scheper-Hughes 1992). The ways in which we understand care are entangled within late-capitalist strictures of precarity, such as ‘delay, forgetfulness, inattention, and misuse’ (Hyde and Denyer Willis 2020: 297). Assuming

care is inherently a ‘self-evident good’ obscures the ways in which it circulates within discourses and logics of capitalism (Martin et al. 2015: 632). Han’s (2018) ethnography of residents of a Santiago neighbourhood in Chile explores how Chilean neoliberalism is lived through relations constituted by limits of care, within contexts of poverty and economic precarity. For these residents, care is a ‘problem’ in everyday life, rather than something tangibly routine and sequenced (Han 2018: 24). In the lives of Chilean residents, caring for others is a struggle; it is enacted through the everyday, which is informed by history and institutional structures. Han asks what the shifting lines and limits of care are in contemporary Chile, in a context in which violent neoliberal reform continues to take place, not only in personal memory, but in the institutional state structures providing ‘care’ to citizens in the form of irregular health care provision. In this way, ethnography helps us to attend to the conditions of the ‘possibility of care’ (Martin *et al.* 2015: 635).

Hyde and Denyer Willis (2020), care and care taking consist in the everyday, and are as marked by absences as they are by caring activity. These authors suggest we need to ‘destabilize standard thoughts about the way to manage care and caretaking’ (*Ibid.* 2020: 300). For example, Duclos and Criado (2019) turn our attention to the way in which we might consider protest as a form of care, in which protesting *gilet jaunes* in France ‘fight for care for their everyday life’ (Duclos and Criado 2019: 161). Protesters ‘voice their distress in precise, direct terms. They describe an increasing economic strangulation. They express the ordinary stress of privation and of taking care of themselves and their families’ (Duclos and Criado 2019: 161). This literature helps us understand how protest and care might intersect for midwives; that a unifying project of care, premised on, for example, an ethic of care *as* service, does not make easy conceptual space for talking about the absences, lacks, disaffects and deficits of care midwives experience. In following this thread of ‘troubling care’, space is made to ask questions about protest.

1.4. Overview of the thesis and chapter storylines

In this thesis, I explore the ways in which midwives respond to different requirements to live, work and care with and within different kinds of deficits. In this section of the introduction, I provide an overview of the thesis, and introduce the forthcoming ethnographic chapters.

Chapter 2: Methodology and ethics: being a midwife and an anthropologist

In the next chapter in the thesis, turn my attention to the ways in which a politics of care underpinned my methodology. I outline and discuss the methodology of the ethnographic research, first exploring how the fieldwork was shaped through becoming a patient and the ensuing process of ‘accidental ethnography.’ I detail the specifics of the research process, the scope of the field, how I conducted fieldwork, and the research participants of the ethnography. I discuss my positionality as a midwife and as an anthropologist, reflecting on how this complicated the process of ethnographic work; I explore how turning an anthropological gaze on the politics of midwifery work and care, through the process of fieldwork, challenged the ideas and identity I held as a professional and as a researcher. In the last section of this chapter, I reflect on the ethics of conducting anthropological research in Iceland, focusing on the issue of anonymity, visibility and participation in a small professional community.

Chapter 3: Care and deficits: the midwives’ dispute

In this first ethnographic chapter, I introduce the midwives’ *kjarabarátta*, the ‘wage and working conditions struggle’ of midwives, as a significant ethnographic event through which we might ask how questions of care were foregrounded. This chapter opens up the theme of care

deficit in relation to the *kjarabarátta* in order to understand how midwives protested against a normalisation of crisis and deficit. The aim of this chapter is to introduce and set out ethnographic information about the midwives' wage dispute as a key event for understanding a particular politics of care. In this chapter, I first describe the context and key events of the *kjarabarátta*, and reflect on anthropological literature on crisis and affect, suggesting we can understand crisis as a 'structure of feeling', and that this in turn focuses our attention on experiences of affect. Using ethnographic description and interview data, I then explore some of the key events of the dispute and midwives' experiences of them to unpick the ways in which the crisis was described and felt by midwives, and the ways in which they articulated their discontent. I ask how crisis, protest, and dispute might be understood discursively, and point us towards an understanding of the politics of care for midwives. This chapter addresses the *kjarabarátta* as a critical event through which midwives articulated their disaffect with care, and addressed their experience and negotiation of a care deficit. This chapter examines how the *kjarabarátta* was a larger cultural battle over inequalities and inconsistencies in the ways in which midwives earned a living through their work. It asks how the dispute was about a struggle for recognition of work, a recognition of value, a set of demands for a better life, and a reassessment of care. This chapter argues that we can consider the *kjarabarátta* as a moment in which a refusal of a deficit of care is erupting, and a moment in which midwives protested not only a wage deficit, but a deficit of care.

Chapter 4: Midwifery futures: inside a midwifery conference

In this second ethnographic chapter, I explore professional midwifery events through an ethnography of the Nordic Midwifery Congress. This chapter argues that professional events, such as conferences, are places in which midwifery reproduces itself, and we can examine the congress as one site where this takes place. I suggest that the reproductive, relational work of

sociality and talk at the conference is work midwives do in order to provision a future for themselves. Drawing on anthropological research on conferences as particular professional events, I explore the ways in which midwives were at work with care at the conference: the different practices and techniques used to create a particular identity around and of care work, and the work of sociality in creating collective, professionalised identities around care. Drawing on the concept of the economy as the effort to make a life worth living, I explore how conferences might be thought of as comprising economic practices that are about securing a future. How is life projected into the future, and in what ways do people experience ‘hope’ for the possibilities and reproduction of a future life (Narotzky and Besnier 2014)? In what ways are midwives engaged with this form of reproductive activity and hope for their own individual lives as well as collective professional futures? How might attending to these reproductive practices recenter our understanding about midwifery work, the experiences of midwives within contemporary capitalism, and broader anthropological questions about what economic life is?

Chapter 5: “This motherhood feeling”: responsibility for care in midwifery

In the third ethnographic chapter, I explore the relational work of midwives to understand how midwives experience an affective economy. This chapter shows how a deficit of care led to a framing of specific forms of required affect for midwives, in which they were required to demonstrate and inculcate “this motherhood feeling”: altruism, kindness, and an ethic of sacrifice. I examine how midwives’ talk of ‘working for pleasure’ and working for a God’s wage’ were discursively central to their protests. I draw on ethnographic observation and conversations with midwives in different workplace contexts, including a birth centre, an antenatal education class, and an along-side midwifery unit, in order to explore how midwives negotiate and articulate different forms of relational care. I argue that quotidian, relational work can be understood as part of an affective economy, in which midwives cultivate, negotiate and tend to relationships of

care. In the context of a reproductive crisis for midwives, in which midwives negotiate multiple, entangled deficits of finance, resources, affects and care, I turn attention to the relational work involved in this affective economy. I show how midwives experienced requirements to care in this affective economy, in which they experienced inadequate exchange. I explore how moral framings of work, involving a work ethic of maternal altruism, might be understood (Hunter 2010, Kirkham 1999). In this chapter, I suggest that midwives' refusal to participate in a particular work ethic, in which they refused the extraction of particular altruistic affects from them, can be understood in terms of economy. Midwives contested working in exchange for feelings of pleasure, responsibility and altruism. Midwives found a historical continuity with a past in which midwives were required to work for 'a God's wage.' I show that midwives sought to negotiate a deficit of care through the refusal of extraction of affect, and the creation and pursuit of relationships in which affective exchange did not leave them depleted.

Chapter 6: "Doing the job the midwife originally wanted to do": the work of doulas in a deficit of care

Before turning to the Conclusion of the thesis, in this final ethnographic chapter, I turn to a different context of maternity care, and explore the work of doulas in Iceland. In this chapter, I argue that a care deficit has created a market for doula work, and that doulas are emerging as a particular kind of labourer capable of working where midwives are lacking. Through an ethnography of doula training, I explore the ways in which doulas position themselves as a remedy to a care gap, and understand this provision of care and work as necessary. The chapter explores two different threads to an ethnographic analysis of doula training and work. First, I explore how learning to become a doula involves learning to see particular absences and gaps in care, and requires understanding this care deficit as a market. Second, this chapter argues that doula training is about learning how to occupy this market and remedy gaps in care through

entrepreneurial approaches to providing care work. I explore how the inculcation of particular affects around birth work as doulas, such as love, enthusiasm, and passion, speaks to midwives' experience of affective dissonance in learning to live without much care. I suggest that using the concept of a care deficit to frame the emerging work of doulas is a useful way to make sense of the changing context of maternity care.

Chapter 2

Methodology and ethics: being a midwife and an anthropologist

2.1. Introduction

In this chapter, I present the methodology of the ethnographic research of this thesis. This thesis is about the politics of care work; in this chapter, I turn my attention to the ways in which this politics underpinned my methodology, and how my ethnography was shaped by questions of care. I reflect on the accidental ethnography of entering the field as a patient, and how this impacted the experience of fieldwork, and the choices I made in the field. I discuss the ethnographic research process, where and how I conducted fieldwork, and the participants involved. I discuss my positionality as a midwife-anthropologist, reflecting on the theme and pursuit of ‘care’ as a research topic, how this thematic focus is rooted in my own experience of politics, care and affect as a midwife. In the final section of this chapter, I examine the ethical implications of doing research in a small community.

2.2. Fieldwork as a patient

During fieldwork, I broke my foot. I was run over by a car while crossing a car park during a furious winter storm. This incident in my fieldwork was both disruptive and productive. Speeding through torrential rain, by taxi, towards the accident and emergency department of the National Hospital as a patient was not part of my research plan. I treated this experience with the bewildered, yet focused approach of ethnography-by-accident, in which my body was massively implicated. I couldn’t walk for six weeks, it took several months to regain a normal degree of

strength in my leg; it stalled and complicated a research process I'd been approaching with an expectation of pace and legibility. However, the strange alienation of this accidental participation pushed me to focus on the experience of clinical work in a different way, reflecting on bodies, on the texture of space and process without a professional lens. My position of dependency led to an expansion in my social field: new friendships emerged and the support and help I experienced during these winter months anchored relationships that would continue to sustain the rest of my fieldwork. As Enloe (2013) suggests, one's research site must be as broad as the relationships that shape it, and the site of my research was reconstituted by the friendships that emerged through the accident.

I had spent the preceding months preparing for ethical approval from both The National Hospital and the National Bioethics Committee. Not appreciating the calendrical rhythms of Icelandic office culture, it took six months of being in the field for my research to reach full review and approval. Having arrived in the field with a sense of professional momentum, I had withdrawn from talking to clinicians as I wanted to wait to receive ethical clearance before stepping into any clinical space, including conversations with midwives. I felt I needed to respect the timeline of the process and decided not to access any professional networks at the hospital until I had official permission to do so. I felt at risk of jeopardising an ethical process by prematurely moving within a small, close-knit community (Loftsdóttir 2019). I received the approval letter to begin my clinical ethnography from the hospital, by post; sat in my apartment with my left leg propped on a chair in a knee-high plaster cast.

During my appointments at the hospital, I experienced care as something fragmentary, and found systems and processes I expected to recognise as a clinician absent; I couldn't understand them. My fieldnotes from these weeks detail my confusion and observation of singular moments and scenes from the hospital and at home, reflecting on the irony of waiting to 'enter' the hospital, the angst of loss of control over the research process, the indignance at finding myself in

this unexpected space, neither clinician nor ethnographer but hobbling through a parade of clinical encounters and processes. I spent a lot of this time—often in waiting areas—collecting things to notice, adding it to a fieldwork narrative. On my arrival at the accident and emergency department, for example, I was surprised to find a “cashier” desk at the reception, signposted in both Icelandic, *‘gjaldkeri’*, and English. I learned that mandatory charging for acute patient care, such as emergency care or a visit as an adult to a GP, had only been implemented a few years previously. It was through participation as a patient, therefore, that I began to understand the organisation of Icelandic healthcare.

This ‘accidental ethnography’ impacted my fieldwork in several ways. Being unable to access clinical maternity spaces as a researcher made me consider where ‘else’ I might find midwifery work, and encouraged me to think about contexts of midwifery practice more broadly. This fieldwork detour unsettled my assumptions of care work being primarily about ward-based shift work, and about hands-on, direct work with patients. Having arrived in the field directly from a work context in which I worked on a high-risk, multi bedded delivery suite as a midwife, I brought this framing of intensive clinical work to the field. In the field, it was necessary for me to look for midwifery work in a variety of places, and I was challenged to foreground and explore unplanned field sites, such as social media platforms, news media, reports, meetings and professional events.

2.3. Methodology

I conducted eighteen months of fieldwork in south-west Iceland from April 2016–October 2017, and made a subsequent visit in April 2018 to follow up on the midwife union dispute.

Arriving in Reykjavík in April 2016, I landed in the city one week following the publication of the Panama Papers papers scandal, and the biggest protest in Icelandic history. I spent this first month orienting myself to the city and following the aftermath of this political event, securing somewhere to live, introducing myself to key contacts, and beginning the process of confirming my visa and research permits. I spent an initial six months taking Icelandic language courses in Reykjavík. I rented a room in a private apartment in the city, living in a 1930s worker's apartment with a large basement communal laundry, huge cast-iron radiators, and the company of my two Icelandic flatmates. I wrote at a small desk in my room in the evenings, and was also given desk space with other PhD students at the University of Iceland. The ethical review process, through the National Hospital and National Bioethics committee, took six months; I was unable to 'start' conducting ethnography and interviews during this time due to waiting for full ethical approval. I was very aware that my presence as a researcher was highly visible to those around me.

Following my traffic accident at the end of this six month period, and while waiting for my foot to heal, I turned to internet-based research, exploring news articles on the hospital and management, and on midwifery. I translated public and patient-facing information: brochures and leaflets on maternity care choices, service provision, health guidance and public health information. I examined professional, and healthcare employee-facing information, including the website of the Icelandic midwifery association, and the Icelandic midwifery journal *Ljósmæðrablaðið*. I followed developments in the hospital keenly, seeking to understand the implications of a newly-elected government cabinet on the National Hospital of Iceland, as well as following midwifery news in Icelandic broadsheet and tabloid media.

Approaching my research field as multisited (Marcus 1995), I explored the context of Icelandic midwifery and maternity care through a range of settings through participant observation, as a researcher. I observed midwifery and nursing work within the Women's Health Department at Landspítali, the city midwife-led birth centre, and visited maternity and education

settings in separate stand-alone clinics and a district hospital. I participated in antenatal and parentcraft education classes in a Reykjavík clinic. Within these clinical settings, I followed, observed and spoke to midwives on wards, in corridors, in offices, staff rooms and canteens. I went to midwife-led information sessions for migrant women on navigating the Icelandic maternity system. In addition, I attended a range of non-maternity clinical settings including participating as a regular donor at the blood donation bank. In unexpected overlaps of my professional and personal roles, I attended other clinical sites at the National Hospital including the gynaecology ward while supporting a friend through a miscarriage.

During the course of my fieldwork, I interviewed twenty-eight midwives about their work, care, and experiences of the protests, some of these conversations happening in workplace settings, outdoors at protests, and at professional events detailed below. In addition to maternity staff, I conducted interviews with people holding expertise and experiential knowledge of Icelandic maternity care, including three trainee doulas. I spoke with staff at Landspítali hospital, including administrative staff, security personnel, nurses and doctors employed in the broader context of the hospital as a work environment. In addition, I interviewed a journalist working in print media during the protests, and a film director creating a documentary on home birth in Iceland.

Over the course of my fieldwork, I sought out non-clinical places to participate in midwifery research, with the primary aim of using these events as places to meet participants and to understand the shape and scope of Nordic midwifery, and in what ways it might appear different to the context I understood in the UK. I conducted participant observation at professional midwifery events: I attended local conferences, seminars and midwifery doctoral defences at Háskoli Íslands. I became fascinated by these professional events in Iceland as distinct, unique events with their own distinct, professional culture, involving a particular kind of celebration of legacy and heritage. As my research developed, I realised these events were also sites of midwifery

work, where professionalism was made and displayed, and were part of the texture of Icelandic midwifery. I explore these professional events as a particular form of field site in Chapter 4. I attended large annual events including Ljósmaðradagurinn (the International Day of the Midwife) in 2016 and 2017, and two occasions of the triennial Nordic Midwifery Congress, in Gothenburg, Sweden in 2016, and in Reykjavík in 2019, during which I participated as a panel chair. I interviewed midwives at these events, and in turn I was interviewed by a Dutch midwife about my fieldwork and interest in Iceland, and published in a podcast, a curious doubling over of ethnography. Following on from the Congress, I participated in a working group discussing midwifery work and wellbeing across the Nordic region, in the UK and in Australia. I conducted archival research at Kvennasögusafn Íslands (the Women's History Archives) on the Icelandic Association of Midwives' involvement in the Nordic Midwifery Congress.

I conducted participant observation at protests and vigils during the union dispute, attending outdoor events to mark specific negotiation meetings, developments and rallies. Midwives and lay supporters, including friends and families of midwives, attended these events, and these are explored in Chapters 3 and 5 of this thesis. As the midwifery dispute developed, social media became a key site for understanding how the midwifery protests and union negotiations were unfolding, and this was a place where midwives expressed disillusionment around working conditions. Facebook also functioned as a place for clinical staff to report on the wellbeing of the hospital, as a form of institutionalised, internal network. Social media sites, such as Facebook, news sites commentary, and community and special interest groups, are a particular iteration of Icelandic social life (Loftsdóttir 2014, 2018, Loftsdóttir and Mixa 2017), have become 'extremely influential' and 'allow individuals to engage in various acts of self-representation' (Loftsdóttir 2014: 342). Anthropologists accept that multisited ethnography is therefore also inclusive of social media (Hannerz 2003). My immersion in the field looped me into these places, and social media became an important place through which to understand what mattered to people. I

explore this locality and multiplicity of sites in Chapters 3 and 5, examining the social media petitioning of state-employed midwives threatening to strike.

In addition to a focus on midwifery, over the course of ten months during 2017, I conducted participant observation in a doula training course at the city birth centre, attending workshops and training sessions as a student doula. I enrolled on two separate organisational digital training sessions in becoming a doula. I attended doula-support and business training webinars, listened to podcasts, and read blogs and books as part of my enrollment as a student on the course. I also participated in a broader support network for new doulas, organising a 'doula café' and information event with student colleagues to promote the work of doulas in Iceland. This ethnographic research is presented in Chapter 6 of this thesis.

I also attended public events, conferences and meetings concerning plans for the redevelopment and building of 'the new hospital', the Ministry of Health, the coalition governments and their plans for the health system, all set within Iceland's post-Panama Papers and post-financial crisis landscape. Participating in these events helped me understand the continuing, and varied sense in which crises of finance, of health determinants, of geography, and of futurity were tied up with the provision of health care.

On returning from the field, I sought to create a narrative order to my data, sifting through and reviewing hundreds of ethnographic field note entries, photographs, my lived experiences, interactions and interview transcripts. This process of collating, coding, storytelling and analysis is best described as 'thematic analysis,' in which a sequence of coding themes in the data, identifying repetition of these themes and the relationships between them, producing writing about this, making assertions, organising this writing into a narrative sequence, occurs (Bailey 2013). It is important to recognise that this process involves an inherent *messiness*; the research stages of data collection, analysis, producing writing and writing up are not separate processes but

interwoven and repetitive, and creative. Ethnographic research, and the use of thematic analysis, involves an “iterative-inductive” practice in which a researcher makes ongoing analytic choices and crafts assertions as the research progresses (O’Reilly 2012: 180). The conclusions I have drawn from my data are part of this process of thematic analysis.

2.4. Positionality and care: being a midwife and being an anthropologist

As other ethnographers have encountered, the positionality of being a clinician while conducting ethnography in and on the professional context one is familiar with, is challenging (see for example, Fitzgerald 2004). In this section, I reflect on my positionality as a midwife and a researcher, and how this impacted my choices and experiences in fieldwork. My focus in this thesis, the shape this thesis has become, is directly informed by my positionality, inculcation, and politicisation as a midwife. This ethnography is not only defined by the period I spent on fieldwork in Iceland, rather my midwifery identity spools out either side of the fieldwork: it informed the development of the research proposal, the way in which I entered the field, the decisions I made during fieldwork, my experience of ethnography, and the ways in which I have drawn conclusions from my data.

I also note here that my positionality was not limited to my professional identity as a midwife. My identity as a white, middle-class, English-speaking woman created a particular form of “situatedness” to my ethnography (Nencel 2014: 76). I experienced my positionality as layered, smoothing some relationships and complicating others. Conducting research in an Icelandic context involved a complex balance, as has been explored by ethnographers, of living as both an insider and outsider (*Ibid.*). My positionality afforded me the ability to ‘pass’ as a white Icelandic, and I could move through public spaces with ease and found myself addressed with the

assumption that I spoke Icelandic and ‘belonged’ to a social context in which others were excluded. My position as an outsider, however, was often revealed in my halting and accented Icelandic, and I found myself positioned alongside social impasses which took me some time to recognise. My exclusion from tight-knit kin and friendship networks, established for many Icelanders in childhood, marked me as an *útlendingur* (foreigner, literally ‘out-of-lander’), and in the social context of a tourism boom and increased migration to Iceland, positioned me as an outsider to inclusion in these complex webs of relatedness holding many Icelanders in place.

Bracketing an identity as a midwife

When I set out to commence fieldwork, I had a legible sense of the ways in which I was going to have to ‘bracket’ my identity as a midwife. I understood I was bringing bias with me, in terms of a professionalised identity I had nurtured for some years, a clinical lens through which I understood work, and a particular kind of institutionalisation within the profession, and within the collegiality I shared with colleagues. Several years of training and working during a particular era of deeply politicised shifts within the NHS during the reforms brought about by the Health and Social Care Act (2012), and the ways in which public maternity services were funded and organised, had shaped my experiences and interests in the politics of care within an socioeconomic context of austerity and welfare reform. I was motivated by political sympathy towards the plight of overworked midwives, and was frustrated by the lack of critique of managerial strategy and neoliberal doctrine within midwifery. This perspective was complicated, however: it both narrowed my vision to the exclusion of issues another researcher would have noted, and also gave me a privileged degree of focus, allowing me to cut through to what I felt mattered within midwifery as a professional field.

I set about entering the field with a series of questions about workplace tensions in midwifery, understanding that Iceland had seen a series of strikes among midwives and nurses during 2015. What are the institutional politics of midwifery work? Why did midwives go on strike? Had these workplace tensions been resolved? I had a sense that there were a set of tensions in Iceland I might find to be parallel to those I had experienced as a midwife in the UK. Unlike other anthropologists approaching ethnography as an inculcation of new skills and routines, I was already a midwife. I arrived in the field with a tacit understanding of this work. The ethnography was about unravelling the discipline, the ideologies of work, and extricating this from my body, rather than taking it in. The requirement to be positive about midwifery, comes with its own complicated politics that I have found difficult to manage, and balancing a critical desire to ‘trouble care’ (Dulcos and Criado 2019), alongside professional requirements to inculcate positive affect about midwifery has been challenging. One of the reasons I became so interested in midwifery in Iceland was the difference between the way in which there was conceptual space and support for industrial action in the UK and in Iceland. It was a stroke of ethnographic luck, then, that during the course of fieldwork, a union dispute specific to the time and politics of that particular socio-political moment erupted. I cared about asking questions of institutional and work politics, and rather than exploring this through a clinical ethnography, my attention was turned to other places in which I found this occurring.

Leaving my midwifery job to pursue fieldwork felt a release, and I was thrilled to be able to conduct the research. However, I felt an acute sense of guilt at not being ‘at work’ in the field. While I observed, and spoke to clinicians, I was not a participant within midwifery. I was not a student, so I could not participate or act with any degree of clinical responsibility, and I was qualified with experience under my belt, which made sitting on my hands feel rather strange. What became relevant to me during this fieldwork was a disentangling of feeling about my work, my identity as a midwife. I was asked by midwives if I was there to work. This was always friendly, with the emphasis on being welcomed as a fellow midwife, ‘are you going to take some shifts with

us?', and 'do you want to move your [NMC] registration over?', with offers of help to smooth the complicated bureaucratic process of registering with the Icelandic Health Directorate. Through the process of ethnographic fieldwork, care emerged as a central to the ways in which I navigated my identity, in which as both midwife and anthropologist, I became 'implicated in the lives of others' (Han 2018: 26).

Learning about the specific politics of Icelandic midwifery was a process of what Ingold suggests is 'guided rediscovery', through the process of telling and hearing stories 'people do not acquire their knowledge ready-made, but rather grow into it' (Ingold 2011: 162). The process of ethnography was not isolated to or defined by this specific period within the geographical field of Icelandic midwifery, but drew on my experience as a working midwife. This experience was visceral: a bodily understanding of the texture and content of thirteen-hour shifts when there wasn't an opportunity to stop work, and the physical and ethical impossibility of finishing a shift on time when there was no available staff member to handover the care of a patient to. Time off from work was spent building up resources so that one could return to work and be depleted all over again. These experiences underwrite this ethnography, and because they are shared, have become a sounding board for addressing the lived experience of being at work more broadly. Some of the dissatisfaction, discontent and indignation I felt as a midwife led me to ask questions about midwifery work while at work as a midwife, and got me curious about the kind of space a doctoral research project would allow me to explore these. Some things felt corrosive: my capacity to be deferential was challenging to reflect on. I felt, as Hochschild has so clearly described (2003a), a significant mismatch between how I felt at work, and how I was supposed to feel. This experience was alienating. One of the issues I experienced qualifying in the middle of a period of sharp NHS underfunding was that the support to make this transition and to develop at work, meant that there were repeated experiences in which I was working within a resource deficit: with too little time, support, material things, and feelings to adequately care in the way I expected good care should unfold. A focus on deficits, affect and care in this thesis is tied to my own

experience of emotional labour, the ways in which I learnt and became accustomed to mobilising my feelings in work, and I have often drawn on this experience of negotiating feeling in the process of researching midwifery work politics. Understanding too, in the course of the research, the extent to which I needed to address these experiences which weren't solely mine, but were shared by many of my colleagues. Some of this emotional labour, the management of feeling at work, was not pleasant.

Reflecting on care and economy

Hage (2009) argues that conducting ethnography involves a particular kind of emotional state he names 'ethnographic vacillation', which is produced by the movement between participation and analysis. It is particular to the ethnographic project because it is about the specific feelings brought about by 'the attempt at investing oneself in both social realities with their contradictory demands', at the same time (Hage 2009: 77). Hage's framing of emotions in the field captures the peculiar tension I felt produced by the duality of roles and places: of alignment with midwifery and with anthropology. The capacity to both recognise and critically reflect on 'ethnographic vacillation' is key, Hage argues, to conducting ethnography. The process of sifting through my fieldnotes, though painful, played into the process Hage encourages: bringing emotional experiences into the fold for analysis, 'without them losing their specificity as emotional 'wilderness'' (Hage 2009: 77). In this way, I addressed the concept of care. In pursuing research, I became my 'own alienated principle informant', an experience of confusion and disaffectedness other ethnographers have described in the course of their research (Fitzgerald 2004: 332). Fitzgerald describes the ways in which she used her experience of working within a clinical institution in order to conjure the strangeness required to conduct anthropology on something 'familiar'.

While Ingold suggests that ‘someone who knows well is able to tell’ (Ingold 2011: 162), I tell a story about Icelandic midwifery at a particular moment in time, with the awareness of how my own narratives play into this. I understood that how my ability to care and be cared for as an employed midwife is shaped and created by policy, and ‘the economy’. I sought to find language through which I might express less about how political decisions and policy drip down into the everyday of midwifery work, but how woven together and reinforcing this politics is. How a politics of resource scarcity is reproduced in the day-to-day of midwifery work; how politics, the economy, seeps into the everyday, how our imaginations are informed by it, how it is present in our hands, in our bodies, in how we feel, and in what is imagined. This challenged me to think discursively about crisis (Loftsdóttir et al. 2018).

As a midwife, my prior experience working with doulas during labours and births got me thinking about the ways in which an emotional deficit, or care deficit, was at play. Care work, like other forms of embodied activity, is a ‘deeply personal expression’ (Prentice 2008: 57) of both a technical ability and a cultivated style. I came to understand doula-ing, freed as it appeared to be from the litigation and risk-management constraints of some forms of midwifery work, as a different expression of a compulsion to care, to be in one’s body while doing so, and through which to mobilise oneself in a fuller way. This was about both unpicking and formulating ideas about what care work constituted. How I held care in my body, how pursuing doula work as a form of maternity care work and employment could be a better choice for me than pursuing midwifery.

The lived experience of entering the hospital, and clinics, not only as a researcher, but as a patient, as well as participant observation of midwifery work, professional research events, protests and *doulanamскеið* (doula training), helped me to unpick and examine more closely some of these ties. When I learned to be a midwife, I was taught ‘techniques of the body’ (Prentice 2008: 55), in order to wield the kind of responsibility and technique necessary for

caring and facilitating care around pregnancy and birth. Fieldwork complicated this positionality for me, and the process of conducting ethnography forced me to examine the professionalised identity I had become accustomed to, despite my discomfort with it at times. When work is foregrounded, it brings into view both the woman and midwife, and doula, if they are present. The ways in which the midwife is limited, or subject to other power differentials—staff hierarchies, requirements of emotional labour, the effects of a speeding up of work, time constraints, competing responsibilities, understaffing, inadequate resources—these also come to the foreground. It is easier, and I argue in this thesis, important to consider the socio-political context in which midwifery work is taking place. Foregrounding work, the different labours going on, is important. The presence of doulas showed the different labours going on.

This is also about the ways in which fieldwork afforded me an assessment of the kind of work I'd been doing, and my own sense of alienation. The course helped me experience my body as a tool through which I learned to care in different ways. This made me reflect on the kind of care work I was embodying as a midwife, the way my body and self were orientated towards particular tasks and objects (such as a computer screen). But this doula work was about being present in and with bodies in a way that made me reflect deeply on how estranged I was from bodies in my midwifery work; from my own and from others. In order to cope with the work I had broken my professional engagement with people down into component tasks. During an activity learning to appreciate different strategies of distraction around pain, I was sat on the floor with a cube of melting ice in my hand. In activities such as this one, I returned to some of the parts of midwifery I had not looked at or considered for months: activities that were less about specific clinical tasks, and more about coping with an experience, helping someone navigate something difficult, such as the temporary pain of an ice cube, or a contraction. The doula course shifted my focus on what this work was about, how it could feel, what it could contain. I realised I felt quite alienated from certain parts of my midwifery role, especially those to do with being emotional support.

The doula course helped me examine my own sense of ‘burnout’, and think honestly about the ways in which I avoided or reduced certain capacities to care.

Other course attendees commented that ‘I like having her here’, although I found this uncomfortable at times. I was sometimes asked to clarify certain clinical procedures—for example, why a particular position for labour was preferred by clinical staff over another—I didn’t want to be singled out as an ‘expert’, as I felt this created a false hierarchy in the room, when much of the doula approach was about lay, community support for labouring women, not replicating the midwifery role. I was also very aware of not wanting to undermine the role of the trainers, and defer to them as professionals in their own rights. I wanted to be present quietly, as a participant-observer, which is why being brought to the centre of attention as a midwife was uncomfortable. This doula training encouraged me to reflect on my own work as a midwife, the kinds of work I had prioritised.

Producing writing

During fieldwork, I experienced a series of personal losses that impacted my research. During a conference panel addressing grief in the field at EASA2020, the biennial conference of the European Association of Social Anthropologists, presenters addressed the question of what it might mean to produce knowledge through shock, alienation, grief and distress. Presenters recognised an ethical discomfort in theorising grief and distress, citing Rosaldo’s (1993) work on grief as one of few ethnographic texts exploring the experience of grief in the field. I turned to this text, too, while on fieldwork. During this panel, presenters reflected on Malinowski’s split diaries (Malinowski 1989), reflecting on the use of a diary and the practice of recording fieldnotes. I was struck by the anthropological commonality of my own ‘diary split’: my fieldnotes take the form of a typed computer note recorded daily, with a line striking through the middle. The notes above

are my ‘official’ fieldnotes, observations, ideas, recordings, while below the line is the space for the mess of emotional difficulty, reflections on grief and bereavement. My data collection process made it difficult, particularly during the early months of returning from the field, to go into my fieldnotes. Search terms would unwittingly direct me to the messy, difficult text below the line, and often in pulling up a digital field note, I would be careful to avoid reading anything written below this line, focusing only on the text above. I reflected on the methodological implications of how this ‘diary’ writing space, in which feelings such as grief are recorded, is classed as inferior knowledge. In listening to anthropologists discuss experiencing grief in the field, and the impact on the dislocation and alienation that fieldwork seems to often necessitate, it has helped me think through how grief has ended up determining my field, restricting some routes while opening up others. The networks of support and friendship I established while in the field speak of the latter. It feels important to note that distress caused by alienation—from familiarity, and one’s established networks of support—is normal in the field, and there are emotional implications for living in unstructured time, as well as methodological implications for this dislocation (Van Bavel 2020).

In a provocative, reflective piece of writing on the politics of conducting ethnographic research within Canada’s Northern Territories, Moffitt, Chetwynd and Todd (2015) ask ‘what does it mean to be here to stay ethically and relationally in a context of research?’ Their question interrogates a particular, historical precedent of conducting research when the anthropologist is positioned within a structural configuration of power and privilege which allows them to negate relational and ethical responsibilities when leaving the field. In reflecting on this question, I turned attention to the potential imbalance of power and privilege inherent within my own work; less within Iceland as a specific field site, but within the occupational, professional, disciplinary and emotional terrain of midwifery. What did it mean for me to have a continuing relationship with midwifery, to be here to stay within it as both an anthropologist and as a midwife? How do I represent this place that I will continue to remain in? This responsibility

towards midwifery as a place in which I would continue to belong caused me to feel uncomfortable, at times, of being a critical participant-observer. I felt a duty to ‘protect’ midwifery as a member of this professional terrain myself, yet desired the space and freedom to be critical of political context. The process of writing helped me understand that I could be critical of midwifery while maintaining an ethical and relational responsibility towards individual midwives. This helped draw my attention to the professionalised rhetoric of midwifery, about how professionalism is made and communicated as normative, and unpick how processes and techniques of creating and maintaining legitimacy were wound up in midwifery as a site of work and meaning-making.

2.4. Ethics, power and place

Ethical processes

Anthropology is an intervention into other’s lives (Association of Social Anthropologists 2011), central to any ethnographic project are the principles of openness, candour and trust, and the duty of the ethnographer to act with respect for research participants, colleagues, and the wider communities in which she moves (ASA 2011). These principles extend to a number of practicalities for conduct while being present in people’s lives, and are especially pertinent within medical settings, as clinical encounters are recognised as sites of intensive human intimacy, feeling and precarity (Hunter 2004, Street 2014). Practicing fieldwork involves participating in an ethics of intersubjectivity (Biehl 2013, Jackson 2002). In practice, this means recognising that people ‘come first’, and that the lives into which an ethnographer enters are vaster than the ethnographic project (Biehl 2013). This ethic also involves honouring what Biehl (2013) refers to as ‘an equality of intelligences’: respecting participants’ expressions and understandings of meaning on their

own terms. For me as a midwife, this drew on a professionalised ethos of midwifery: the imperative to ground midwifery work and identity, professional codes of conduct and occupational aspirations within relationships and sociality (Hunter *et al.* 2008). Understanding midwifery work as relational and reciprocal fed into my approach to research, and was an important ethical orientation with which to guide my conduct as a midwife-anthropologist. Unpicking the politics of participants' activities, and resisting an urge to create a clean analysis foregrounding participants' agency does not have to compromise their meaning and the integrity of their world. I have found working through a critical perspective as an anthropologist challenging at times, with a slight professional clash between midwifery and anthropology, such as the process of being critical of normative language and concepts.

This ethnographic research sought and received ethical approval through the Social Sciences, Arts and Humanities Cross-School Research Ethics Committee (C-REC) at the University of Sussex. In Iceland, I sought and received ethical approval from Landspítalinn, the National Hospital of Iceland in Reykjavík. I also sought ethical approval from Vísindasiðanefnd, the National Bioethics Committee of Iceland, and received confirmation that the research did not require their approval, due to the fact I was not handling patient data or collecting information about service users.

The maintenance of clear boundaries between being a clinical practitioner and ethnographer was crucial during this project (ASA 2011). I did not practice as a midwife while on fieldwork, and was careful to reiterate to participants that my role was not a clinical or advice giving one. While my position as a midwife afforded me a privileged degree of integration and acceptance, as well as solidarity with participants, I also worked to not hide behind my identity as a midwife, introducing myself as a PhD researcher on midwifery. I found myself being introduced primarily as 'a midwife from England, who's come to learn about our kind of midwifery' as the main descriptor to put my presence in place. My research focus was not necessarily understood as being

the principle motivator for my presence, but rather my position of being a midwife from a different work and research context was reason to understand my presence. This difference is important, as a shared identity and professional role as a midwife were enough to understand why I might be interested in investigating midwifery, and I came to understand that Iceland's place in a broader context of Nordic midwifery included a breath of cross-cultural midwifery research as well as migration of Icelandic midwives to other Nordic countries for work. The research culture of Icelandic midwifery is celebrated and understood as a central part of midwifery work and life. Ethnography was an understood research process, and I found myself early on in my research being introduced to the staff in on the maternity wards as "she's going to listen to what we say, but it might not be the things we say, but the meaning behind it."

This was an important part of my experience conducting doula training in particular. In participating in the doula training, as students we were encouraged to create a website profile to register ourselves as employable students; my identification with this role and experience of the training meant this was a temptation to do and I wanted, too, the pleasure of membership into that community of work (Prentice 2008). I thought about crafting a position for myself where I could work as an English-speaking doula for migrant women. What stopped me from pursuing this was the knowledge that I'd been very clear with the local institutions that I would only ever be present in clinical spaces, or in any maternity work environments, as a researcher. Leaving the field necessitated the kind of critical reflection on the politics of doula work, and this ties to Prentice's (2008) reflection that immersion comes with a particular kind of ethnographic risk: that anthropologists, by way of participation, become enthralled by local informant's visions to the extent that they become the anthropologist's own.

Small places and large issues: the scale and place of research in Iceland

Iceland's demographic profile, as outlined in Chapter 1, presents a challenge to anthropology in speaking of—to borrow Hylland Eriksen's (2001) well-cited turn of phrase—'small places, large issues.' In beginning this project, I noted that the challenge of discussing smaller populations in relation to broader complexities of maternal health politics, is not an impossible task. Maraesa's (2012) work on prenatal risk assessment in Southern Belize is a notable example of an ethnography focusing in on a comparatively small population. However, in conducting this ethnography, I was aware of the size of Iceland's population as presenting a key methodological tension when zooming out to consider wider issues. On the one hand, demographic and GDP data can look skewed, presenting Iceland as an anomaly, which in turn can play into a tendency towards Icelandic exceptionalism (Durrenberger 1996). It was important to me to not fold Icelandic midwifery into this narrative, but rather to balance a methodological tension between a focus on Icelandic midwifery as something unique and specific, and worthy of ethnographic examination, and between a focus on a broader context of Nordic and international midwifery. Midwifery in Iceland forms a small professional community, and as discussed in Chapter 1, there are approximately 260 registered midwives at work in Iceland. By looping in my ethnography into spaces of discussion of a broader Nordic midwifery context, such as the triennial Nordic Midwifery Congress, I posit that a focus on Iceland speaks to other contexts of midwifery work, and that the work 'crisis', dispute and politics this thesis describes are not exclusive to Iceland, but reverberate across many different context of midwifery work. It was through the Nordic Midwifery Congress that I first had a sense of the scale of the work politics being discussed in Iceland.

While the social field of my research was large, the entanglement of relationships was determined by the scale of the research context (Hylland-Eriksen 2001). As ethnographers have pointed out, the interweaving of personal and professional can be complicated to navigate during

ethnography; one's self is one's primary research tool (Abdulrehman 2015, De Neve and Unnithan-Kumar 2006). During the course of my fieldwork, I experienced an entanglement of personal and research-professional I was not prepared for, given that my research context as a PhD student and as a midwife in the UK were geographically and socially distant and distinct from one another. For example, over the course of my fieldwork in Iceland, I visited clinical spaces as a friend and for necessity other than primary research, though all these experiences folded into my understanding of Icelandic healthcare. I attended the paediatric accident and emergency department with a friend and his injured child, visited a friend on the psychiatric ward, the blood diseases ward, attended the sexual health clinic, gave blood at the blood donation bank. I sat with a friend as she miscarried on the gynaecology ward. Friends who were prospective student midwives and student doulas wanted to learn about what the work was like and would talk with me about their plans. Friends introduced me to midwife relatives and friends. Although my fieldwork did not involve the narratives of patients or clients, I often found myself told stories of birth, and of midwifery care and work, by people who had experienced maternity or gynaecological care in Iceland, and these stories too folded themselves into my fieldwork. I interviewed a film director working on a feature about home birth in Iceland, and I met the clinical director of the National Hospital at a football match. As time developed, and as I accrued more social connections, the web of relationships and kin I found myself in thickened and blurred the boundaries between my research field and personal life when I returned home (Unnithan-Kumar 2006).

Another key issue in ethnographies of 'small places' is anonymity. In her ethnography of post-crisis Icelandic identity, Loftsdóttir (2019) reflects on conducting research 'at home', the intersection of the personal in a broader ethnographic project, the implications of scale and anonymity, and the drawing of stories from personal life. Loftsdóttir explains that most people she interviewed were fearful of being identified by other Icelanders, particularly in the context of 'the fragile job security' following the crash, the politicised nature of the work being talked about,

and the smallness of Icelandic society (Loftsdóttir 2019: 10). She also explains that participants in her ethnography inevitably included people from her ‘own personal history’, because their histories were interwoven with her own. The autoethnographic work of narrativising the financial crisis required that she situate national ‘events’ within the context of the aspirations and desires of particular, individual histories. Loftsdóttir also notes the emotional acuity of reflecting on the crash. She shows how the folding of a secure, expected sense of futurity was an intensely personal experience, and the fear and sadness of this was something shared by a majority of other Icelanders. Loftsdóttir (2014) also talks through the ethical dilemma of conducting research within a community where individuals, specifically those identifiable by professional status, are at risk of exposure, and this is something I reflected on at length in the process of conducting my own research.

In order to protect participant confidentiality, I have made the decision in the thesis to *not* set out a descriptive list of protagonists, and to anonymise the identities of all research participants. This has included removing individual characteristics of nearly all midwives and doulas in this text. I acknowledge that this has created an absence of detail around specific midwifery or birth worker subjectivities in the writing. My ethnographic immersion in Iceland afforded me a lived experience of participation in the day to day life of a small community, where professional communities are intimate, the members of which are easily identifiable, and networks of kinship and relatedness intersect multiple professional and personal circles. In the Icelandic context therefore, the risk of unwanted identity exposure is high and professional communities do not comprise a privileged group of elite actors. It is also important to note that during the course of fieldwork, issues of researcher accountability in relation to anonymising participants were foregrounded among the research community I belonged to. Anthropologist colleagues at Háskóli Íslands drew my attention to a recent case of a researcher who had hurt an entire community in the course of disclosing identifiable personal data in their thesis. The ways in which research participants had experienced a violation of trust in the research process of

disclosing personal information had been viewed as unethical and unfair, and was talked about as an example of poor research practice. My experience of fieldwork informed my ethical practice and orientation as a researcher; while I committed to participant anonymity in the ethical review-board process (see Appendix 1), these conversations, alongside my learned, tacit understanding of a requirement for privacy in a community where one could be highly visible, informed my decision to anonymise. I note here, too, that the inclusion of any identifiable attributes in the writing has been made with the enthusiastic consent or request of those participants to be visible in the research.

In my own research, I found a general, public sense of scale and visibility present in Iceland in a way I was unprepared for: early on in my research, I was messaged by a colleague that they'd just seen me on the national evening news as I stood in a protest against the deportation of a pregnant asylum seeker outside the city police station. This feeling of visibility was on loop during fieldwork. For many Icelanders, this visibility was bound around an idealised, civic sense of knowing one another, while respecting individual privacy. I'd also suggest this was limited by class and nationality; many 'foreign' residents — those with permanent residence and Icelandic citizenship — were still cast as foreign and 'unknown' to other Icelanders. While some of these anecdotes appear harmless and comically idiosyncratic of the small-town familiarity of Reykjavík, other experiences of overlapping social connections and roles were less comfortable and challenging to navigate. Once, on a visit to a municipal swimming pool with a friend, an *útlendingur* (a foreigner) like me, I was subject to her long, frustrated tirade in English at the difficulties of living in Iceland while we undressed in the shared changing room. Across the bench from me was the mother of a friend I knew and respected immensely, and I knew she was listening to my friend's tirade. In the swimming pool changing rooms there is a careful etiquette of recognition and privacy, and I felt caught in a bind between two different, important relationships. In my sympathy listening to my friend, it was inappropriate for me to interrupt her and state that I felt differently. I was unable to catch the older woman's eye to show I

acknowledged her, and suggest my distance from the rudeness of my friend. I worried about the damage this might cause our relationship; she was kind to me and generous with her time. I found myself suddenly trapped on one side of a social divide between foreigner and local, and it was uncomfortable. Ethnographers have documented the difficulties of navigating fieldwork and the moving boundary between acceptance and familiarity, and foreignness (see for example, Abdulrehman 2015).

A civic sense of knowing one another through multiple, overlapping networks—such as school friends, neighbours, neighbourhoods, family and kin, workplaces, professional groups, unions and hobbies—was celebrated in Iceland, as well as limited by nationality and class. I was surprised to find myself strung in these nets at times, at once an enthralling thing to feel held in place and company, and also unnerving, involving a sense that I was highly visible and could not escape this visibility. Contacts who were residents of foreign origin, including those with permanent residence and Icelandic citizenship, experienced varying degrees of civic membership and visibility; for some, a feeling of being foreign and ‘unknown’ to other Icelanders, despite several years of work and living in Iceland, was present. Speaking Icelandic with an accent could distinguish those who were not born in the country or brought up in a primarily Icelandic-speaking household, and accurate pronunciation could afford intimate membership to conversations. I found part of this experience of connectedness came from specific forms of data and the accessibility of this information; for example, the information available through access to someone’s *kennitala* (social security number), the access of names and identities of other people within my online banking account, was evocative of a general sense of traceability and visibility. Iceland has a long, particular history of civic record-keeping, and it is on these records that current data mapping projects are based (Lock and Nguyen 2010, Pálsson 2007). Reading the volumes of *Ljósmaður á Íslandi* (Einarsdóttir 1984) for the first time, and peering into the lives of hundreds of Icelandic midwives pointed to this data collection and social visibility.

2.5. Conclusion: doing ethnography and the politics of care

Ethnography requires attention to care, and practice of caring (McGranahan 2014). During the course of fieldwork, care became a major theme for me, and underwrote my professional and personal life in the field. As I will go on to explore, anthropological approaches to troubling care and exploring the politics of what it means to care, to be carers, and to be cared for, was important work in which I grounded my personal and professional orientations (Alber and Drotbohm 2015). Becoming a patient was a specific experience of care, and as I have explored in this chapter, was a form of accidental ethnography that impacted the decisions I made and the methodology I pursued while in the field. I have reflected on the ethics and politics of doing research in a context where scale and community grants particular degrees of visibility. My positionality as a midwife shaped the ways in which I went about asking questions of care and its absences. This led me to ask questions of what ‘care’ meant for working midwives in Iceland, in the context of different forms of deficit. As an ethnographer, my experience in the field led me to understand that researchers cannot take for granted the lifeworlds of participants, that research requires humility, trust and vulnerability, and that we cannot assume that we understand care (Hyde and Denyer Willis 2020). There remains an ethical orientation to ‘troubling care’, and in the following chapters of the thesis, I explore the politics of care work and the experiences of midwives in negotiating different forms of deficit through the ethnography.

Chapter 3

Care as politicised: the midwives' dispute

3.1. Ethnographic beginnings: joining the midwives' protest

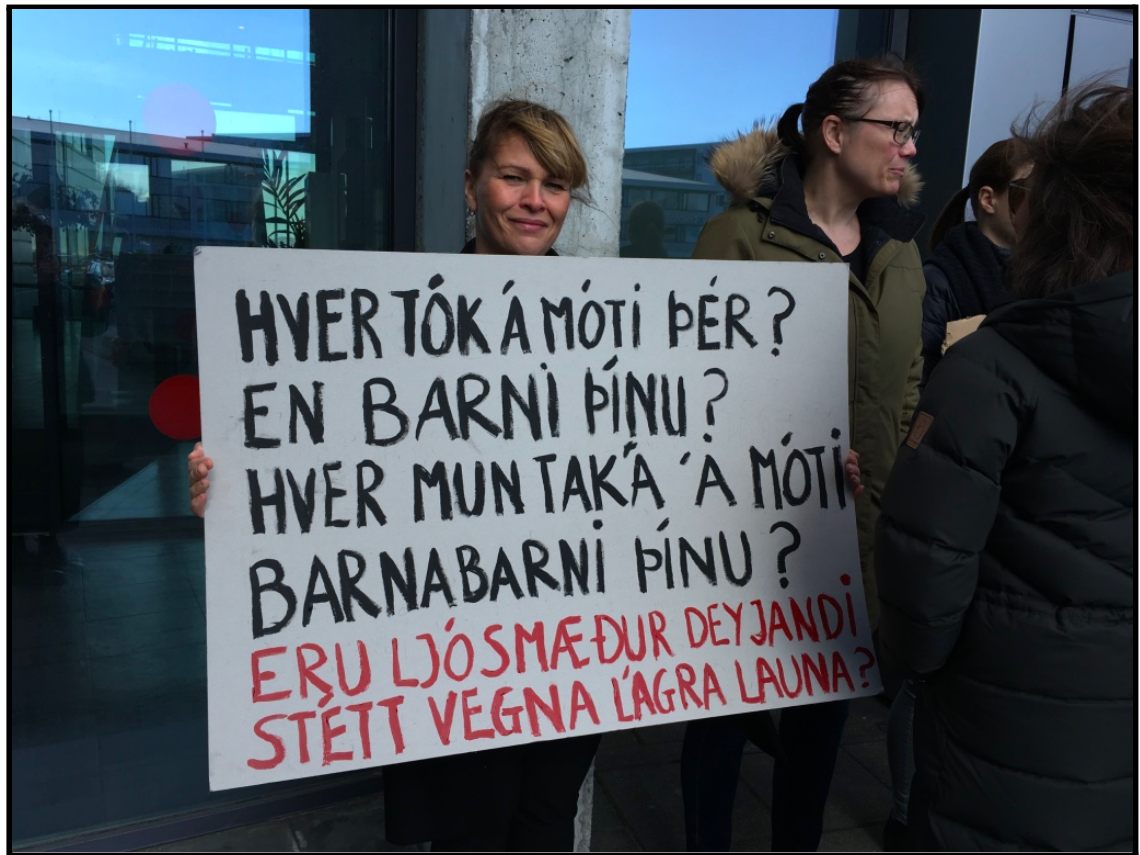


Figure 3.1: A midwife stands with a placard outside the office where the negotiation meeting on midwives' wages is taking place. The placard reads, "Who received you? And your children? Who will deliver your grandchildren? Are midwives a dying profession due to low wages?"

In Reykjavik, on a bright, windy spring day, I walk down a street parallel to the bay in the north of the city. It is full of new office blocks, businesses serving the office employees in the district, the

road marked by a bank of sharp, white mountains. This part of the city is cold and bright; the light refracting from the steely sea water in the bay. It is one of the parts of the city where one feels encircled by water and mountains, the experience of this magnified by the shiny buildings slicing up the view. A little over a decade ago, this street was designed as the new financial quarter for the Icelandic banks spearheading the economy before the financial crash of 2008. The office blocks here remain the corporate headquarters of big Icelandic companies, and the banks, now renamed. Nearly ten years following the financial crisis, it is difficult to see the memory of this event rendered in the sharp authority of these buildings. One would think that the crisis of 2008 had, in fact, been cleaned up. The pavements are clean, the cars smart, and brisk trade continues at the cafes and delis littering the area. However, the current scene interrupts the clean setting: the fallout of the financial crisis is being felt and expressed in a way that celebrants of Iceland's post-crisis recovery would not recognise. Rounding a corner to the city offices, I find a group of 40 protesting midwives and supporters are assembled outside a squat, glass-clad building. People are dressed in coats zipped up against the cold. A convoy of prams are parked up with the crowd, with thick, insulating covers secured over them. A group of midwives hold placards outside the doorway.

The protest is one of several which will occur over the course of several months, part of the midwives' *kjarabaráttta*, the 'wage and working conditions struggle' which unfolded during the course of my fieldwork. Inside the municipal building, a meeting is taking place between members of Ljósmaðrafélag Íslands, the Icelandic Association of Midwives, and representatives from the government's Ministry of Finance to discuss the state of the midwives' salaries. There has been a solidarity vigil outside the entrance to the municipal offices every time a negotiation meeting takes place, with people assembled in protest to time with the arrival of the committee. Two midwives hold a large, pink bedsheet over the entrance to the doorway. It has been ripped and embroidered to suggest a vulva, and the midwives are using it to block the building entrance, and force anyone entering the building to attend the negotiation meeting to clamber through this

giant, textile vagina. The images of this scene have been in the national papers. Some attendees would slip around the edge, reluctant to be photographed climbing awkwardly through the pink cloth. Slogans have been painted in black and red on large pieces of packing cardboard, the words capitalised and urgent: ‘Are midwives a dying profession due to low wages?’ ‘Why do I still need to live with such a disdainful attitude towards women?’ ‘Bloody fucking patriarchy!’ The images of these placards are all over the news, and have been so for weeks.

3.2. Introduction: understanding the midwives’ dispute

This chapter focuses on the midwives’ *kjarabarátta*, the ‘wage and working conditions struggle,’ as an ethnographic event in which experiences of ‘crisis’ and care were pulled to the foreground in public conversation. In this chapter, I ask how a ‘crisis event’, protest, and dispute, might be understood discursively for midwives. I examine the *kjarabarátta* as a particular experience of crisis for the midwives involved, and consider how these midwives negotiated this sense of crisis unfolding in their professional and personal lives. ‘Crisis’ is a concept central to anthropological approaches to economic life, and I draw on work by Narotzky and Besnier (2014) and Loftsdóttir et al. (2018) to explore how crisis works as a metaphor and category through which people express a lack of security in the structures and institutions they need to provide the framework for a stable life, and a predictable future. I suggest it is useful to draw on these approaches to crisis in order to ask questions about the ways in which midwives were experiencing a structural crisis in midwifery work, and how this was tied to affect, and their experiences of multiple deficits.

This chapter opens up the theme of deficit in relation to care and the *kjarabarátta* in order to ask how midwives protested a normalisation of crisis and deficit. In this first ethnographic

chapter, I introduce the midwives' *kjarabarátta*, the 'wage and working conditions struggle' of midwives, as a significant ethnographic event through which we might ask questions of care. I ask how crisis, protest, and dispute might be understood discursively, and point us towards an understanding of the politics of care for midwives. This chapter addresses the *kjarabarátta* as a critical event through which midwives articulated their disaffect with care, and addressed their experience and negotiation of both a wage and a care deficit. In this chapter, I first describe the context and key events of the *kjarabarátta*, and reflect on anthropological literature on crisis and affect, suggesting we can understand crisis as a 'structure of feeling', and that this in turn focuses our attention on experiences of affect. This chapter examines how the *kjarabarátta* was a larger cultural battle over inequalities and inconsistencies in the ways in which midwives earned a living through their work. It asks how the dispute was about a struggle for recognition of work, a recognition of value, a set of demands for a better life, and a reassessment of care. This chapter argues that we can consider the *kjarabarátta* as a moment in which a refusal of a deficit of care is erupting, and a moment in which midwives protested not only a wage deficit, but a deficit of care.

In this ethnographic chapter, I begin by introducing the context of the *kjarabarátta*, detailing the history and key events of the dispute which unfolded during the course of my fieldwork. In the following section, I reflect on anthropological literature around crisis and affect, to ask questions about the ways in which we might understand protest and dispute as discursive. I then go on to introduce key parts of the ethnography in order to explore the politics of the dispute, and ask what we can think through when we talk about care. In section 3.5., I explore two different protest sites at which midwives assembled and voiced a sense of crisis. In section 3.6., I explore midwives' reflections on clinical work during the dispute. In section 3.7., I reflect on discussions with midwives in order to tease out some of the key politics of the dispute. Drawing on this ethnography, I then turn to discuss how we can consider the *kjarabarátta* as a way to consider the politics of care work for midwives. I suggest a focus on a 'deficit of care' is a useful

way to understand the politics of crisis and care for protesting midwives in Iceland. I ask how the *kjarabarátta* helps us understand the layering of crisis and discontent midwives reported experiencing. How does this crisis talk articulate a sense of anxiety about the future? How much is this talk an attempt to shape or lay claim to that future? How might we understand midwives as protesting not only a deficit of wage and resources to live on, but a broader deficit of the ways in which they were cared for, and able to care?

3.3. The context of the midwives' dispute

The midwives' *kjarabarátta*, the 'wage and working conditions-struggle of midwives', was a lengthy dispute between *Ljósmaðurfelag Íslands*, the Icelandic Association of Midwives and professional union for midwives, and the Icelandic state. *Kjarabarátta* means 'wage dispute', the 'baráttu' signifying a battle, or struggle for something. In 2017, a group of midwives belonging to the Icelandic Association of Midwives formed a negotiation committee in order to address an ongoing issue of inadequate salaries, and a situation of payment they found to be unfair. It lasted for eighteen months and gained public prominence in 2018.

At this time, midwives graduating as postgraduate clinicians from the University of Iceland found themselves receiving a lower salary than the one they received as nurses prior to qualifying as midwives. As discussed in Chapter 1, midwifery training in Iceland takes six years to complete, and midwives must first take a four-year degree in adult nursing, before taking a two-year post-graduate course in midwifery. This is important to mention for two reasons: firstly, that in the way their education is organised, midwives struggle to identify themselves as a distinct, autonomous professional group, rather than a speciality of nursing—in some countries like the UK, midwifery is a direct-entry degree, so there is no requirement to qualify as a nurse before being permitted to 'specialise' in midwifery. Secondly, one of the issues central to the union

dispute was that the salary midwives received once they qualified as midwives was less than they received on graduating as nurses. Midwives effectively received a pay cut for pursuing midwifery training. Because the course is oversubscribed, with only eight to ten students accepted onto the midwifery course every year—there was a sense that the privilege of the role trumped any issue with the very real fact that this training involved a salary drop. This pay gap varied depending on experience, so for women who were going on to ‘retrain’ as midwives after several years working as nurses, rather than those women who completed the full six years back to back, the pay gap would be larger. The pay itself was too small to live on: women could not support themselves alone, or with a family, to live in Reykjavík, and this deficit in wages gave rise to a loss of security about a playable, and reproducible future in the municipal region. Midwives wanted this pay discrepancy rectified, and in engaging in a series of public protests, strikes, media engagement and mass resignations, the dispute became a very big conversation about the role of care and feminised work within post-crisis Iceland.

The socio-historical context of the 2008 financial crisis, and the political changes concurrent to this, underscored midwives’ protests; they pointed to a catalogue of conditions, of which financialised crisis was a part, that went into the creation of a deficit of care. This was about protesting a social consensus in which the security of a social contract with the government—for many Icelanders, not only midwives—had been undermined by the ways in which the banking crisis had unfolded, the ways in which it had been managed, the impact this had on the everyday lives of Icelanders, and how working and living conditions adequate to a secure and stable life had been eroded (Durrenberger and Palsson 2015). Midwives took issue with the creation of a care deficit made through consecutive neoliberal government administrations, in which public services had been privatised, health care services scaled-back and centralised, the cost of living increased, and in which financialised crisis had led to increased inequality, and exposed and exacerbated government corruption. Midwives perceived a widening gap between the interests of government ministers, and their requirements to provide safe, effective and equitable maternity

care as a public good. Midwives felt they worked in a context in which they were required to draw on personal, affective resources in order to plug gaps in funding and service provision created by the greed and corruption of a succession of government ministers. The focus of midwifery protest were two serving government ministers, the Minister of Finance, Bjarni Benediktsson, and the Minister of Health, Svandís Svarvarsdóttir. Bjarni Benediktsson, known colloquially as ‘Bjarni Ben,’ was seen by midwives as emblematic of a government administration that had eroded the conditions required for a secure, cared-for life, and was mired in repeated scandals undermining his self-presentation as a good family man, and committed feminist. In 2016, Bjarni Ben was named in the Panama Papers as having stakes in an offshore investment firm; in 2017 during his tenure as Prime Minister was found to have concealed the role of his father in the acquitting of a convicted sex offender; and in late 2017, was reappointed Minister of Finance under Katrín Jacobsdóttir’s coalition government, a role during which he belittled and patronised midwives for threatening strike action. Midwives contested this, and perceived Bjarni Ben as emblematic of a care-less and corrupt politician who had eroded social security while chastising a feminised workforce for contesting the care deficit they were expected to shore up.

As will be explored through the ethnography, midwives were motivated by the anger and frustration of the continued inequity in pay, the lack of resolution and fairness of a previous strike, and an urgent material need for their pay deficit to be addressed. In 2015, a strike had occurred among working midwives and nurses in Iceland, over inadequate salaries and poor working conditions. This strike lasted over several weeks, for a few days at a time, and while central to the lives of working midwives at the time, did not receive a great deal of publicity, and the pressure of public sympathy. In response to the strike, the government docked the salaries of all midwives. The negotiation committee formed in 2017 found themselves explaining the history of the previous strike. The umbrella union for the Icelandic Association of Midwives, *Bandalag Háskólamanna*, (the Icelandic Confederation of University Graduates), along with the midwives’

union, sued the government for the docked strike salaries and won, yet following a government appeal against this decision in the High Court, fought for the salary repayment again, and won.

In early 2018, while the negotiations were underway, frustration mounted among working midwives and they started to talk about their experiences of being at work, and the discrepancy of their pay, on social media. These posts, containing the same short, descriptive text, the words pointing to the unfairness of pay, and featuring a photo of the midwife posting, gained momentum across Icelandic social media and quickly became ‘viral’, with each post being shared across people’s private profiles several hundred times. The photo used in the post usually pictured a midwife holding a newborn, standing in a clinical room, the photo taken by the parents she had cared for. Proudly holding a newborn baby swaddled in a hospital towel, the midwife smiles at the camera, wearing her hospital scrubs, the composition slightly askew as though the parent took it seated, glancing up at the midwife holding their child. It was eye-catching; the writing accompanied a picture of a midwife holding a newborn baby inside a hospital room, the midwife dressed in her cotton scrubs, looking into the camera and smiling. As the days unfolded, more midwives posted similar captioned photographs. News articles and opinion pieces began to circulate in the media: the daily papers and accompanying news sites detailed these wage stories being shared by midwives.

Soon after, a popular public Facebook group sprung up in response to the social media posts circulated by midwives. Titled *Mæður & föður standa með Ljósmeðrum!* (‘Mothers and fathers stand with midwives!’), this group gained over 18,000 members in less than a week. The administrator of the group, a well-known and respected TV personality who was a strong advocate of homebirth and midwifery, encouraged a popular series of photo post protests and vigils during the negotiation meetings. For several months, this group became an important site of digital protest, with support statements, commentary, discussion and sharing of media, *við stöndum með Ljósmeðrum alla leið í baráttu þeirra fyrir réttmætum launum og starfsumhverfi,*

‘we stand with midwives all the way in their fight for a fair salary and working conditions.’ Lay members of this group began publicly posting photos of their abdomens—many pregnant, some not—with the words ‘I stand with midwives’ inscribed on in lipstick or eyeliner, the photos taken inside home interiors, in bedrooms and living rooms surrounded by the paraphernalia of home. Midwives I spoke to would reference this Facebook group and its membership as an important anchor of support and solidarity, and they were proud of it. They felt supported by the size and popularity of the group, and the momentum of activity on this site spilled out into further public support and solidarity as in-person protests and vigils developed. It made many midwives feel that their campaign and politics were respected by the very people they needed to be in solidarity with, and that they were being listened to by: the Icelandic public.

The social and news media campaigning grew, with midwives handing in their resignations publicly. During the most tense period of the dispute, the state ruled that it would be unlawful for midwives to go on strike, and through this legal ruling prevented midwives from staging an all-out strike, such as those experienced in 2015. The response to this was for midwives to publicly resign en masse from hospital contracts, and these were organised so that multiple midwives would exit their jobs on the same day in the summer, with the pressure of multiple resignations happening, and the resulting staff shortages, at the same moment. Over ten per cent of all working midwives in Iceland handed in their resignations; following the subsequent negotiations, some midwives rejoined the maternity team at the National Hospital, while others moved into other areas of work, as I will explore in the next ethnographic chapter. These resignations were public-facing, with midwives writing open letters in the press, and publishing photographs on social media of pairs of clinical shoes placed outside the entrance to the National Hospital. Midwives also began ‘opening their pay slips’, and posting images of these online to draw attention to the exact amount they were able to take home each month of their salaries, drawing attention to the inadequacy of this to cover rental properties and living costs in the city. Midwives commenced an overtime strike, working only to their contracted hours and taking

breaks. In a separate protest around the state's handling of contracts for independently employed 'home visit midwives', to whom the care of women and babies are discharged once they have left their place of birth, started a bureaucratic strike by coding themselves as 'unavailable' for providing home visits, causing a gridlock in the hospital as it was the hospital's responsibility to make sure the required maternity care is in place following the end of the woman's stay in hospital.

The dispute which unfolded in 2018 was multisited; the events of it took place in people's homes, in public and on social media, in streets and public parks, in wards and places of work, and through people's computers. Vigils, such as the one described at the beginning of this chapter, began occurring every time a meeting of the negotiation committee took place in the city municipal offices; involving supporters assembling outside the municipal buildings during the meeting times. Press photographers would attend to take photos of the assembled crowd of midwives and supporters, the vast majority of attendees women, and many lined up along the glass walls of the offices with prams; these images found their way quickly onto news channels and news websites. Those attending held cardboard placards, with angry slogans painted on in red and black. In the cold winter weather, the crowd would disperse quickly, these events lasting for half an hour before everybody piled into cars to retreat home. The enclosure of the meetings, and the gagging order imposed on attendees, was amplified by the presence of these vigils, standing outside a building in which they were not permitted to enter, and the windows of which they could not see through. Solidarity protests at Austurvöllur, a public square outside *Alþingishúsið* the Icelandic parliament in the centre of downtown Reykjavík, was organised and promoted through the support Facebook group. Several hundred attendees attended the largest, assembling with homemade placards. A microphone was set up under the building adjacent to the Parliament, so the orators could speak both to the crowd and address the seat of parliament, across the grassy square.

The negotiation meetings continued, and over the year were a prominent feature in the national media (Arnadóttir 2018, Birgisdóttir 2018, Gunnarsdóttir 2018). The dispute was, eventually, temporarily resolved—in 2019, midwives had had some of their demands met. However, the contractual and salary agreements were agreed to be in place for a year, and midwives, exhausted by the previous year's campaigning work, faced a renewed struggle for improved, secure and adequate wages a year after the dispute was resolved. The multiple, intersected deficits of pay, futurity and care, entangled in discourse and practice, continued for these midwives. I examine the *kjarabarátta* as a particular experience of crisis for the midwives involved, and consider how these midwives negotiated the multiple deficits unfolding in their professional and personal lives. In the next section, I explore how using crisis as an organisational metaphor is useful in turning our attention to these multiple experiences of deficit.

3.4. Crisis in the literature

In order to explore these conditions and experiences of deficit and crisis, this section turns to recent literature to examine how crisis has been understood discursively as metaphor and category. I draw on recent anthropological discussions of crisis, in order to understand how we might approach it as a concept that describes both a set of structural and material conditions, as well as an affective state (Loftsdóttir *et al.* 2018, Narotzky and Besnier 2014), and what this can open up in discussing the midwives' *kjarabarátta*. Anthropologists suggest that 'crisis' is a concept that can be thought of as both 'an experienced reality' as well as 'a folk and expert conceptual category' (Narotzky and Besnier 2014: S8). Authors suggest that it works as an 'organising metaphor' in which a broader set of tensions and inequities are contained (Loftsdóttir *et al.* 2018: 3). 'Crisis' therefore might work as a discursive container to express a diversity of conditions and affects that are brought about by difficult socioeconomic conditions. In the literature, talk of a state of 'crisis' can refer to both structural or institutional processes beyond

the everyday control of people (Harvey and Krohn-Hansen 2018), as well as describing an affective state in which people experience a lack of confidence in these structures and institutions to provide the framework for a stable life, and expectations for a known future (Ganti 2014).

‘Crisis’ belongs to a vernacular of economic life such as precarity, austerity, and other economic conditions in which people experience insecurity. Crisis is a useful place through which to explore the economy given the ubiquity and multiplicity of the experience of challenging economic circumstances for many people (Narotzky and Besnier 2014), and it is part of an economic vernacular pointing to these challenges. It has salience in the way in which the concept of precarity works; authors suggest how talk of precarity and living through conditions of crisis point to a contrast with a past in which there was a sense of stable futurity (Muehlebach 2013), and how this sense of a loss of a future, and nostalgia for something secure, is tied to feelings of being ‘deprived of the past promise of a predictable future’ (Loftsdóttir *et al.* 2018: 22). In exploring the proliferation of ‘crisis talk,’ Loftsdóttir *et al.* (2018) argue that the pervasiveness of ‘crisis’ has become a way to speak about public affect. The term ‘crisis’ has ‘become an organising metaphor in the twenty-first century, comparable to the salience of the term “risk” in the 1990s’ (Loftsdóttir *et al.* 2018: 3). These authors show how crisis is something discursive, and unpick, ethnographically, the ways in which crisis is mobilised as a way of articulating the precarity of contemporary capitalism, the uncertainty of stable futures. Crisis draws our attention to structure and affect, and the sense of intolerability people experience in these conditions.

As explored in Chapter 1, anthropologists show us that when we talk about the economy, we are talking about the ‘effort’ to make life; and this involves not only material conditions and waged labour, but people’s feelings, their hopes and desires for a life (Ganti 2014, Narotzky and Besnier 2014, Ortner 2011). In exploring crisis, authors argue there is a ‘structure of feeling’ to the contemporary moment, which is one characterised by ‘persistent anxiety and uncertainty’ (Loftsdóttir *et al.* 2018: 23). A ‘structure of feeling’, according to Williams (1977, cited by

Loftsdóttir *et al.* 2018: 22), is a way to understand how a specific historical moment may come to be felt, and that we can consider common affective experiences as signifying specific socio-historical moments. Williams argues that these structures of feeling can be understood as ‘a particular quality of social experience and relationship, historically distinct from other particular qualities, which gives the sense of a... period’ (Williams 1977: 31). Common affective experiences, these structures of feeling, pinpoint how it feels to live through or be in a particular situation, ‘the sense of how lives are lived and experienced, which includes the affective practices and emotions circulating in society’ (Loftsdóttir *et al.* 2018: 22). By understanding crisis as a structure of feeling, we pay attention to the ways in which feelings comprise experience, and that affective experience matters. It speaks to a period, or moment, in which a particular social experience is occurring. The concept of structures of feeling as designating an experience of crisis, is a useful way to frame the ways in which midwives articulated their experiences of crisis, and to foreground affect as something central to an ethnographic understanding of how people live through and negotiate crisis. The literature on how affect and emotional labour is central to economic life, and helps us understand the intertwining politics of care, affect, and work, and the ways in which gaps in care are about experiences of feeling (Hochschild 2003b). Work by Jordan (1993) and Martin (1989) is useful in pointing to the affective and practical deficits of esteem, value and authority that protesting midwives articulate, and work on how midwives experience a sense of emotional dissonance in their work pushes us to consider the ways in which talk of crisis expresses discontent (Bone 2002, Hunter 2010).

As an organising concept, crisis opens up questions for ethnographers about both the conditions required for a reproducible life, as well as the everyday experience of living with and through uncertainty. Ethnographic research points to deficits in expectations for people’s lives; ‘the end of secure gainful labour as an expectation of a developed economy, and to the anxieties and strategies that this unforeseen reality produces’ (Narotzky 2018: 40). In this ethnographic research, then, I take my cue from this; examining the anxieties and strategies of midwives

negotiating a life lived without deficit in contemporary Iceland. I ask how the *kjarabarátta* was about a discourse of affect, in which midwives articulated a sense of frustration and anxiety about their own futures and the professional future of midwifery. I ask how the *kjarabarátta* was about opening up a discourse on care: the provision of care, and how it mattered to and was experienced by midwives. In the next ethnographic section, I turn to the ethnography of the dispute to examine the ways in which midwives were experiencing, articulating and protesting a felt sense of ‘crisis’.

3.5. Protesting midwives: at the negotiation vigil and at parliament

Svandís, a midwife who works on the delivery suite at the national hospital in Reykjavik, is standing at the vigil, squaring her body firmly against the wind. The ward she works on sees over 75% of all births in the country. The place for most births in Iceland, and the most heavily concentrated place for midwifery work, is this one ward. Over the past 20 years, maternity services have been steadily centralised, with smaller, rural maternity units and midwife-led birth centres in the countryside closed, forcing families, and midwives to attend the central unit in Reykjavik. The midwife Svandís is fed up, she says “This is about women, and we are not treated the same. I want to see this dealt with once and for all, it can’t go on.’ She is holding one of the placards, her hands bare, loose threads of her hair caught by the sharp wind whipping around the building. The large black lettering on her placard asks a series of questions: *‘Hver tók á móti þér? En barni þínu? Hver mun taká á móti barnabarni þínu?’*: ‘Who received you? And your children? Who will receive your children’s children? Are midwives a dying profession due to low wages?’ The words are specific to an Icelandic description of work at a birth: in Icelandic vocabulary, a midwife does not ‘deliver’ a baby, but ‘receives’ it. The words suggest a sense of fractured responsibility for care. These words, which will appear printed in photos in the newspapers the following day, are asking what will happen to midwifery in Iceland.

Expecting the meeting would be long, the midwives assembled outside in the cold have wrapped themselves up to weather the cold. They met with the midwives attending the negotiations to share food together before the meeting began. Svandís and her colleagues are resigned to the expectation that the discussions will continue, and our talk moves on to what they think the outcome of the meeting will be. If nothing comes of this meeting, they agree, and if the dispute continues, then more midwives will resign. Freyja, another midwife stood with us, says “we thought these meetings would last for some days, then days became weeks, then weeks became months, and now here we are, a whole year has passed.” She states that striking won’t work for midwives, they are stuck in a bind. When the strike happened in 2015, it lasted for three days, and while on-call midwives were brought in to cover the striking midwives’ shifts, no one got paid as this work happened over official strike days. Midwives were still chasing these unpaid wages three years on. Svandís explains some of the politics of a potential strike to me: that the shift midwives at the hospital might consider an overtime strike, but that this won’t necessarily work. The midwives working on the hospital wards cannot just stop being at work or leave for specific allowed breaks due to the responsibilities held. However, midwives have started resigning, and both Svandís and Freya share a sense that this will continue. The shared dissatisfaction over the pace and development of the negotiations will lead to more resignations, potentially placing the hospital wards in a state of understaffed crisis. There is no resolution to these meetings, yet. There is no resolution to the midwives’ working conditions, the issues of their pay, their contracts, and the responsibility for granting these midwives the respect they ask for. As time passes, so this sense of dissatisfaction and discontent grows. The futurity of midwifery, and midwives’ individual careers, their futures as midwives, are on the line.

After less than an hour, there is a quiet decision to vacate the vigil. Supporters start to peel off into the street, pushing their prams, and the assembled midwives wave one another good-bye, quickly slipping into car seats. A woman late in her pregnancy collects the placards and stacks

them into the boot of a car. The words on these placards speak of a fraught and angry situation, and people are gathered here to vocalise and protest a sense of gendered 'expendability' (Rakopoulos 2019), that their work does not matter, and that the future of midwifery work is uncertain. Who will receive your family? What will happen to midwives? Who can be responsible for a future in which people are cared for?

Several months later, in the centre of downtown Reykjavík, I attend a midwifery-solidarity protest on the grassy square outside the parliament. There is a big gathering of six hundred people, midwives, families, children in pushchairs, babies. There is a sense of occasion about this, it is the largest protest that has happened since the dispute began. The woman who has been organising the solidarity protests while pregnant has now had her baby, and stands to address the crowd at the microphone with him, bright-eyed and wool-clad in her arms.

Midwife Elín and her daughter are stood on the grass holding signs. One declares "midwives' demands are for FAIRNESS and JUSTICE!" Elín is one of the group of midwives who resigned from her job at the National Hospital and left work earlier in the month. She tells me she's moved to tears seeing the support, and yet cannot believe the dispute is still ongoing. She is concerned that midwives are starting to split up, and that one midwife left the negotiation group as she thought the committee's position was becoming too weak.

I stand with another midwife, Rakel, and meet some of her midwifery colleagues, introduced as her *ljós-systirs* ('sister midwives'), members of the same cohort she completed her midwifery training in Reykjavík with. Rakel explains she is working an 80% contract on the antenatal clinic and ward, mainly 'doing inductions and sending women up' to the understaffed delivery suite. She is coping, but it is difficult. This understaffing is tactical, but the balance is delicate: managing public approval, each individual pregnancy, medical need, the wellbeing and conditions of those still at work, the solidarity with those who have left. Chatting in a small group, these midwives

seem positive about the current state of affairs, but are still caught in this bind, wondering how to put pressure on those at the top. It has worked to appeal to a public solidarity. Hildur has been writing several well-circulated blog-posts, poetry and comment pieces in the daily papers. We stay to see the politicians leave parliament at close of work at 4pm, but word reaches the crowd that they have ‘escaped out the back’.

3.6. Discussing value and crisis during the dispute

“Filter coffee for me”, Erla says as we order coffee at the kiosk in the entrance to the National Hospital in Reykjavík. I have met with Erla in the midst of the dispute to talk through some of the things I have been hearing about in the media: the overtime strikes, the mass resignations, the publicised retention issues, and I have also met to find out how she is. Erla is a staff midwife at the hospital, and she has just worked for several hours on the postnatal ward, an inpatient ward that forms part of the maternity department. She has changed into her own clothes, and carries the air of busyness of having just finished a shift. We sit down at one of several small white tables in the foyer, the entrance is bright and lit by large glass windows. The foyer emits the warm, clean, clinical atmosphere typical of Icelandic hospitals.

We talk about her shift: there is a situation on the wards affecting Erla’s work. The ‘home visit’ midwives, to whom the care of women and babies are to be discharged, have gone on strike. Women and babies are unable to be discharged home because each home visit midwife has marked herself as ‘unavailable,’ coded as a black dot on the computer system, and the postnatal ward is full of families unable to be discharged home. There is not a single home visit midwife available in the Reykjavík area, as they are all on strike. It is April 2018, and there is a great deal happening for midwives at this moment. While these home visit midwives are self-employed on a separate contract with Sjúkrjatyggingar Íslands (Icelandic state health insurance) to midwives, such as Erla, working at the hospital. The midwifery union is embroiled in weekly meetings with

the Icelandic state over pay negotiations. Midwives are resigning en masse as a form of protest at the pace at which these negotiation meetings are taking place. Every day, there are social media posts and media coverage of the dispute, spanning out into wider grievances about the conditions in which midwives work, the value of the work they do, the future of midwifery in Iceland. “We value our work a *lot*”, Erla says, speaking to me with her hand placed on her chest. She explains one of the issues for her at the moment is this discrepancy between how different people value midwifery. Erla and her midwifery colleagues “know the value of the work they do”, but they feel that this is not recognised by government ministers; they do not understand the necessity of midwifery, or its value. As a midwife and a member of the Icelandic Association of Midwives, like the majority of midwives in Iceland Erla is directly involved in the union dispute. She is professionally implicated in it: it has a direct effect on and speaks to her employment status, the terms of her employment, what she should and should not expect of the parameters of her work. It is also a deeply emotional experience. It involves navigating feeling. There is a lot of care of one another going on, as well as friction between midwives due to differences of opinion. It involves her family. It is disruptive. It is happening all around her.

Erla reaches down to her handbag and pulls out her phone, scrolling through pictures on her social media feed to find the images she wants to show me. She explains the images have been shared between midwives on Facebook, they are making clear graphs showing the current predicament of workforce numbers, attrition rates, age ranges of midwives. At a union meeting Erla attended several days ago, this information was shared, and the slide images have now been posted on social media. We peer at her phone screen, Erla translating the text on the slides and explaining the coloured graphs, showing workforce planning. She explains to me how the statistics show the age variation in the midwives currently registered in Iceland. “You can see there are 125 midwives over the age of fifty, and only *one* midwife under the age of thirty. This is a crisis for us.” With the number of midwives concentrated in a particular demographic, there is concern amongst midwives and the midwifery union that midwives will hit a point over the next decade

where there will be too few midwives. This complicates the unfolding crisis of longevity. This is something explored in the media over the weeks and months of these negotiations, commentary on the sustainability, value and worth of midwifery. What is a wage for care work? What is reproductive labour? Whose labour matters?

3.7. Layering of crises: interviews with midwives

Several months after the protests begin, I sit drinking coffee with Ásdís, who is explaining some of the key parts of the dispute to me, and how the staffing levels are organised during the strike. Her words point to a layering of crisis: that the crisis experienced by midwives is something different to the one that is happening within the institution of maternity care.

“And when only 12 midwives had finished their time to work after they resigned, you know the three months? And they left their jobs together on the first of July. It only took a few days for everything to collapse in *Landspítalinn* [the National Hospital] and there was a national crisis, because they had to close the biggest unit, the women’s unit, in *Landspítalinn*, for the postnatal and antenatal care. And also they had to—we have here two screenings during pregnancy, both 12 weeks and 20 weeks ultrasound, and they had to lay down the 12 week ultrasound. And so there was a big national crisis. And everything was collapsing. Only by 12 midwives quitting their jobs. We really had a crisis, we really had too few midwives here. We do not have the essential amount of midwives that we need to keep this service going on for many years to go. We do not have that.”

“And when we had the strike, and when—because it’s a necessary service that has to be provided so we had to have this emergency staffing, as little staff as possible, for emergency

measures. So we have these crisis lists in case of a strike, you have this list of what is the crisis amount of people that has to be, you know, working. At that time [of the strike], we had better—we had more people working than usual. So the emergency lists were actually counting for more people on shifts than we had normally. So people are very, very, very tired. And we are seeing more and more people falling off because of long term illnesses. Because of—they just give up, they start working somewhere else. We had very, very many nurses and midwives working as stewardesses. Flying, because they got better salary and better working hours and conditions.”

Svala, a midwife working in a small birth centre in south-West Iceland, explained how the conditions of work had become untenable for many midwives:

“We started pointing out that from the time of the bank crisis, healthcare workers—and of course midwives, also—they have been working *harder*. Running *faster*. Because we wanted to help our, our birthing women and we wanted to help our job provider, you know the hospital and clinics and whatever, so we worked harder and we ran faster, and always waiting for this era to be over. You know, for a new balance to come. But it hasn’t. It hasn’t. It’s still like, we are always with few—we are understaffed. We do not have enough people.”

The spilling out of discontent, dispossession from value, self, feeling, occurs because there is this profound mismatch between what should be felt and what is actually experienced by midwives. This, I found, was at the root of the midwifery protests I experienced during fieldwork. The context to this is one of neoliberalised health-care, post crisis Iceland, austerity and midwives having to care more with less: increasing workloads, less time, more tasks.

“So, we are working the jobs for maybe two people, and sometimes you can’t go home after your shifts or you are standing maybe for 16 hours, and you are standing, you are in the delivery room stuck and there is no one to take over, if you could just go and pee, and maybe you can’t pee for 10, 12 hours. Tough shit. But it doesn’t happen only once, or twice, it’s a *constant* thing.” [Svala]

Here we can see midwives articulating a layering of discontent and disaffect: of the experience of work speeding up, that this is a difficult thing to accommodate, to work fast and efficiently in a way that is detrimental to ‘care’ (Hochschild 2003a): there is less time for relationships and developing trust between midwives and families. This occurs together with the emotional requirement to enjoy the work, to feel passion and to be directed by altruistic feeling even when this speed-up occurs; this requirement for altruistic affect will be explored further in Chapter 5, in which midwives felt obliged to ‘enjoy’ this speeding up. Instead, I suggest that through the *kjarabarátta*, midwives protested this configuration, and pace, of work.

In addition, midwives voiced anxieties about the erosion of rural, midwife-led maternity services in Iceland, the effect this had on their livelihoods, and the implications of this for relations between generations of Icelanders, and of midwives. Eyrún, a midwife working at a small urban maternity unit outside of Reykjavík, pointed to this issue, voicing her frustration at the closure of many birth places for midwifery work outside of the capital region.

“For the last twenty years or so, there has been a shut-down in lots and lots of birthing units around the country. And women have just stood by and said nothing. And I do not understand it... maybe if women, the young women who are having their first children, they maybe do not know what’s going on, and they do not know what kind of service is being turned down, you know? But their mothers do. Their grandmothers, they know. And why aren’t they fighting for their daughters? Why are they not fighting for their unborn children?”

In the context of shifts towards a centralisation of maternity care within the capital region, Eyrún was frustrated at what she saw as passivity towards this change: that people had stood by and allowed for this erasure of services. For Eyrún as well as other midwives, they saw this in part to do with a disconnect between what people—the general public, politicians, service users—understood of their work, and the specific skills they provided in reproductive health care as midwives. Something had gone awry with the kinship networks that should have secured midwifery as a desired service, and small birthing units as the preferred option for birth for many families. Eyrún voiced a familial disconnect, where generations of families had trusted and wanted midwives, and yet had been part of a disintegration of midwifery in the countryside. This speaks to anthropology in which we can understand people's expressions of generational anxiety as being about fears of reproduction into the future.

3.8. Discussion: understanding crises and dispute

When we look at crisis anthropologically, we can understand it as both a way of describing a set of structural, material conditions in which the security of a life requiring these conditions is at stake (Loftsdóttir *et al.* 2018, Narotzky and Besnier 2014). Crisis also refers to an affective state in which people experience a lack of confidence in a future, and there is an emotional dissonance in which their hopes and desires are entangled with feelings of anxiety, grief, loss and nostalgia for a future that is in disrepair. Understanding crisis as both structure and feeling enables us to talk about this kind of economic and political event as something that people experience in different ways; it draws attention to people's affective experiences, and the importance of attending to a felt sense of crisis, instead of crisis being something that is happening outside of oneself, and belongs solely in material structure and policy. Rather than locating economic processes elsewhere, an

anthropological attentiveness to crisis grounds the economy in people's everyday lives and feelings (Ganti 2014, Ortner 2011).

As an organising concept, crisis opens up questions for ethnographers about both the conditions required for a reproducible life, as well as the everyday experience of living with and through uncertainty. In tandem with ethnographic research that points to the experience and persistence in deficits in expectations for people's lives (Narotzky 2018), this ethnography explores the ways in which midwives voiced anxieties about both the ways in which midwifery was no longer a form of secure and gainful labour for them, as well as the ways in which they created strategies and voiced anxieties about the future of their profession, and their own lives. In this chapter, I suggest that midwives' protest raises questions about the ways in which people negotiate that experience and persistence of deficit in their lives, including a sense of a deficit of expectation. Rather than the *kjarabarátta* being solely about protesting a deficit of wages, the anxieties midwives voiced, and their talk of crisis, point to an experience of multiple deficits: deficits of expectation, of a secure future, of material resources, of midwives, and of care. Entangled in midwives' discontent and negotiation of a wage, was a commentary about the ways in which they felt unable to securely reproduce a life.

This sense of crisis worked, as Loftsdóttir *et al.* (2018) suggest, as an 'organising metaphor' for a broader set of tensions in which midwives felt themselves embroiled: gender inequity, unfair working conditions, and inadequate salaries. The dispute bled into wider social discussions on gender, value, work and care, as I will go on to explore. The dispute became between midwives, those who used midwifery services, and an experience of neoliberal politics that framed feminist discourse in order to deflect actual structural and institutional change. This dispute was happening at a time when there were reflections on the financial crisis of 2008, the Panama Papers scandal, political corruption, institutionalised misogyny, and a broader trade union movement seeking to disrupt neoliberal hegemony. This crisis of midwifery care contrasts, as I have suggested

in Chapter 1, with popular understandings of Iceland as a place in which a secure and gainful life, as a woman, is guaranteed and to be expected (Benoit *et al.* 2011). In Iceland, ‘crisis’ had become an everyday reality for midwives in which they needed to contend with making a living, and, as I will explore in the following chapter, strategise about how to invest in the reproduction of the next generation of midwives, as well as their role in people’s reproductive lives, and ensuring that the reproductive lives of people in Iceland involved the role of midwives. The midwives’ *kjarabaráttta* therefore raises questions about the ways in which discourse and popular framings of the economy, what it means to attain and have economic security, and gender equality, are understood.

Anthropologists have pointed to the ways in which ‘anxieties about livelihood are often couched in terms of the relations between generations’, and that this brings into focus the role and place of reproduction (Narotzky and Besnier 2014: S5). I suggest that through protest, midwives were expressing their anxieties about the reproduction of midwifery in terms of this generational relation. Placards, commentary, debate and the union negotiations were couched in terms of this reproductive anxiety: fears about the future of generations of Icelanders and of future midwives. Midwives were deeply worried about not only a future in which midwives would be present and available to attend to reproductive life and people this work, but were also anxious about the possibility of midwifery existing in the future. The midwifery crisis, therefore, speaks to a sense of a breakdown in social reproduction. Midwives were protesting not only a wage deficit, but a deficit of care. Crisis therefore worked as an organising metaphor for a broader set of tensions in which midwives felt themselves embroiled: gender inequity, fair working conditions, hours worked. It was a way of articulating a sense of anxiety about the future: of midwifery as a profession, and the ways in which midwifery could be expected as a form of care. Talking about a crisis of retention and midwifery staffing levels was also about pointing to individualised, affective experience, in which individual midwives felt they could not cope with the current configuration of work. Women’s own futures, as midwives, were also framed by this

sense of anxiety: the current configuration of work, salary, pay, wellbeing and care, could not continue. How, then, did crises and dispute work as a way to describe both anxieties around professional futures, as well as anxieties around personal ones? Midwives found themselves embroiled in this bind, as I will explore in this thesis.

Paying attention to affect as a central part of the *kjarabarátta* and midwives' articulations of crisis allows us to foreground the ways in which affect is central to economic life. As 'a structure of feeling', and 'organising metaphor' (Loftsdóttir et al. 2018), crisis turns attention to people's material and affective experiences of living through difficult conditions, and living with a lack of a clear future. Anthropological work suggests we can understand the persistency of feelings of precarity, of anxiety, and of uncertainty, as affects that structure the feeling of a contemporary moment (Muehlebach 2013). Drawing on this approach to crisis raises questions about the affective experience of crisis, and the centrality of this to economic life. It brings affect into focus at the same time as articulating a specific structural and material reality in which the present conditions of life are untenable, and the state of future life is uncertain and insecure. Feelings of an absence of care were central to midwives' experience of the midwifery disputes and was an important part of their participation. We can understand the midwifery *kjarabarátta* therefore as importantly affective, as a way of articulating, mediating and challenging disaffect.

Midwives disputed not only the conditions of their employment and the wage they received for their labour, but also disputed the ways in which they were expected to feel about their work. In the midst of living, working and caring through multiple, entangled deficits, midwives protested requirements for emotional labour that ignored this context. The experience of working more, with fewer material and temporal resources, and requirements to appear to enjoy this work regardless of these changes (Hochschild 2003a) raises questions about how midwives resisted a care deficit. While during periods of crisis people strategise and cope in order to secure the resources they need to live their lives, an ethnographic focus on midwifery protest here draws

attention to the ways in which we can consider these economic strategies and practices as being about an *economy of affect* (Narotzky and Besnier 2014). Relationships, in which people experience and cultivate trust and care, were also being tended to through the *kjarabarátta*, and paying attention to this opens questions about the ways in which we frame the economy as being about different forms of effort to create and maintain a life. In focusing on contesting a deficit, we can view networks of social media support for midwives as a form of this affective economy, in which people reciprocate ‘both tangible and intangible resources’, feel morally obligated towards one another, and exchange emotional as well as material resources (*Ibid.*: S6). On the other hand, the political mistrust involved in the dispute, in which midwives felt manipulated in the negotiation meetings, in which they were vocally belittled, secretly recorded and the content of their negotiation discussions was ‘leaked’ to the media, created not only an atmosphere of mistrust and uncertainty, but was also about an affective economy in which midwives experienced a deficit of trust and relationships of exploitation and unequal exchange.

Turning attention to the ways in which the *kjarabarátta* is about economy and affect opens questions about the ways in which they were protesting requirements and obligations to care rooted in moral obligations and professional values of kindness and devotion. The premise that midwifery care and work should be done out of a sense of kindness and devotion was contested by midwives raises questions not only about midwives’ experience of a work ethic involving ‘service and sacrifice’ (Hunter 2010, Kirkham 1999), as will be explored in this thesis, but also about the ways in which midwives contested the *extraction* of these affective resources. By talking about and protesting a crisis of care in midwifery, anxieties about the reproductive future of midwifery, midwives drew attention to the ways in which they participated in an affective economy, and were having to live, care and work with multiple, unsustainable deficits. I ask how the *kjarabarátta* was about opening up a discourse on care: the provision of care, and how it mattered to and was experienced by midwives as part of an affective economy.

3.9. Conclusion

In this first ethnographic chapter, I have introduced the midwives' *kjarabarátta*, the 'wage and working conditions struggle' of midwives, as an ethnographic event through which we might ask questions of the politics of care. Through a focus on ethnographic research attending protests, vigils, and interviews with midwives involved in the union dispute, this chapter has explored the ways in which midwives articulated a sense of discontent and disaffect towards and through a normalisation of crisis and deficit.

I have explored crisis as a concept central to anthropological approaches to economic life, focusing on the ways in which crisis works as a metaphor and category through which people articulate both the material and affective conditions of their lives as untenable (Loftsdóttir *et al.* 2018). In expressions of crisis and discontent, I have explored how people express a lack of security in the structures and institutions they need to provide the framework for a stable life, and a predictable future. 'Crisis' brings into focus both the structural and affective dimensions of economic life. It brings affect into focus at the same time as articulating a specific structural and material reality in which the present conditions of life are untenable, and the state of future life is uncertain and insecure. Approaching crisis as both a structural problem beyond the everyday control of people, as well as describing an affective state in which people experience a lack of confidence in these structures to provide the material for a stable life, and expectations for a known future (Narotzky and Besnier 2014). I suggest it is useful to draw on these approaches to crisis in order to ask questions about the ways in which midwives were experiencing their participation in 'the economy': how they experienced multiple, entangled deficits and

relationships of affective exchange, as well as a structural and material crisis in midwifery work in which they attempted to negotiate a wage deficit.

This ethnographic chapter has explored how in public interviews and media, in protest, and in interviews, midwives spoke about the ways in which feeling frustrated by working conditions, and uncertainty about the future, were feelings that they experienced, and this played into the everyday, common experience of ‘crisis.’ This chapter has addressed the *kjarabarátta* as a critical event through which midwives articulated their disaffect with care, and addressed their experience and negotiation of a care deficit. The concept of a care deficit (Hochschild 1995), pulls into focus the context in which care is occurring, the emotional experience of care, and the labour of caring. It shifts us away from understanding feeling as an isolated, individualised experience, and roots it in the socioeconomic context in which lives are being lived: of financialisation, resource scarcity, managerialism. It also allows us to see, and ask questions of, feeling at work: recognising that feeling matters.

How do midwives understand the politics of their care? I argue that we can consider the *kjarabarátta* as a moment in which a refusal of a deficit of care is erupting: midwives protested not only a wage deficit, but a deficit of care. Midwifery protest was about creating collective strategies to address this deficit of care, strategies which were about addressing a sense of individual and collective ‘well-being’ among midwives; ‘well-being’ referring here to a sense of having secure expectations about material and emotional stability as midwives, and recognising that these expectations rely on the ability to access resources and experience the working conditions necessary to this stability. I have shown how a sense of a precarious, uncertain professional future in midwifery was being articulated through the course of the *kjarabarátta*, and how midwives voiced anxieties about how they could care, and be cared for.

In the next chapter, I turn to an ethnography of a midwifery conference in order to explore more closely the ways in which midwives worked to reproduce their profession, and work to enhance the well-being of future generations of midwives.

Chapter 4

Midwifery futures: inside a midwifery conference

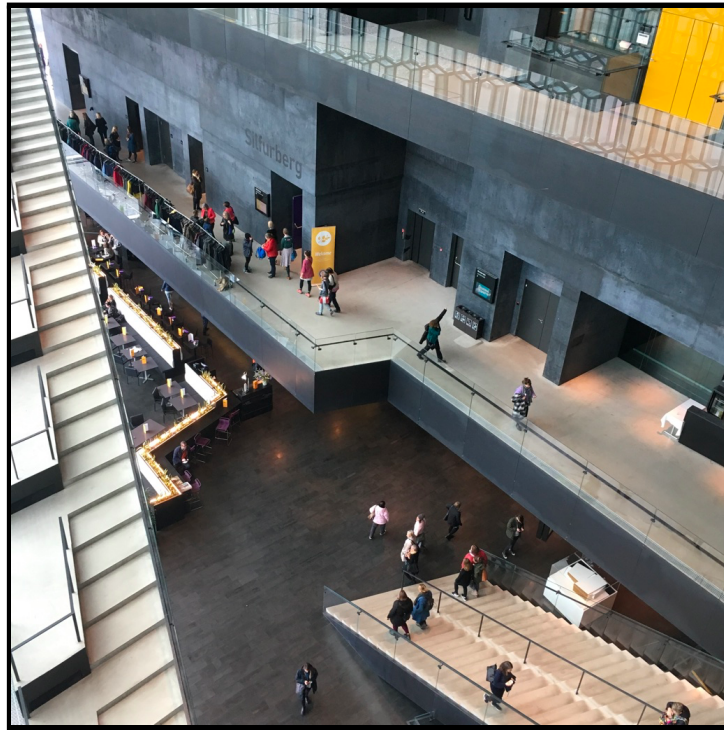


Figure 4.1: Inside the 21st Congress of the Nordic Federation of Midwives, at Harpa concert hall and conference centre, Reykjavík.

4.1. Introduction

In the large, glass conference venue of Harpa, I stand sipping coffee with Dóra, a retired Icelandic midwife. I am in Reykjavík, at the twenty-first congress of *Nordisk Jordmorförbund*, the Nordic Federation of Midwives. We watch other delegates arrive, pouring into the reception area with

branded lanyards, greeting one another excitedly. The Nordic Midwifery Congress is a three-day, triennial event during which several hundred midwives come together to meet, share research and collaborate. It is an opportunity for friendships to be rekindled between midwives working in different countries of the Nordic region. The midwifery associations of Norway, Sweden, Finland, Denmark and Iceland ('the big five'), and the Faroe Islands are all in attendance. Individual midwives from beyond this region, including Australia, America and the UK, twenty-seven countries in total, are included; 'a sign of growing globalisation,' according to one presenting midwife. I meet labour ward coordinators, academic midwives, sexual health specialists, entrepreneurs and newly-qualified midwives. The congress is also a place where midwifery work within this region is described, and where it is defined. Each of the Nordic midwifery associations takes it in turn to host the congress in their home country, and it is not often held in Reykjavík.

This year is special: *Ljósmaðrafélag Íslands*, the Icelandic Midwives' Association, are celebrating their one-hundredth anniversary this same weekend, and are hosting this year's congress to commemorate it. Many Icelandic midwives have dressed up in traditional national dress for this first day and Dóra and I watch them holding themselves high, clasping at their long skirts to stride across the room, stopping to have photos with other delegates. The stark glass and granite structure of the conference venue contrasts with the elegant black and white lace designs of their costumes. Dóra is not in national dress, but is here to celebrate the congress, and her own working life: an event in the midwifery calendar when midwives from these geographically diverse regions gather to discuss what they are doing, what they are working on, tell stories about their working lives and understand what the common ground is between them. It is both a celebration and a warning signal of the state of midwifery in Iceland and the wider Nordic region. It feels like a reunion.

4.2. Introduction

In this second ethnographic chapter I explore the Nordic Midwifery Congress as a site at which we can explore the reproduction of midwifery. This chapter argues that professional events, such as the Nordic Midwifery Congress, are places in which midwifery reproduces itself; and we can examine the congress as one site where this takes place. The chapter explores the ways in which midwives were at work with care at the conference: the different practices and techniques they used to create a particular identity around and of care work. The presence and experience of crisis and discontent, as explored in Chapter 3, belongs to a broader context of midwifery work in the Nordic region, in which the future of midwifery as a coherent profession, and the professional futures of individual midwives, are uncertain. I argue that conferences such as the Nordic Midwifery Congress are not only about meeting to share research evidence and compare regional-specific work in midwifery, but are important sites where midwives reproduce themselves and go to work to provision the future.

In this chapter, I first examine the method of following one's participants to professional events, reflecting on the wider context of these professional events during fieldwork. I examine the Nordic Midwifery Congress as an ethnographic example of a professional midwifery conference. Drawing on my participant observation at conferences, presentations, commemorative talks and formal events such as doctoral defences, including two congresses in Reykjavík and Gothenburg, where midwifery work and theory is presented to other midwives and the wider public. I then turn to the anthropological literature on conferences in order to reflect on the ways in which conferences have ethnographic significance; I show how conferences are important sites for socialising, networking, and collaborating in, as well as for the organisation and articulation of professional identities (Faucher-King 2005, Nyqvist, Leivestad and Tunestad 2017). Drawing on anthropological approaches to economic life, I explore the ways in which this reproductive work

at conferences are economic practices and the work of provisioning a future (Narotzky and Besnier 2014).

The chapter then turns to the Nordic Midwifery Congress, outlining the context of this professional event and the role it has in the calendar of Icelandic midwifery. The chapter draws on ethnographic participation in professional events in order to discuss the ways in which the conference worked as an event for communicating affect, collective remembering and identity making. Through an ethnographic focus on the Congress, I demonstrate how the quotidian work at this conference is in fact deeply, significantly reproductive for midwives. First, I explore the Congress as a place of collective remembering, in which midwives seek to reproduce their professional identities. Second, I explore the work of sociality as a way in which midwives seek to reproduce their profession through attending to relationships at the Congress. Third, I explore the imaginative work of technological innovation as a means of addressing midwifery futures. Fourth, I reflect on the ways in which ‘crisis talk’ around the midwives’ *kjarabarátta*, the wage and working conditions dispute, emerged at the Reykjavík Congress. Finally, I examine how work at the Congress was about articulating specific anxieties about midwifery futures, through research panels and presentations. I argue that the work done at midwifery conferences is about perpetuating the reproduction of midwifery: reproducing midwifery as a viable, sustainable occupation, and imagining a future for midwifery.

4.3. The anthropology of conferences and professional events

In this section, I turn to the anthropological literature on conferences, trade fairs and professional events to explore the ways in which an ethnography of these events can help us understand professional midwifery events as significant and meaningful. In this literature, ethnographers show how the method of following one’s informants to the conferences they attend is a means of

taking the social worlds of professionals seriously (Hannerz 2003, Nyqvist 2017, Nyqvist, Leivestad and Tunestad 2017).

Anthropology can help us examine how conferences are a common feature of professional associations and groups. Though they are ubiquitous, routine events in the lives of professionals, conferences are unique, historically meaningful places through which professions and professional selves are made (Leivestad and Nyqvist 2017). Nyqvist, Leivestad and Tunestad (2017) demonstrate how trade fairs and conferences have become a major global industry; as large gatherings of professionals, the history of conferences is rooted in the practice of large gatherings for exchange and trade, and in their contemporary form, conferences have become important sites for how professions are made (Nyqvist, Leivestad and Tunestad 2017). Conferences are particular, temporary, localised sites through which broader professional communities and contexts may be understood (Nyqvist, Leivestad and Tunestad 2017). What is understood as ‘the local’ is about a specific site, and it being occupied within a specific time and historical context (Strathern 1995). Large-scale professional gatherings can therefore ‘resemble a village of professionals’ in which the personal and professional are ‘intimately related’, and through which the interpersonal nature of these events enables processes of social formation and making (Nyqvist, Leivestad and Tunestad 2017: 4).

Conferences are not only about the exchange of ideas, objects, and practices, but are also about the reproduction of social relationships: they are about sustaining social ties and reinforcing social connections (Nyqvist, Leivestad and Tunestad 2017). In an ethnography of British political party conferences, Faucher-King (2005) explores how these taken-for granted events on the political calendar are crucial to the identity and ‘life’ of a political party, and are events where people learn new forms of organising, articulate ideologies, and are places where identities are recalibrated, remade, and reproduced (Faucher-King 2005). Conferences are important spaces in which the culture of something, the norms and habits of a group, and a group’s identity are

reproduced, as the interpersonal contact that the conference facilitates is the medium through which social structures and integration are reproduced. Faucher-King demonstrates how political party conferences contribute both to the imagining of communities, as well as framing the interactions between conference attendees. Conferences are places of collective identity-making, where boundaries are drawn between collectives and others, including those judged to be 'opponents'; these collectives are continually reinterpreting and redrawing their collective pasts (Faucher-King 2005: 68). In Forrest's (2017) ethnography of obesity conferences, conferences are shown as places where the fact of obesity as a disease category is produced, as well as being a place where experts on obesity are produced. The conference is productive of social relationships, ideas and definitions, and conferences are therefore places where expertise, and experts, are made.

The reinterpretation and renewal of collective identity and history is a commonality of conferences (Faucher-King 2005). Conferences are places at which a 'sense of community' is constructed, and where solidarity and trust is cultivated (Aspers and Darr 2011: 8). Professional gatherings are places in which professional values and beliefs are shared, negotiated, and through which they are institutionalised (Aspers and Darr 2011). Faucher-King's (2005) analysis of political party conferences highlights how 'sociability' is one of the main reasons delegates attend conferences (Faucher-King 2005: 38). The sociality of conferences allows people to spend time and converse with others who share similar world views and hold similar political values. Participants socialise in markedly different ways, ranging from those who spend the whole conference networking, leveraging recognisability and power through being personable and forthcoming in speaking to other delegates. In the spaces of conferences, people do not have to spend time and emotional energy justifying their belief and action, rather this is a space where these beliefs are implicit, and the complicity with one another's values plays into the sociality of these events. The conversations participants have 'refresh the implicit nature of their worldview' (Faucher-King 2005: 38). Attending these political conferences allows participants to reaffirm

their trust in the worldview they hold, as well as the political commitments within the party they support (Faucher-King 2005: 39).

Nyqvist's (2017) ethnography of investment conferences helps us understand that socialising at conferences is an integral aspect of these events; sociality is expected, and it is organised for participants. Though it is relegated as informal, it has an equal significance to attending or participating in a panel discussion or presentation. The interviewees in Nyqvist's research were 'at work' while cultivating conversations, friendships, and contacts during 'unscripted' time for coffee, in designated spaces and time slots in the investment conference. Participants reported they were there to 'work the room' to maximise the opportunity to network with other attendees (Nyqvist 2017: 24). The conference in Nyqvist's analysis is an intensive place for forming social connections and asserting power, and one of the central ways in which this sociality is cultivated is through the informal in-between times when participants are neither engaged in a panel discussion or presentation. These processes of networking and sociality are necessary processes of identity formation and belonging (Nyqvist, Leivestad and Tunestad 2017); for professionals such as midwives, this sociality is necessary, as I will go on to explore in this chapter. This sociality often takes place outside of the formal meeting places of the conferences, in bars, restaurants and corridors (Aspers and Darr 2011, Nyqvist, Leivestad and Tunestad 2017). Faucher-King (2005: 51) unpicks how direct, 'face-to-face interactions help reaffirm a sense of collective purpose' among conference attendees. Informal discussions in corridors, outside of formal meetings or presentations, elicit a sense of collective identity because attendees feel they are participating in something collective. Collective emotion is brought together at large presentations, where presenters might reaffirm a sense of common experience by describing the importance of the experience of those in the room. These authors show how 'informal talk and gossip' are important ways through which participants socialise, exchange information, and strategise (Nyqvist, Leivestad and Tunestad 2017: 10).

Having explored how ethnography is about delving into the presentations and corridor conversations that show how midwives negotiate the parameters of what they care about/what they feel matters about what they do, I will next set out the ethnographic context of the Nordic Midwifery Congress.

4.4. What is the conference?

4.3.2. The experience of being a Congress delegate

The Nordic Midwifery Congress is a large three-day, triennial conference. Over eight hundred delegates attend from across the Nordic region, as well as other countries including Australia, the United Kingdom, and the Netherlands. Those attending from outside of the Nordic region tend to be established midwives with careers in teaching and research. The language of the Congress is English. The majority of attendees are practicing midwives, and the vast majority of those attending are women. I meet newly-qualified midwives, research midwives, labour ward coordinators, lecturers, PhD students, community midwives, department heads and union representatives. Many midwives attend in groups identifiable by nationality and research interests, and research groups from different institutions and organisations attend. Among the Icelandic midwives in attendance, I meet midwives whose research careers I have followed for the period of my fieldwork, and with whom I have attended other professional events, such as doctoral vivas and local conferences. Research I have seen presented at other events is presented here at the conference. There is a lively, bustling atmosphere as friends recognise one another at the cloakroom stands, embracing as others try to hang up their coats.

Delegates arriving for the first morning of the conference are required to register at a row of registration tables. The conference staff are not midwives, but have been hired through a smaller company. They are all dressed in black, and stand behind tables decorated with white tablecloths. We each receive a lanyard branded with the conference logo and date, attached to which is a square name tag detailing one's name and institutional affiliation. We are gifted a free conference tote bag, and a small sample of 'gynaecological foam', an Icelandic medicinal product marketed for women post-birth. Moving from the registration desks, delegates enter an open hall overlooking the harbour. Small tables covered with clusters of chocolate, Nóa, a popular Icelandic confectionary brand. The Congress is accommodated in a large venue, centring around a single main auditorium able to host the full number of delegates. Numerous small meeting rooms and lecture halls are used to host panel discussions, paper presentations and meetings during the course of the three-day event. Prior to the Congress, delegates received an email with a link to download a conference planning app, and it is through our smartphones that we check panel schedules and event timings over the three days, navigating our way around the multiple floors and meeting rooms in Harpa. There has been time preceding the conference to plan one's schedule, using the app to highlight and set automated reminders for particular sessions.

The conference runs over three days, starting at 8.30am in the morning, and the final panel finishing by 6pm. The schedule is packed with talks, presentations, meetings and performances; there are over 160 presentations and workshops. Each day begins with a large event in the main auditorium, on the first day this is an 'opening ceremony', and on the subsequent days this early slot is for an opening performance with a comedian, and for the keynote speaker who delivers a lecture to the packed hall, standing at a podium in front of a large presentation screen. Each day is divided into multiple 'sessions' lasting ninety minutes, and scheduled throughout the day. These sessions may be workshops, seminars or paper presentations, and up to five would be happening concurrently at any one time. It is up to delegates to choose the sessions they wish to attend using the conference app, and then make their way to the meeting room hosting them. Some sessions

take place in small, packed single-floor rooms, others in lecture halls with a stage, or with seats arranged at a sloping angle in front of the speaker. There are designated times for coffee, lunch, and opportunities to visit the poster exhibition hosted in one of the open-plan ground-floor halls. Food was laid out by staff employed by the conference centre, piled high on serving platters on long tables. Delegates queued at these tables set out in open-plan areas, helping themselves while often speaking to other delegates. Coffee and refreshment breaks were loud with the sound of voices in conversation, the noise amplified by the concrete and glass interior of the hallway. These breaks were 'scheduled' times for networking and meeting with other delegates (Nyqvist 2017). The Congress included smaller, spin-off meetings for focused interest groups; I attended one exploring a transitional approach to researching midwives' emotional wellbeing.

The Congress promotes itself as a leading research event, and there is a strict entry criteria for presenters. Those interested in presenting a paper submitted an abstract to the Congress organisers six months earlier, and abstracts are reviewed by a 'scientific committee', who decide which papers to accept, and work on organising these papers into groups arranged by research themes. The presentation sessions were therefore varied and spanned a wide range of themes and areas of midwifery research; panels included 'Mental health in pregnancy', 'Violence in childbirth', 'Antenatal care for immigrant women', and 'Interprofessional cooperation.' At the paper presentations, up to four presenters would present their papers in a single session, with a tight time limit of fifteen minutes per presentation, and a following five minutes for questions from the audience, facilitated by a panel chair.

The cost of the conference was significant: a full, three day pass following early registration was 90,000 Icelandic króna, approximately £565. A student pass, at the early registration price, cost 40,000 Icelandic króna, approximately £255. These fees included admission to three days of conference proceedings, lunch and refreshments. Registration fees were not inexpensive, and for delegates travelling from outside Iceland, the cost of travel, airport transfer and accommodation

made the conference a costly trip to attend. Some participants I met had received sponsorship from their workplaces, others had saved for the trip. Additional costs included a ticket for the second-day, Friday night Congress dinner, as well as additional, pre-congress workshops. These three-hour workshops included ‘hands-on training’ in perineal repair, such as ‘Surgical skills, repair of labia and 1st degree tears’, and ‘Pain relief for repair of birth lacerations’, each costing 27,000 Icelandic króna, approximately £170. At this particular Congress, the Midwifery Department at the University of Iceland also hosted a three-day, intensive PhD course in midwifery and related health sciences prior to the Congress, designed for post-graduate students specialising or intending to specialise in midwifery theory. This cost 10,000 Icelandic króna, approximately £65, and included seminars, lectures, and a take-home 5,000 word essay to be graded as a pass or fail.

The Nordic Midwifery Congress is a big social event on the Nordic midwifery calendar, and the host country curates not only the conference. The Congress included an optional package of tours once the conference weekend had finished, exploring maternity units along the coast, with afternoons visiting natural features—the geysers, waterfalls and hot springs packaged as part of Iceland’s must-see attractions. Delegates were encouraged to purchase these tours at additional cost to the price of the conference, when purchasing Congress passes on the booking website. A promotional video, featuring soaring drone footage of waterfalls and landscapes, by the government-funded tourism campaign *Inspired by Iceland*, was embedded in the booking page, along with links to details of private company excursions and organised Congress tours. These included a 10 day coach tour titled ‘Midwifery in Iceland’, led by an Australian midwifery professor and featuring excursions to visit popular tourist attractions as well as Icelandic maternity units. This tour was arranged for the days following the conference, and cost £2,995.

The Congress took place in a large events venue. A large, shimmering glass structure perched on the northern edge of Reykjavík, blocking the city’s view of an otherwise uninterrupted vista of

mountains, Harpa was designed in the years preceding the financial crisis as the headquarters of Landsbanki, one of the largest Icelandic banks embroiled in the crisis. The city of Reykjavík took on Harpa as an architectural project following the collapse of this bank, and it now functions as an events venue, with multiple auditoriums for large music events, concerts, and performances. It is also more recently marketed as an international conference venue, with the exhibition space and resources to accommodate large events such as the Nordic Midwifery Congress, and over the course of my fieldwork, I run into advertisements for Harpa as a conference venue, such as during trailers for the cinema. In the city of Reykjavík, Harpa is one of the key architectural features of the past decade, marking the country's changing relationship with finance as the main mover of the economy. It is now a highlight of the city's relationship with the tourist boom underway throughout my fieldwork, and serves as a tourist information point, car rental centre, gift shop location and restroom for visitors disembarking tour buses from the car park outside. As I walked through the large glass corridors at the conference, along walkways and to smaller meeting areas to listen to midwifery discussions, I thought about this juxtaposition, imagining the room full of bankers, in a different future if the financial crisis had not occurred. Midwifery here would look different, too. Listening to research on the state of midwifery and midwives' experiences of work in Iceland, in a building designed at the peak of the financial boom, and completed in the aftermath of the crash. Listening to a different, but connected, professional crisis unravel through the stories told by midwives attending the conference.

Although the midwifery associations in each Nordic state coalesce the professional status of midwives, midwives have existed prior to the establishment of these professional collectives, which were established to hold a list of registrants, educational requirements, and to cohere a community of people working as midwives. At 100 years of age, the Icelandic and Faroese associations are the youngest in the region, with *Svenska Barnmorskeförbundet*, the Swedish Association of Midwives, founded in 1886. Midwifery work predates these professional bodies:

the professionalisation of midwives through formal training dates back over 200 years in Iceland, and 300 in Sweden.

Later, sifting through the archives of the Icelandic Midwives Association at *Kvennasögunasafn*, the Women's History archive at the National Library in Reykjavík, I found this sentiment echoed in email print-outs, handwritten letters, and menu plans. At the first congress of *Nordisk Jordmorförbund* in Sweden, in 1950, the inaugural president commented that while formal midwifery organisations were a recent establishment in the Nordic region, 'midwives of these countries would have always watched each other and shared joy and sorrow' (Kristjánsdóttir 2006). 300 midwives took part in this initial Congress, with over 200 midwives from Sweden, and a single midwife attending from Iceland. The Nordic countries have 'cooperated' (*samstarf*) since the seventeenth and eighteenth centuries, however the first formal cooperation through the Nordic Federation of Midwives was in 1950. The Federation meets annually, and organises a Congress to be held every three years, with representatives elected from each member organisation. The aim of these meetings is to share information about the work of each association, its union activities, and a report from each country. The associations work together with the aim of improving the quality of maternity care in each country, supporting one another with advice, and working in collaboration with the World Health Organisation (WHO) and International Confederation of Midwives (ICM) (Kristjánsdóttir 2006).

The congress has changed over several decades from a four-yearly to a triennial event, with each congress themed and incorporating professional information and research by midwives as midwifery established itself and developed as its own academic discipline. The congress therefore has become a marker for midwifery research, and is a place for midwives to showcase the research they are working on. The professional friendships, not only formalised by the federation as a sign of professionalised status (Kristjánsdóttir 2006) but also consisting of interpersonal, affective relationships, echo back through the decades; in the archive slipped among official documents

and brochures are photos of jubilant previous congress dinners, midwife attendees in permed hair styles and blouses smiling out from the 1980s.

4.5. The opening plenary: the reproduction of professional identities

After coffee on the first morning of the Congress, Dóra and I join several hundred other midwives pouring into a large auditorium to watch the opening celebrations. The concert space is dark, a grand piano sits ceremoniously on top of a stage, framed by bouquets of yellow flowers, matching the conference branding. A popular Icelandic singer, Ragga Gísla, strides out dressed in a black silk suit and velvet platform boots. She smiles at the crowd as the piano sounds behind her, saying into the microphone ‘you have the best, most beautiful job in the world. It’s good to see so many angels.’ I shift in my seat, uncomfortable at hearing the crooning praise. I am reminded of listening to a tutor at the start of my own midwifery training, stating sardonically ‘oh, you’ll hear it all the time, “you’re all such *angels*.”’ It reminds me too, of a recent public vote decreeing the word for midwife, *ljósmóðir* or ‘mother of light’, as the ‘most beautiful word in Icelandic’. Ragga Gísla starts singing, and the audience of midwives is hushed and quiet under the low light of the theatre. A particular atmosphere is being created, and an affective understanding of midwifery work is being reproduced here.

Common experiences of pressure, stress and the requirement to work fast and thoroughly is shared by many of the midwives gathered at this conference. While there are many features of midwifery within these different states that render them unique to the particular locality of each region, there is much that is shared. Having attended the previous congress in Sweden, I was struck by the sense of commonality between the experiences of midwives from across the Nordic region, and I am interested to understand how the discussions at this event will pick up from

where the last left off, three years ago. At the plenary of the last Congress, the midwifery presidents from the five national associations spoke about the challenges facing midwives in each country, and the shift in tone was markedly different to the celebration of clinical and social research headlined through the previous days of the conference. ‘Midwives are tired, and they are fed up’, stated Mia Ahlberg, the Swedish midwifery president. Other presidents asked how they were to deal with ‘lousy work conditions’, how to address the challenge of retention when so many midwives are leaving the profession, how to address burnout, and how to shape midwifery as a viable occupation for women, and men, throughout their working lives. In Reykjavík, I was struck by the continuation and development of conversations around these issues, the experiences of Icelandic midwives during the course of my ethnography magnified by this regional commonality in midwives’ experiences of stress, alienation, and disillusionment. There was frustration and indignation among presenting midwives, and the difficulties of work were not held back from talk and presentation. There is an intense danger of professional and personal burnout among midwives in this region. This is about a disconnect between how midwives are viewed as having some form of occupational grace, as ‘angels’, and the lived reality of work as a midwife. There is a tension here between how midwives feel valued as women working a ‘beautiful’ job, and the way work is experienced as valuable, and midwives’ actual experiences of being valued.

The deliberate creation of affect and atmosphere is a feature of conferences (Fisher 2017), in which the use of emotional affect through music, performance, and interior style is carefully managed in order to cultivate a particular mood for the conference. In Fisher’s ethnography of corporate conferences, participants were expected to do work at this conference on themselves to get in touch with their ‘authentic feminine selves’, in order to become better, improved leaders, entrepreneurs and managers; the management of the setting in which an atmosphere conducive to this work was central to the conference (Fisher 2017: 44). At the Nordic Midwifery Congress, this cultivated atmosphere of celebration of midwifery work jars. It not only contrasts starkly

with a public appreciation of midwifery work, but the difficulties of midwifery work experienced by midwives jar with the ways in which the Nordic region is celebrated for consistently topping international league tables on birth outcomes, gender equality, mortality and morbidity, and healthcare provision (World Economic Forum 2021). These measurements are used to determine what reproductive labour is like for women in terms of broader health outcomes: how and if it harms women, and whether reproduction is something that aligns with high levels of death. Norway, Sweden and Iceland are, by global health standards, the best countries in the world to be a pregnant woman, or seeking any form of reproductive or maternal health care (Renfrew et al. 2019). Midwifery as a profession has much to celebrate in being an integral, established part of primary maternal health care. In Iceland and other countries in the Nordic region, every pregnant woman is cared for by midwives, and women experiencing low-risk, clinically uncomplicated, 'normal' pregnancies and labours will see a midwife as the only health care professional during their maternity care. Given the high-status of midwives in these resource-rich countries, that have much to celebrate in maternity care provision, the conference provided an opportunity to understand the atmosphere of discontent and the discourses of crisis in circulation among the midwives staffing these healthcare services.

Other midwifery conferences, such as the Nordic Midwifery Congress, as well as the research conference held on the International Day of the Midwife, were also events in which collective identities were renewed and reimagined, through presentation, conversation and ritual. The Nordic Midwifery Congress was an event large enough to hold performative ritual as a layering on top of the quotidian ritual of conference, such as receiving a name-badge, asking questions of presenters in the designated time-slot, the viewing of power-point slides (Nyqvist, Leivestad and Tunestad 2017). The Congress included explicit processes of collective remembering—such as keynote speeches, the handing over of flowers to esteemed Federation members, and the encouragement to wear national costume at the opening ceremony. The 2019 Congress also involved the celebration of 100 years of the Icelandic Midwives' Association. On the morning of

the first day of the Congress, a crowd of midwives in national dress met at a downtown address where the Association was first founded, unveiling a ceremonial paving stone to mark the centenary of the Association.

Press and other delegates attended to celebrate, and take photos of the spectacle of forty midwives assembled in lace shawls and tail-caps. Following the final plenary of the Congress, three coaches pulled up to take all attending Icelandic Midwives to Bessastaðir to meet Guðni Thorlacius Jóhannesson, the President of Iceland, for a formal reception at his residence to celebrate the Icelandic Midwives' centenary. Later that weekend, my Facebook feed fills with images of smiling midwives posing with drinks at the reception. The President, known colloquially by his first name as 'Guðni,' is thought of fondly; 'everyone needs a Guðni', commented Sunna, showing me the photos she has taken with him on her phone. The Congress was organised so as to facilitate explicit forms of collective remembering, and Hildur's speech on the first morning of the conference was a clear example of this collective remembering, the gathering of common experience and meaning, and a renewal of collective identity.

4.6. The work of sociality at the Congress

As well as the cultivation of atmosphere at the Congress, the space and scope for sociality was an important feature of the work of the Congress. During a scheduled break for lunch, I approach a circular table with a plate of food at which two women are standing, having a conversation in Swedish. They welcome me to the table and we introduce ourselves, reading one another's lanyard tags: Lena and Maria are both Swedish midwives and work as clinical midwives and as midwifery educators. They are in their fifties, both have PhDs, and they exchange a wry, comical look between them while describing how they 'go way back', having trained together as nurses, before going on to qualify as midwives. We talk about differences in midwifery education, their

visit to Reykjavík, the food. We are conducting ourselves in the way the conference has organised us to do so: the tables arranged like this to stand and share a meal, allow movement between them. It feels as though there is a performativity to our meeting. We finish our meal and walk to the other side of the exhibition area together, where rows of posters are displayed, detailing different research projects. The noise is loud, the din of several hundred attendees speaking at once, the noise reverberating off the glass and concrete interior. At the poster presentations, some of the authors are hovering close by. Maria and I stop to look at a poster on water birth statistics. We talk about what we can see in the photos, the setting looking clinically familiar, but unknown, to us, and the context of work different to ours. They are interested in my own research, and we speak about what we understand of the current situation unfolding for midwives in Iceland.

These informal, timetabled spaces in the Congress are designed to be deliberately conducive to developing relationships. While there is a common awareness that participation at professional events includes periods such as this in which one ‘networks’, the understanding of this as a particular form of midwifery work is less obvious. In an ethnography of investment conferences, Nyqvist (2017: 24) shows how these events include periods of ‘scheduled schmoozing’, where participants are encouraged to have productive, strategic conversations with one another. Rather than approaching the liminal time between the ‘traditional’ conference events of meetings and presentations as mere coffee ‘breaks’, Nyqvist shows how these ‘interlude’ moments are also about work. The work of Lewis (2019), and Mitchell, Marston and Katz (2003) shows us how the relegation of uncounted, informal, or social time is routinely made to be of less value and that this relegation is deeply political. Examining conferences as a place of work, and the sociality of conferences as labour disrupts a perspective of affective, social work as something uncounted, quotidian, and of little value. Socialising at a conference therefore is a way in which midwives go to work, as the conference is a site of reproduction for midwifery. At the Congress, breaks and intermissions are important events which are about the work of sociality, for developing and reproducing social relationships. This sociality is formalised, or organised through the structure

of the Congress through the architecture of the conference: coffee breaks, a conference dinner, the space and time for networking. In a broader sense, this quotidian collegiality is the fabric of the conference: the interpersonal work to establish what the scope of midwifery work and identity is.

We can understand the reproductive work of sociality in two key ways in midwifery. First, we can understand that in midwifery, relationships and relational care are central to professional ideology and the organisation of work (Hunter et al. 2008, Kirkham 2010). Sociality is therefore important to midwifery work: developing relationships is about enacting relational care between midwives and midwifery clients, and between colleagues. It is about developing trust, the aversion of risk, by developing trusting relationships with others who would be able to assist and help navigate a difficult clinical or professional situation. It is also, as I demonstrate here, about the extension of midwifery into the future. I suggest that while sociality in midwifery is important, it is often codified as inappropriate, idle work, at times through the trope of ‘gossip’ (Latimer 2000). This is about a particular moralisation of idleness, and framing of what is legitimate work, and what is not. When work is understood as a series of unifiable tasks, the work of creating, maintaining, and reproducing relationships, becomes something seen as outside of work. Within a neoliberal frame, the pace of work and moralisation of work has become something specific (Weeks 2011), and this shapes our understanding of what is meaningful or legitimate about midwifery works and the activities of midwives. Within midwifery, the requirement to appear busy, and the chiding of relaxation at work, even though there was no clinical or occupational requirement to be busy or unrelaxed, has been documented in midwifery writing (Marlow 1979). The work of feminist scholarship (Federici 2012), shows us how the ‘soft’ work of sociality and talk is demeaned, and has historically been cast within moral framings of idleness, laziness, and danger. I argue that we should pay more attention to, and respect, the work of sociality in midwifery, as central to professional socialisation (Parsons and Griffiths 2007) as well as the reproduction of midwifery and of midwives.

Second, the reproductive work of sociality can be understood within the context of professional events, by understanding the work of organising large professional gatherings, such as conferences. I suggest this is something misrecognised in representations of midwifery work. The archives of *Ljósmeðrafélag Íslands* archives contain extensive documentation of the Nordic Midwifery Congress, detailing the organisational work that had gone into each of these events when they were hosted in Iceland, such as email commentary on menu options to be served at the conference during a 2001 Congress dinner. In exploring these archives, I found this paperwork a window into the kinds of organising work midwives are conducting (Allen 2015). This is important because firstly, this work often gets discounted as too mundane to matter and is not imbued with the emotional content of ‘proper’ midwifery work, which is to care, and to be at work at a birth, and to be hands-on and giving direct patient care. Allen’s work (2015) explores this in terms of the invisible organising work of nurses, showing that much of the work nurses do in order to perpetuate nursing goes unrecognised, unvalued, and uncounted. Further, this is important secondly because this work is about reproducing a future: making sure that people can eat at the conference, but that the space being created for midwives to come together, tell stories, share research, and perpetuate a future for themselves as selves and an occupation is happening at these conferences.

4.7. Technologies and imaginative work at conferences

In the exhibition hall, a long presentation table is set out and covered with tablecloth. A small team are stood at one side of the table, promoting a company providing online perineal repair tutorials, a package of videos to be used alongside a range of equipment designed specifically to help midwives learn how to suture tears following a birth. The wares are neatly stacked up on a

bright red tablecloth. I stop to talk to the exhibitor, and am talked through some of the products she has on display. She hands me a small stack of what appear to be notelets, much like a shopping list, except the paper is not plain, each sheaf of paper in the stack features a full-page illustration of a vulva. The exhibitor takes out a pen and explains how to use it as a teaching aid, pressing it into my hand, 'here, it's yours to take home.' Further down the table I examine a recently patented design for a speculum to be used while repairing perineal tears. The attendee lets me hold it and flex the plastic into an embroidered, cushioned vulva. It is a clever design, the attendee pointing out the rivulets on the model to help organise the suturing thread, with indents in the structure to hold needles. It is designed as something comfortable for women to experience during post-birth suturing, and is a model to help redesign the midwifery work around this task: making it more comfortable for midwives to do this work. I am struck by this, thinking of times when I have felt I have had too few hands to carry out the tasks required, needing additional fingers to hold gauze, stem bleeding, and arrange sutures. There is something of a do-it-yourself ethos around this product development here. These are midwives designing gynaecological equipment for other midwives, understanding the specific contexts of midwifery work that loop into the development of these products. It matters to develop a piece of equipment to replace another midwife's hands: at a time of chronic understaffing and lacks in other midwives to step in and assist, there is a need for equipment to do the job another person's hands might do. The exhibitor and I talk through the design of this piece of equipment: though the work of suturing tears following a birth is delicate, and there is a medical necessity for swiftness, it compensates for the lack of an assistant and the experience of working in a setting where the task of suturing needs to be performed well, but fast. Another pair of sterile hands are unavailable, so this speculum has features for setting aside additional suture material, needles, and keeping in place parts of anatomy that need to be focused on. I comment on this, and the exhibitor says 'well, yes! You can tell it's been designed by midwives, *for* midwives.' The design looks and feels comfortable to hold. I notice midwives attending the conference walking around with single earrings featuring this speculum in miniature dangling through their hair: the

speculum looking like a winged sycamore seed. Here is a design that speaks to a specific context of midwifery work at a birth: the requirement for more support when there aren't many midwives available, and the ones that are working are being pressured to work fast, to get through the tasks required following a birth, and to move on to caring for the next woman and her family.

Work at the congress takes on different forms. Through the sharing of research and evidence, and the rewriting of codes, standards, guidelines and algorithms, midwifery work at conferences is about establishing where the parameters of midwifery work and expertise can be found, and is about territorialising midwifery as an occupation. There is a vast amount of work done around not only enforcing and delineating these parameters, through the act of measurement, advice-giving, conversations between staff and clients, but also around defining them.

4.8. Reproductive futures at the Congress

At the Congress, one central theme that has developed is a wider conversation about the sustainability of midwifery work once people qualify as midwives. Throughout the Congress I hear references to this. I speak to Vigdís, a midwife selling branded, promotional t-shirts for the Icelandic midwifery association, boxes open in the reception hall and midwives rummaging through piles of colourful clothing. Vigdís spent a number of years working in Denmark, and she has since moved back to south-west Iceland to work and live there, and works in a midwife-led birth centre outside of the capital. She explains to me that in Denmark, she understands through anecdotal reports among midwives that the current 'lifespan' of a midwife is around seven years in duration, and after working for this time, many midwives quit: they move into other areas of work. It is a warning sign for midwifery, and something she feels is unfolding in many different places, including Iceland. She explains there is no clear data on it, but from her experience she

would expect the numbers to be something similar: the average time spent working as a midwife in Iceland is now only seven years. While my research outside of the Congress has led me into numerous conversations about the sustainability and longevity of midwifery in Iceland, this coalesces here at the Congress as a regional issue. While midwifery is a popular training course, the midwives being trained are not staying long in the profession. A work 'lifespan' is about the number of years a midwife might stay in midwifery, the end of this span being the point at which burnout, alienation and disillusionment become too big an issue to ignore. So whereas at the previous Congress I was left with a sense of this being a question—how to address the issue of making midwifery a sustainable, viable occupation for people over the span of a working life, at this Congress it seems that a bigger crisis for these midwives is underway: too few people are staying in midwifery.

One of the ways in which this particular layering of crisis—in this instance, a crisis of retention—emerges at the Congress is through stories of midwives leaving midwifery to work as flight attendants in Iceland. Sitting in a glass-walled room on the top floor of the conference centre, I listened to Sigfríður, a presenting midwife talk about midwives' experience of attending 'acute circumstances' in labour and birth in Iceland. This is a way of describing emergency situations: her discussion was about the ways in which midwives described their experiences of a pervasive sense of threat and risk to life during shift work on an obstetric-led labour ward. Sigfríður Inga Karlsdóttir's research (Tryggvadóttir *et al.* 2018) found that 10-43% of health professionals felt the effect of this attendance, reporting symptoms such as excessive fatigue, sleep disorders, anxiety, guilt, lower job satisfaction, and would relive the incident. Midwives she interviewed described feeling 'detached', anxious about coming back the next shift to work on the ward, or 'just fell apart.' Midwives carried these acute incidents with them for a long time. Sigfríður read through the transcript quotes on the slides. 'I wanted to go back to being a flight attendant,' stated one interviewee.

This statement hung in the air, and some of the audience, made up of midwives from not only the Nordic region, but Australia, England and Germany, seemed surprised by the reference to parallel forms of work, a shuffle of attendees moving in their seats rippling through the audience. This was not the first time I heard mention of the work of flight attendants. References to midwives leaving midwifery work were told through repeated references to work as flight attendants. These stories surfaced in research, such as the transcript quoted by Sigfríður Inga. As the congress progressed, the rumours of these absent midwives circulated through presentations, comedy performances, and conversations with individual midwives. Ari Eldjárn, a popular Icelandic stand-up performer with a speciality in comedically switching between Nordic accents and impersonations, had performed a skit on the recent bankruptcy of an Icelandic budget airline. As a row of Norwegian midwives sat in front of me were dabbing their eyes in laughter, he quipped that many Icelandic midwives were now becoming stewardesses. The federation president, Hildur Kristjánsdóttir, talked about the specific pressures on women health care workers in Iceland, the stress they endure and the burnout they risk, stating ‘there are a lot of nurses that are stewardesses in Iceland, at least.’

As these stories emerged at the congress, I went searching for more evidence of them. I couldn’t find any individual midwives who had worked as flight attendants, but a few said they knew of individual midwives who had moved into flight attendant work. These absentee midwives were invisible in my research as identifiable people, but they were present as missing midwives, a negative space I had not recognised. The stories of these defecting midwives mattered. The congress was not the first time I’d heard reference to the defecting of health care professionals to stewarding work; it had been something reported on in the news, with a specific focus on the shifts in nurses opting to work as flight attendants. The congress was the place in which I found these stories proliferating around midwifery. The circulation of these rumours about the work of ex-midwives was, in part, a commentary on the precarity and insecurity of particular forms of care work, including midwifery. The presence of these rumours at the congress suggested that

midwives recognised that much of their work was unviable, and that it was insecure, and that the realities of other forms of affective work made more sense to midwives in terms of providing a secure income, planning time, allowing for a good work and life balance, and a sense of a secure future. Narotzky and Besnier (2014: S6) refer to the work done by people in professional roles at times and in situations of precarity; where ‘even doctors and civil servants may moonlight as taxi drivers and small-scale business entrepreneurs’ in order to find some economic security. In a parallel way, midwives in Iceland were reported to have sought work elsewhere, a way of coping with precarity that may involve not only economic insecurity, but an insecurity of affect, fulfilment, value and hope that are resources needed in order to make and reproduce a secure life (Hunter 2010, Narotzky and Besnier 2014).

If conferences, as I argue in this chapter, are places in which particular forms of interpersonal, relational work are done in order to define and perpetuate a clear sense of professional work and identity, then the role of talk around this work, or indeed, the absence of it, are necessary and important. If conferences are about sustaining a sense of futurity in midwifery, then it matters that these rumours of midwives leaving to work as flight attendants are present. Rather than being clear evidence of a particular occupational shift, and evidencing particular truths about midwifery work, and the ways in which midwives leave, these rumours instead point to a difficult precarity in midwifery. They were a way of articulating anxieties about the future of midwifery. Rather than following these rumours in order to trace and evidence a particular trend of work, of midwives shifting into different forms of occupational work, and different kinds of labour, these stories identified a particular set of anxieties about the instability of midwifery work.

4.9. Crisis talk at the Congress

During a morning plenary at the Congress, Hildur Kristjánsdóttir, president of the Nordic Federation of Midwives and an Icelandic midwife, takes to the stage to address the seated crowd. She is dressed in a long skirted *upphlutur* (bodice-dress), an everyday dress popular in the nineteenth century, consisting of a skirt, a lace or striped apron, white blouse and an embroidered bodice. The tassel of her black *skotthúfa* (tail-cap) drapes down along her silvery hair. Hildur is retiring from her role this year. She is one of the many Icelandic midwives dressed in national costume, and she speaks out from the podium in this grand hall—the epitome of modern, post-crisis Iceland—to address the Congress. It has been a difficult three years for these midwifery associations, and the Icelandic association, of which Hildur is a member, has been embroiled in a lengthy and unresolved wage dispute. There is solidarity here between these associations, and Hildur addresses this, stating ‘we have stood by each other in strikes and hard times.’ Midwifery, she says, is ‘so much older than the age of the associations.’ Three years on from the discontent expressed at the previous Congress, the content of Hildur’s words focused on these same themes: ‘we have fought, as midwives do, for women’s rights. In our battles for women, we forgot ourselves. Us, midwives. We need to look at our working conditions, and our care. We have to care for ourselves properly.’ Hildur’s speech is about a discourse of crisis, and frames the sense of urgency over the reproduction of midwifery for the midwives assembled at this Congress. For Hildur, and many of the midwives assembled, ‘care’ is a necessity, and it is through care that midwives feel they will be able to reproduce their own futures.

During her speech, Hildur explains that in Iceland formal education for midwives has existed since the 1700s, yet ‘when we got formal education, it was almost always in the hands of learned doctors.’ This history is documented in Ólafsdóttir’s (2006) thesis on the history of midwifery work and storytelling in Iceland. People worked as attendants at births prior to this, and Hildur mentions that the medieval Icelandic sagas document stories of birth ceremonies attended by

midwives. This history is politicised for midwives: Hildur states that research shows there is an intense reliance on ‘goodwill’ from midwives in order to provide adequate care. Care is not only something to be measured and understood in metrics around health outcomes for women and the reproductive labour of reproducing humans, but is more complex: care is also about a cost for midwives, an imbalance of being cared for and providing care. The congress is a place to consider the ways in which the reproduction of midwifery is at stake, through this misalignment of ‘care’. Standing on the Congress stage in her nineteenth-century dress, in a building built at the pinnacle of the financial crash of 2008, while speaking to several hundred midwives about this scope of history, Hildur’s speech conjures a strange dislocation of time. The longevity of this midwifery work, the changing roles and status that birth attendants have held, is brought into the room. So much of this conference will go on to address the future: not out of a sense of adherence to traditionalism, but with the emphasis on developing midwifery into the future, on how it will go on to grow and change and adapt, and how it will sustain itself, how midwives will sustain themselves, in response to the union crises in the present. Hildur’s talk reminds me just how recent this neoliberalised shape of midwifery is, and how difficult it is to think out of. It is about how midwives are presenting themselves, and what this melding of past and present and future is about, in Reykjavík.

4.10. Understanding work at the midwifery Congress

In this chapter, I argue that the Nordic Midwifery Congress is a site where midwives are at work, and that this work is reproductive of midwifery: the Congress is one site where midwifery reproduces itself. The congress was a place of sociality and negotiation for midwives, and at it, I found midwives caught between a celebration of professional legitimacy, and the worsening conditions of their own labour. Much of the work being done at the conference, as I have

explored in the ethnography above, was about mediating this tension so as to be able to reproduce midwifery work. The Congress was a place in which midwives articulated, shared and discussed their experiences of multiple deficits; the context of midwives' employment, working conditions and labour were undercurrents to Congress proceedings. How midwives confront a precarious future on a wider, professional level and across the Nordic region; the kinds of conversations they were having about this future. Work done at these conferences was about negotiating a care deficit: presenting research, having conversations, about the kinds of strategies and technologies that could be deployed to continue working as midwives.

In my own professional life and during the course of my research, I found professional conferences for midwives to also appear as predictable, common-sensical events on the midwifery calendar. They are understood within the midwifery community as an important part of a midwife's professional development, and an expected event for midwives to meet and network in. Yet they are also deeply idiosyncratic to midwifery work. The organisation of the Nordic Midwifery Congress allowed midwives to feel as though they were part of a regional collective and a midwifery movement larger than themselves and their own workplaces. The attendance of delegates from outside the Nordic region, such as the UK and Australia, also added a sense of internationalism to the conference. The majority of these international delegates from outside of the Nordic region tended to be high-profile, senior members of the midwifery communities they belonged to, such as union leaders, organisational presidents, or high-profile researchers. The presence of Franka Cadee, the president of the International Confederation of Midwives (ICM) at the Nordic Midwifery Congress was an example of this.

How is life projected into the future, and in what ways do people experience 'hope' for the possibilities and reproduction of a future life (Narotzky and Besnier 2014)? In what ways are midwives engaged with this form of reproductive activity and hope for their own individual lives as well as collective professional futures? How might attending to these reproductive practices

recenter our understanding about midwifery work, the experiences of midwives within contemporary capitalism, and broader anthropological questions about what economic life is? Conferences are social, relational places where ideas and stories are exchanged (Nyqvist 2017). The architecture of it is set up to encourage this to happen, it is a place for a sociality that is about sharing ideas and values that make up the social fabric of the profession. An ethnography of conferences shows us how this informal talk is necessary to the construction and reproduction of professional identities, strategies and sociality. Sharing stories about the ways in which midwives are defecting to other kinds of care work makes sense in the social fabric of the conference. These stories were ways in which to understand the state of Icelandic midwifery, a collective recognition of work, and of the shared precarity of midwifery. Conferences are about communicating and reproducing this professionalism; it explores what midwifery territory is, what constitutes midwifery, what stories are told, and what futures are imagined. This imagination is also about the work of provisioning the future; an ‘imagining of possible futures and how to make them happen’ (Narotzky and Besnier 2014: S4). We can understand this imaginative, relational work as being part of an economy, in which midwives place effort and care into making a future for themselves on a broader professional scale. Social reproduction is about a generational continuity in which people are collectively involved in projects of making a living, reproducing power and social relations (Kuusela 2018), as well as disrupting and subverting inherited roles and relations (Verdugo-Paiva 2020).

This futurity is aided by developing midwifery relationships and collaborations, and the work of conferences or professional midwifery events is primarily about this. Articulating the value of midwifery work matters because it is about being able to describe the value of what one does with one’s time. It matters because futurity is at risk because burnout is a significant risk for midwives, and this is about midwives experiencing a loss of value. The viability of a future is about ensuring, in part, that midwives don’t burn out and experience such a short career path in midwifery.

4.8. Conclusion

In this chapter, I have argued that professional midwifery events, such as the Nordic Midwifery Congress, are places in which midwifery reproduces itself. Following Narotzky and Besnier's (2014) call to understand the economy as being about the effort people make to make a life, I argue that we can understand conferences as economic practices, where midwives are engaged in the work of provisioning a future. I have explored the Congress as one site where this reproductive work is taking place. Through a close examination of different forms of midwifery work and activity occurring within the conference, I have shown how midwives work to reproduce themselves and their collective futures. Through examining an ethnographic context of conferences, anthropology helps us examine how conferences are a common feature of professional associations and groups. The ubiquity of meetings as an everyday occurrence in the lives of people can be viewed as necessary, and informative events in which people purposefully gather to exchange ideas, resolve tensions, and solve problems. An anthropology of conferences also shows us how attendance at conferences has become a routine and expected part of professional life, in which the project of making the professional self, making oneself as a professional, is conducted (Forrest 2017, Nyqvist, Leivestad and Tunestad 2017, Tunestad 2017).

Midwives were engaged in the reproduction of their professional identities, and through the conference, this took place in part as an explicit form of collective remembering. The work of sociality, through which midwives develop and maintain close relationships with colleagues, is important to midwifery work as it is about the extension of midwifery work into the future through the renewed attention to relationships that will sustain this. Sociality is necessary too, for the work of making professional events happen. The imaginative work of planning for and creating technologies to address a futurity for midwifery was present at the Congress. Midwives also gave space, through research presentations and discussion, to talk of anxieties over what this

future would look like, engaging in ‘crisis talk’ to understand how they experienced multiple deficits, the current challenges of midwifery work and the political context to this. Midwives felt the reproduction of their profession, and their sense of a secure, professional future, was precarious: retention is a problem specific to Iceland, the lifespan of midwifery has become shorter, and the immediacy of the politics of the *kjarabaráttta* made this future for midwifery uncertain. Professional midwifery conferences, presentations and congresses are about reproducing midwifery futures: the futurity of midwifery as a coherent, viable profession, and of the futures of individual midwives. Through a close ethnographic analysis of the congress, I have shown how it is a place through which to examine the broader ethnographic significance of these other professional events. The unfolding crises in midwifery work in the Nordic region, in which the future of midwifery as a coherent, sustainable profession, and the professional futures of individual midwives, are tensions midwives attempt to navigate.

Chapter 5

“This motherhood feeling”: balancing an affective economy of care
in midwifery



Figure 5.1: Placards are laid out against the walls of Alþingishúsið, the Parliament House, following a protest in Austurvöllur, Reykjavík. The placards read, “Midwives: 6 years of University, Ministers?”; “Who received you?”; “Midwives are precious!”; “I stand with midwives!”; “A salary that says thanks! And not ‘fuck you!’”; “Would a male midwife get a fair salary?”

5.1. Affect and “this motherhood feeling”

In a small harbour town south of Reykjavík, I sit at a red café table with Hilda, a midwife involved in the union dispute. We are sat on the upstairs floor of an old wood-panelled building by the harbour. Looking out from our window across the street is a branch of Íslandsbanki, an Icelandic bank renamed after the 2008 financial crisis. It is noticeable: the bank occupies a 1960s building clad in green tiles, the colour of pond water, and red branded flags and corporate adverts are set in the windows advertising the banks' financial services. Hilda and I have met to discuss the progress of the union dispute, and her involvement in the negotiation committee meetings.

Hilda sweeps up forkfuls of food from her plate, an occasional interruption to her urgent, detailed discussion. She is in the middle of a busy day of meetings and work commitments, driving to different municipalities in the area to liaise with other committee members, midwives at her workplace, and plan her clinical work for the week. Threaded around her neck on a silver chain is pendant in emblem of *yggdrasill*, the ash tree of Norse mythology and the common symbol of the midwifery associations of the Nordic region; this particular emblem is the one belonging to *Ljósmeðrafélags Íslands*, the Icelandic Association of Midwives. Hilda speaks with urgency and warmth, but she is angry. “We need to change the way we evaluate our jobs. Because, it’s not just midwives, it’s midwives, nurses, teachers, everyone who is actually taking care of our people. We do not value it. We want to do the job, but do we actually value it as much as the man in the bank who is counting money all day? It’s a very stupid strategy to try to keep this ongoing guilt and shame upon women that they should work for pleasure, and for responsibility. And, you know, it’s like that we should have this motherhood feeling that we should have to save everyone, and we just have to do it because we are so fucking kind.”

5.2. Introduction: affective economies

In this third ethnographic chapter, I turn to explore economies of affect and the relational work of midwives. I ask how we might consider midwives' expressions of 'working for pleasure' as speaking to their participation in affective economies. As is being explored in this thesis, paying anthropological attention to the economy opens questions about the ways in which we frame the economy as being about different forms of effort to create and maintain life. I argue that a focus on the exchange of feeling, paying attention to relational work, and bringing this quotidian midwifery work into focus in terms of economic practices foreground important tensions and experiences for midwives. Through ethnographic description of everyday midwifery work in different contexts, and interviews with midwives, I show how midwives participate in affective economies.

In previous chapters, this thesis has explored the midwives' *kjarabarátta*, in which midwives disputed not only the conditions of their employment and the wage they received for their labour, but the ways in which they were expected to feel about their work. By talking about and protesting a crisis of care in midwifery and anxieties about the reproductive future of midwifery, midwives drew attention to the ways in which they participated in an affective economy, and were having to live, care and work with multiple, unsustainable deficits. I have argued that we can consider midwives' protests as a form of economic practice, and that these economic strategies and practices are part of an 'economy of affect' (Narotzky and Besnier 2014) through which midwives negotiate a care deficit. Through an ethnographic focus on conferences, I have argued that we can understand some of the ways in which midwives go about the work of reproducing themselves as professionals and as a collective profession, and provision a future for midwifery. In this chapter, I build on this work to explore the relational work of midwives. I argue that quotidian, relational work can be understood as part of an affective economy, in which midwives cultivate, negotiate and tend to relationships of care. In the context of a reproductive crisis for

midwives, in which midwives negotiate multiple, entangled deficits of finance, resources, affects and care, I turn attention to the relational work involved in this affective economy. I consider the ways in which this was about the work of mediating a care deficit.

In this chapter, I draw on literature in order to frame midwives' experiences of relationships within an economy of affect. Anthropological approaches to economic life in terms of focusing on the affective work people do in order to reproduce their lives and create stable material and affective conditions in which to live is foregrounded (Narotzky and Besnier 2014), alongside work on emotional labour in which we might explore the ways in which people experience affect as a transactable resource (Hochschild 2003a). I draw on anthropological approaches to 'the calling' to explore how people experience a work ethic in their lives, and how this might work to obscure the political economic context in which it is practiced. Using broader literature on a work ethic (Weeks 2011) and the 'ethic of sacrifice' present for working midwives (Kirkham 1996), this chapter uses this literature to explore the ways in which a specific work ethic framed around affect was at play for midwives. This chapter draws on midwifery scholarship that discusses relationships as being foundational to midwifery ideals of care (Hunter et al. 2008, Kirkham 2010). I use this literature to explore the ways in which midwives experience requirements and obligations to care rooted in professional values of kindness and devotion, as part of an economy of affect. This builds on the work of this thesis to consider how people reciprocate 'both tangible and intangible resources', feel morally obligated towards one another, in the exchange of emotional as well as material resources (Narotzky and Besnier 2014: S6).

It is important to note here that not only are reciprocal, trusting relationships foundational to ideals of care in midwifery, but that relational care during pregnancy, labour, birth and the postpartum period is linked to better outcomes for women and babies (Kirkham 2010, McCourt and Stevens 2009, Page and McClandish 2006). For example, a *Cochrane* review (Sandall *et al.* 2016) of the evidence presented by 15 controlled trials found that when maternity care was

delivered through midwife-led continuity of care models, in which relational care is central, women were less likely to experience instrumental vaginal birth, were less likely to have a preterm birth prior to 37 weeks gestation, and that foetal loss and neonatal death were significantly lower. Relational midwifery care is supported by ‘hard evidence’ for fewer clinical interventions, such as intrapartum anaesthesia, amniotomy and episiotomy (*Ibid.*). In addition, the studies included in this review suggested that women were more likely to experience satisfaction with their maternity care, a finding explored in midwifery studies scholarship exploring how midwife-mother relationships based on trust, reciprocity and longevity throughout the childbearing period were fundamental to a positive experience of pregnancy, birth and early parenthood (Finlay and Sandall 2009). As I will explore in this chapter, midwives foreground this evidence for working conditions that allow for relational care, in order to underscore the value of their work, the necessity of fair remuneration, and the importance of relational and emotional wellbeing.

In this chapter, I explore the relational work of midwives through a multi-sited ethnographic focus on a birth centre, an antenatal education class, and an along-side midwifery unit. I use this comparative angle in order to demonstrate the diversity of ways in which midwives go to work to cultivate and provision relational care as part of an affective economy. I draw on interviews with midwives to explore how people described the politics of affective exchange, and argue that we can understand feeling and relationships as important economic practices. I draw on discussion of ‘a God’s wage’ to show how midwives negotiated the tensions of this affective economy.

5.3. Calling and the work ethic

Recent anthropological work on the ways in which people experience a sense of purpose or duty in their lives draws attention to the affective force of having a ‘calling’. Ethnography has explored Weber’s (2001[1930]) ideas of vocation, profession, and ‘calling’ in order to understand

how the specific emotional experience of a calling creates a sense of purpose (Vacchiano and Afailal 2021). Vacchiano and Afailal (2021) explore this intertwining of calling and affect in relation to the narratives of young activists participating in the Arab Spring in Morocco, in which interviewees experienced an affective shift in becoming protestors. Calling, in their analysis, is an emotional process, and in producing a sense for the shape of one's life is connected to a sense of the future. It is about a sense of purpose that is intensely emotional. Ethnographers have also explored how central the notion of a 'calling' is to people's occupational identities within care work (Fitzgerald 2004). Fitzgerald explores how care is understood across a range of occupations—managers, clinicians, administrative staff—within a single hospital setting in New Zealand, during a period of health care reform. She found that some participants identified with a style of care in which it mattered that they strived to exhibit 'excellence'. The ways in which these workers were able to maintain a moral identity through their work depended on being able to fulfil 'the ethical requirements of their jobs' (Fitzgerald 2004: 336). Fitzgerald uses Weber's (2001[1930]) idea that the manner in which a job is performed matters to these participants more than the labour through which it is done. These ethnographies help us understand how people's sense of a purpose and motivation is deeply intertwined with affect, and that protest, work, or care can be underwritten by a sense of responsibility involving specific affect.

Weber's essay on the ethic of work (Weber 2001[1930]), as developed through Protestantism, remains an important text in exploring the work ethic, as central to the Protestant work ethic is 'the command to approach one's work as if it were a calling' (Weeks 2011: 42). (Weeks 2011). Weber traces the inauguration and development of the idea that there exists an ethical imperative to work, arguing that the development of capitalism happened in conjunction with the development of this ethic of work (Weeks 2011). Weber (2001[1930]: 122) calls the 'idea of the calling' 'one of the fundamental elements of the spirit of modern capitalism'. For Weber, the idea of the 'calling' refers to a sense of duty, or moral obligation, that the individual needs to fulfil. Weber traces this notion through this history of the reformation, arguing that being 'called' to

fulfil a particular moral duty in the workplace, or through work, comes from the sense of being predetermined to fulfil this moral responsibility; ‘the idea of duty in one’s calling prowls about in our lives like the ghost of dead religious beliefs’ (Weber 2001[1930]: 124). In discussing how we can understand work as something that has come to be valorised, Weeks (2011) draws on Weber’s ideas in order to problematise the ways in which much contemporary work necessitates a work ‘ethic’. In Week’s reading, this work ethic has developed under late-stage capitalism. Weeks (2011) seeks to unsettle and unfamiliarise the work ethic, in which we find the concept of a calling. She explores Weber’s work on the concept of a dutiful ‘calling’ to work, and the ways in which his analysis unsettles ‘the reified common sense about work that it manages to produce’ (Weeks 2011: 43). Weeks takes issue with the ways in which the value and centrality of work has become ‘stubbornly naturalised’ and ‘self-evident’ in late capitalism (Weeks 2011: 43). Her analysis shows how the experience of vocation and calling to work underpins normative attitudes towards being at work.

Parallel to Weeks’ analysis is a pool of literature within midwifery which examines a work ethic particular to midwifery (Benoit 1994, Hunter 2010, Kirkham 1999). This literature focuses on the ways in which a gendered ‘ethic of service, self-sacrifice and conformity’ (Hunter 2010: 261) frames the practice of care provision and professionalism in midwifery. Exploring the culture of NHS midwifery, Kirkham (1999) found midwifery underpinned by a highly gendered internalisation of ‘caring and commitment’, in which midwives conformed to an ‘ethic of service’ (Kirkham 1999: 734). Through her analysis of everyday conversations within midwifery workplaces, Kirkham identifies a normative culture in which a role of service towards women and an attitude of self-sacrifice is predominant in midwifery (Hunter 2010). In this reading, the performance of deference towards those being cared for is understood as a job requirement, integral to the role of being a midwife. This normative culture, in which specific affects are inculcated, happens within a context of neoliberalised healthcare and maternity services (Benoit *et al.* 2010, Benoit *et al.* 2012, Kirkham 2019, Sandall *et al.* 2009, Stacey 1981, Zadoroznyj *et al.*

2012). As I have explored in Chapter 1, there is little work in midwifery reflecting on the political economy of midwifery, how midwifery is practiced through capitalism, and how developing an analysis of this might help us understand this normative culture and work ethic of midwifery better.

The literature on emotional labour can show us how this work ethic, specific to midwifery, involves the cultivation and performance of specific forms of affect (Hochschild 2003b). In line with the inculcation of deference, service, and self-sacrifice presumed to be part of the vocational ethic of working as a midwife, are the concurrent affects of experiencing gratitude for, and fulfilment through, work (Weeks 2011). However, emotional labour also involves the suppression of discontent (Hochschild 2003b). Hochschild (2003b) argues that a significant part of the emotional labour of nurses involves the suppression of disappointment or exasperation, negative feelings elicited, for example, by the absence of recognition of work done, such as a lack of feedback. While Hochschild frames this as ‘appreciation starvation’, in which this labour is caught in a bind of giving and receiving emotional care (Hochschild 2003b: 69), I suggest that focussing on this aspect of labour can help us understand why midwives’ refusal of the performance of particular affects in Iceland were important.

5.4. Affective economies: at the city birth centre

On a cold, dark winter night in Reykjavík, I walk through the entrance of the city birth centre with Sabína, her partner Tómas and their two small children, the smallest strapped to her chest in a padded carrier. Inside the entrance is a crowd of families and midwives, a table laden with *pipparköku* (spiced biscuits), clementines and large jugs of thick hot chocolate. Laufey, a midwife, is pouring a mug of it out for a woman holding a baby. We are visiting the birth centre for their

annual *jólagleði* (Christmas party), a festive event hosted to gather together the families they have cared for over the year, and Sabína and I have come here together to celebrate the work these midwives do, as well as the births of her own children. Many of the children here this evening were born on the floor of this centre. I help Sabína undress her children from their snowsuits, pulling off their woollen balaclavas to static hair, and placing rubber boots on a shoe rack. We accept mugs of chocolate from Laufey, caught between conversations with another set of parents. Moving to a place where we can stand and keep an eye on her children, Sabína turns to me and whispers ‘I just feel this enormous sense of adoration when I see them!’ Laufey and her colleague Jórunn were the midwives to her second child, now eighteen months old, born at home in their third-storey apartment, and Sabína will soon begin training as a midwife the following year.

Birgitta, a tall midwife with long blonde hair hanging over her shoulders, stands holding a sleeping baby in her arms, swaying to the music in the room. This is a child she ‘caught’ six months earlier, and she is listening to the baby’s mother describe her birth. Birgitta joins in to recount the story, explaining the work she did to hastily arrange a contingency plan for when the mother arrived. She explains how, on the same day of this baby’s birth, another woman had just given birth in the single available birthing room in the centre, and Birgitta had to work quickly to move her into the open-plan workshop room, “make her comfortable there”, and free the single birthing room up. In the birth room, the midwives there have immediate access to the equipment they might need for a birth. It is easier to work in: to plan for different interventions and expect how a birth might unfold within a particular space. Listening to this story, my attention turns to this quick, organisational work done by the midwives to facilitate this event: the arranging, preparation, cleaning and moving to accommodate a birth. As well as being there to ‘catch’ the baby, all of this logistical work is midwifery too, and is an integral part of the life of this birth centre. The midwives hold a specific form of responsibility for maintaining the work of the birth centre: not only the responsibility of caring for the women who attend the birth centre, but the responsibility for care of the birth centre, and for the care of midwifery work itself.

This birth centre is the only of its kind in Reykjavík. Opened during my period of fieldwork, the centre is the first freestanding birth centre in the city since the closure of an alongside midwife-led unit at the national hospital several years earlier. The lack of a midwife-led birth centre has troubled many of the midwives working in the city, and the closure of the older one in Reykjavík followed a pattern replicated throughout the country. Many smaller midwife-staffed maternity units and birth centres, often in rural locations, have been closed during the past decade. This backdrop of centralisation to maternity services underscored many of the tensions midwives described when talking about their work. I came to understand how place was closely tied to the shape of midwifery work conducted in each. What midwives spent time doing was closely circumscribed by place. Much of the midwifery work midwives conducted was about organising work in place (Allen 2015), to maintain the space for midwifery work, and maintain the possibility of this space existing; a provisioning of a future for midwifery work in this place. Caring for and about midwifery, the perpetuation of it, is an activity that stretches beyond the work of clinical service; the work of care is seen at this *jólagleði*, too. This work of midwives, I suggest, is about participating in an economy of affect (Narotszky and Besnier 2014).

5.5. Affective economies: organisational care at the antenatal class

Inside a health clinic, a large reception area is set behind a set of glass double doors. Rows of chairs are set alongside a wall, with small tables scattered with Icelandic-language editions of fashion magazines, dog-eared from multiple readings. A reception desk is screened behind glass panelling, and a pair of receptionists working late are tidying up the area. Pairs of people attending the class assemble on the seats, waiting for the midwife to come and collect them. Bryndís, the clinic midwife, emerges bright and smiling from the set of double doors, and

welcomes the twelve or so people who have come for the class. She buzzes everyone through a separate door using a swipe card hanging from a lanyard around her neck. We walk together down a corridor, with clinical appointment rooms set at each side. It feels like an office space. It is quiet; most of the clinicians have gone home for the day. The class is happening out of normal clinic hours, in the evening, so there are no other clinical staff members present.

Prospective parents are attending the clinic for an antenatal class. These are structured, educational classes designed for new parents to begin to understand the kinds of processes, events and interactions they might encounter when accessing maternity services during labour and birth. The classes vary in content depending on the midwife teaching them. Bryndís teaches her classes in fortnightly pairs, splitting the content between ‘what to expect during labour and birth’, such as specific procedures, information on medication and medical events, and ‘parentcraft’, including techniques for holding, dressing, feeding and caring for a newborn child. Most of the attendees are becoming parents for the first time, and antenatal classes are an optional part of state-provided midwifery care, promoted as an opportunity to receive professional advice and recommendations.

The clinic is set on the first floor of a shopping mall on the outskirts of Reykjavík. Unlike the polished feel of downtown Reykjavík, this area is markedly poorer. Yellow Strætó buses stop here at a large transport interchange, a large charity shop selling second-hand clothing (cheaper than the ones in the centre of town) takes up a large corner of the mall. A fishmonger’s, bakery, American-brand supermarket, Icelandic bank and fashion retail stores line the hall downstairs, indoor plants littering the floor in large pots reaching towards the large glass windows. This is a 1980s-era shopping centre, with similar kinds of aspirations, or an aspirational feel to it that doesn’t belong to the tourist branding of downtown Reykjavík as a gateway to a rural idyll.

At the class, Bryndís leads the group into a small conference room. A small side table is set with pots of coffee, hot water and tea bags, and a large table, circled by chairs, is organised with neat piles of birth-themed books and bowls of fruit we have set out together. Her phone buzzes and she receives a text message from a couple who are lost downstairs in the shopping area. Bryndís hands me her lanyard so I can open the clinic entrance for them. I use her ID card to unlock a set of doors, finding the lost couple wandering around a set of plant pots downstairs. When I return to the room, Bryndís is preparing to start the class, and notes that she is a few minutes behind schedule. She is on her mobile phone, hunched over some papers at the end of the table, flicking through her diary, annotating a list of names with a pen. She speaks brightly to the person at the other end of the phone, gently reminding them that the class was tonight. She leaves a friendly message on the answerphone of another.

Bryndís stands at the end of the conference table, loading a set of slides from a desktop computer. She has recently updated the slides from the ones used by a previous midwife, who had been running this weekly class for many years. She has conspiratorially shown me the older versions of the slides, pointing out the dated word-art, the tired, 'off-brand' feel of the midwifery professionalism communicated. Bryndís's slides are fresher: quotes and information interspersed with high-resolution professional labour and birth photos, the kind seen on an instagram feed. She talks through her presentation, using a plastic, replica pelvis and a soft doll to demonstrate how a baby might manoeuvre itself during labour. The content of the presentation is precisely about communicating organisational as well as clinical knowledge to the attending clients. Bryndís talks through a list of what one might need to bring to a hospital, for example, and why. She advises the class on when to call the labour ward and ask to speak to a midwife, and details the clinical signs that parents should respond to. Her classes are about making it legible for how prospective parents might fit into the system. After the class, some parents stay to talk to her about booked appointments. She opens her diary and jots down details, reminders to herself to follow up on a couple's requests the following day.

While ‘proper’ midwifery work is often collapsed into narratives of service and direct, hands-on care, such as attending the moment of birth, I want to draw attention here to how much midwifery work also comprises skilled, organisational and relational work necessary for perpetuating midwifery in these places (Allen 2015). While the premise of these antenatal classes was an educational one: the role of the midwife being to impart knowledge to prospective parents, I found that Bryndís worked as a kind of organisational broker. So much of her work was organisational, and yet this wasn’t the important part of what she was recognised to be doing. I suggest here that not only was her work about this organisational brokerage between a clinical institution and its staff, and the people requiring the services of this clinical world, but her organisational work was fundamentally about reproducing midwifery knowledge, and making midwifery legible for those accessing it. In this way, I suggest that organisational work is care for midwifery; it is about the reproduction of midwifery, and it is about making it viable.

Listening to midwives describe their work, and watching midwives *at* work turns attention to the constant, repetitive work of organising the space for midwifery to happen in: the relational space between midwives and colleagues, and families; the physical space of a clinic or workplace.

5.5. Affective economies: at the midwife-led unit

Midwives María and Sunna, employees at a small maternity unit, described how their place of work, set in the countryside outside of the capital region, functioned. They described how there had been a change in culture over the past twenty years, in which fewer people wanted to live near and birth in these units. These midwives recognised that demographic shifts threatened the sustainability of smaller maternity units in rural Iceland. María lived close to the unit, and talked

about how she found it challenging to maintain her life there. Standing together by a large window in the staff area, overlooking an industrial unit with lorries stationary in a pot-holed car park, María described how, while at work on a night shift several years previous, she had stood at this window watching the eruption of a large volcano, visible on the horizon. Her daughter and grandchildren lived in the city, and she sometimes felt as though she was marginalising herself by staying put in this smaller unit:

“It is difficult being so isolated, and everyone wants to go to Reykjavík to live and work.”

Both midwives recognised that part of the work they did in order to perpetuate midwifery outside of the central city hospital was to make it attractive and imaginable for families to choose to have their babies with midwives in a smaller unit. I was struck by the architecture of the space as a place of work specific to midwifery. The unit felt well looked-after and tended to, and María and Sunna spoke about their work there with a sense of pride, and María had come in on her day off to show me around, picking me up in her car in the middle of a rainstorm. Space was cultivated to allow for sociality between colleagues and families. Small details spoke to the careful atmosphere created in the centre: low-light lamps set up at clinical worktops. The reception area had a surface for examining newborns, with scales and an easily-accessed resuscitation table set up, a heat lamp attached to the wall and a mattress surface covered with a neatly laid towel. Families having their newborn children checked over could occupy the same social space as that used by midwives. Near the assessment area stood a table set against a wall close to a large window, a shelf with a row of blue ceramic mugs bearing each staff midwife’s name hanging above.

When midwives leave midwifery after only a few years of work, this places the profession in a precarious position. After several years, the majority of the working population of midwives will be less experienced, junior midwives who while being competent and qualified, lack the longevity

to handle and pass on the kinds of nuanced skills developed over a lifetime of work. The defecting of qualified midwives out of the profession, well before retirement, poses the risk of creating a vacuum of expertise and skills in midwifery work in Iceland. This marked difference between professional eras in midwifery—a past in which midwives developed a lifetime of experience, the present crisis and erosion of long-term skills, and a risky, precarious future—was emphasised to me in a story told by Soffía, a midwife working in a birth centre in south-west Iceland. Over coffee, Soffía reflected on the recent retirement of Margarét, an older, experienced midwife colleague. She described how Margarét had been present at the birth of well over a thousand children, and that her expertise and experience was unparalleled in the region. Soffía was experiencing a great sense of loss, shared also by other midwife and obstetric colleagues. This midwife's retirement signified a loss of particular, embodied skills, and the gravity of this midwife's capacity to deal with whatever presented her could not be easily replaced. While the loss was also to do with collegiality, it signified a deeper sense of irreplaceability, with maternity service staff understanding that it was becoming rare for midwives to stay in the profession long enough to develop this kind of embodied expertise. Soffía commented that she knew that "everything would be alright when Margarét came in the room to attend a birth, even the doctors felt this sense of relief", that the difference in skills between a more junior member of staff and those of this midwife accrued over the course of a long working life was particularly marked, and not easy to replace. The repeated references to flight attendant work at the congress was an expression of this pervasive unease, and sense of precarity, throughout the profession.

Work at this smaller midwifery unit facilitated 'relational care' for the midwives working there, and for the families using the service. Relational work is about place, and relational care is seen by midwives as an ideal for midwifery as a professional standard and value. In Iceland, this organisation of midwifery work means that most midwives meet women and families in line with scheduled work patterns, and when particular, guideline-directed tasks need to be enacted. Within hospital shift-work, there is little 'continuity of care' because women are seldom looked

after by the same midwife. This varies across Iceland, however, depending on the place of care. While there has been a sharp move to centralise midwifery services, resulting in a concentration of midwifery shift work in the capital, smaller maternity units where small teams of midwives work will mean that these midwives develop more familial relationships with the families they care for. This is seen as an ideal in midwifery care; because it is about practicing a 'model of care' that allows for the development of relationships, familiarity, trust, between midwives and the people they care for, as well as among midwives.

The midwives working at this unit had to put effort into keeping the unit open. This maternity unit had been at risk of closure, and reduced opening hours, for several years. In order to protect the maternity unit from threat of closure following the 2008 financial crisis, the midwives on the unit petitioned to be able to stay working there. One of the deals struck with senior management was that they would routinely work as a "*second nurse*" for the geriatric ward next door, a ward physically at the end of the corridor to the midwifery unit. Sunna explained that this was something of an administrative role, though it carried a degree of clinical responsibility rather than providing direct patient care, "being a second nurse usually just means we go to administer some medication or sign off on some drugs." The midwives' involvement in the life of the neighbouring ward was an anchor to the sustainability of midwifery in this small, in-patient medical facility, even though the work they did had nothing to do with midwifery. The "signing-off" of medication was a recordable, visible marker of the work they did, and it meant that their role remained legitimate. During a night shift, for example, the midwife unit could remain quiet with no in-patient families and no direct patient care required, but the midwives there might remain busy tidying, auditing, organising and preparing the unit for the next admission. Their role documenting medication on the adjacent ward was a visible indication in monitored data that they had in fact completed a tangible, audible task while at work. However, conversations with these midwives drew attention to the ways in which so much of their work

was about provisioning the future of midwifery care in this unit, and that their participation conducting relational, emotional care in an affective economy, was paramount.

5.7. 'Working for pleasure': midwives' experiences of duty and affect

At the café table with Hilda, we continue to talk about the union dispute. What does it mean to work 'for pleasure' and 'for appreciation'? In this conversation, Hilda explores the ways in which midwives disputed a particular framing of their work; that the goodwill, and positive affects, of midwifery work should be enough to sustain them. As explored in Chapter 3, talk of "a God's wage" points to a framing of history of working for duty, and goodwill. In this section of the chapter, I explore this conversation with Hilda in order to reflect on the ways in which midwives experienced requirements to inculcate feelings of maternal altruism, kindness, and pleasure, and challenged this in the course of the dispute, as well as their everyday working lives.

Hilda reiterates the conflict in responsibility involved in her complex midwifery and union work, and the work of looking after her family. Like her, many of her colleagues have "big homes with a lot of children". Hilda found evidence of this historical service ethic present in the way her midwifery work was organised.

"We have been on call 24/7 for many, many years. And our families, our children, they are raised up by knowing that mummy needs—Landspítalinn *owns* mummy. When Landspítalinn calls, mummy must run. Even though we are in the middle of a birthday, or whatever, mummy needs to go."

The 'drop and run' had become a normal part of work as a midwife. These midwives understood this politics as continuous with a longer history of being required to leave one place of responsibility for care in order to be responsible for another. While these midwives did not point to an unequal politics of care between themselves as carers and the families they cared for, they experienced a particular care deficit (Hochschild 2000, Ehrenreich and Hochschild 2003). Midwives identified a pattern of women leaving their own families to work providing care to other families. They understood this as historical, a cycle in which midwives were caught negotiating and managing a lack of care. These midwives sought to express that they were acting out of responsibility for provisioning affect. All of this played into a situation where midwives sought to make evident that their work carried enormous responsibility. For example, this was contrasted with the work of "the man in the bank who is counting money all day", because the people who are "actually taking care of our people" carried responsibility for this work in a way that could not be compared.

Hilda emphasised how during the meetings, the midwives felt patronised and that the feeling they should be carrying was one of shame. Shame for shunning the responsibility of the work, and for not being at work as midwives. This is laid out in her comment when she describes the atmosphere of the meeting with ministry officials:

"They didn't want to listen, and they just laughed at this, and you know, and the atmosphere around this, this negotiation table, was like, it was... patriarchal, because we were like little girls who should be very privileged and grateful for being able to work with other people and help our sisters, and we should smile, and be cute, and shut up, and not make this noise. That was the atmosphere, all the time, and they, you know, laughed at us like, 'my god girls, isn't this stupid, isn't this enough? Now you should be ashamed of yourselves and just go home, go back to work and be grateful', you know."

Midwives contested the specific, gendered and affective forms of responsibility they were asked to take, in which the complexity of their work, the skills they required, and their mixed feelings of

work commitments, were collapsed into requirements to demonstrate and feel altruism, kindness, and self-sacrifice.

Midwives understood their current predicament as explicitly tied to the financial crisis of 2008. Hilda explained it as such:

“we started pointing out that from the time of the bank crisis, healthcare workers—and of course midwives, also—they have been working harder. Running faster. Because we wanted to help our, our birthing women and we wanted to help our job provider, you know the hospital and clinics and whatever, so we worked harder and we ran faster, and always waiting for this era to be over.”

The experience of working more, with fewer material and temporal resources, as a consequence of neoliberalised change to healthcare work context, involved requirements to appear to enjoy this work regardless of these changes (Hochschild 2003a).

It took professional expertise and skill to be able to engage with these negotiation meetings. The dispute was another part of the work of being a midwife at this time. In the way in which midwifery had become untenable for many midwives, a speeding up of work, a business that bled into personal time and life outside of work, Hilda’s comments point to her experience of disruption to her personal life. Yet, midwives referred to the sense of responsibility they felt *to* participate in the dispute.

“our board was built up by five midwives who were, had, we all of us had big homes with a lot of children and we were working full time jobs and doing this also, so it was a *crazy* job, 24/7 for—and we thought it would of course only be some days or maybe weeks, but it came out to be many many months and almost a year. So it took blood, sweat and tears. *Really.*”

Hilda put this sense of personal ‘cost’ of being involved in the dispute into perspective. Being involved in the board of the *kjarabarátta* was in addition to the responsibility of maintaining a family and a house. Hilda describes here the layering of work and of responsibility: of maintaining a home, a family, a full-time clinical role, and of the work of the negotiation board. For Hilda and other midwives involved in the dispute, the *kjarabarátta* was markedly about participating in the emotional labour of multiple forms of care. In talking about their work in the dispute, midwives were attempting to make this work visible, to frame it as work integral to midwifery because it was about a provisioning of the future; not only the future of midwives as a profession, but of the potential of people to be cared for by midwives.

Hilda drew attention to the ways in which a moral framing of midwifery work played into their experiences of exchange. Further, there is a moral imperative to feel shame if work is not being done for pleasure. The midwives involved in this dispute felt that they were living with this sense of required ‘shame’, or ‘guilt,’ for not approaching work as something which was done for pleasure. Asking for money as part of an exchange of labour for wages, was inappropriate in framings of work that cast caring as a moral imperative, rather than something that could be waged.

“if you are working with people, it’s yeah, it’s very good, you’re a very good person. And I will give you a hug, and maybe a chocolate if you’re cute and kind. And if you’re working with money, I will pay you, just how much you want. I will pay you.”

An ethic of service and sacrifice prevalent in midwifery (Hunter 2010, Kirkham 1999), tied to a work ethic (Weeks 2011), can be explored in terms of how this, as a particular work ethic, shapes midwives’ participation in economic life and how midwives experience this economic participation. In the course of the interview, Hilda pointed to the ways in which the morally correct experience of midwifery work was seen, through the course of the union dispute, to be

one of enjoying the provision of this service, of being the caring provider. The correct relationship to have with one's work should be one of receiving pleasure and good affect for it, rather than experiencing a secure wage relationship that could provide the material foundations for a secure life. A work ethic predicated on the exchange of affect was being pointed to, at the same time as midwives experienced a multitude of deficits in the ways in which they experienced their work, including inadequate pay, an inadequate resourced service, and an inadequate work-life balance. The premise that midwifery care and work should be done out of a sense of kindness and devotion was contested by midwives raises questions not only about midwives' experience of a work ethic involving 'service and sacrifice' (Hunter 2010, Kirkham 1999), but also about the ways in which midwives contested the *extraction* of these affective resources and the exchange of resources within an economy of affect.

"I can only see it like—if I use a metaphor—I am building a house. And I need a secure roof. And I need help from a carpenter. And I asked the carpenter to do the job because he is educated and he can do it. And he can do it the proper way, I cannot. But, I'm not willing to pay him. I can give him some things, and I can pat his shoulder and say 'wow, you did a great job', but I'm not going to pay him the salary that he deserves. And he says 'no.' Who's responsibility is it that my house is still leaking? Is it his? For sure, is it his? No. No way. I am educated, I am a very, very well educated woman, and I need to be able to feed my children, and I am selling my work. If you are not willing to pay for it, it's not my responsibility."

On the one hand, midwives protested extraction and depletion, in which exchange for their feeling, time and and resources were inadequate, and they resisted the requirement to be compensated or rewarded with 'good' affect, such as pleasure, the satisfaction of responsibility, and selflessness. Drawing on discussion of a work ethic in terms of a 'calling' (Weber 2001[1930]), Weeks (2011) points towards how we might discuss how these affects for doing work are experienced in capitalism. I found that midwives disputed being 'called' to work,

disputed having their responsibility for their work framed as a moral imperative, and challenged the ways in which embodying particular feelings for their work were supposed to create an ethical orientation to perform this work.

Relationships, in which people experience and cultivate trust and care, were being tended to through the *kjarabarátta*, as well as challenged. The political mistrust involved in the dispute, in which midwives felt manipulated in the negotiation meetings, in which they were vocally belittled, secretly recorded and the content of their negotiation discussions was ‘leaked’ to the media, created not only an atmosphere of mistrust and uncertainty, but was also about an affective economy in which midwives experienced a deficit of trust and relationships of exploration and unequal exchange. Paying attention to this opens questions about the ways in which we frame the economy as being about different forms of effort to create and maintain a life. I suggest that midwives sought to draw attention to the unequal forms of affective exchange they experienced. They sought to balance the ideal of unpaid service inherent in framings of care within the socioeconomic context, and sought different forms of affective investment that addressed and countered a care deficit. In addressing these moral framings of work, midwives contested the ways in which the value of their work was framed, and the ways in which care and caring in the context of a deficit required different forms of affective and professional depletion.

“But a lot of women turned in their—what is it called? Resignation? And we got to hear on the negotiation table that there are only a few who are resigning, and it didn’t matter, and if we were trying to threaten someone and that we should be ashamed of ourselves for running from the responsibility that we had. And if we didn’t think about any further than about ourselves, what about the people who we are supposed to serve, and so on, and so forth. And I was even asked by the media if I didn’t feel guilty, or sad? Because we were leaving from responsibility. And, ‘Hilda, what is your responsibility in this? Do you not feel bad about this?’ And I was so shocked. People actually think like that.”

Midwives experienced requirements to inculcate feelings of maternal altruism, kindness, and pleasure, and challenged this in the course of the dispute, as well as their everyday working lives. I suggest that we can understand this as midwives' participation in an economy of affect. I suggest that midwives sought to draw attention to the unequal forms of affective exchange they experienced. They sought to balance the ideal of unpaid service inherent in framings of care within the socioeconomic context, and sought different forms of affective investment that addressed and countered a care deficit. Midwives sought a rift with a past in which relationships of insecurity and inequality were being reproduced. In the following section, I explore how this was articulated through the idea of 'a God's wage' in compensation for midwifery work and care.

5.8. The God's wage

On the weekend of the 100 year anniversary of Ljósmaðrafélags Íslands (The Icelandic Association of Midwives), I visit a commemorative exhibition at the Women's History Archive at Þjóðarbókhlaðan, the National and University Library of Iceland, examining the quiet exhibits with Birta, a homebirth midwife on her day off. We read the exhibit texts and trace the stories being told from the inauguration of the midwifery association to the events of the present. There are glass cabinets and display cases proudly showing photographs, texts, books and small artefacts from midwives' medical bags. The photos document artistic projects celebrating midwifery work, and a particular series presents a sense of lineage: portraits of adult Icelanders with the midwives who 'received them'. Birta examines a photograph, describing the older midwife in it with tenderness and respect. The exhibit documents the history of the association's involvement in campaigning for midwifery wages: 'The main women involved in establishing the Association were Bára and Hildur. They had sent letters to all the registered midwives in the country, about

200, and told them of the company's expected establishment and purpose. Replies had been received by another hundred midwives. They wanted to start a company and they were also willing to retire if their wages were not paid. *The midwife's fight is therefore an old story and a new one.* A wall panel with photographs and texts of the recent *kjarabarátta* features prominently on display, images of midwives holding placards, and a short timeline of the politics of the event.

In this section of the chapter, I reflect on the ways in which midwives framed and understood protest and dispute as necessary, and spoke about their responsibility *to* protest. I examine the ways in which midwives drew on a specific professional history of absent wages in order to make evident the necessity and urgency of having their labour valued, and adequately compensated, in the present. Midwives located their current wage dispute with a historical precedent of not receiving a salary. Midwives felt the the wage dispute was a continuation of this unpaid work, in which midwives were stuck in an ethical bind: their work was required, they had a clinical and ethical responsibility to do the work, yet they were continually working within a deficit of time, money, and resources. Birta framed it to me as such,

“We’ve been fighting for our salaries for 100 years, at least. Because we were so gifted we should be very grateful for [our work], that should be enough. And this has somehow gone through all these years, and still the aims of it are with us today. Because where we compare ourselves to other professions that have similar education and responsibility, we are way back in salaries.”

The issue of pay during the union dispute was highly publicised. As detailed in Chapter 3, during the *kjarabarátta* midwives contested the significant wage decrease they faced upon qualifying as midwives following a period of postgraduate training. The amount midwives received as a salary varied, depending on the experience they had accrued. A newly qualified midwife who had completed her training immediately after her nursing degree might be looking at a monthly 6,000 ISK salary decrease on qualifying. However, a midwife who had accrued a

decade of clinical experience as a nurse would experience a salary decrease on qualifying as a midwife of around 100,000 ISK in her first year.

I suggest that midwives' refusal to participate in a particular work ethic, in which they refused the extraction of particular altruistic affects from them, can be understood in terms of economy. Midwives contested working in exchange for feelings of pleasure, responsibility and altruism. Midwives found a historical continuity with a past in which midwives were required to work for 'a God's wage.' In the contemporary, neoliberalised economic context, neoliberalism reproduced inequities and inequalities of care, requiring midwives to work within a deficit and exchange affects unequally. In drawing attention to 'a God's wage', and the relational care they conducted, midwives sought to negotiate a deficit of care through the refusal of extraction of affect, and the creation and pursuit of relationships in which affective exchange did not leave them depleted.

5.9. Conclusion: midwifery work in an economy of affect

Through this ethnography chapter, I have shown how midwives contested the specific affective dimensions they felt required to experience: that they should be called to work and compelled to work out of maternal altruism, pleasure, good affect. They felt that this was exploitative and that talk of working for pleasure, midwifery as a calling, obscured the work they did, and obscured adequate payment. Weber's (2001[1930]) concept of the 'calling' can be used anthropologically as a way to frame midwives' protests and talk of responsibility. Calling frames the sense of responsibility midwives were expected to carry. Talk of 'responsibility' and framings of a specific work ethic for midwives around a duty to feel particular compulsions to work, were

for midwives a way of obscuring the care deficit they were embroiled in and the deficit of care they felt.

Being ‘called’ to work was about showing up a different kind of calling—a requirement to work. A sense of a calling in itself was not the problem—I don’t seek to critique this meaning-making of midwives (Basu 2005), but rather the way in which this sense of a calling belongs to a wider context. We can critique the ways in which a sense of a calling emerges, is understood, and is experienced within late capitalism, and the ways in which framing of midwifery work as involving a calling can be exploitative. In my research, midwives were saying that the way their affect was extracted from them as a resource, and that their experience of affect was an adequate part of an exchange relationship in which they received this as compensation for their labour, was problematic. Because midwifery was identified as a ‘calling’, the affective experience and compulsion to work were normalised. Midwives traced a history of this politics ‘back’ to early professionalisation, tying stories of women working for a ‘God’s wage’ to the feminisation of care and subordination of women under the requirement for them to work for affect and moral worth, rather than a wage that would afford them autonomy and security. In the context of a broader ‘crisis’ of midwifery work, as I have explored in Chapter 3, this imperative to work for pleasure was part of a broader politics of care work for midwives. Midwives drew on a historical practice of paying midwives a ‘God’s wage’ in order to draw attention to the ways in which midwifery work had historically been excluded from waged labour. Instead, the work was seen as having moral value. It could not be, or did not need to be, financially compensated. The motivation of midwives to conduct this work was seen as vocational, and therefore beyond compensation. That they got paid was seen as an addition, not a central part of the work or of the motive to do it. There was a sense that people were uncomfortable at the idea that midwives would work for the money. Midwives appealed to a popular, post-crisis understanding and public experience that life in Iceland had become increasingly unaffordable on a normal salary. This God’s wage midwives cited did not exist in the contemporary moment, but midwives saw the way

in which they were paid, in 'kindness', and 'a pat on the back' as a continuation of this valuation of their work.

Muehlebach has described this particular formation of labour, stating that the public 'relies on a particular labouring subject, one that desires and takes pleasure in working for nothing, for free. The public thus weds hyperexploitation to intense moralization, nonremuneration to a public fetishization of sacrifice' (Muehlebach 2011: 75). I suggest that midwives' recognition and negotiation of this feeling of exploitation of a service and sacrifice ethic, through taking issues with 'working for pleasure and responsibility', speaks to this issue of fetishisation, and reflects on the ways in which this is part of an economy, in which midwives become *alienated* from their own labour, including the labour of affect. For midwives, work involved a form of layered, affective 'dissonance' (Hunter 2010, Lewis 2016), in which midwives work within a feminised role and receive payment for 'what is supposed to be a spontaneous desire rooted in women's nature' (Weeks 2011: 130). Furthermore, they experience relationships as inadequate in some work contexts, and are required to expect compensation within an affective economy of good feeling. I suggest here we can follow anthropological calls to 'trouble' care (Duclos and Criado 2019) in order to problematise the ways in which being in a caring role is necessarily about the elicitation of good feeling. Lewis (2018) argues that 'we are deeply attached' to the processes of care involved in the labour of gestation and mothering, involving tensions between the ways in which these processes of care and labour are both undervalued as well as 'morally sacralised.' Anthropological work on surrogacy helps reflect on the ways in which, within processes of mothering, different forms of labour are obscured and in tension, with the 'natural' processes of becoming a mother in tension with the labour of this and the ways in which this can be marketed (Unnithan 2019).

Anthropology helps us to understand 'the economy' as a complex interweaving of practices, events, and affects constituting the effort to make a life worth living (Narotzky and Besnier 2014).

Anthropology shows us how money is about relationships; it is about an obligation, a contract (Day 2007, Kuusela 2018), and can be thought of as ‘an instrument of collective memory’, conveying value through time (Narotzky and Besnier 2014: S10). While the dispute was about an inadequacy of money, of salary, of the precarity of life lived with those wages, of the inequality of wages received for education, then all of these things were also about relationships, about a social contract around what it is to care, to be caring, to be cared for. It was that midwives’ relationships were inadequate, precarious, unequal. And this was what was being pointed to in interviews, and in protests. My ethnography shows how the issue of wages was connected to many other issues and meanings for midwives; ostensibly about wages, the wage dispute brought up, for midwives and others, questions about the value of work, of care, of being cared for, of the role of midwives, of the work ethic underpinning midwifery work. All of this was brought to the surface. Social worth is central to anthropological understandings of the economy, being about how a society places value in people, not only the value of people but how value is found through people, and how value is invested and accumulates through people (Narotzky and Besnier 2014).

I argue that this work ethic particular to midwives involves a framing of work where midwives are required to show affective allegiance to this work ethic. In this chapter, I explore the ways in which midwives attempted to unravel this work ethic. They disputed and countered the framing of their work as motivated by altruism, and that the work they do is for ‘pleasure’, or good feeling. Rather, midwives framed their work ethic as something exploited and mobilised against them. Midwives argued that the lack of adequate wages and working conditions was directly tied to a politics of care that framed care work as motivated by and reducible to ‘good feeling’.

If the midwives’ dispute was about the inadequacy of money, of salary, of the precarity of life lived with those wages, of the inadequacy of pay, of the inequality of wages received for education, then all of these things were also about relationships, about a social contract around what it is to care, to be caring, to be cared for. It was that midwives’ relationships were

inadequate, precarious, unequal. And this was what was being pointed to in interviews, and in protests. In the following, final ethnographic chapter, I turn to an ethnography of doula training to explore the ways in which payment for care work was understood within an emerging market for care work.

Chapter 6

“Doing the job the midwife originally wanted to do”: the work of
doulas in a deficit of care



Figure 6.1: Learning how to use *rebozo*, a technique for intrapartum support, during doula training.

6.1. Talking with doulas

Pála takes a sip of her coffee, and sits back in her chair. “My mother is a nurse. She said to me, ‘don’t be a nurse. The hours are bad, the salary is bad.’ What a *doula* seems to do is what I

thought a *midwife* would do.” Pála is a trainee doula, like me—a non-clinical, privately-employed birth support worker—and we are sat at a small table in the University canteen, where we have met for a morning coffee. It is the middle of November, and though it is 9am it is still as dark outside as though it were the middle of the night. It is snowing, hard pellets of snow drive down past the windows; Pála is delighted by it. She works as an interpreter, and while she is not a clinician she often attends clinical appointments with her clients. Pála is keen to move into work with the maternity services in south-west Iceland. Over the past several months, we have been students together on the same doula training course. Pála had “no idea” what a doula was the previous year, but went on to have some interpreting assignments with midwives. It happened that she worked a lot with the same midwife during some antenatal appointments and births. Following one appointment, this midwife suggested to Pála that she should be a doula. Pála was encouraged by this; “I had thought about midwifery when I was sixteen. I had a day of work experience and spent a day at the delivery suite. I was interested in some parts of midwifery, but then I found these were in the doula’s role. You see, a doula is doing the job the midwife originally wanted to do.”

6.1.2. Introduction: the work of doulas

In this final ethnographic chapter, I turn attention to the training and work of doulas in Icelandic maternity services. I explore how, in Pála’s words, doulas are “doing the job the midwife originally wanted to do.” This chapter argues that a deficit of care has created a market for doula work (Benoit *et al.* 2014), and that doulas are emerging as a particular kind of labourer able to fill the gaps where midwives or midwifery is lacking. This argument is made in two parts: first, that the process of learning to become a doula involves learning how to see this care deficit as a market. Second, that doula training is about learning how to occupy this market. Trainee doulas learn to see this market, seeing a care gap unfilled by midwives. As well as learning to develop tactile,

relational skills in order to provide care, trainee doulas also learn to develop entrepreneurial skills and understand these as fundamental to the care they should provide. This is about ‘doing the job the midwife originally wanted to do’, shaping this work as undone, necessary, and organised through entrepreneurship, in which doulas step in to provide an essential, privatised care service. I show how doulas learn to occupy these lacks, through marketing their skills, becoming good entrepreneurs, and ‘learning to love [one’s] salary’.

In this chapter, I draw on several months of participant observation in *doulanamsketð*, doula training, in which I learned to be a student *doula*. The ethnography is rooted in interviews with trainee doulas, and online research of doula training companies and doula-focused information resources available through companies offering accreditation in becoming a doula. The chapter first outlines who doulas are and the fieldwork context of the training course, describing the process of learning to be a doula in Iceland. Anthropological literature on doulas is reviewed, and I demonstrate how the chapter speaks to debates around the rise of doula work in the context of neoliberal healthcare in the literature available. This chapter draws on anthropological work on doulas, focusing on rising forms of privatised birth work within a context of care deficit. In order to explore the market for doula work, and the ways in which doulas are ‘doing the job the midwife originally wanted to do,’ I examine two parts to the doula training course: the process of learning to see gaps in maternity care, and the process of learning to occupy these lacks as a self-employed, entrepreneurial worker.

6.2. The context of the doula role and understanding who doulas are

In many contexts of maternity health care, doulas are emerging as a contemporary form of worker within maternity services (Apfel 2016, Campbell-Voytal *et al.* 2011, Castañeda and Searcy

2015a, Lundgren 2010), and why and how this is happening is deserving of anthropological attention. Doulas are important to investigate because their presence and rising popularity is about transformations in the ways in which work in maternity services is organised (Benoit *et al.* 2014, Mander 2011). In Iceland, as in other contexts, they are a new phenomena, and there is very little research on their rising prominence, and what this can tell us about broader changes to work within maternity services (see, for example, Mangindin 2018).

A doula is a person who offers support during any part of pregnancy, labour, birth or early parenthood (Bohren *et al.* 2017). They are generally understood as someone in an autonomous role providing emotional support, advocacy and guidance alongside other professionals providing clinical care. While this role is diverse and unregulated (McCabe 2016), organisations such as DONA International have created standards for doula work, a code of ethics and professional standards, and training packages (DONA International 2017). The scope of their work and responsibilities is decided by the individual doula themselves, and in negotiation between the client and doula. These pledges of care are often presented as a care package, and may include: a programme of meetings at the clients' home during pregnancy to discuss options for labour and birth, and make plans for what they would like to happen; antenatal education classes; being 'on call' around the due date, typically during the 38th-42nd weeks of pregnancy, providing emotional and therapeutic support during labour, such as massage, presence, coaching; presence and support during the birth; following the birth, support with establishing and maintaining breast feeding, help with domestic tasks at home such as preparing food, cleaning, pet care, offering to be with the newborn for an hour so the parents can sleep. These are 'tangible, high-intensity supports' (Benoit *et al.* 2014: 87).

Because the role of a doula is so broad, there are exceptions to the general role: some doulas will be the exclusive companion to people who choose to 'free birth' and decline any clinical or professional assistance. Other doulas will be employed by a hospital to provide additional support

alongside that of the midwife, and therefore will, like the hospital clinical staff, be meeting a family for the first time once they attend the hospital for intrapartum care. In Iceland, doulas are employed privately by women to provide additional antenatal, intrapartum or postnatal support, depending on the family's preference. Doulas are a form of birth worker, and can be considered part of a diverse array of 'entrepreneurial care workers... who sell their services to women and families who seek support before, during, and after birth' (McCabe 2016: 179). A doula may be employed and paid directly by a 'client', they may be part of a group business, they may be employed by a hospital to provide in-house doula services, or they may be part of a voluntary scheme organised within a hospital, community, or alone, wherein they do not receive financial payment for the work they do. They are usually for-profit service providers, and researchers point out that these for-purchase services have grown to fill the care gap left by a shrinkage in care provided by the state (Benoit et al. 2014). Families seeking 'care' find it is their private, individual responsibility to do so, and the increasing use of private support services, such as doulas, is becoming an increasing trend in some industrialised countries (Mander 2011, McCabe 2016). Media interest in the entrepreneurial spirit of the doula role has suggested doulas are a 'booming business' (Baker 2017), with research suggesting that the purchase of birth worker services 'constitutes a kind of "work" itself' (McCabe 2016: 181).

Doulas are generally recognised as providing an emotional support role particularly during the immediate transition to parenthood, and suggest they are able to humanise a clinical encounter that may otherwise feel overwhelming and alienating (Castañeda and Searcy 2014). Doulas are a growing trend among families seeking to have certain forms of caring guaranteed during their interactions with maternity services. They can be understood as 'experts of conduct' (Rose 1999) who manage and 'craft' maternal identities around individual responsibility for reproductive health, and the exercise of choice in participating in maternity care (McCabe 2016). They can be seen to counter medicalised maternity care (Davis-Floyd and Sargeant 1997, Kasstan 2019). Because they will often have developed a relationship with a client and family prior to the birth,

they are often in a position to provide a degree of relational care unavailable within the care relationships provided by midwives working shifts. Women experience a lack of continuity of midwifery care and non-medicalised birthing options, and doulas offer an antidote to this: research demonstrates that doulas can increase provision of continuity of care, reduction of stress, reduced interventions during birth, and increased breastfeeding rates (Lundgren 2010). Dahlen *et al.* (2011) argue that the recent rise in women employing doulas in Australia is due to increasing dissatisfaction with maternity care services, and that doulas are ‘fast replacing the lay midwife that flourished in the 1970s and 1980s’ (Dahlen *et al* 2011: 49). The doula role is non-clinical, and unlicensed, and legislatively, doulas hold no clinical responsibility for the work they do or a duty to provide certain standards of care; while there is no mandatory qualification required, some doulas, however, hold degrees in nursing or midwifery, or specialist training as lactation consultants.

6.2.1. Doula training

Over the course of ten months, I attended a training course in Reykjavík to learn how to become a doula. These were organised over several weekends, a group of us gathering on Saturdays and Sundays at the freestanding, midwife-led birth centre in the east of the city. There were eight of us enrolled on the course; all women, with ages ranging from 24 to mid 50s. These doulas brought different kinds of life, parenting and employment experience with them to position themselves as doula students. I was the only midwife on the course, and while Benoit *et al.* (2014) point out the occupation of the doula role as an extension or change of professional status for some, it is useful to point out here that it would not make sense for a midwife to seek employment as a self-employed doula, in Iceland, when the work routines and prestige of her work as a midwife (and nurse) were more secure. As I have explored in previous chapters, midwives feel a hard-earned responsibility to care for midwifery, and reproduce it into the future.

In Iceland, midwives can't easily occupy the role of a doula because it undermines midwifery solidarity. This is coupled with the difficulty of finding secure, regular, full-time employment as a doula, and the discomfort of asking parents for money directly, rather than providing care with the state mediating one's salary. I also suggest here that by the time a midwife reaches the position of wanting to leave midwifery, the burnout and disenchantment with that kind of care, and that kind of landscape and workplace of care, is too significant to allow space to work as a doula, and as I have explored in Chapter 4, working as a flight attendant would likely make more sense than continuing in maternity care as a doula.

In addition to attending the hands-on training weekends, we are expected to complete homework on key texts we must read for the course, books on labour and birth, and guides on being a birth companion. We wrote reflective assignments, and in order to graduate from the course, were required to attend two births as a student doula within twenty-four months. The course was taught part in English, part in Icelandic, with a trainer and doula attending from America as part of a broader doula membership and training network. This organisation provided accreditation for the course, so we would be 'qualifying' under the recognition of a particular, reputable organisation. During the course of my training, I realised that there were many smaller, accreditation businesses in existence: not in Iceland, but online schools, networks and businesses with America as a primary site, offering an array of different courses and qualifications to build a doula portfolio and legitimate one's capacity to practice as one. On the recommendations of student doula colleagues, I drew on some of these courses in pursuing my own training as a doula, attending free webinars, listening to coaching podcasts, and reading material uploaded to different company websites. Rutherford and Gallo-Cruz (2015: 83) note that the internet has become a necessary and important site in which the role of 'medical consumers' is constructed. If maternity consumption is something being constructed on the internet, then using the internet as a place of fieldwork in which to explore how this construction occurs was necessary.

6.3. Doulas in the literature

Doulas are an under-researched area in the anthropological literature, and there is little ethnographic work on the work of doulas, their emergence, or how they fit into the changing landscape of maternity care, particularly in the context of increasing privatisation and the rollback of state-led services. Within midwifery and health care literature, there is an emerging body of work exploring the role of the doula in providing relational, supportive care to women and families, and the ways in which this form of care work impacts on maternal outcomes and experiences of gestation and birth (Bohren *et al.* 2017). Doulas are presented as a legitimate, sensible option for maternity services and women planning for their pregnancies and births (Lundgren 2010). There is no literature available on the process of training to become a doula, or the making of this identity. In this section, I explore how an ethnographic focus on doulas helps turn attention to the politics of a care deficit, in order to explore how doula work may create, and occupy spaces where there appears to be an absence of care. Two ethnographies of doula work stand out as examples of exploring this contemporary aspect of maternity care in its socio-political context, work by Kasstan (2019) and Castañeda and Searcy (2015a, 2015b), and I review them here.

Kasstan's (2019) ethnography of Haredi Jewish midwives and doulas explores the role of doulas as broker between families and state biomedical care services in Manchester, reflecting on the role doulas understand themselves as playing in shoring up the gaps left by shifts in maternity service provision. Haredi Jewish doulas work as part of a redistributive economy, taking no payment for their work, reporting that they were motivated to work as doulas by a strong desire to support women and follow a 'calling.' Similarly to the doulas I met in Iceland, and in parallel to other work on doula services, this group of doulas saw themselves as plugging a gap in care that they felt should be available to women using state maternity services (Kasstan 2019). This ethnography draws our attention to the ways in which doulas saw their role as necessary in a

context of service lacks: doulas reflected on service provision changes they had experienced during the course of their professional work, such as finding midwives in situations of understaffing, over-focus on clinical task completion, preoccupation with paperwork, and an absence of provisioning of adequate emotional care and support. In Kasstan's ethnography, doulas saw their role as providing focused emotional support in a way that was tailored to the specific needs of their community, as well as providing care that they felt to be lacking.

Castañeda and Searcy's (2015a) edited collection of anthropological work on doulas is a key text in providing ethnographic insight into this form of work. Castañeda and Searcy's (2015b) ethnography on intimate labour examines doula entrepreneurship and professionalism, looking at the emergence of doula work within a neoliberal market for care. They argue that relational, 'intimate labour', involving the cultivation of specific affect to form emotional connections, and prioritising individualised decision-making, are central to doula work. Castañeda and Searcy (2015b: 130) find that doulas described two contrasting 'logics' underpinning their work: one was about providing 'embodied care', and the second was about working within a 'neoliberal market.' Embodied care is a 'doula spirit' about relational, emotionally responsive and interactive care, and 'competes' with a 'neoliberal market model in which individuals see themselves as sets of skills that need careful marketing' (*Ibid.*: 130). There is therefore a complex difficulty for doulas in balancing authentic 'care' 'within an increasingly commercialised birth culture' (Castañeda and Searcy 2015b: 131). The doulas in their research needed ways to negotiate this difference between the two competing logics, and used resources from professional organisations, as well as learned marketing techniques, in order to 'mediate' the difference. Doulas learned to be 'entrepreneurial' in order to smoothly transition between places of work, and between clients. This book addresses what the authors term the 'doula effect'; individualised decision-making and intimate connection are hallmarks of the doula's role.

Both ethnographies point to the importance of understanding doula work in the context of neoliberal economies, and research exploring the ways in which private forms of birth work are emergent within neoliberal contexts supports this (Benoit *et al.* 2012, 2104, McCabe 2016, Rutherford and Gallo-Cruz 2015). As I have outlined, the literature shows us how a ‘care deficit’ (Hochschild 1995) has created a market for private forms of birth work (Benoit *et al.* 2014), and in this chapter, I explore this market for doula work in Iceland through an ethnography of doula training. I will show how a deficit of care has created a market for doula work in Iceland, and that the training programme of learning to become a fully-fledged, self-employed doula involved learning to see, and to occupy, this market.

6.4. Learning to understand the role of a doula and see a care deficit

In a large room at a free-standing, midwife-led *faðingastofa* (birth centre), I sit on a beanbag amongst a group of eight women. We are attending a weekend of *doulunámskeið*, an eight-month course set over several weekends to learn how to be doulas: self-employed pregnancy and birth support workers. The dark morning light is still visible at the windows, opening out onto neighbouring parking lots and retail units. Large, inflated birthing balls are stacked in the corner of the room, and a bookcase holding an array of childbirth publications in English and Icelandic is topped with photos of newborns and smiling parents. We have paused for a coffee-break, and the room is filled with the loud sound and scent of coffee grinding through the electric machine in the corner of the kitchenette. Embla, one of the doulas leading the training, pushes a door closed and we assemble in a circle on the floor. On a projector screen on the wall, we watch a fifteen-minute video of a labour, attended by a doula. The focus of the short film is on the work the doula is doing: our attention is drawn to the ways in which she exercises her skills, the ones we have come to recognise as essential for doula work. She is constantly present with the woman she

sits with, breathing with her in time, murmuring softly into her ear, shifting positions as the woman moves. This video presents us with an aspirational view of what doula work can be. The doula is completely focused on the woman she is with. Her work is emotionally authentic, caring, and it is relational. We see from the video how the labouring woman's experience of her labour is one in which she has complete support, and that she is cared for is not in doubt.

In this section, I examine the ways in which doula training, and being a doula student, was about learning to understand the role of the doula as essential. The doula was seen to be filling a void in maternity services, in which emotional support and care were lacking. I explore the ways in which doula students understood the role of the doula in providing an essential, though lacking, emotional support for labouring women accessing maternity care.

On the first weekend of the course, our trainers are Alex, a North American 'mamapreneur' doula with twenty years' experience, and Embla, a doula who has been working in a self-employed capacity for several years in Iceland. Alex also trained as a midwife prior to becoming a doula. She introduces her doula training company and its affiliation to a larger, umbrella organisation that serves as a network of doulas, doula organisations and provides accreditation for doula courses in which one can learn and certify a process to become a doula. The course I attend is one such training programme. Over this weekend, Alex and Embla guide us through the rudiments of providing doula care to families at different stages of pregnancy, labour, birth and early parenthood. We are presented with research evidence for doulas as a public health intervention, and learn about the social role doulas play in maternity care. There is a complex history of childbirth support and service to learn about. We are given plastic folders for the study handouts we receive: photocopied pages on acupressure points, on scripts, and on mapping out the progress of a labour. Over the duration of the course, myself and fellow doula students were encouraged to explore the shape and scope of the doula role. We watched videos, read books, and experimented with physical techniques to help women cope with fear, pain and anxiety around

labour and birth. These included techniques for handling *rebozo*, a long piece of woven cloth used to help position women's bodies during labour.

6.4.1. Understanding the role of doulas: discussions with doula students

Doula students had chosen to train as doulas for reasons such as not wanting administrative responsibility, and the moral coding that the doula work symbolised to them. It felt more meaningful to these doulas, and more accessible, to pursue work in 'care' through doula training. Other trainee doulas had, in one form or another, considered going into midwifery training, but had felt that the role of a doula was closer to the kind of care they wanted to provide, and that some parts of the midwifery role were not appealing to them. Katrín, one of the students on the course, described her understanding of the role of a doula:

"A woman I spoke to once explained it really nicely to me, that in the past, there were women looking after women, and then there were midwives, and then there were midwives and doctors, and now there are doulas."

Katrín's comment identified the role of the doulas as something new, using her hands as she speaks to segment the words, by profession, emphasising the distance between these categories of people. For Katrín, "looking after", or the caring of women, had shifted over time, involving different professional roles. As 'caring' became a professionalised activity, the way in which different roles have been seen as necessary has shifted. Katrín understood the role of the doula as a contemporary one; doulas were there to provide care where there was a lack of it, because the role of midwives in providing care had also shifted.

For Katrín, her understanding of the role of the doula was that she had different responsibilities compared to those of the midwife:

“The main differences are between the responsibilities of the two. The doula is responsible for a woman’s comfort and wellbeing, and the midwife on the other hand has clinical responsibilities, including the baby.”

This was echoed by other student doulas I attended the course with. Pála, a trainee doula who had been introduced to the role through her work as an interpreter on maternity wards, saw midwives as being trapped in a series of tasks:

“A doula’s encouragement is different, the focus is on you. It’s never about getting it [labour and birth] over with. The midwives, their focus is different. It can be about encouraging it to end. Midwives are stuck in clinical work, paperwork, stitching up, checking for vital signs.”

Pála’s comments point to the ways in which the role of a doula is responsive to shifts in midwifery work towards institutional-focused work.

Skúla, a trainee doula, commented that she had heard of midwives feeling under pressure to fulfil their multiple clinical and administrative responsibilities within tight time constraints. Skúla described a conversation with a senior midwife at the hospital, in which the midwife had stated that a midwife could not be thought to be “a proper midwife” if she is unable to complete everything that needs to be done for the woman within an hour after the birth: a complex list of administrative and clinical tasks including paperwork, updating an electronic patient record, arranging transfer or discharge home, an examination of the baby, suturing and breastfeeding support. Skúla noticed that younger midwives were stressed and worried about the work they had to do, though this stress was not necessarily about being present at the birth itself, but the pressure to work fast. Laufey, a student doula and the daughter of a midwife, had recently contacted some doula colleagues working in other areas of the Nordic region, and had found that

some of them limited their work to attending a select three or four births each year, handpicking their clients and choosing to focus their work on a limited number of families. Laufey commented, “it was just so good to hear that it’s not about being a machine.” Midwives and doulas were frustrated that efficiency, as a goal in itself, was often the focal point of work. Laufey’s comment that midwives felt under pressure to complete all their tasks in an hour was about showing how the definition of a good, ‘proper’ midwife was about being able to care under very specific resource constraints, such as time and emotion.

Laufey explained how her mother, a midwife with close to twenty years experience working in both Iceland and Norway, was “not warm” to the idea of doulas ten years ago, as she thought there was no need for them, and that “they were taking away from the midwife’s role.” Now, however, Laufey’s mother felt it was necessary, as doulas “offer something midwives often cannot.” Laufey, with experience of using maternity services as a parent herself, and while pursuing doula training, agreed:

‘Midwives have so much to do. They have more women on their hands in hospital.

Midwives, they want to do so much more, but they don’t have the time. *There’s* the spot for a doula. But a little bit in my heart, I would want to see midwives do that again.’

Laufey explained that before starting the course, she had felt that the doula “was stealing from midwives,”

‘Inside I felt a little that doulas are a little bit annoying [*laughs*]. I had this image of doulas attending unattended home births. I really did not want to be a part of this.’

Pála, a student who wanted to integrate her work with being a translator, understood the doula role, unlike that of a midwife, meant she could work with more autonomy and time around feeling. This was significant of providing proper care: an ability to be emotionally present. The issue for her became one learning to maintain boundaries and developing some

efficiency around resources of time and emotion, to demarcate when her care was work, and when it was not:

“Most women who tend to be doulas are women who connect to the feelings of other women. But this also means they can connect to their anxiety, even good feelings. It’s hard—they’re not your feelings. You are supposed to be neutral, there can be a feeling of getting too involved. But, I feel if I don’t allow myself that, I wouldn’t be me. It’s difficult to know when you’re at work. You just have to know yourself. Do a lot of self-work in order to not get lost.”

During the course, there was some discussion about the appropriate word for ‘doula’ in Icelandic, and how the translation and use of the word could work. We discussed problems with the word itself: Katrín, a student doula, pointed out that the word ‘doula’ originates in a Greek term for ‘women’s slave.’ On the other hand, ‘doula’, pronounced in Icelandic however, sounds very like *doulla*, an Icelandic word meaning ‘cute.’ Katrín commented that it becomes ‘a challenge to explain to people.’ Embla pointed out that people had suggested using an older word for midwife, *yfirsetukona*, but that many had felt this word belonged to midwives, and it was not right for doulas to appropriate this word; doulas and trainee doulas had agreed they would ‘not take this name from midwives’, and it was too disrespectful. However, the significance of this word, as discussed in Chapter 1, was that it captures a particular content of work attending a birth; a person who ‘sits over’ and attends a labour as it unfolds. Doulas understood their role as a form of attendance, or ‘sitting’ over; an emotional presence, and anchor to the uncertainty of labour and birth. Dahlen et al. (2011) observation that doulas have come to replace the lay midwife’s role is applicable here.

In the course, Embla talked through the potential for doula work to become more central, more a normal part of maternity services, and for payment to be made through state health insurance ‘as those models come out.’ The legitimacy of being a doula, and the ways in which this enabled specific forms of employment, varied. Alex, a doula from America who attended the

doula training course in Reykjavík, described how she worked part-time as a doula employed as part of a business collective within a public hospital in America: within this role, she was paid directly by the hospital as her employer; no money exchanged hands between herself and her clients.

For some course participants, it was important for them that the employment relation between doula and hospital remained clear: the doula was the employee of a woman. Katrín emphasised this:

“That’s the point of a doula, right? To not have any connections to the institution. It’s the doula’s relationship to the mother that’s important, the doula is employed by the woman.”

Through the doula training course, trainee doulas came to understand the role of the doula as central to a successful, healthy and fulfilling maternity experience. We learned to see the role of the doula, and understand it as necessary. In part, this was about learning to see a particular deficit of care: understanding the existence of gaps in service provision that left women and families without adequate emotional support, and that left midwives required to focus on the completion of clinical tasks within specific timeframes, above the provision of relational, affective care. Trainee doulas learned to see a requirement for this relational care, and part of learning to become a doula was about understanding the parameters of this care deficit, and why it was necessary for doulas to address this deficit. In the next section, I explore the ways in which trainee doulas learned to occupy this deficit of care.

6.5. Learning to be an entrepreneur and occupy the care deficit

In order to explore the market for doula work, and the ways in which doulas are ‘doing the job the midwife originally wanted to do,’ in this section I examine the process of learning to occupy the care deficit as a self-employed, entrepreneurial doula. Learning to be a doula was about learning to market our skills. In this section, I explore two parts of the ethnography in which doula students learn to be entrepreneurs. First I examine how students learned to become comfortable with charging for care work. Second, I explore how doula students were encouraged to organise their emotion, set boundaries and correctly mobilise ‘passion’ in order to occupy the role of a successful doula. For students wanting to be doulas they needed to understand their role as work, and that to be successful carers, we should pursue a salary. While doula students learnt to understand their role as an important and necessary one in filling a care deficit, doula students were also uncertain about occupying this space of work, being unsure how to charge for something that seemed fundamental. Part of the course, therefore, was about overcoming discomfort with learning to ask for money in exchange for care, learning to charge for emotional labour. Both these roles: being a skilled, emotionally-attuned carer, and being self-employed and comfortable with asking for payment for one’s work, were melded together in the course.

6.5.1. *“Love your salary”: charging for care and being a successful doula*

During a *kaffi* break in an afternoon workshop, we write out anonymised questions to ask other doulas on small squares of pink paper. We take it in turns to pick up each to read out and attach to a board. ‘*Does it ever get hard to charge for your doula work, especially if you have a close relationship with the mother/parents?*’, asks one hand-written question. Presenting this question to the group of us, other student doulas voiced being uncomfortable with the potential

commercial aspect of their role, at ‘marketing oneself’, and at the thought of negotiating payments. For the group of us, addressing the requirement to make an income through this particular form of care work seemed an uncomfortable task, in part, because the activity of asking for money seemed to contradict the authenticity of the emotional support and care student doulas hoped to offer. It was interesting, therefore, that the training course explicitly addressed this anticipated, and actual discomfort with seeking payment for doula work; a section of one of our weekend workshops was titled *elsku launin okkar* (‘love our salary’). I explore here how shame and affect around discussions of money were addressed by trainee doulas.

In a conversation with Pála, she explained:

“I don’t like selling myself. I see my work as a doula—I would probably keep it on the side, tops two births a year. Someone told me that some doulas have another job, which they call in ‘sick’ to.”

For these doulas, this is how they negotiate having a stable income, and also establish and maintain doula work. Pála’s understanding was that working as a doula full-time in Iceland, and earning a stable, secure income from it, was not possible.

“Then it’s a matter of marketing myself and selling my job. But I’ve always been a really bad salesperson. I don’t want to be an influence on pregnant women. I hate charging people, even if I’m lending them money. I don’t like that. If I was going to go there, I would probably organise some payment thing by access into the bank—a transfer.”

She explained the she felt she was able to “sell the idea” of a doula to someone with ease, as long as they weren’t pregnant, and a potential buyer of the service.

Talk of ‘success’ frames our discussion of business models in the course. Embla emphasises to us it is important to know how to pay taxes, how to build and maintain a website, find clients, establish a business name; “we want to know that you’re finding success.” Embla talks us through

the understanding that most clients will have two to three birth experiences in their lifetimes, and the gravity of attending to these can make it seem difficult to charge for being present at this unique moment. Embla explains, “but if you don’t charge, you can’t be successful in it. We need to get used to asking for money.” The course involved training in understanding how to become self-employed as a doula, and secure an income while managing this kind of relational care and affect. Alex emphasises the necessity of ‘having a preset idea of what a package (of services) involves’, and ‘finding ways to create value’ in terms of recognising the value of one’s care, and seeking payment for the work that is done. Alex discusses arranging and accepting payment ‘in kind’, using an example of how she has arranged for families to pay her in what they can offer, such as having the windows of her house cleaned by the partner of a woman she cared for. While the care work provided by a doula is understood on our course to be relational and emotional, the sustained provision of this form of care is reliant on doulas seeking a financial register for this form of care, and understanding that care can be both emotionally authentic, necessary, and compensated for through pay. Alex also discusses the benefit she sees in organising payment through a ‘mediator’, such as using a transfer service such as Paypal later in a woman’s pregnancy, rather than cash exchanged directly. These discussions and reflections on earning income from providing doula care speaks to Castañeda and Searcy’s framing of the ‘entrepreneurial doula’, in which the work of ‘drawing boundaries, getting certifications, putting price on it, making contracts, and running [it] like a business’ are necessary parts of the doula role (Castañeda and Searcy 2015b: 131).

During the course of the training, and on the recommendation of other doula students, I signed up to webinars and listed to podcasts on branding support provision and how to ask for money, through doula websites in order to understand this uncertainty around money, and also to explore and allay my own discomfort on the course. Reading Castañeda and Searcy’s (2015) book examining the work of doulas, I recognised myself in their suggestion that ‘doulas turn to professional organisations and marketing techniques to find spaces that help regulate and mediate

the conflict of interest inherent in neoliberal alliances’ (Castañeda and Searcy 2015: 131). These authors point to a tension in doula work where doulas work under ‘two contrasting logics’ or models of care: of ‘embodied care’, and ‘a neoliberal market.’ (2015: 130). Embodied care is about relational, interactive work: the labour of emotionally connecting to people, communicating with them, being physically present. On the other hand, Castañeda and Searcy point out that doulas see themselves as professionals and entrepreneurs, as individuals with a specific skill set needing to be marketed within a neoliberal model. This tension of contrasting logics points to what I experienced during doula training: how to be a good doula requires navigating and combining both of these, being successful requires incorporation of both. The notion of success was predicated on being able, on being skilled enough to balance the tone of each, and in the words of one training course, ‘you love what you do so much that it doesn’t even feel like “work”.’

These conversations speak of a tension, navigated through the doula training course, around learning to occupy an entrepreneurial role, and this was voiced by the trainee doulas I have cited above. Participating in the course, watching films about doula work, reading course materials and practicing hands-on care techniques, created a particular framing of doula work as essential, and one we could learn to step into. The framing of the work as entrepreneurial set up the parameters for this work. Watching a film about a doula-attended birth, as described above, the film can be understood to function as a kind of marketing strategy, incentivising doula provision, it is about creating a particular story about doula work as an essential, necessary intervention. The video of a doula attending a labour presents both a story about the unique, experiential nature of birth, as well as a story to reinforce a particular kind of work and business. The film however, evades the entrepreneurial framing; the work of doulas appears to be one of service, and about portraying companionship in birth as necessary, not a luxury. Attending birth as a form of employment is hidden: the care that is given is meant to be authentically altruistic, free of financial imperative. But, we are complicit in understanding that the work is paid, that we would attend—that this

doula attends—as a form of employment. This is absent from the video, and so it makes it difficult to visualise the part of the interaction that involves a monetary exchange, or negotiation: this exchange is muted. The tension for us in this course is that this framing is incomplete, because the course too is about making a living from care. The care deficit, then, is something that doulas not only participate in, but contribute to.

I diverge from Castañeda and Searcy's (2015b) argument that doulas work within two competing logics: rather, my research shows that doula work goes hand in hand with this marketing in many contexts, the two are not divisible and rather doulas work to make sure they are comfortable sitting with both. On the one hand, this was about legitimating doula work as a valuable form of maternity service provision that lessened risk and provided 'better outcomes,' it was not 'just' a provision of care that might otherwise be provided for free. In Kasstan's ethnography (2019), doulas work as brokers between state midwives and Jewish families; the care would not exist otherwise. On the other hand, this was about negotiating complex feelings around placing a price on care, and understanding how to value one's work in terms of financial value, earn an income, and have doula work as a sustainable form of work that would provide income for one's family. In the following section, I turn to the ways in which trainee doulas were encouraged to mobilise their affect in order to occupy the role of a doula, and address a care deficit.

6.5.2. Being 'a birth junkie': organising emotion and boundaries for 'success'

During the first workshop of the training course, a number of participants introduced themselves as "self-confessed birth junkies", implying they couldn't get enough of birth information and had an interest in birth which was a motivation and part of their reason for seeking out the training. Skúla talked about using Facebook page '*Skúla Doula*', "it is already a huge success. Everyday someone new visits it." I found over the course that this attitude shifted.

Two participants, Marta and Skúla, both expressed disappointment that they had not yet attended any labours or births. In another instance, Skúla, who midway through the course had been very glad of her new doula profile on social media, and the hits it was generating, became despondent that social media appreciation was not amounting to her idea of work. She was not getting employment offers through her profile and site, and her earlier passion for her work had given way to feeling ‘despondent’ at her work prospects, and a vague disinterest in working with maternity care. Two of the trainee doulas, Katrín and Pála, sound organised and have a sense of momentum with what they are doing - one has amassed a substantial amount of reading and research, and the other has attended one birth already as a doula. Marta and Skúla are uncertain about both what their role is and if there will be any employment for them as doulas. They feel they are putting in a lot of time and effort into something that doesn’t seem to be leading anywhere; Skúla says “it is a lot of work!”.

‘Passion’ for birth work was presented and participated in as an occupational requirement, and mobilised as a business ethic. Feeling passion for one’s work was a central theme for doulas in pursuing training and planning their work. The curious tension between an imperative to be ‘passionate’ and a ‘birth junkie’, while managing self and time so that passion does not lead to burn out.

During a break in the workshop at a later weekend, I sat with other doula colleagues discussing our plans for the coming months. Marta began eagerly discussing her ideas for promoting doula work: she felt the presence of doulas in Iceland needed to be made far more visible, and suggested inviting a high-profile speaker from abroad. The idea would be to use this speaker to leverage public interest in progressive birth ideas and practices. Marta listed a number of progressive birth workers and doulas who could be invited to run a workshop, many of them being names we were familiar with in the books and resources we had been reading. Other doulas in the group nodded enthusiastically: we had got together to host a ‘doula cafe’ during the previous month. Making

the work of doulas evident in progressively changing birth practices felt a wholly positive thing for us. Katrín was quick to respond and discourage Marta's idea. Katrín said she had done a lot of this kind of organising work over the years, but that the personal toll, the work that was created, was not viable. "It is *a lot* of work to make it happen, get people to attend, and look after the person visiting. The cost of the visitor coming is high. It is good to screen it first, but there is a lot to think through—how much would it cost? What will be provided?" Embla, a doula with several years of experience, noted that people would attend, but that it would usually be the same group of people, the same group of midwives, who would attend events with high-profile visiting speakers. She found it hard to make these visitor events financially viable, and there was no payment for the work she put into making it happen. Organising a workshop therefore wasn't a good idea for two reasons: one was that it was a drain on personal resources, taking a lot of time, energy, and possibly money, to organise and host the event. The second was a concern that these events mainly functioned to preach to the converted, and therefore did not work as a good business strategy for attracting new, potential clients, either directly, or through midwives who did not have a connection to doulas. This felt like a swift rebuttal to Marta's enthusiasm for showing her 'passion', a requirement for being a doula, but at odds with the entrepreneurial spirit of the work. There needs to be a balance of 'passion' with a viable, income-generating workload. Part of the course is about being taught to respect the work that goes into establishing a successful business, and the success of Embla and Alex was on display for us to see. Course participants also encouraged Marta to consider how she could set up pre-natal classes in her local area, moving the emphasis away from specific work with and in labour and birth, to other forms of support and encouragement.

This was about negotiating a balance between an excessive enthusiasm for maternity work, and a disillusionment with this work; it felt as though learning to think through the doula's role with business acumen was the necessary, practical step for ensuring that an excess of passion for the role did not move into a state of disillusionment over the stasis of not being caught up in the

immediacy, and the rawness, of labour; as well as the difficulty of being overworked and attending too much. Both Alex and Embla focused in on this balance, the ‘reality’ of working as a self-employed doula. This affect, necessary for becoming a doula, needed to be managed. Doulas needed to be strategic with how they spent their energy, and strategising was part of what we were learning to do in the training. I suggest here that a focus on this management of affect helps us reflect on the politics of care in a particular way. On one hand, it is necessary to feel and experience this passion to pursue training and to be a legitimate worker, on the other hand, it is understood as counter to being a successful doula. Managing affect was central to being successful. This involved a form of ‘self work’ (Gallicchio 2015), as being a successful and employable doula was about being emotionally appropriate.

Maintaining affective boundaries around work and care was necessary in Iceland. Embla pointed out that the size of Iceland, and the ways in which neighbourhoods are organised, whether we worked in Reykjavík, or a smaller town, means it is often inevitable that we would cross paths with clients. In Iceland, doulas found that they would often work for the same group of friends, therefore working as a doula here meant a careful negotiation with confidentiality, as well as work boundaries. Alex discussed what happens in her own neighbourhood, and meeting clients when she is shopping in a grocery store, the importance of asserting that she is ‘having a day off’, and ‘showing that I am being a mum and not a doula at that time.’ Understanding the parameters of work and care, and managing enthusiasm for work, was important in adjusting to the prospect of being on-call and available within one’s care package contract with a client. During a discussion with Pála, who was a parent of two children, she sighed and said:

‘The reality is that my home takes up most of my time. This [doula work] is a job!

Everything that takes me away from my family is a job, especially during crucial hours—like our dinner time, when we’d be together as a family.’

Tie together ideas of ‘success’ here in occupying the care deficit. Success was about making this territory our own, through management of affect: managing shame around asking for money and charging for care, and managing one’s passion so as to be a better entrepreneurial self. I suggest here that this was about not only occupying a deficit of care, but the creation of it, or contribution to it, too.

6.6. Discussion: “doing the job the midwife originally wanted to do”

The argument that a ‘care deficit’ (Hochschild 1995) has created a market for private forms of birth work, including doulas, is not new. Benoit *et al.* (2012, 2014) have examined the field of post-birth care in Canadian maternity services. This research argues that a care deficit within Canadian maternity services has created a market for private forms of birth work. Benoit *et al.* (2014) examine changes in post-birth care provision in Canada, using interviews with maternity service-users to examine their experiences of postnatal care, arguing that changes in the ways in which postnatal care is provided, such as the early discharge of women home from hospitals following birth, are occurring at the same time as many families face barriers to ‘privately organised care’ (Benoit *et al.* 2014: 85). These private forms of care include the work of doulas. The ‘care deficit’ Benoit *et al.* identify is when individuals are unable to afford maternity care services promoted as filling the gaps left by a shrinking welfare state. Postnatal services provided by state healthcare are, the authors argue, based on surveillance, guidance and referral, rather than more intensive, emotional support (Benoit *et al.* 2014). In Iceland, I suggest that a similar politics of care work is unfolding, in which midwives, and doulas recognise the absence of this intensive, emotional support, and seek to act on it.

The labour of doulas, therefore, is explicitly about affect and care. The provision of emotionally intensive, relational support is integral to doula work. According to DONA

International, a doula is professional, trained to provide ‘continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible’ (DONA International 2018). Trainee doulas saw their role as addressing a care deficit arising from a number of lacks: of adequate numbers of staff to ‘care’ effectively and authentically, of emotional care, of presence, of touch, of translation (Kasstan 2019). In learning to live without much care, this group of doulas had orientated their work around addressing this deficit of care they found for families they looked after. This work, however, unlike midwifery services within Iceland, occurs in an entrepreneurial frame in which doulas are presented as an essential need (Mander 2011). There is a need for affect, a new emphasis on experience, and doulas are ‘selling’ an experience - a better birth experience as the affective register of birth is provided for. Doulas can be relied upon to safeguard this affect and provide the ‘right’ kind of affective tone. In line with Freeman, I too suggest here that affective dimensions of labour are central to contemporary labour regimes and demand close ethnographic attention (Freeman 2013: 98). In turn, Rutherford and Gallo-Cruz (2015: 76) argue that ‘the pressures of commodification and consumer movements are...pivotal for understanding contemporary birthing practices’, and I suggest here that we can understand the emergence of doula work as a way of not only responding to a deficit of care, but participating in it also. Doulas responded to ‘to consumer preferences for birth as an experiential commodity’ (Rutherford and Gallo-Cruz 2015: 76), by focusing on the necessity of emotional support in order to create a good birth experience for clients. A rhetoric of empowerment which positions the consumer as responsible for change (McCabe 2016: 181) is creative of a particular kind of care deficit, in which adequately intensive emotional support is seen as absent in state-provided maternity care, and the responsible choice to mediate this becomes framed as a consumer need, and involves purchasing the service of a doula to remedy a perceived deficit of care. In my ethnography, I show how this became a difficult tension for trainee doulas to mediate, as on the one hand, trainee doulas were learning to understand and mediate a particular reverence for

intrapartum care and experience, as well as understand the necessity of charging for provision of care to uphold this.

Gallicchio (2015) addresses the ‘self-work’ that doulas must do in order to be effective and good at their work: to leave different kinds of baggage at door when working with clients; the politics of ‘ethical becoming’, ‘a kind of mastery over herself’, an ‘expertise of the self’, in which being a ‘good’ doula was about being able to individualise care (2015: 118). Doula work is occurring within neoliberalised contexts in which affect and ‘resilience’ are valorised as techniques of self-work or self-management in order for individuals to cope with increasingly difficult (isolating, underpaid, challenging) work structures and conditions (Gill and Orgad 2018). Emotional management is a skill (Hochschild 2003), and is promoted in capitalist economies as such, rather than an unremunerated, and assumed natural essence of gender (Freeman 2013). There is an economy of emotion in which people seek the experience of emotional connection and intimacy through consumer and entrepreneurial culture. Freeman’s argument points to the discomfort experienced by trainee doulas in negotiating payment and setting up work as entrepreneurs. I suggest here, that one of the fascinating aspects of the emergence of doula work in Iceland, was that as well as this appearing to be a valuable form of meaningful employment, this work also appeared to be more emotionally secure than work as a midwife: for trainee doulas, there was a sense of security in being an entrepreneur of affective labour.

Doulas have sometimes been imagined, or idealised, as the professional self of the midwife, in Pála’s words, as ‘doing the job the midwife originally wanted to do’. Doulas I trained with recognised this issue, that the work they were doing was originally, ideally, the role of the midwife. This is the task of providing emotionally intensive, relational care, involving activities such as coaching, facilitating movement, advising, reassuring, listening, a presence of care that could be described as a form of ‘sitting over’, and tied to an older Icelandic term for midwife, *yfirsetukona*,

the ‘sitting over woman’. While these activities remain folded into the everyday work of midwives, midwives hold clinical and institutional responsibility and must also facilitate the needs of their employers. The structures in which they work mean that work is done for different people, different parts of the system. In my ethnography, I found that there is an ethic to doula work that strikes a chord with midwives: midwives recognised the necessity of relational care, and saw doulas as increasingly necessary in providing this at a time when the organisation of their work created an inability for midwives to do so. Dahlen et al. (2011: 49) have noted the presence of tensions between midwives and the ‘emerging role of the doula’, where while doulas feel they are filling a lack in services, midwives perceive doula work as trespassing on the midwifery role. In my ethnography, I found that doulas were emerging as an integrated, necessary part of contemporary maternity services. They were trained and housed in a midwife-led birth centre, and as I have discussed, older midwives who were suspicious of the trespass of the doula role on midwifery several years ago, were increasingly supportive of the doula role, understanding the limitations of many midwives to provide emotionally engaged, relational care. In parallel to ethnographic research on doulas (Kasstan 2019), desires for care and to provide care, to be caring, were part of the occupational and emotional landscapes framing women’s work as doulas. The politics of the organisation of care made space for doula work and these particular configurations of and desires for care. Doulas were understood as necessary in plugging the affective gaps in the service, and remedying the care deficit midwives found themselves working in.

6.7. Conclusion: a market for private birth work

In this chapter, I have explored the emergence of the doula as a contemporary form of birth worker, in Iceland, in the context of a ‘care deficit’. I have argued that a care deficit has created a particular market for doula work, in which the necessity of emotionally intensive, relational care, is understood as central to a good birth experience, as well as being absent from state-led

maternity services, due to the workplace pressures midwives experience, and which they protested during the *kjarabarátta*. I have argued that within the context of doula training, trainee doulas learn to both see the care deficit as a market, and the role they have as a crucial and necessary one to fill. Trainee doulas also learn to occupy this market, through addressing tensions with charging for and valuing emotional care work, and learning to manage one's emotions to be a 'successful' entrepreneur.

Chapter 7

Conclusion: midwifery and care deficits

7.1. The scope of the thesis

In this thesis, I have used the concept of a ‘care deficit’ to articulate a particular politics of care, and have explored this through an ethnographic context of midwifery, financialised crisis, industrial action and protest in Iceland. In this chapter, I draw together the ethnographic threads of the thesis to present a conclusion. I show how using the concept of a ‘care deficit’ helps us understand the work midwives do to reproduce themselves and their work at a time when they are required to live with and within different, multiple forms of deficits, and negotiate a life as midwives. The care deficit is a concept that helps us to make sense of protest, and the intersection of midwifery, the economy, financialised crisis, and work. In Iceland, neoliberal reforms and the 2008 financial crisis have impacted not only the material conditions and structures through which people negotiate their lives, but the ways in which midwives experience a sense of self, feelings about and meanings of work and care (Ganti 2014). People have been living with different kinds of deficits, and gaps between experiences of care, work and life that are desired, and those that are possible, have broadened. This has created conditions of life that require the extraction and giving of affective and tangible resources which midwives cannot sustain the provision of.

In this ethnography, I have sought to trouble understandings and assumptions of care, and the ways in which midwives experience work within different forms of deficit. My ethnography explores what it means to be a midwife in Iceland, at a particular historical moment, and I have shown how this experience is connected to gender, the politics of care work, neoliberalism, and

labour. I have drawn together anthropological perspectives on the economy, midwifery, care and work, to ask questions of how we might understand midwifery care and work as being about economic practices. How do midwives live within and experience neoliberalism? How does neoliberalism shape midwifery? I have suggested that using ideas of social reproduction and the economy as the ‘effort to make life’ (Narotzky and Besnier 2014) in order to think about the reproduction *of* midwives and midwifery is important and useful. I have explored the reproductive work midwives do to secure their own futures, and I have asked questions about the kinds of material, affective, and imaginative work we might understand to be involved in midwifery, in order to draw attention to the labour of midwives. I have argued that this is an area of midwifery in urgent need of ethnographic attention. In this Conclusion, I explore the implications of this ethnography for our understanding of midwifery, care and reproduction, and neoliberal economies.

7.2. An ethnography of Icelandic midwifery

This thesis has presented an ethnographic exploration of midwifery work, care and protest, as well as the emerging role of the doula, through four main chapters. Through these chapters, I have sought to explore a specific politics of care at play for midwives, and I outline the ethnography below.

Chapter 3. Care and deficits: the midwives’ dispute

In the first ethnographic chapter, I introduced the midwives’ *kjarabaráttta*, the ‘wage and working conditions struggle’ of midwives, as an event through which we might ask questions of how care and care and crisis are experienced and understood. I examined the *kjarabaráttta* as a

particular moment of crisis and deficit for the midwives involved, and consider how these midwives negotiated this unfolding in their professional and personal lives. This chapter examines how the *kjarabarátta* was a significant struggle over inconsistencies in the ways in which midwives earned a living and experienced a recognition of value in their work. Drawing on anthropological framings of crisis to understand how it might work as a metaphor and category through which people express a lack of security in the structures and institutions they need to provide the framework for a reproducible life (Loftsdóttir *et al.* 2018), I suggested this framing raises questions about the ways in which midwives were experiencing a structural crisis in midwifery work, and how this was tied to affect, and their experiences of multiple deficits. This ethnographic chapter explored how, through public interviews and media, in protest, and in interviews, midwives spoke about the ways in which feeling frustrated by working conditions, and uncertainty about the future, were feelings that they experienced, and this played into the everyday, common experience of ‘crisis’. I showed how midwives disputed not only the conditions of their employment and the wage they received for their labour, but also disputed the ways in which they were expected to feel about their work. The midwives’ *kjarabarátta* can be understood as a particular moment of protest and discontent in which they contested not only a wage deficit, but refused a deficit of care. I argued that an ethnographic focus on midwifery protest draws attention to the ways in which we can consider these practices of protest and articulations of discontent as economic strategies and as part of an *economy of affect* (Narotzky and Besnier 2014). In the midst of living, working and caring through multiple, entangled deficits, midwives protested requirements for emotional labour that ignored a neoliberalised context in which they were required to work more, with fewer material and ‘intangible’ resources. This chapter addresses the *kjarabarátta* as a critical event through which midwives articulated their disaffect with care, and addressed their experience and negotiation of a care deficit.

Chapter 4. Midwifery futures: inside a midwifery conference

In the second ethnographic chapter, I explored the Nordic Midwifery Congress as a professional event through which midwifery reproduces itself. I asked questions of the ways in which midwives are engaged with this form of reproductive activity and hope for their own individual lives as well as collective professional futures. I argued that drawing on the framing of the economy as about the effort to make life, we can understand conferences as economic practices in which midwives are involved in the work of provisioning a future for themselves, and that this work takes different forms. In the ethnography, I explored the quotidian work conducted at these professional events, and the Nordic Midwifery Congress as a place of collective remembering, in which significant reproductive work is conducted by midwives in order to reproduce their professional identities. I explored the work of sociality as a significant way in which midwives seek to reproduce their profession through attending to relationships at the Congress: the different practices and techniques used to create a particular identity around and of care work, and the work of sociality in creating collective, professionalised identities around care. I explored the work of technological innovation as a means of imagining possible midwifery futures, and how to bring these about. Through attention to research panels, presentations and discussions of broader contexts of maternity care crises in the Nordic region, I examine how work at the Congress was about articulating specific anxieties about midwifery futures. I explored how conferences might be approached anthropologically as not only about places in which collective professional identities are negotiated and reproduced (Faucher-King 2005, Nyqvist, Leivestad and Tunestad 2017), but as places in which attendees go about experiencing hope for the possibility of a professional future, and go to work to provision a future.

Chapter 5. “This motherhood feeling”: balancing an affective economy of care in midwifery

In this ethnographic chapter, I explored the relational work of midwives to understand how midwives experience an affective economy. Building on the work of the previous two ethnographic chapters, I explored how midwives experienced moral framings of required affects as part of a work ethic within a deficit of care. Midwives experienced requirements to inculcate feelings of maternal altruism, kindness, and pleasure, and challenged this in the course of the dispute, as well as their everyday working lives. Through the ethnographic description of everyday midwifery work in different contexts, including a birth centre, an antenatal education class, and an along-side midwifery unit, and through interviews with midwives in these places, I show how midwives participate in affective economies. In the contemporary socio-economic context, neoliberalism reproduced inequities and inequalities of care, requiring midwives to work within a deficit and exchange affects unequally. The experience of working more, with fewer material and temporal resources, as a consequence of neoliberalised change to healthcare work context, involved requirements to appear to enjoy this work regardless of these changes (Hochschild 2003a). An ethic of service and sacrifice prevalent in midwifery (Hunter 2010, Kirkham 1999), tied to a work ethic (Weeks 2011), can be explored in terms of how this, as a particular work ethic, shapes midwives’ participation in economic life and how midwives experience this economic participation. In Iceland, this ethic of sacrifice and service was a central tension at a time when midwives were questioning their own individual as well as collective capacity ‘to serve’ at a time when they were required to take on increasing responsibility for the lacks of an adequately resourced service, adequate pay, and an adequate work-life balance. Relationships, in which people experience and cultivate trust and care, were also being tended to through the *kjarabarátta*, and paying attention to this opens questions about the ways in which we frame the economy as being about different forms of effort to create and maintain a life. I suggest that midwives sought to draw attention to the unequal forms of affective exchange they experienced.

They sought to balance the ideal of unpaid service inherent in framings of care within the socioeconomic context, and sought different forms of affective investment that addressed and countered a care deficit. In addressing these moral framings of work, midwives contested the ways in which the value of their work was framed, and the ways in which care and caring in the context of a deficit required different forms of affective and professional depletion.

Chapter 6. “Doing the job the midwife originally wanted to do”: the work of doulas in a deficit of care

In this final ethnographic chapter, I explored the context of doula training and work in Iceland, and argue that a deficit of care has created a market for private maternity work. I demonstrated how doulas are emerging as a particular kind of labourer to occupy the places where relational midwifery care is lacking. Through an ethnography of doula training and interviews with doulas, I explored the ways in which doulas position themselves in order to remedy a care deficit. Doulas understand the provision of their work as a necessary form of care through two techniques. First, trainee doulas learn to see a care deficit, where particular absences of care are present, and learn to frame this gap as a market. Second, trainee doulas learn to occupy this market as entrepreneurs, inculcating particular subjectivities and affects around birth work, such as love, enthusiasm and passion for birth work. In exploring this ethnographic context of doula work, I argue that attention to a care deficit makes space to understand the emerging work of doulas as tied to neoliberal economy. Doulas negotiated their positionality and feeling in relation to midwifery work, seeing their role as necessary, essential, and as filling a gap in care where a midwife used to be. Doulas expressed understanding of a changing socioeconomic landscape of maternity work, in which midwifery and the role of the midwife had shifted and exposed absences in experiences and capacities to provide relational care. As emerging

protagonists in maternity work across a variety of contexts, doulas are an under researched in the anthropological literature (Castañeda and Searcy 2015a), and in this chapter I show how reflecting on their role and work speaks to discussions about neoliberalised change in maternity services, and highlights the changing scope, content and orientation of midwifery work, in which emotional, relational care is experienced to be in deficit and is outsourced to a private market.

7.3 Towards an anthropology of deficit: implications of the thesis

In this thesis, I have explored how the concept of deficit allows anthropological exploration of conditions and experiences of austerity and welfare shrinkage in the context of neoliberal economies and financial crises. It turns our attention to the ways in which people experience an inadequacy in the resources they need to reproduce their own lives. I have shown how these conditions are about both material and affective experiences, an economy involving both ‘tangible and intangible resources’ (Narotzky and Besnier 2014: S6) in which midwives negotiate practices and experiences of care. I have drawn on Hochschild’s (1995) concept of a care deficit, used to describe care arrangements in which shrinkages in the availability of care occur at the same time as expansions in requirements for it. In Chapter 1, I showed how this has been explored in contexts of maternity healthcare, through the work of Bone (2002, 2009). Drawing on Hochschild’s (1995) framing of a ‘post-modern’ solution to a structural deficit of care, in this literature Bone suggests that this involves a peculiar dissonance for midwives, as efforts to remedy a care deficit involve both denying the need for care, and changing the ways in which need and wellbeing are conceptualised, including feelings of uncertainty, grief, nostalgia, insecurity and anger. Hochschild’s concept of a care deficit, then, raises multiple questions about contemporary labours of care in maternity services. Following Bone’s ethnography, we can think about what a

deficit signifies, how it shapes experiences of work, how structural healthcare change challenges occupational identities, roles, and work, and how a ‘deficit’ might be profoundly affective.

In approaching ‘the economy’ and economic life anthropologically, I understand the economy as the ‘effort to make life’ (Narotzky and Besnier 2014: S14), grounding economic processes and practices in the everyday activities of people. Literature on precarity (Muehlebach 2013) shows us how uncertainty ‘affects people’s ability to reproduce materially and emotionally, creating difficulties in forming new families, maintaining existing ones, forming caring relations, and feeling respected’ (Narotzky and Besnier 2014: S8). Anthropological approaches to neoliberalism as a focus of ethnographic enquiry suggest that it represents a ‘force’ impacting on the ways in which people form and align their subjectivities in relation to specific values of work (Ganti 2004). I suggest we can think about the ways in which midwives might be forming subjectivities in terms of values of individualism, entrepreneurialism, and market competition (Ganti 2004: 94, Sandall *et al.* 2009), as well as the emergence of the role and work of doulas as a part of this (Castañeda and Searcy 2015a). This framing is important as it disrupts mainstream assumptions about what the economy is, how people participate in economic processes, and live lives within and through late-capitalism and neoliberalism. As introduced earlier in the thesis, ethnographic research (for example, Scamell and Stewart 2014) is suggestive that midwives might often be strategising in order to negotiate the provision of care within a deficit context, in a way that avoids depletion, or alternative forms of caring as resistance to the effects of neoliberal change (Fitzgerald 2004). I argue that it is important, necessary, and timely that we ask questions of midwifery, not taking for granted the experience of midwives, the necessity of particular working conditions, or the economic paradigms that generate them (Narotzky 2018). It is necessary to locate midwifery within neoliberal regimes, and talk about ‘the economy’ as something in which midwives are located (Kirkham 2019).

Narotzky and Besnier (2014: S6) suggest that within neoliberalised socioeconomic conditions, people produce ‘livelihood resources’ which ‘circulate outside or on the margin of market practices.’ Here, I suggest that we can think about social relations of support and solidarity, and the affects these relationships produce, including through the medium of social media, as a ‘livelihood resource’. This is about expanding our understanding of the economy, as well as including midwifery protest within economic life, as well as integrating important work done within midwifery foregrounding the necessity of relational care to the wellbeing of both midwives and the families they care for (Hunter and Deery 2003, Kirkham 2010). Reflecting recently on the politics of midwifery, Kirkham (2019) draws attention to how ‘capitalism is a dirty word’ in midwifery writing, pointing to the lack of critical analysis on cultures of capitalism within midwifery. This raises the question of why there is a lack of reflection on capitalism in scholarship of and on midwifery. I suggest that the way midwifery is framed as ideology, as a profession, and as rhetoric can discourage or circumvent a critique of capitalism, and in the anthropological literature this lack of attention to the ways in which midwives experience their own labours is apparent. This thesis addresses that deficit of attention to the ways in which we can understand midwifery and maternity care as practiced, reproduced and imagined through neoliberalism. Being able to describe this normative state of midwifery in neoliberalism matters (Fisher 2009). In this thesis, I have drawn attention to the ways in which focusing on deficit and economies of affect is a way to talk about midwifery in terms of anthropological approaches to the economy.

Given the high-status of midwives in these resource-rich countries that have much to celebrate in maternity care provision (UNDP 2020), it is important to understand the atmosphere of disillusionment and crisis among the people staffing these healthcare services, and my thesis has pointed towards this. Exploring this atmosphere of disillusionment and crisis matters because it speaks to other contexts in which midwives are attempting to negotiate entanglements of deficit, and it brings these precarious work contexts to the foreground. In Iceland, an unfolding situation

in which the number of midwives due to reach retirement age within the next decade is not being matched by an adequate number of midwives being trained poses a particular kind of crisis for midwifery. The number of midwives staying in the profession is too few, and as shown through the course of the *kjarabarátta*, midwives are leaving work, and registration in the profession, before reaching retirement age. There are a declining number of older colleagues who have accrued a set of skills over the course of many decades, who have worked in jobs long enough to have been exposed to and acclimatised to many different clinical situations. The sense of what one can be responsible for—literally, what one has the resources, the capacity, and the skills to *respond to*—is changing. This is happening at a time when the sense of responsibility for junior midwives, including myself, feels insurmountable, and overwhelming. Further, this is occurring during a time when care is becoming increasingly prescriptive and enshrined in guidelines and protocols for how midwives should work (Kipnis 2008, Lane and Reiger 2013). Within a few decades, midwifery in the Nordic region, as well as other European contexts (Hunter 2018) has shifted from being a job held over the course of a working life, to something manageable for around the length of a decade. Attention to a care deficit opens up anthropological questions of context and experience in relation to this.

This has numerous implications for midwifery as an occupation, including the erosion of skills gained throughout a working life, the intangibility of skills developed over several decades, leads to a particular form of professional precarity for midwives. The 'skills mix' required to create a community of working midwives who are able to grow and learn alongside more experienced midwives is eroded. The erosion of specific skills, such as handling unusual forms of birth, means that not only are individual midwives unable to develop the competencies and skills to deal with these scenarios, and the confidence to deal with them, this erosion also means that midwifery as a profession loses the skills ground on which it is able to claim expertise and competency to practice. These clinical presentations will not subside: women will still present in clinics with unexpected breech presentations, labours will still become obstructed, but the capacity for

midwives to handle these events is diminished. I point to this context as in order to iterate first, how attention to these contexts of midwifery work, and the ways in which midwives negotiate and protest them is important for our understanding of midwives' experiences of care. The spilling out of discontent, dispossession from value, self, feeling, occurs because there is this profound mismatch between what should be felt and what is actually experienced by midwives. Furthermore, I suggest that attention to the ways in which cultures of capitalism create this midwifery work are necessary, and further work exploring the effects of neoliberalism on midwifery are important (Sandall *et al.* 2009).

In reflecting on anthropological approaches to care, Duclos and Criado (2019: 154) have suggested that 'the replacement of the capacity to imagine possible futures by a politics of minimal care reflects a broader collective paralysis which must be attended to.' In midwifery, relational models of work and care (Kirkham 2010) have the potential to disrupt the grain of neoliberalism, through an ethic of care in which midwives and those they care for are in reciprocal, trusting and supportive relationships of care, and in which a doctrine of individualised self-maximisation is refused (Ganti 2014, Nartozky and Besnier 2014). Part of a project of a feminist turn to questions of the economy should be about breaking the dominance of neoliberal orthodoxy in the organisation and imagining of public care services, such as maternity care (Wærness 2005). As well as thinking about how neoliberalism creates different kinds of deficit, we might also consider how people understand capitalist imaginaries as a deficit of care. Fisher has suggested that while capitalist realism is encompassing, there are gaps within it; 'the failure of the future haunts capitalism' (Fisher 2012), and in this thesis I have shown how we might understand midwives and midwifery as pulling at these gaps through protest. By addressing the failure of a secure and imaginable future for midwifery, midwives addressed the deficit of accepting neoliberalism as a set of normative conditions through which to practice midwifery.

In the context of the *kjarabarátta*, midwifery protests and disaffect speak to a context of inequity and inequality which are inadequately foregrounded in representations of Iceland (Pálsson and Durrenberger 2015). Midwives' anger at inequality, in terms of class (being a member of the working poor despite the social value of the work being done), being able to afford to live as a single parent, alone, in the municipal area, and fund the affective, material infrastructure needed to work as a midwife were brought to the surface in the course of the dispute. Where midwifery work should have been about having possession of security, warmth, nutrition, and a future that can be planned. Midwives' practices of protest and resistance marked a rupture of this social consensus on equality, speaking to an experience of dispossession, of being deprived of wellbeing and the capacity to reproduce a secure future, no matter the effort put into it. I have argued that neoliberalism creates and maintains specific deficits of care, feeling and affect, and that we can think of the economy in terms of the efforts people make to balance relationships and affects. Care, feeling, longings, hopes and desires are central to economic life. My ethnography speaks to anthropological attention to the ways in which people cope through crisis, navigating relationships of care (Bear et al. 2020), and 'economies of affect' (Narotzky and Besnier 2014), in which they exchange, mediate and provision the resources they need to make a life.

I have drawn on anthropological understandings of care as something requiring 'troubling' (Duclos and Criado 2019), in order to explore the uneven, messy ways in which experiences of care and caring map out in people's lives. I have explored messier ideas of trouble, lacks, extraction and economy in order to understand the midwives' *kjarabarátta*. In asking what kinds of resources are being extracted from people in order to remedy deficits, I have shown that midwives experience affect as something extracted and transactable, at the same time as a work ethic in which one is professionally required to love one's work is at play. The work ethic (Weeks 2011) is something continually shifting and mired with tension and instabilities, midwives can be seen as pulling at these unkempt moral boundaries around why they should work and accept

certain conditions for their work. I have shown how the concept of deficit encourages us to take notice of the gaps, absences and lacks people experience in the context of financial deficit. Lacks and shrinkages in public finance, in the context of healthcare, require healthcare workers to remedy these gaps in care through the provision and extraction of other resources. I have drawn attention to the ways in which discussion of financial deficit, wage gaps, and inadequate salaries are not solely about abstract absences circulating and widening in a ‘market’ or ‘economy’ separate to people’s lives. Instead, this ethnography shows how the everyday experience of loss resulting from the necessity of managing, remedying and contesting these deficits is significant.

7.4. Contributions and future directions for research

In this thesis, I have explored how representations of midwifery as a priceless and sanctified occupation jar with the ways in which midwifery is experienced by those who work as midwives. I have argued that there is a risk of professional and personal burnout among midwives in the Nordic region due to a disconnect between how midwives are viewed as having a form of occupational grace, and the lived reality of work as a midwife. This thesis evidences that midwives both desire *and* require recognition for the content and value of their work, beyond understandings of it as sanctified and vocational. As discussed in the ethnography, there is a tension between how midwives feel valued as women working a ‘beautiful’ job, the way this work is experienced as valuable, and midwives’ actual experiences of being valued. What is contained in work, and what is seen as central to the role of being a midwife—such as the capacity to provide and experience relational care, trust, reciprocity, and sociality—requires attention and consideration. A central contribution of this thesis has been to demonstrate that midwives’ experience of collegial relationships and of having the necessary space and time for the sociality that these relationships depend on, for example, at professional conferences, could be better

explored, recognised and valued. When midwifery work is cast as only meaningful when it is in the form of hands-on, direct patient care, the nuance and necessity of work that also involves rest, recuperation, social support, organising, strategising, and administration, is lost and depleted in analysis. Understanding midwifery as involving a wealth of skills and capacities to provide care and conduct valuable work through correspondence, telephone calls, digital technologies, audit, research, and housekeeping, for example, point to the ways in which we might better understand how to value and support midwifery work as it is experienced by midwives, when midwives are attempting to reproduce their professional lives within capitalism. This thesis contributes to the anthropology of midwifery by addressing the ways in which concepts of valid work are framed in midwifery, and has suggested that challenging and broadening our framings of caring allows recognition of the ways in which health care providers also experience care, and the absence of it.

Given the limits of this doctoral research, I suggest here some directions for future research, developing the evidence presented by midwives in this part of the Nordic region. Strikes, protests and industrial disputes are emerging events in midwifery workforces in places beyond Iceland, and I suggest these require ethnographic attention in order to understand how midwives experience inequity and discontent, and how they seek to enact this. In contexts where industrial dispute is not occurring, or is muted, I suggest that attending to the ways in which midwives seek out alternative forms of employment, in a full or partial exit from midwifery work, also requires further ethnographic attention. As I have presented in this thesis, while the narrative of midwives leaving the profession to find employment as flight attendants suggests that a small number of midwives in Iceland have opted to change careers, this remains a resonant area for future research in the Nordic region, as well as other European settings. Understanding the employment strategies of midwives seeking to address a deficit of care is urgent in attending to issues of staff retention and return in different countries. Future research could involve exploring how midwives shift to part-time work, and subsidise their income with alternative employment both in and out of maternal health care. This could involve following stories of midwives working in

the service sector, in small businesses, in clinical administration, and setting up private midwifery work in antenatal education provision, hypnobirthing, lactation consultancy, doula-ing, massage and yoga for pregnancy, alongside their work as a state-employed midwife, or as a strategy to exit the profession entirely. These future directions for research could address the ways in which midwives go about negotiating care deficits in work contexts beyond Iceland.

7.5. Matters of care and writing

Finally, in addressing how we might understand and challenge practices and understanding software care, I suggest that anthropological attention to a care deficit is timely and necessary. Completing this thesis during the COVID-19 pandemic has contextualised questions of care. Questions of how people's relationship to labour and care are changing have been foregrounded in public discussion, this discussion itself mediated through a physical shrinkage in the material ways in which people occupy their lives. While the ethnography I present in this thesis belongs to a pre-pandemic social context, I have written parts of this thesis and reflected on care and caring during a time when responsibility for care, and the texture and social fabric of care, is centre stage in public discussion around the pandemic. Commentators have suggested that people's relationship to work has been made strange (Shahvisi 2021), and recent, multi-sited and rapid ethnography on the impact of the pandemic on people's experiences of care following policies governing the boundaries of social life and physical life has explored new, changing iterations of care (Bear *et al.* 2020). Bear *et al.* (2020) point to the ways in which we are living within a period of time in which people experience the relationships through which they negotiate and experience care as inadequate. Reflecting on this, I suggest that thinking through the concept of a care deficit is both useful, and urgent. We are all living with multiple deficits: inadequate space, intimacy, a shrinkage in social and physical worlds, and a lack of being able to plan for a future.

Turning our attention to the ways in which these intersect, through a concept of deficit, is important.

Writing in early 2021, with a nursing strike in the UK looming in the face of a proposed 1% pay rise, Shahvisi (2021) notes the ways in which media and political rhetoric of heroism plays into a particular framing of value. The recognition of ‘incredible’ work done well, and the rhetoric of recognising sacrifice and service, plays into a framing of work as beyond salaried value. Nursing, like midwifery, is both technical *and* care work. It is the deployment of focused, precise skill under high-pressured conditions, as well as ‘the reproductive labour of making sure bodies endure from one day to the next’, ensuring that people experience both the alleviation of discomfort and a feeling of being cared for (Shahvisi 2021). In this thesis, I have presented and challenged different understandings of what constitutes midwifery work and care, and the contradictions and tensions between moral framings of midwifery work and midwives’ experiences of their own labours. I have shown how midwives continue to be invested in attending to and provisioning their futures. In spaces of deficit, midwives go about reproducing, hoping, and aspiring to different futures.

I have asked what if we approached labour, within scholarship on childbirth and the work to facilitate this, as also being about the labour of midwives, and the reproductive work they do to secure their own future? What forms of material, affective, and imaginative work does this involve? How do midwives reproduce their professional lives within capitalism? Through an ethnographic focus on midwifery protest, professional events, relational care work and the emergence of doulas, within a deficit of care, I have drawn attention to the diversity of quotidian work midwives are engaged in in order to provision their futures, the everyday work of making a life possible, and the possibilities people experience to care for one another.

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Appendix 1: Approved University of Sussex Ethical Review Application

Ethical Review Application (ER/REJA20/2) Rebecca Ashley	
Parent Application:ER/REJA20/1	
Project Title	The politics of birth work: an ethnography of Icelandic midwifery (COPY)
Status	Approved
Email	R.E.J.Ashley@sussex.ac.uk
Phone No.	07971138706
Applicant Status	PG (Research)
Department	Anthropology
Supervisor	Prentice, Rebecca J
Project Start Date	15-Feb-2016
Project End Date	01-Mar-2016
External Funding in place	Yes
External Collaborators	No
Funder/Project Title	
Name of Funder	ESRC/Sussex DTC

Ethical Review Application ER/REJA20/2 (continued)

Project Description

This project forms the fieldwork component of my anthropology PhD. It will be an ethnographic examination of the lives of working midwives in Reykjavik, Iceland, and will involve participant observation, interviews and focus-group research methods over a period of 12 months, within the Landspítali University Hospital, the University of Iceland, and the Icelandic Midwives' Association offices.

The aim of this project is to create an ethnographic portrait of midwifery work at a time when a proliferation of bureaucratic risk technologies, financialised crisis, and industrial action are shaping the experiences of midwives. It is guided by a series of key research questions:

1. What are the institutional politics of midwifery work in Iceland?
2. What new forms of risk governance are emerging in Icelandic maternal health services, and why?
3. How do routines of risk management shape the work practices and professional identities of midwives?
4. How are the everyday politics of midwifery work affected by post-2008 economic instability, and how are midwives negotiating this change?

Although financialised crisis and institutionalised birth has impacted upon maternal health services and women's lives across a range of industrialised contexts, Iceland exemplifies a stark trend that is taking muted form elsewhere. A proliferation of risk governance technologies, alongside work-place and practice instabilities stemming from a post-crisis economy, are entangled in Icelandic maternity care. This is occurring alongside popular assumptions of economic well-being and a well-functioning welfare state, refracted through reports on Iceland's economic recovery, its reputation for excellent maternal health rankings (World Economic Forum 2014), and on its well resourced, equitable and fair health care system (Pálsson and Durrenberger 2015). There is a lack of anthropological attention to how midwives navigate their role as workers, and this project will provide a timely and necessary portrait of how women cope through varying intersections of 'crisis' and of risk (Muehlebach 2013).

The project is divided into four stages:

Stage 1. February - April 2016: entering the field

I will establish myself in the municipality of Reykjavik, register at the University, visit the Landspítali Hospital and begin establishing key contacts within the University community and among student midwives. I will enrol on an Icelandic language course through the University of Iceland. I will also use local library and archival resource to research and historicise Icelandic midwifery practice.

Stage 2. May – July 2016: establishing relationships

During this second phase of research, I will be focused on identifying key research participants within different 'categories' of midwives I have met, as detailed above. I will commence participant observation at Landspítali Hospital and at the IMA office.

Stage 3. August – November 2016: focused data collection

I will use interview and focus-group methods to hone in on my key research questions, and those issues that will have emerged from the previous months of exposure to the field. This will involve midwifery students who are new to midwifery training and predominantly classroom-based; more experienced midwifery students on clinical placement; midwifery faculty at the University; practicing midwives; retired midwives; IMA staff; and union officials.

Stage 4. December 2016 – February 2017: data consolidation

I will consolidate the data I have gathered and address any 'missing' areas.

Ethical Review Form Section A (ER/REJA20/2) (cont.)

Ethical Review Form Section A (ER/REJA20/2)	
Question	Response
>> Checklist	
A1. Will your study involve participants who are currently or potentially vulnerable or unable to give informed consent or in a dependent position (e.g. people under 18, people with learning difficulties, over-researched groups or people in care facilities)?	No
A2. Will participants be required to take part in the study without their consent or knowledge at the time (e.g. covert observation of people in non-public places), and / or will deception of any sort be used? Please refer to the British Psychological Society Code of Ethics and Conduct (or similar guidelines) for further information.	No
A3. Will it be possible to link personal data back to individual participants in any way (this does not include identifying participants from signed consent forms or identity encryption spreadsheets that are stored securely separate from research data).	No
A4. Might the study induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks likely to be encountered in the everyday life of the participants?	No
A5. Will the study involve discussion of sensitive topics (e.g. sexual activity, drug use, ethnicity, political behaviour, potentially illegal activities)?	No
A6. Will any drugs, placebos or other substances (such as food substances or vitamins) be administered as part of this study and will any invasive or potentially harmful procedures of any kind will be used?	No
A7. Will your project involve working with any substances and / or equipment which may be considered hazardous?	No
A9. Will financial inducements (other than reasonable expenses, compensation for time or a lottery / draw ticket) be offered to participants?	No
>> Risk Assessment	
A10. If you have answered Yes to ANY of the above questions, your application may be considered as HIGH risk. If, however you wish to make a case that your application should be considered as LOW risk please enter the reasons here. Researchers should note that SREOs or C-RECs may decide NOT to agree with the case that you have made.	

Ethical Review Form Section B (ER/REJA20/2) (cont.)

Ethical Review Form Section B (ER/REJA20/2)	
Question	Response
>> Data Collection and Analysis (Please provide full details)	
B1. PARTICIPANTS: How many people do you envisage will participate, who are they, and how will they be selected?	<p>Between 20-40 primary participants will be recruited to this project. The primary group of participants will be midwives: either practicing midwives currently in employment, student midwives in training, and retired midwives who have a history of clinical practice. These participants will be female, and between 21-70 years of age. The group of practicing midwives may further be divided into subcategories of hospital midwives, community midwives, and midwifery lecturers.</p> <p>Secondary participants will include auxiliary healthcare staff such as maternity support workers, obstetric team members, paediatric nurses, and non-clinical hospital or office staff such as ward clerks, administrators, union representatives, managers and cleaners. These participants will be part of the day-to-day social world of the research locations I will be based in, and I expect to involve between 10-20 participants from this group in the study. This group will be a mix of genders and between 21-65 years of age.</p> <p>All participants be selected via opportunistic and snow-ball sampling, depending on their availability and presence within the locations described below. I expect some participants to self-select on being introduced to the research, and I expect some will introduce other potential participants within their social fields to the study.</p> <p>This balance of participants, including numbers, gender, age-range and occupational identity, is in keeping with the aims of this research project, the scope and limits of the research, and will provide a manageable and fair participant base from which to conduct my study.</p>

Ethical Review Form Section B (ER/REJA20/2) (cont.)

<p>B2. RECRUITMENT: How will participants be approached and recruited?</p>	<p>Participants will be approached and recruited in the following ways:</p> <p>a) via myself, in person within the locations described below, using participant information sheets, providing contact details, and allowing potential participants a minimum of 24 hours to decide if they wish to consent to participating.</p> <p>b) via email sent from my official university email address (r.e.j.ashley@sussex.ac.uk).</p> <p>c) via information posters and sheets displayed in the locations described.</p> <p>Please see the documents attached for examples of recruitment literature to be used.</p>
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Ethical Review Form Section B (ER/REJA20/2) (cont.)

<p>B3. METHOD: What research method(s) do you plan to use; e.g. interview, questionnaire/self-completion questionnaire, field observation, audio/audio-visual recording?</p>	<p>This research study will be an ethnography and will predominantly involve the qualitative methods of participant observation, interview, and focus-group discussion.</p> <p>Participant observation will involve both primary and secondary participants. Primary participants will be shadowed by myself within the locations described; much like the relationship between an experienced midwife and a new trainee - a circumstance all midwives and trainees will be familiar with due to the nature of midwifery training and education. These will be workplaces, such as clinical ward areas, clinical offices, stock rooms and reception desks. I will be a participant observer in so far as I will be present (only ever when appropriate) within the midwifery workplaces described, and will observe the work that midwives do there. I will not conduct any midwifery work myself, and will not have any clinical role or responsibilities. I will make this clear in recruitment literature, and will verbally explain my role when present in research locations. I will also ensure I am wearing clear identification. I may take handwritten notes during participant observation, but only when this is appropriate to the situation, and with the permission of those present. Data will for the main part be recorded in my own time, separate to the fieldsite and participants - for example, at the end of a shift when I have left the research location, I will write up my fieldnotes on a password-protected laptop.</p> <p>Semi-structured interviews will be conducted among primary participants. With consent, these may be recorded and transcribed. I expect these interviews to take place in a comfortable, private place, such as a room or office. Interviews will last between 15 mins and 1 hour.</p> <p>Focus-group discussions will be conducted with primary participants, including trainee midwives. These will take place in an available institutional setting, such as a seminar room or office at the University of Iceland. These discussions will be used to explore specific issues or questions at a later stage of the fieldwork, and will be recorded and transcribed with consent of those participating.</p> <p>The data accumulated through these methods will be stored safely and securely as outlined below. Data available through transcriptions of interviews and discussions will be coded and thematic analysis used to identify key themes within the data.</p>
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Ethical Review Form Section B (ER/REJA20/2) (cont.)

<p>B4. LOCATION: Where will the project be carried out e.g. public place, in researcher's office, in private office at organisation?</p>	<p>Three main locations form the setting for this fieldwork.</p> <p>1 - The Landspítali University Hospital, Reykjavik. This institutional environment includes clinical and non-clinical spaces. Spaces I expect to conduct participant observation within include: corridors, stairwells, medical wards, offices, storerooms, reception areas, the immediate hospital grounds. Tertiary clinics associated with the Landspítali Hospital will be accessed, and these are standalone facilities comprising a main reception area, storage rooms, and clinical consultation rooms. Some parts of this location will be accessible by the public - for example, waiting areas and reception areas; some will be accessible by staff and those admitted as inpatients, such as wards, corridors; finally some parts of the hospital will be limited to staff and students only, such as offices and storage areas for medical equipment.</p> <p>2 - The University of Iceland. Within this institution I expect to be located within the Department of Anthropology, and the Faculty of Nursing and Midwifery. Research conducted here will involve locations such as classrooms, lecture halls, corridors and offices. I expect to share a office with other PhD researchers within this location.</p> <p>3 - The Association of Icelandic Midwives offices - this is a small, office-based facility, accessible to visitors but operating as an independent organisation.</p> <p>Finally, I expect my research, through the method of participant observation, may extend to public areas such as pathways or roads, and private dwellings, such as rooms inside participants' homes.</p> <p>Due care and attention will be paid to conducting myself safely and appropriately within all of the locations described above. As an trained midwife with clinical experience, I am confident I will be able to conduct myself in a safe and responsible manner, ensuring the wellbeing of participants and myself is central to my research activities.</p>
>> Confidentiality and Anonymity	
B5. Will questionnaires be completed anonymously and returned indirectly?	Yes
B6. Will data only be identifiable by a unique identifier (e.g. code/pseudonym)?	Yes
B7. Will lists of identity numbers or pseudonyms linked to names and/or addresses be stored securely and separately from the research data?	Yes
B8. Will all place names and institutions which could lead to the identification of individuals or organisations be changed?	No

Ethical Review Form Section B (ER/REJA20/2) (cont.)

B9. Will all personal information gathered be treated in strict confidence and never disclosed to any third parties?	Yes
B10. Can you confirm that your research records will be held in accordance with the data protection guidelines? (http://www.sussex.ac.uk/ogs/policies/information/dpa)	Yes
B11. Can you confirm that you will not use the research data for any purpose other than that which consent is given?	Yes
B11a. If you answered NO to any of the above (or think more information could be useful to the reviewer) please explain here:	<p>B8. As one of only two public, university-teaching hospitals in Iceland, it will be difficult to anonymise the hospital in which this research will partly take place - changing the name of this hospital will not prevent it from being identifiable to an audience with some geographic knowledge of the area or knowledge of maternity and healthcare service in Iceland. However, with consent of this clinical institution I will anonymise it as far as possible. I am currently seeking research clearance from this institution, in partnership with the University of Iceland, so as to ensure I obtain local and organisational ethical clearance for the use of these institutions within the study.</p> <p>I will make it clear to all research participants that the institutions involved may appear in reports, the project thesis, and subsequent publications, and that although the identity of individual participants will be protected and anonymised through the use of pseudonyms and data coding, the place-name in which the research takes place will remain identifiable. I will include this information on information sheets to be circulated to potential participants, as well as informing them verbally.</p> <p>I will make it clear to participants that all research data will be stored securely on a password-protected laptop, and data will be coded to ensure it is not traceable to individual persons. Data will be gathered, stored and used in full accordance with the data protection guidance accessed on the University of Sussex research governance website, the Data Protection Act (1998), and with local Icelandic data protection regulations accessed via the National Bioethics Committee of Iceland.</p>
>> Informed Consent and Recruitment of Participants	
B12. Will all respondents be given an Information Sheet and be given adequate time to read it before being asked to agree to participate?	Yes
B13. Will all participants taking part in an interview, focus group, observation (or other activity which is not questionnaire based) be asked to sign a consent form? If you are obtaining consent another way, please explain under 15a below.	No
B14. Will all participants self-completing a questionnaire be informed that returning the completed questionnaire implies consent to participate?	Yes

Ethical Review Form Section B (ER/REJA20/2) (cont.)

B15. Will all respondents be told that they can withdraw at any time, ask for their data to be destroyed and/or removed from the project until it is no longer practical to do so?	Yes
B15a. If you answered NO to any of the above (or think more information could be useful to the reviewer) please explain here:	<p>B13. Though information sheets will be provided to all participants, it may not be practical for all participants to sign a consent form - due the nature of the hospital environment, the time constraints of those working in it, the swift movement of people. However, I will ensure I obtain verbal consent from all participants, by always introducing myself in the context of my research project, asking for consent to participate, as well as informing all participants of their right to be excluded or withdraw from the project at any time. I will respect verbal consent equally to written consent, as well as treating verbal and written withdrawals equally.</p> <p>As identified above, all research participants will be given a paper or electronic copy of the research information sheet, and allowed a minimum of 24 hours before consenting to participate.</p>
>> Context	
B16. Is DBS (Disclosure and Barring Service) clearance necessary for this project? If yes, please ensure you complete the next question.	Yes
B17. Are any other ethical clearances or permissions (internal or external) required? Please see the help text (i) for further details	Yes
B17a. If yes, please give further details including the name and address of the organisation. If other ethical approval has already been received please attach evidence of approval, otherwise you will need to supply it when ready. (You do not need to provide evidence of a current DBS check at this point)	<p>I am seeking ethical approval from:</p> <ul style="list-style-type: none"> - The National Bioethics Committee of Iceland: http://www.vsn.is/en - The University of Iceland: http://english.hi.is/ - The Landspítali University Hospital in Reykjavik: http://www.landspitali.is/ <p>I will supply evidence of this when completed and available.</p> <p>Due to the nature of the research taking place, in part, within a public clinical institution, I have obtained recent UK CRB clearance (valid November 2015).</p>
B18. Does the research involve any fieldwork - Overseas or in the UK?	Yes
B18a. If yes, where will the fieldwork take place?	Reykjavik, Capital Region, Iceland. Including the primary locations listed above - the University of Iceland, the Landspítali University hospital an associated clinical areas, and the offices of the Icelandic Midwives Association.
B19. Will any researchers be in a lone working situation?	Yes

Ethical Review Form Section B (ER/REJA20/2) (cont.)

<p>B19a. If yes, briefly describe the location, time of day and duration of lone working. What precautionary measures will be taken to ensure safety of the researcher(s)?</p>	<p>I expect to occasionally be in a lone working situation while on campus at the University of Iceland, as there are likely to be times when I am the only person present in the shared office. This would be during the daytime or early evening, and would be for a period of 4-6 hours maximum. In order to ensure researcher safety, I will familiarise myself with local security and firesafety policies/protocols when I arrive at this research site. I will make sure I understand how to leave the building quickly and safely, if necessary. I will ensure I have necessary contact numbers (for security staff, emergency services) stored on my phone.</p>
<p>>> Any further concerns</p>	
<p>B20. Are there any other ethical considerations relating to your project which have not been covered above?</p>	<p>Yes</p>

Ethical Review Form Section B (ER/REJA20/2) (cont.)

<p>B20a. If yes, please explain:</p>	<p>In addition to the above I would like to clarify that I am a registered midwife in the UK, and governed by the Nursing and Midwifery Council (NMC), through which my registration and licence is held. I will not be practicing as a midwife while on fieldwork in Iceland - not only does my licence to practice midwifery not extend to Iceland, it would be unethical for me to complicate my identity as a researcher by working or practicing as a midwife while conducting fieldwork.</p> <p>The maintenance of clear boundaries between practitioner and ethnographer will be crucial during this project: I will conduct myself in a manner so as to make clear that I am positioned as a participant-observer within both clinical and non-clinical settings. This will involve disclosure to both staff and members of the public who may be accessing clinical spaces as patients of my role as a researcher, and the scope of my project, and seeking informed consent as detailed above. The way I conduct myself within all settings will be necessary to ensure that I do not assume any right to research others (ASA 2011), and this includes sensitive composure such as understanding when my presence may be unwanted, when it is appropriate to be silent, and tact towards clinical and work scenarios that may be intimate, difficult and emotional for those involved. Though managing my research presence in this way will draw on my extensive experience of work as a midwife, and in how I will bring this embodied understanding to the field, I will enter the field as a researcher, and will maintain this as my principal identity throughout. This is in accordance with my professional affiliations to the Nursing and Midwifery Council (NMC), and my adherence to the NMC code of practice (Nursing and Midwifery Council 2015) as a registered midwife, as well as to ASA ethical guidance (ASA 2011) as an anthropologist.</p> <p>I have consulted the Kings College London guidance paper 'Research in the Workplace'; I can confirm that I will not be conducting research among anyone who knows me within my professional role as a midwife, and that I have never conducted midwifery work within the research locations I will be accessing.</p>
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Appendix 2: Ethical review approval letter, Landspítali University Hospital



Jónína Einarsdóttir
Háskóli Íslands – Gimli
101 Reykjavík

Reykjavík, 1. nóvember 2016

Varðar: Erindi nr. 10/2016 til siðanefnda stjórnsýslurannsóknna á LSH

„Vettvangsathugun á starfi ljósmæðra á Íslandi: skilningur á skrifræði, áhættu og efnahagshruninu“.

Siðanefnd stjórnsýslurannsóknna hefur fjallað um innsendar viðbótarupplýsingar þínar og svara þær að fullu fyrirvara nefndarinnar frá 4. október sl.

Endanlegt samþykki siðanefndar stjórnsýslurannsóknna fyrir ofangreinda rannsókn er hér með veitt.

Siðanefnd stjórnsýslurannsóknna óskar eftir því fyrir hönd LSH að fá rafrænt eintak af niðurstöðum úr rannsókninni að henni lokinni.

Gangi þér vel við rannsóknarstörfin

Virðingarfyllst fyrir hönd siðanefndar stjórnsýslurannsóknna,

Þorvarður Jón Löve, formaður