TRUST AND TRANSFORMATION: WOMEN’S EXPERIENCES CHOOSING MIDWIFERY AND HOME BIRTH IN ONTARIO, CANADA

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts
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Abstract

Using a critical feminist approach, and with attention to participants’ broad life experiences, this qualitative study explores seven women’s challenging, transformative decisions to give birth at home with midwives in Ontario, Canada. To make this choice, the women had to draw on their own strength, take responsibility for their decisions, and resist the dominant view of birth as inherently risky, and of women’s birth experiences as unimportant and incompatible with more narrowly defined good outcomes. As participants became informed decision-makers, resisted medicalized birth, and envisioned more woman-centred possibilities, they were empowered as active agents in their births. They were able to trust that with the care of their midwives, and the support of their partners or close family, they could have satisfying and safe births at home.
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PREFACE

The point isn’t home birth....The point is that you are informed about it—your choices. The point is that you are a part of the decision-making...that you...are actively engaged with the process, and that you are listened to and respected...The details are going to be different for every [birth] story but...what matters was how you were treated and...it’s not like there was all this stuff happening to you...you were an active part of it...And that’s part of the philosophy of midwifery care...all the different choices are presented to you as choices. [Natalie, mother of one]

Using a critical feminist approach, and with attention to participants’ broad life experiences, this qualitative study examines Ontario women’s experiences of choosing to give birth at home with midwives.¹

¹ Unless otherwise stated, I use the term midwife to refer to primary care providers for childbearing women and their newborns, and who in Ontario are regulated under the Midwifery Act, and are referred to as Registered Midwives (RMs). In the context of this study, midwives also refer to traditional Aboriginal midwives who may practice under an exemption clause in the Midwifery Act. I use home birth as shorthand for midwife-attended planned home birth. The qualifiers planned and midwife-attended differentiate between unintended out-of-hospital births (e.g., precipitous births) and home births without a health care provider present. Unintended and unassisted home births are outside the scope of my study.
Chapter 1: Introduction

Childbirth in Ontario: The Personal is Political

Women experience childbirth against a backdrop of personal, social, and political realities. Until several generations ago, most women in Canada gave birth in their homes attended by a care provider from their own community, whether a midwife, family physician, community elder, or family member (Biggs, 2004; National Aboriginal Health Organization (NAHO), 2008). Childbirth occurred amidst the events of everyday family life, and knowledge about pregnancy and birth was primarily the domain of women (Biggs, 2004; MacDonald, 2004; NAHO, 2008). Over the last century, the dominant conception of childbirth as a family or community event has been overshadowed by a new orthodoxy: a view of pregnancy and birth as a medical condition. As such, childbirth has been increasingly shaped by medical priorities, concepts, concerns, language, rituals, technology, and spaces (e.g., hospitals, clinics) (Declercq, DeVries, Viisainen, Salvesen, & Wrede, 2001). This medicalization of childbirth is evident in present day Ontario where almost 98 per cent of women give birth in hospitals, and four out of five are attended by specialist physicians, sometimes those they have not met before giving birth (Birth Outcomes Registry Network (BORN) Ontario, March 2013; Discharge Abstract

2 The practice of midwifery, including midwives’ responsibilities, training, status, and relationships with their communities and other care providers has varied greatly across Canada, and over time. Different ethnic and cultural communities each name and conceptualize this role of childbirth attendant. The term midwife is Anglo-Saxon (mid wif) in origin and means “with woman” (Biggs, 2004; Benoit, Carroll, Eni, 2006; Hawkins & Knox, 2003, p.1; MacDonald, 2004).

3 The medicalization of childbirth occurred differently across communities and cultures in Canada (see Biggs, 2004 for further historical outline).
Database (DAD), Canadian Institute for Health Information (CIHI), 2013). Close to one in three women in Ontario give birth via caesarean section—major surgery—a proportion that has increased considerably over the last decades, while the rate of vaginal birth after caesarean (VBAC) has declined and currently accounts for less than three per cent of all births (DAD, CIHI, 2013; CIHI, 2004; Public Health Agency of Canada (PHAC), 2008). Many medical interventions and tests are common, if not routine elements of “modern” maternity care in Ontario, and elsewhere in Canada (CIHI, 2004; PHAC, 2009).

I contrast these current and earlier practices to draw attention to the profound changes that have occurred over a relatively short period of time, and to highlight that in addition to being biological processes, pregnancy and birth are social constructions. The “normal” conditions for giving birth are influenced by cultural beliefs, values, and expectations. As such, women’s childbirth choices must be examined in their cultural context.

Although physician-led care for childbearing women is the norm in Ontario, since the integration of midwifery into the health care system about two decades ago, the proportion of women receiving primary care from midwives has increased, from one per cent in 1994, to 12 per cent in 2012 (Ontario Midwifery Program (OMP), Ministry of Health and Long-Term Care (MOHLTC), 2012; BORN, 2013). This is likely, in part, the result of the increasing number of practicing midwives, from approximately 60 in 1994 to almost 700 in 2013; public funding for midwifery services; and access to hospital births for midwives (prior to regulation midwives practiced as unregulated caregivers and

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4 Midwifery utilization data in this study have been drawn from two different sources: the Ontario Midwifery Program (OMP), Ministry of Health and Long-Term Care (MOHLTC) for fiscal years 1994/95 to 2005/06, and the Better Outcomes Registry Network (BORN), from 2006/07 to 2012/13. As a result, there may be minor inconsistencies between data captured in each source.
attended home births only). It should be noted that if the “supply” of midwives met “consumer demand,” midwifery utilization rates would likely be higher. Currently, 40 per cent of women who seek midwifery care cannot be accommodated because there are too few practicing midwives (AOM, n. d.).

Approximately 80 per cent of midwifery clients give birth in hospitals; 20 per cent give birth at home (BORN, 2013). Planned home births attended by Registered Midwives (RMs) have increased from 0.5 per cent of all Ontario births in 1994 (approximately 700 births) to just over two per cent in 2012 (approximately 3,200 births) (OMP, MOHLTC, 2012; BORN, 2013). These statistics demonstrate that despite an increase in home birth rates, this practice remains uncommon. In Ontario, and elsewhere in Canada and many other moderate- and well-resourced countries, home birth is widely perceived to be dangerous—or more risky than hospital birth—and there is a strong cultural expectation that women give birth in a hospital. Physician management of perinatal care for low-risk pregnancies is also the norm in Ontario and the rest of Canada. It would be difficult, if not impossible, for a woman considering out-of-hospital birth in Ontario to be unaware of these norms and expectations, and my research findings will show, for some women, these are at the crux of their decisions.

This research project was driven by my curiosity about how and why, despite great cultural pressure to have a hospital birth, some women choose to give birth at home in the care of midwives. I began this research with parallel interest in these related but

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5 Although raw numbers of midwife-attended home births have been included so that readers may envision what the stated percentages represent in terms of actual births, these raw numbers do not take into account population growth over time.

6 Awareness of this cultural expectation of hospital-based, physician-led birth is also likely among women who immigrate to Ontario from cultures where home birth is more common.
potentially separate decisions: choice of care provider and choice of birthplace. However, I soon found that the decision to give birth at home was much more complex and challenging for the women I interviewed and therefore required a deeper exploration. While this study does look closely at women’s decisions to seek midwifery care, especially since the women I spoke with emphasized that having woman-centred midwifery care was their priority regardless of where they gave birth, I do so because for almost all of the women, this choice of care provider was a critical prerequisite for their much more difficult decision to give birth at home.

The decision to give birth at home is a private, personal decision that for many women is not politically motivated (Murray-Davis, McNiven, McDonald, Malott, Elarar, Hutton, 2012). However, from a critical feminist perspective such a decision is always politically significant because it requires that women resist the normative medicalized view of childbirth, which tends to restrict women’s control over their pregnancies and births and devalues their childbirth knowledge and experiences. In this study, participants’ decisions to plan midwife-attended home births are understood not only as a way of having more woman- and family-centred births, but also as part of a broader political struggle for women’s reproductive autonomy and human rights.

**Study Rationale**

It can be difficult for women to find current, accurate, and relevant information about midwifery, and especially about home birth. As my research findings will show, even in a context such as Ontario, where midwifery and home birth are integrated into the public health care system, there is a great deal of misinformation and conflicting perspectives. Childbearing women (and the public in general) are likely to be exposed to
outdated or inaccurate depictions of midwifery and home birth in mainstream media and childbirth advice books, and are unlikely to have access to first-hand experiences from friends and family (Kennedy, Nardini, McLeod-Waldo, & Ennis, 2009; Klein et al., 2006; MacDonald, 2004; Pincus, 2000). Also, medical care providers (obstetricians, family physicians, nurses) on whom women may rely for advice, may be unable to provide balanced information because they do not attend home births, may only be exposed to home-to-hospital transfers, and may be increasingly unfamiliar with low-intervention birth in general (Dahlen, 2010; Davidson, 1997; Klein et al., 2006; Kornelson & Carty, 2004; Liva, Hall, Klein, & Wong, 2012).

Because of practical and attitudinal barriers to informed decision-making, and because there are relatively few midwife-attended home births in Ontario, there is a need for research that sheds light on women’s decision-making experiences in this particular cultural context (Murray-Davis et al., 2012). My study contributes to these efforts by presenting insights from seven women in Ontario who recently planned to give birth at home in the care of midwives. Knowledge about women’s experiences may contribute to a greater understanding of midwife-attended home birth and may empower childbearing women and others to think critically about the various choices offered (or not offered) in the models of maternity care available in Ontario.

In addition, my study may support midwives as they promote informed decision-making among their clients and (see Appendix A: Advice for Women and Midwives to Support Informed Decision-Making) (Murray-Davis et al., 2012). Although the number and percentage of home births has increased over the last two decades in Ontario, home births as a proportion of all midwife-attended births have declined, from 39 per cent in
1994/95 to 19 per cent in 2012/13 (OMP, MOHLTC, 2012; BORN, 2013). If this trend continues, midwives may not be able to meet the College of Midwives of Ontario’s (CMO) requirement that home births make up at least 16.7 per cent of their caseload to remain registered (Sharpe & Gold, 2011). Mary Sharpe and Leah Gold (2011) have found that Ontario midwives are concerned about this decline, particularly the potential de-skilling of midwives, the erosion of informed choice for women, and the impact on clients’ perceptions of birth as a healthy, normal process. Sharpe and Gold have found that midwives perceive this decline to be related to several factors, including midwives’ increased scope of practice since regulation; shifting midwifery culture; midwifery practice protocols becoming increasingly conservative; hospital protocols and culture; and changes in midwifery clientele (Sharpe & Gold, 2011). They have also observed that midwives have mixed feelings about the seriousness of this trend, and whether and in what ways it ought to be addressed at practice, professional, policy, or public education levels (Sharpe & Gold, 2011).

Home birth has been described as a “political symbol” and “cornerstone” of the informed choice model of midwifery in Ontario (MacDonald, 2007, p. 71; Sharpe & Gold, 2011, p. 6; Shroff, 1997, p. 20). This is, in part, because it is the site where midwifery principles of women-centred birth may be most readily and fully achieved (James, 2011; Sharpe & Gold, 2011). Ensuring that women continue to have a choice of birthplace depends on midwifery client demand. It also requires that midwives fully support this choice and recognize some of the unique benefits it may afford women and their families. (James, 2011; Sharpe & Gold, 2011).
Midwifery and Home Birth in Ontario

*Historical Overview*

Midwifery and the practice of home birth has existed, declined, remained, and re-emerged differently among the many communities and cultures in Ontario and the rest of Canada, and as such, cannot be summarized with a single universal narrative (Biggs, 2004; MacDonald, 2004). A detailed history is outside the scope of this thesis; however, a number of Canadian scholars provide thorough and nuanced accounts (Biggs, 2004; Benoit, Carroll, & Eni, 2006; Bourgeault, 2006; Burtch, 1994; Cook, 1993; NAHO, 2008; MacDonald, 2007; Nestel, 2006; Sharpe, 2004; Van Wagner, 2004).

Regulated professionalized midwifery in Ontario emerged from a broader social movement beginning in the 1970s and 1980s among childbearing women in North America and elsewhere in the West who were dissatisfied with mainstream obstetric care and hospital practices (Arms, 1977; Barrington, 1985; Bourgeault, 2006; Burton & Ariss, 2009; Daviss, 2000; Sharpe, 2004; Van Wagner, 2004). Researchers, medical care providers, and childbirth educators and activists who were critical of the obstetric system for its lack of evidence-based practice and its provider-centredness also contributed to this movement (Bourgeault, 2006; Burton & Ariss, 2009; Daviss, 2000; Ehrenreich & English, 1973/2010; Oakley, 1984; O’Brien, 1981; Van Wagner, 2004). In Ontario, childbearing women who wanted demedicalized and more woman-centred childbirth sought perinatal care from a small number of community-based midwives (Bourgeault, 2006; Sharpe, 2004; Van Wagner, 2004). Although they are sometimes referred to as *lay* midwives in the literature, this is in misnomer, since these midwives had gained relevant knowledge, skills, and credentials through various education backgrounds (e.g., nursing, apprenticeship, midwifery education abroad) (Benoit & Davis-Floyd, 2004).
Clients paid for midwifery services out-of-pocket, often on a sliding scale based on what they could afford (Van Wagner, 2004). Because midwives were not recognized as primary care providers in the health care system, midwifery clients also typically had physician involvement in their care (e.g., provide other prenatal visits) (Bourgeault, 2006). In instances when a labouring woman or newborn transferred to a hospital, midwives sometimes served as labour support persons (Sharpe, 2004; Van Wagner, 2004). Some midwives had collaborative relationships with supportive physicians who might provide back-up at home births, order diagnostic tests, prescribe medications, or consult as needed (Sharpe, 2004). However, with no formal policies supporting midwifery, and the history of antagonism by the medical professional toward midwifery in North America (discussed further in Chapter 2 and 4), midwives and their clients often encountered disapproval and hostility from physicians (Bourgeault, 2006). In 1982, the College of Physicians and Surgeons of Ontario (CPSO) discouraged its few members who attended home births from doing so, and the following year issued a formal position statement against home birth practice (Bourgeault, 2006). After this point, midwives, with few exceptions, became the only caregivers attending home births (Bourgeault, 2006).

In 1991, following years of activism, regulatory review, and consultations, midwifery was regulated through the Midwifery Act, and over the next few years, integrated into the health care system (Bourgeault, 2006). A formal baccalaureate degree program was developed at three Ontario universities; a self-regulating college was

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7 In 2001, the CPSO rescinded its position against home birth. It does not currently have a published position on home birth (Ontario Hospital Association, 2006).
established; funding for midwifery services was secured through the Ministry of Health and Long-Term Care (MOHLTC); professional liability insurance for midwives was obtained; and hospital privileges for midwives were negotiated.⁸,⁹ Although integration into the health care system was a significant milestone in the struggle for midwifery in Ontario, it is seen as part of an ongoing social movement toward woman- and family-centred health care (Burton & Ariss, 2009). Ensuring pay equity for midwives and accessible, culturally appropriate midwifery care for diverse women, especially Aboriginal women, are among the many important priorities of the movement as it continues (AOM, 2013; AOM, 2012; Couchie & Nabigon, 1997; Ford & Van Wagner, 2004; National Aboriginal Council of Midwives (NACM), n. d.; Van Wagner, 2004).

The Midwifery Model of Care in Ontario

According to Ontario’s Midwifery Act, “the practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies” (Midwifery Act, 1991, p. 1). Women self-refer to midwifery care and are typically cared for by the same two to four midwives from early in pregnancy until six weeks post-partum. Registered midwives are accountable to the CMO, while Aboriginal midwives who choose to practice outside of the regulated framework, are accountable to their communities (CMO, 1994; Midwifery Act, 1991). With few

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⁸ The Ontario Midwifery Program is offered through a consortium of Laurentian University, McMaster University, and Ryerson University. A certification program for internationally trained midwives is offered through Ryerson University.

⁹ Hospital privileges are negotiated between hospitals and midwifery practices. Midwives’ scope of practice varies by hospital. Not every hospital in Ontario has midwives with privileges at it. Some midwifery practices have encountered challenges or opposition when seeking hospital privileges. Some experience collaborative relationships, and midwives are included in decision-making and interprofessional opportunities.
exceptions, Aboriginal midwives do not receive government funding for their services (Couchie, 1997; Six Nations Health Services, n. d.).

Choice of birthplace, along with informed choice and continuity of care, are the three central tenets of the Ontario midwifery philosophy (AOM, n. d., CMO, n. d.). Midwifery clients may choose to give birth at home and in a hospital, and sometimes in other locations, such as a midwifery clinic (M. Sharpe, personal communication, March, 29, 2012). With government funding for two midwife-led birth centres (one in Ottawa and one in Toronto) announced in 2012, some women will soon have access to an additional possible birthplace (Government of Ontario, 2012). At the time of writing, a single birth centre, *Tsi Non:We Ionnakeratstha Ona:Grahsta* (The Place They Will Be Born, A Birthing Place), exists and serves the Six Nations of the Grand River Territory in southwestern Ontario (Six Nations Health Services, n. d.). In a survey of midwifery clients in Ottawa and Toronto, Judy Rogers and Ayeshah Haque (2012a, 2012b) found that while 64 per cent of respondents in Ottawa and 62 per cent of respondents in Toronto were currently planning hospital births and 26 per cent (Ottawa) and 28 per cent (Toronto) were planning home births (the remainder were undecided), 40 per cent (Ottawa) and 45 per cent (Toronto) would choose a birth centre for their present birth if it was available (Rogers & Haque, 2012a, p. 5, 6; 2012b, p. 5, 6). This suggests that out-of-hospital birth is of interest to a considerable proportion of clients, regardless of whether they are currently planning home or hospital births.

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10 The Six Nations Birthing Centre (*Tsi Non:We Ionnakeratstha Ona:Grahsta*) is funded by the Government of Ontario’s Aboriginal Healing and Wellness Strategy, a joint initiative of five government ministries (Ministry of Community and Social Services, n. d.)
Approximately 25 per cent of midwifery clients plan home births, of which three quarters ultimately occur at home (remaining 25 per cent involve hospital transfers) (AOM, n. d.). Most (97 per cent) hospital transfers are non-urgent and typically occur because of prolonged/arrested labour, a request for pharmacological pain relief, maternal fatigue, or newborn instability after birth (Darling & Gagnon, 2013; Sharpe, personal communication, March 29, 2012). Hospital backup for transfers are understood to be part of good clinical care (AOM, n. d.). Midwives are also prepared to respond to complications at home. They are trained in emergency skills, carry health care equipment and drugs (e.g., for maternal and neonatal resuscitation, to control bleeding, sterile instruments) and monitor the woman and fetus to anticipate potential reasons for transfer (AOM, n. d.). In some scenarios midwives provide primary care after a transfer to hospital; in others they may consult with or transfer care to specialists (e.g., obstetrician, paediatrician).

Midwives believe that a woman should be knowledgeable about the advantages and disadvantages of all birth settings available to her as part of making an informed choice of birthplace (CMO, n. d.). Choice of birthplace is facilitated differently among midwifery practices. For instance, some midwives may view this decision as a fluid one, and may keep the choice open to their clients up to and into labour. Others may prefer that clients decide by a certain point during pregnancy (Sharpe, personal communication, March 29, 2012). It is possible that varying practice- and/or practitioner-level approaches may play a role in women’s decision-making.
Chapter 2: Literature

The Medical Model of Childbirth and its Implications for Childbearing Women

Many scholars have examined the social construction of childbirth as a medical condition, and considered the impact on women (Arms, 1977; Cheyney, 2008; Daviss, 2001; Davis-Floyd, 1992; Declercq et al., 2001; DeVries et al., 2001; Ehrenreich & England, 1973/2010; Jimenez, Klein, Hivon, & Mason, 2010; Jordan, 1997; Kitzinger, 2005; Martin, 1992/2001; O’Brien, 1981; Oakley, 1984; Rothman, 1989). The framing of “birth as an illness” is fundamental to this view and rationalizes many childbirth practices, including compulsory hospital birth and the management of pregnancy by physician-specialists who are trained to focus on and treat pathology (Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Declercq et al., 2001, p. 9; Klein, Sakala, Simkin, Floyd-Davis, Rooks, Pincus, 2006). In her analysis of important obstetric texts, Emily Martin (1987/1992/2001) observes an overarching metaphor of reproduction as production, with the woman’s body envisioned as a “defective machine” and the physician as the technician who “fixes” it (p. 54). Here, the uterus (envisioned independent of the woman) works to expel the fetus; however, it is ultimately the physician with his specialized knowledge and tools, who delivers the fetus safely and efficiently from the woman (Martin, 1987/1992/2001).

Robbie Davis-Floyd (1992) and others argue that the constellation of ideas related to the dominant “technocratic” model of birth are normalized through rituals (e.g., hospital routines, doctor-patient interactions), language (e.g., referring to pregnant women as patients, and categorizing them as high-risk or low-risk), and rules (e.g., hospital policies and, medico-legal regulations) that make it difficult to recognize this
conception of birth is only one of many possible social constructions of a complex human experience (p. 456). Melissa Cheyney (2008) contends that the dominant medical model informs a powerful cultural “metanarrative” about pregnancy and birth: that it is dangerous, messy, and unbearably painful, and that this encourages profound and widespread fear about childbirth that is ultimately disempowering to women (p. 256).

It is generally acknowledged that medical interventions can offer lifesaving benefits when genuine instances of pathology arise, and that obstetricians and other medical care providers may play a vital role in these instances (Klein, 2010). Where critics and supporters of the medical model tend to diverge is in their differing views about how and when these interventions ought to be used and who ought to have authority over decision-making (i.e., control over the birth process). Critics contend that some obstetric practices are overused and tend to be driven more by tradition, opinion, and provider convenience, benefit, or fear (e.g., fear of litigation) than by available evidence (Bewley, 1996; Cartwright & Thomas, 2001; Dahlen, 2010; Davis-Floyd et al., 2009; Enkin, Kerise, Nielson, Crowther, Duley, Hodnett, & Hofmeyr, 2000; Klein et al., 2006; Klein et al., 2011; Wagner, 1997).

Divergent views can often be traced to philosophical differences about childbirth, including what are deemed to be priorities in pregnancy and birth and whose knowledge counts (DeVries, 2001; Jordan, 1997). Some scholars argue that the medical model unnecessarily pathologizes what is a normally healthy state of being (pregnancy) and physiologic process (labour) (Davis-Floyd et al. 1992; Klein, 2012; 2010; Wagner, 1997). Michael Klein (2012) contends that physicians’ view of birth as an illness can be explained, to a large extent, by physician education, which “emphasizes the abnormal”
He articulates this observation in the context of obstetricians’ increasing comfort with caesarean birth as a perceived solution to what is seen as the problematic nature of vaginal birth:

When trainees do not see normal birth, but only the problems that can arise, they tend to see vaginal birth as risky and inherently dangerous to both the fetus and the mother. If the educational model were designed mainly to train a consultant who would be available when problems develop, this model would be rational and cost effective for the system. However, in most of North America, primary care obstetrician and gynecologists are fundamentally surgeons. We need surgeons. The problem is that society has turned normal birth over to surgeons (Klein, 2012, p. 308) [emphasis the author’s].

Hannah Dahlen (2010) confirms Klein’s assertion. She contends that a productive discussion about the merits and drawbacks of any childbirth practice must be considered with critical awareness of the participants’ beliefs and values about birth. She advises:

When people argue about the safety or benefits of home birth, episiotomy, continuous electronic fetal monitoring, elective caesarean, etc., do not argue back—ask them what their paradigm of birth is…Do we essentially fear birth or do we essentially trust birth? (Dahlen, 2010, p. 156).

As Dahlen suggests, those who are fearful of birth and see it as a medical condition, are more likely to be assured by interventions or “treatments” that may control or manage it, whereas those who “trust birth” may be more inclined to minimize interventions with the expectation that labour will unfold safely in most instances (p. 156).

Feminist and other critical scholars have observed the tendency for maternity care based on this medical paradigm to be paternalistic and fetocentric, ultimately undermining women’s control and active participation in the pregnancy and birth process. They argue that viewing the childbearing woman as an obstetric patient (sick person) and passive recipient of care, and the fetus as a product has negative implications, particularly for women. For example, Martin (1987/1992/2001) and Iris Young (1990) observe that
the dominant medicalized view of birth reduces the woman’s role to that of an incubator or “container” for the fetus, a “passive host for a contracting uterus,” and a “machine being held to certain standards of efficient work” (Martin, 1987/1992/2001, p. 61; Young, p. 191, p. 160). From this perspective, the woman’s childbearing experience is assigned a relatively low value and can be seen as a potential threat to the fetus. Vicki Van Wagner (1992) notes the tendency within medical discourses to default to “a stereotyped image of the selfish woman seeking comfort over safety” (p. 117). Melissa Cheyney (2008) confirms this view, arguing that women who resist medicalized birth and choose to give birth at home inevitably face “social sanctioning” for their decisions and are perceived as violating “the social parameters of what constitutes a good mother” (Cheyney, 2008, p. 264, p. 260). Barbara Katz Rothman (1989) argues that what ultimately results from the notion of woman-as-vessel and in competition with the fetus, is a view of reproduction that commodifies children and devalues women’s experiences. She attributes this narrow, product-focused view to underlying ideologies of patriarchy and capitalism that underpin Western biomedicine and Western society in general.

**Authoritative Knowledge and Childbirth**

A consideration of knowledge and power is essential for any critical analysis of childbirth beliefs and practices. *What counts as knowledge?* and *Whose knowledge counts?* are two fundamental questions in my study, both to me as the researcher and to

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11 Illustrations of this can be found in physicians’ letters to the editors in medical journals in response to studies demonstrating the safety of midwife-attended planned home birth for low-risk pregnancies. Published letters often include alarmist imagery presumably to highlight the dangers of childbirth without medical management, and describe women, midwives, and others who support women having a choice of birthplace as misinformed, backwards, irrational, and irresponsible (see Fawcett, 2002; Seeras, 1990 for examples).
the women as they navigated their childbirth decisions. While many feminist scholars have discussed the relationship between knowledge and power in depth, Brigitte Jordan’s (1997) description of “authoritative knowledge” in the context of childbirth is particularly salient here. She contends that:

To identify a body of knowledge as authoritative speaks, for us as analysts, in no way speaks to the correctness of that knowledge. Rather, the label “authoritative” is intended to draw attention to its status within a particular social group and to the work it does in maintaining the group’s definition of morality and rationality. The power of authoritative knowledge is not that is it correct but that it counts (p. 58) [emphasis the author’s].

Jordan and other critical scholars observe that in cultures where a technocratic or medicalized view of birth dominates, the knowledge of physicians is privileged while that of childbearing women is often minimized or devalued (Browner & Press, 1997; Davis-Floyd et al., 2009; Davis-Floyd, 1992; Johnson, 1997; Jordan, 1997; Lazarus, 1997; Martin, 1987/1992/2001; Rothman, 1989). In my study and other feminist research, the implications of medicalized birth and the authoritative knowledge of Western biomedicine are examined from the standpoint of women’s everyday experiences (Davis & Sargent, 1997; Jordan, 1997; Klassen, 2001; Murray-Davis, 2006; Smith, 1991). As women make decisions, they must negotiate medically constructed dichotomies—between safety and choice, outcome and experience, and woman and baby—not because these dichotomies are necessarily “real,” but because they represent hegemonic conceptions of pregnancy and birth.

Scientific Evidence about the Safety of Planned Home Birth for Low-Risk Pregnancies

In Ontario a woman’s decision about where to give birth is framed by an ongoing, broader, and politicized debate about the relative safety of home birth versus hospital
Traditionally, the right of women to have a choice of birthplace has been promoted by midwives, women and their families advocating for choices in childbirth, and some medical care providers, researchers, and policy-makers (Burton & Ariss, 2009; Daviss, 2000; Murray-Davis et al., 2012). Opposition has primarily been from the medical profession, especially obstetrician-gynecologists, particularly in the United States, where some medical associations have been very vocal in their disapproval (Davidson, 1997; Daviss, 2000; Klein et al., 2006; Rooks, 2011).

Judith Rooks (2011) attributes the “almost visceral negative response to home births” among American obstetricians to a fear of lost status and economic rewards should another model of care prove safe, satisfying, and more cost-effective for most women (p. 65). As other scholars have pointed out, this view of midwives as “competition” has existed within the medical profession throughout modern Western history and has motivated efforts to limit or eliminate their practice (Bourgeault, 2006; Ehrenreich & English, 1973/2010; Witz, 1992). Also at play in negative or mixed feelings toward home birth may be the tendency among many obstetricians (and family physicians and nurses) to be skeptical of practices that are different than their own, especially those that challenge orthodoxies set out by their professions (e.g., compulsory hospital birth). The possibility of other providers offering care that is more patient/client-centred and safer would be likely to raise concerns among any care provider, not just physicians. Nevertheless, approaches taken by the medical profession, to deter women from out-of-hospital birth and to marginalize midwifery have contributed to many damaging myths and misconceptions, many of which persist in the present day (some of
which are discussed further in Chapter 4) (Ehrenreich & English, 1973/2010; Witz, 1992).

In moderate- and well-resourced countries, it is widely presumed that the perceived safety advantages of hospital birth over home birth have been demonstrated through “scientific evidence” (Dreger, 2012; Rooks, 2011; Rushing, 1993). Since it is on this evidentiary basis that claims against home birth and midwifery have often been made (Rushing, 1993; Ehrenreich & English, 1973/2010), it is not surprising that some of the most persuasive counter-arguments have been accomplished through the presentation of scientific evidence indicating otherwise. Beth Rushing (1993) notes that proponents of midwifery, home birth, and other “natural childbirth” practices have gained legitimacy by drawing on the same “language and logic of science” that was used to advance medicine and malign midwifery in the late nineteenth and twentieth centuries (p. 52). She contends that along with feminism, the “ideology of science” has been a “method that is well-suited for addressing the critics of midwifery because it defuses those critics’ arguments on their own terms” (p. 52).

Over the last several decades, a number of empirical quantitative studies have been conducted comparing birth outcomes in different settings (home, hospital, midwife-led birth centre, etc.). These studies are intended to determine whether planned home birth (or another out-of-hospital setting, such as a midwife-led birth centre) is as safe as

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12 Similarly, the notion that physicians provide superior care to midwives has also been presumed to be confirmed through empirical evidence.

13 Much of the literature discussing the merits and drawbacks of various maternity care practices uses terms such as science, scientific evidence, and scientific information to describe systematically collected empirical quantitative data. I tend to use empirical quantitative studies or data since these terms are more precise, but recognize that scientific evidence is often the familiar term.
hospital birth for women with low-risk pregnancies. In these studies hospital birth is typically framed as the norm against which “alternatives” are to be scrutinized, and “safety” is defined narrowly as the avoidance of maternal and perinatal mortality, and secondarily, serious morbidity (e.g., perineal trauma, hemorrhage). To date, a single randomized control trial (RCT) has been carried out comparing outcomes of home and hospital births; however, the small sample size (n=11) does not allow for generalizable results (Dowswell, Thornton, Hewison, & Lilfold, 1996). Because randomization of intended place of birth is potentially unfeasible, the possibility of a large RCT comparing birth outcomes in different settings is unlikely (De Melo-Martin & Intemann, 2012; Dowswell et al., 1996; Hendrix et al., 2009; Johnson, 1997). Kenneth Johnson (1997) asserts that while RCTs are often perceived as the “gold standard” in health research, and are of great value in evaluating some childbirth practices, a narrow focus on this type of quantitative evidence at the exclusion of other methodologies (e.g., retrospective studies, qualitative approaches) may result in the devaluation of other useful knowledge (p. 356).

Many of the studies comparing birth outcomes in various settings are prospective or retrospective, and authored by researchers who are supportive of planned out-of-hospital birth and midwifery. Those that are methodologically sound have excluded high-risk pregnancies, unplanned home births, and home births without a health care provider

14 See Vedam et al. (2011) for an annotated summary of current literature on home birth (includes quantitative and qualitative).
15 Some studies compare midwife-attended home birth with midwife-attended hospital birth (De Jonge et al., 2009; Hutton, Reitsma, & Kaufman, 2009). Some also make comparisons with outcomes of physician-attended hospital birth (e.g., Janssen et al., 2009).
present (and cases where any of these are unknown). A growing number of quantitative studies carried out in Canada and internationally demonstrate that for women with low-risk pregnancies, and where home birth is well integrated into the health care system, planned home births attended by professional midwives or other health care providers are at least as safe as comparable hospital births (de Jonge et al., 2009; Dowswell et al., 1996; Hutton, Reitsma, & Kaufman, 2009; Janssen et al., 2009b; Janssen et al., 2002; Johnson & Daviss, 2005; Olsen & Jewell, 2009; Olsen, 1997). In these studies, rates of maternal and perinatal mortality have been found to be similarly low in home and hospital births. However, planned home births attended by midwives have been shown to result in lower rates of serious maternal morbidity and medical intervention (e.g., induction/augmentation, pharmacological pain management, episiotomy, assisted vaginal delivery, caesarean section) (Janssen, et al., 2009; Hutton et al., 2009). Since many medical interventions carry their own risks, home birth may be viewed as one approach for reducing these risks.

Empirical quantitative studies comparing birth outcomes have been extremely important in establishing or defending the safety of planned home birth, not only for those advocating for women to have the right to a choice of birthplace and for evidence-based maternity care practices, but also as my research will show (see Chapter 5), for individual women as part of their informed decision-making. However, studies focusing exclusively on outcomes are limited in the sense that they cannot adequately shed light on the many possible dimensions (physical, emotional, social, spiritual, etc.) of childbirth.

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16 Several studies, which found home birth to be less safe than hospital birth, have been criticized for including possibly unplanned and unassisted home births in their samples, and for mathematical errors and other methodological flaws. See Vedam, Schummers, & Fulton (2011) for further information.
that, in addition survival of the woman and baby, may be important and meaningful to women and their families (Abel & Kearns, 1991; Bortin, Alzugaray, Dowd, & Kalman, 1994; De Melo-Martin & Intemann, 2012; Janssen, Henderson, & Vedam, 2009a; Murray-Davis, 2012). A more holistic definition of “safe” birth is needed to encompass women’s and families’ experiences. Raymond DeVries (2001) problematizes the narrow focus on outcomes that is fundamental to the medical model of birth:

“Fetal outcome” is generally the only independent variable that counts: How the mother feels about her body, her husband or partner, her family, her child, her sexuality, her self—all escape measurement, except as they might affect fetal outcome (DeVries as quoted in Rothman, 2001, p. 184).

As implied by DeVries and other scholars, a combination of empirical quantitative evidence on outcomes as well as qualitative research on women’s experiences is necessary to develop a well-rounded understanding of midwife-attended home birth.

**Women’s Satisfaction with Midwife-Attended Home Birth**

Research on women’s satisfaction with midwife-attended home birth indicates that women are, in general, pleased with their midwifery care and home births (Janssen et al., 2009a; Lindgren & Erlandsson, 2008), and when comparisons can be made, are typically more satisfied with this model of care than with other approaches (physician-led care, hospital birth) (Janssen, Carty, Reime, 2006).17 Canadian women report being very satisfied with their home birth experiences, particularly with their midwives’ knowledge and skills, the emotional support and sense of empowerment they experience, the relaxing effect of giving birth in their familiar home environment, and the satisfaction that they

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17 Results from the Canadian Maternity Experiences Survey (2011) indicate that Canadian women receiving midwifery care (both home and hospital births) were more likely to rate their care as “very positive” and to be satisfied with the information provided to them on a variety of childbirth-related topics than women with physician-led care (O’Brien, Chalmers, Fell, Heaman, Darling, Herbert, 2011).
felt from being involved in planning their births (Janssen et al., 2006; Janssen et al., 2009a).

Satisfaction literature provides insights and limitations. Studies reporting data from large samples of women may help inform policy decisions and may be a measure of health care quality. However, health care satisfaction research (not only about midwifery but any health care experience) does not typically account for individuals’ varying standards and criteria for “good” care. They may elicit a “‘what is, must be best’” phenomenon, in which individuals tend to rate the care they receive positively and perceive it to be the best possible, often because they lack comparisons or because they have been socialized to believe they are receiving the “best” care possible (Klein et al., 2006; Porter and Macintyre as quoted in DeVries, Salvesen, Wiegers, & Williams, 2001, p. 260). Also, although studies on women’s satisfaction with midwife-attended home birth may help promote an understanding of how these childbirth choices may impact women’s experiences, they provide fewer insights into the reverse: how experiences impact choices. The impact of life experiences on women’s health-related choices is precisely the focus of my study.

**Women’s Motivations for Choosing Midwife-Attended Home Birth**

There is a small but growing body of literature examining why and how women choose midwife-attended home birth from the standpoint of childbearing women. Much of this literature is qualitative and provides useful context for my study. Some of the reasons reported include: the desire for greater control, flexibility, and choice in the birth process; the assurance of having a known care provider (continuity of care); the desire to avoid medical interventions and associated risks; increased privacy, familiarity, comfort;
the ability to incorporate spiritual or cultural traditions and practices into the birth; a view of home as the place where midwifery principles can be most fully experienced; other concerns or fears about hospitals (e.g., risk of infection, previous traumatic experiences or abuse by medical providers); and practical benefits such as decreased financial costs and greater convenience and comfort for partners and other family (Abel & Kearns, 1991; Bastien, 1993; Bortin et al., 1994; Boucher, Bennett, McFarlin, & Freeze, 2009; Catling-Paull, Dahlen, Homer, 2010; Cheyney, 2008; Godfrey, 2010; James, 2011; Klassen, 2001; Kleiverda, Steen, Anderson, Treffers, & Everaerd, 1990; Lindgren & Erlandsson, 2010; Lindgren, Hildingsson, & Radestad, 2004; Madi & Crow, 2003; Moore, 2011; Morison, Percival, Hauck, McMurray, 1999; Murray-Davis et al., 2012; Soderstrom et al., 1990). Some studies provide insights into women’s home birth experiences in the context of broader explorations of woman-midwife relationships in Ontario (James, 1997; Sharpe, 2004).

In several studies, researchers observe some of the limitations of woman-centred birth in a hospital setting. Vania Jimenez and colleagues (2010) and others (James, 2011; Simonds, Rothman, Norman, 2007) observe that many of the efforts to “‘humanize’” North American hospital-based obstetric care over the last forty years, for example by making hospital rooms more appealing, “allowing” women limited food and drink, and “permitting” the presence of partners, have not necessarily resulted in greater empowerment of childbearing women. They argue that because many changes do less to support informed choice among childbearing women or reverse the message that birth is a risky medical event, efforts toward “‘family-centred maternity care’” are often
superficial. For these reasons, Jimenez and colleagues characterize them as a “mirage of change” (p. 160).

Similarly, Susan James (2011) suggests that efforts in Canada to make hospital delivery rooms more “home-like” (or “hotel”-like) “may actually contribute to a feeling of alienation or strangeness” because “the rooms are more like someone’s idea of what home is like, but too sterile, uncluttered, too bland to be a particular person’s home” (p. 34). She and other midwifery scholars have noted that a subtle but important difference between the status of woman at a home versus a hospital birth may have a significant impact on her experience. She explains: “In the hospital, the woman giving birth is the guest; at home, the woman is the host” (p. 34). As these comments suggest, provided a woman’s home is a safe and supportive place for her (recognizing that for some it is not), she may feel more confident asserting herself during labour because she is giving birth in her space. The relationship between power, agency, and the birthplace are important dimensions of women’s experiences and are discussed further in my findings.

Because most research on women’s experiences choosing midwife-attended home birth has been conducted outside of Ontario and other Canadian jurisdictions where midwifery and home birth be similarly integrated into the health care system, findings from these studies cannot be presumed to apply fully to Ontario.\(^\text{18}\) For example, there are significant differences even between Canada and its closest comparator (geographically), the United States, where a number of studies have been conducted. Both are among the few Western countries where obstetricians manage most care and there are few

\(^{18}\) It should be noted that regulation and public funding of midwifery is uneven across Canada. Ontario was the first Canadian province to regulate and integrate midwifery into the health care system (see Canadian Association of Midwives, for an overview of midwifery regulation by province and territory).
midwives; both have high rates of medical intervention and caesarean birth; and both have low rates of vaginal birth after caesarean (VBAC) and home birth. However, in the United States, unlike in Canada, there are several streams of midwives (nurse-midwives, direct-entry), and there is no single-payer for maternity care (Daviss, 2001; Rooks, 2011). Studies of women’s experiences with midwife-attended home birth conducted in other countries (e.g., Australia, Sweden, New Zealand), where home birth is differently integrated into the health care system, may also be of limited comparability to women’s experiences in Ontario (Abel & Kearns, 1991; Catling-Paull et al., 2011; Lindgren & Erlandsson, 2010; Lindgren et al., 2006; Morison et al, 1999). Women’s experiences in the Netherlands (Kleiverda et al., 1990; Weigers, van der Zee, Kerssens, Keirse, 2000), where a significant proportion of births (approximately 30 per cent) take place at home and the majority of women receive primary care from midwives, may also be difficult to compare with Ontario where regulated and publicly funded midwifery and home birth is a more recent phenomenon, and where physician-led hospital birth is the norm.

To date, there have been two studies in Ontario that examine women’s interest in out-of-hospital birth, or decisions to give birth at home with midwives. The first, a survey of early post-partum women in the Ottawa-Carlton region (Soderstrom, Stewart, Kaitell, & Chamberlain, 1990) is of limited relevance to my study because it was conducted before midwifery was integrated into the health care system. It is also more narrowly focused than my study, looking only at women’s interest in proposed “alternatives” to hospital delivery rooms for childbirth, including the possibility of out-of-hospital birth (p. 963). A second and more relevant study has been conducted recently by Beth Murray-Davis and colleagues (2012) and examines in depth the decisions of women in British
Columbia and in Ontario who planned midwife-attended home births. Through semi-structured interviews with 34 women, the authors identified several important factors in participants’ decisions, particularly their need to engage in considerable self-education efforts and take “ownership” for the decision; their views of birth as a “natural process” instead of an illness; and their confidence in home as the environment where they could labour effectively and with fewer risks of intervention (Murray-Davis et al., 2012, p. 579). The findings of this study and a number of others I reviewed were consistent with the insights of the participants in my study. However, these studies did not typically examine women’s decision-making processes in the context of their broader life experiences in the way that my study aims to do.

Given that the body of literature on women’s decision-making experiences is relatively small and that most studies are not completely comparable with those of women in Ontario, there remains a need for current, qualitative research that can shed light on women’s unique decision-making processes in this particular social context. Exploring these decisions in this way, and in the context of women’s broader life experiences, may enable new connections to be made and may allow for a well-rounded and deeper understanding of the possible meanings of this decision from the standpoint of women who choose it.
Chapter 3: Methodology

Why a Qualitative Approach?

In the *Handbook of Qualitative Research*, editors Norman Denzin and Yvonna Lincoln (2011) observe the wide range of worldviews, ideologies, methods, and forms of representation encompassed in qualitative research. Emphasizing that any attempt to define and understand qualitative inquiry must take into account its complex history, they offer a general definition:

> Qualitative research is a situated activity that locates the observer in the world…. [It] consists of interpretive, material practices that make the world visible… including fieldnotes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretative, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (p. 3).

A qualitative approach is useful when a researcher seeks to explore open-ended questions, especially those related to subjective and complex human experiences. Since my study aims to gather in-depth knowledge about the nature of women’s childbirth decisions from the standpoint of women’s experiences, a qualitative methodology is most suitable.

Locating Myself in the Research Project

Karyn Cooper and Robert White (2011) contend that one of the responsibilities of qualitative researchers is to define our relationship with the subject matter we are studying; that is “to situate ourselves in the research text” (p. 31). They refer to this self-reflexive process as the “autobiographical context” of qualitative research (p. 31). Similarly, Ardra Cole and Gary Knowles (2001) note that because we bring to our research our values and beliefs as participant observers in our own lives, whether
acknowledged or not, “researching is an autobiographical act” (p. 45). For me, the critical self-awareness called for by these authors and others involves recognizing that my identity as a white, educated, middle-class, heterosexual woman shapes my worldview. It also involves acknowledging my personal connection to the research project.

In 1980, my mother gave birth to me at home in the care of her family doctor, my father, and her good friend. Given the unusual circumstances of my birth at the time, it has been an important part of my personal history. By the time physicians were discouraged by their college from attending home births, my parents had become connected with midwives and sought their care for my mother’s three subsequent pregnancies. When I was three years old, my younger sister was born at home with the help of two midwives. I recall being awoken in the night so that I could meet her, and with my father’s help, cut the umbilical cord. When my mother was in labour with my youngest sister, and later my brother, I remember the midwives arriving at our home with their bags of equipment ready to assist. Two decades later, when pregnant with my daughter, I benefited from the same type of calm, caring, and competent midwifery care.

From a young age I was keenly aware that my family’s experiences with birth were different than practically everyone else’s I encountered. I absorbed messages—from people I knew, television, books—that my parents’ choices were strange, old-fashioned, radical, and unsafe. Yet my own experiences had taught me that giving birth at home with known care providers was a normal and reasonable thing to do. Undoubtedly these personal experiences impressed upon me the culturally mediated nature of childbirth, and have shaped my current research interests.
My interests in the politics of gender and health and the cultural creation of knowledge have also informed my research. Having worked in the health system for the last 10 years, I have observed how quantitative information and biomedical knowledge, especially the opinions of medical experts, are privileged, and how other types of knowledge are often overlooked, marginalized, or not well understood.

Critical feminist perspectives have sharpened my awareness of the unequal distribution of power in social relations, and have introduced me to strategies for resistance. My commitment to social justice in childbirth is shaped by several important beliefs; first, that individuals have the right to personal autonomy—to make decisions about their reproductive health, including the conditions in which they give birth; second, that pregnancy and birth are inherently healthy and normal processes, uniquely viewed and experienced by each childbearing person; and third, that midwifery is a woman-centred model of care that has the potential to empower women and families, contribute to healthy birth outcomes, and transform health care in positive ways.

**Critical Feminism as a Theoretical Framework**

Feminist research methodologies explore and legitimize ways of knowing other than those privileged in the dominant patriarchal Western tradition (Harding, 1987; Smith, 1990). In the case of childbirth knowledge, which is dominated by the authoritative knowledge of Western biomedicine, a critical feminist approach recognizes intuitive and embodied knowledge as well as systematically conducted research, and accepts various modes of expressing this knowledge, including narrative and arts-based approaches, as well as more traditional academic forms.
My research has been shaped by feminist scholars who explore power relations in their cultural analyses of reproduction and maternity care professions, including, Ivy Bourgeault, Robbie Davis-Floyd, Faye Ginsburg, Brigitte Jordan, Margaret MacDonald, Emily Martin, Sheryl Nestel, Rayna Rapp, Barbara Katz Rothman, Ann Witz, and Iris Young as well as many midwife-scholars, such as Carol Couchie, Elizabeth Davis, Betty-Anne Daviss, Susan James, Beth Murray-Davis, Mary Sharpe, and Vicki Van Wagner. These theorists and practitioners shed light on the challenges of women who make childbirth and parenting choices amidst rigid cultural expectations about how women ought to think and behave. My study is also influenced by feminist standpoint theory, which seeks to understand the world from the standpoint of women’s everyday experiences (Smith, 1990). Standpoint theory resists narrow, hierarchal, patriarchal constructions of knowledge, and argues that situated knowledge provides a valuable perspective on social relations (Hartsock, 1987; Smith, 1990).

As a critical feminist researcher, I do not seek to attain the kind of neutrality believed possible and desirable in positivist research (Harding, 1987). In the dominant paradigm of positivism, where the world is seen as made up of universal truths and laws, the social “scientist” is understood to be “uncovering facts about the human condition” through value-free methods of inquiry (Christians, 2011). In contrast, I understand that like all researchers, my values and interests in the subject matter I am investigating shape my observations and interpretations. One woman I interviewed remarked that like her midwives, I made the personal effort to get to know her in our interview, and that this was appreciated. Within the paradigm of positivism such efforts might be criticized as introducing “bias,” potentially compromising the views expressed by the “subjects,” and
therefore the “objectivity” of the research. However, in my view, with adequate acknowledgement and careful attention, my personal engagement with the research may enhance my data gathering and enrich my analysis. Ann Oakley’s (1981) reflections on the limitations of this positivist perspective correspond with my view:

A feminist methodology…requires…that the mythology of “hygienic” research with its accompanying mystification of the researcher and the research as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias—it is the condition under which people come to know each other and to admit others to our lives” (p. 58).

Oakley’s statement highlights the value of relationships in producing research that serves those being “studied.” Rather than being seen as obstructing or contaminating so-called objective data, I view research relationships as a possible site of solidarity between participants and researchers. Critical theorists recognize and accept that research on human experiences is inherently value laden, and that critical self-awareness of one’s beliefs and values can strengthen committed research. In keeping with this critical feminist approach, my aim is to give women space to tell their stories, and legitimize these stories as valid forms of knowledge. Like contemporary midwifery in Ontario, my research intends to be woman-centred.

Narrative Inquiry and Life History Research

Although this project was not carried out under the rubric of a particular qualitative methodology, it is informed by narrative inquiry, and particularly life history research. Narrative inquiry is a qualitative methodology where stories are understood to be a source of knowledge. Connelly and Clandinin (1990) contend that “the study of narrative…is the study of the ways humans experience the world” (p. 2). Donald Polkinghorne (1995)
defines a *narrative* as events or happenings organized around a central plot. This definition fits with my research approach where events in women’s lives are explored in relation to the unfolding of a particular storyline—that being the experience of deciding to give birth at home in the care of midwives. Polkinghorne (1995) and other narrative researchers (Bruner, 1985; Elbaz-Luwisch, 1997) caution against trying to fit narrative inquiry into the dominant positivist tradition, where the goal is to produce general knowledge from particular stories. Polkinghorne argues that while this approach may be possible, it to some extent misses the point of narrative inquiry, which is to use narratives as a form of analysis (the goal should be *narrative analysis* as opposed to *analysis of narratives*) (Polkinghorne, 1995). I kept Polkinghorne and others’ cautions top-of-mind throughout all phases of my study design, particularly my analysis. When discussing the data I have collected, I often point out similarities (and differences) among women’s narratives; however, this is done while respecting the uniqueness of each woman’s decision, retold by the woman at a particular point in time.

Life history research is a form of narrative inquiry that pays close attention to the way that context influences individuals’ experiences (Cole and Knowles, 2001). Cole and Knowles (2001) explain that, “whereas narrative research focuses on making meaning of individuals’ experiences, life history research draws on individuals’ experiences to make broader contextual meaning” (p. 20). While conducting traditional life history research, which involves multiple interviews with one individual, was beyond the scope of this project, central principles of life history research, including *empathy* (reflexivity), *mutuality*, and *relationality* loosely informed my approach (Cole & Knowles, 2001). In a similar way that life history connects individuals’ narratives with issues, concerns, and
realities of “the times,” my research highlights cultural and political dimensions of childbirth through the lens of women’s personal experiences (Cole & Knowles, 2001, p. 20).

**Methods**

**Data Collection**

I gathered data in the Toronto area in Ontario between June and September 2012 through single interviews with seven women who had planned midwife-attended home births. I met one-on-one with each woman in her preferred location: six in their homes, and one in her workplace. I audio-recorded and later transcribed our one- to two-hour-long conversations.

My questions were broad and open-ended, encouraging the women to take the conversation in the direction they desired. I asked supplementary questions to encourage elaboration and clarification when necessary (see Appendix B: Interview Guide for the list of questions). Although women had to have planned a home birth in the last two years in order to be included in my study, I invited each woman to speak about any birth or pregnancy she had had because I recognized that these may have influenced her recent home birth decision.

I provided each woman with a copy of her interview transcript to review and amend as desired. One woman provided several minor corrections to her transcript; the rest approved their transcripts without making changes. To help protect women’s privacy, I have assigned pseudonyms here and disguised any personally identifiable information about participants.
In addition to interviewing women who planned midwife-attended home births, I audited two prenatal classes and two home birth information nights led by three different midwifery practices in the Toronto area. These four sessions, which lasted one and a half to two hours each, provided useful background information but were not audio-recorded or systematically analyzed.

**Participant Recruitment**

To be eligible to be interviewed, a participant had to have: given birth in the last two years; chosen a midwife as her primary care provider; been accepted into a midwifery practice for care in Ontario; been receiving midwifery care at the onset of labour; been eligible, according to midwifery clinical guidelines, to give birth at home; and have chosen to give birth at home up to and into her labour. Participants also had to speak and understand English. Participation was open to those who had positive and those who had negative (and/or mixed) experiences with midwifery and home birth. I did not, however, specifically seek participants with positive, negative, or mixed experiences. Since my interest was in how and why women choose midwife-attended home birth, any woman who chose to give birth at home with midwives but had to transfer to hospital, including a transfer of care to an obstetrician or her newborn to a paediatrician, was still eligible to participate. Among my participants, one woman transferred to a hospital and an obstetrician during her first labour. Otherwise, the planned home births of everyone who volunteered for my study occurred at home.

I recruited participants by approaching midwives in my network and approximately a dozen Toronto-area midwifery practices with a letter of introduction about my study (see Appendix C: Study Overview for Midwives). Midwives interested in sharing...
information about my study were invited to forward an information letter to past clients who had planned home births (see Appendix D: Information Letter for Prospective Interview Participants). The letter invited past midwifery clients to contact me directly if they were interested in participating. I had no knowledge of who midwives forwarded letters to; midwives had no knowledge of who contacted me. Prior to interviews, I obtained written consent from participants (see Appendix E: Consent Form for Interview Participants).

I approached four practices that offer prenatal classes and/or home birth information nights with a letter of introduction about my study (see Appendix F: Study Overview for Midwifery Practice Groups) and a request that I might attend a prenatal class and/or home birth information night. All four practices agreed to my attendance. However, one practice’s response came after I had already completed my data collection so I did not attend any of their classes. Prior to my attendance, midwifery practices and clients provided written consent (see Appendix G: Administrative Consent Form for Midwifery Practice Groups and Appendix H: Consent Form for Prenatal Class/Home Birth Information Session Participants).

Participant Biographical Sketches

I was contacted by 23 women who were interested in being interviewed, 21 of whom met my inclusion criteria. I selected participants of varying backgrounds (e.g., different occupations, parity, ages, etc.) served by different midwifery practices with the hope of interviewing women with diverse experiences. With the exception of asking participants their ages, I did not collect formal demographic data. The women
volunteered information about their backgrounds and identities as they wished and in the context of their narratives. Participant biographical sketches follow:

**Hanna Cohen**

Hanna, 36, is a university professor. She and her partner, Ben, 38, live in downtown Toronto with their three children, who are ages nine, six, and 18 months. Hanna and Ben are Jewish. She and her immediate family are Arabic. Hanna’s parents immigrated to Canada where she was later born. Ben’s parents are also immigrants to Canada. All three of Hanna’s children were born in the care of midwives in Toronto. Her first birth was a planned hospital birth. Her subsequent births were planned home births.

**Sally Felder**

Sally, 34, is an event coordinator and entrepreneur. She recently completed an undergraduate degree in women’s studies. She and her partner, David, are active members of their Jewish community. They live in a suburban town outside of Toronto with their five-year-old and 16-month-old daughters. Sally’s first birth was a planned hospital birth under the care of an obstetrician. She sought midwifery care for her second pregnancy and had a planned home birth.

**Natalie Chauhan**

Natalie, 29, is a yoga instructor and is becoming a doula.19 She grew up in a small town and moved to Toronto as an undergraduate student. Natalie met her partner, Ravi, 35, while travelling abroad. Ravi and his family are South Asian, but his immediate family live in the United Kingdom. Natalie and Ravi are first-time parents to their 18-

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19 A doula is a trained labour support person who provides comfort measures and emotional support, and sometimes other childbirth and/or post-partum support to childbearing women (e.g., breastfeeding education).
month-old son and live in downtown Toronto. With the care of midwives, Natalie planned and gave birth at home.

Corinne Parker

Corinne, 37, is a registered massage therapist with an academic background in sciences. She, and her partner Michael, live in Toronto with their three children, ages four, two, and four months. For all three pregnancies Corinne received care from the same midwifery practice. Her first birth, a planned home birth, involved a physician transfer of care and caesarean section after it was discovered that her baby was in breech position. For her second and third births, Corinne had vaginal births after caesareans (VBACs) at home.

April McLean

April, 32, moved to Ontario from her home province as a young adult. She is a consultant in the social services field and recently completed a master’s degree. April and her partner Kyle, 35, live in Toronto with their soon-to-be two-year-old daughter. During her pregnancy, April and Kyle travelled from Kyle’s hometown several hours from Toronto where they were working and doing research, to receive prenatal care from their Toronto midwives. Upon moving back to Toronto, April planned and gave birth at home.

Mary-Beth Anderson

Mary-Beth, 39, is a stay-at-home mother who also applies her teaching background to the home schooling of her children. She and her partner, Thomas, 41, are American. Before Mary-Beth became pregnant with their youngest child she and her family temporarily relocated to the Toronto area. The Andersons have five children ranging in age from 14 years to three months. Mary-Beth’s first four children were born in
American hospitals under the care of several different obstetricians. Once in Ontario, she sought the care of midwives and gave birth to her fifth child at home.

*Felicia Nowak*

Felicia, 40, works in the insurance industry and lives in Toronto. Shortly before learning she was pregnant she left a long-term relationship. Felicia’s commitment to maintaining a healthy and active lifestyle is something that she values deeply for both herself and 14-month-old son. She hopes to apply this passion toward a future career in holistic health. She received care from midwives and had a planned home birth.

The participants I met with shared many characteristics; they were recruited from the Toronto area, and were educated, middle-class, and heterosexual women, who ranged in age from late 20s to early 40s at the time of being interviewed. All but one were white; all but one were married and living with their long-term partner; and all but one were engaged in paid work outside the home. Despite these similarities their interviews revealed richly diverse life histories, including experiences with immigration, divorce and separation, family violence, parental loss at a young age, seeking health care as an uninsured resident, pregnancy loss, difficulties with breastfeeding, caesarean birth, and VBAC.

*Analysis*

Analysis was a fluid and iterative process that involved careful reading and re-reading of interview transcripts. Close textual analysis of women’s insights allowed me to interpret their language and tone as well as patterns within their narratives. I also considered each woman’s narrative holistically, which enabled me to better understand
how a woman’s decision was situated in her broader life experiences. From the outset of this project I wanted to avoid reducing a woman’s insights to a list of reasons why she chose midwifery and home birth, as I feel this oversimplifies and disconnects decision-making from both the unique circumstances and social context of a woman’s life. I thus decided against using analytic software that might deconstruct women’s narratives and undermine the principles of narrative analysis (Polkinghorne, 1995; Sharpe, 2004b).

**Ethical Considerations**

As a critical feminist researcher, my ethical considerations were primarily concerned with power relations between myself, as researcher, and the participants (Harding, 1987; Oakley, 1981). In this study, the traditionally observed power imbalance between researcher and participants was tempered by the reality that my project depended on women’s participation for it to be successful. I also recognize that my methods excluded some prospective participants (e.g., individuals who cannot speak English, who live outside of the Toronto area, who do not have one to two hours available to be interviewed, or who feel uncomfortable talking about their experiences).

I aimed to create a respectful space for participants to help minimize uneven power dynamics. I used inclusive language in recruitment materials, encouraged study volunteers to ask questions, made efforts to promote privacy and confidentiality, and reminded women they could withdraw from the study at any time. The tone of our interviews was relaxed and informal, and as some other feminist scholars have done, I

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20 In recruitment materials I referred to interested volunteers as *prospective participants* and used other gender-neutral language. I refer to participants as *women* throughout this thesis report because this is the way that the participants referred to themselves.
sometimes refer to interviews as conversations (Burton & Ariss, 2009). I kept my responses to women’s comments to a minimum, but also provided cues that I was actively listening. I appreciated the need to minimize remarks that may lead a participant’s responses, while also recognizing the importance of being a compassionate and engaged interviewer (Cole & Knowles, 2001; Oakley, 1981).

Although I considered women to be active participants in this project, I am aware that opportunities for collaboration were limited. Once interviews and the transcript review process were complete, I assumed final authority over how the women’s stories were represented. Although I am responsible for organizing and interpreting the women’s insights, I have tried to avoid taking license with participants’ contributions in any way that might threaten the authenticity of the final analysis (Cole & Knowles, 2001). Throughout my findings, I quote liberally from women’s interviews and weave in longer accounts from their stories to help ensure that the women remain at the forefront of my exploration of their decisions.

The notion of trustworthiness, as discussed by qualitative researchers, guided my understanding of the concepts of voice and representation (Blumenfeld-Jones, 1995; Cole & Knowles, 2008; Denzin, 2008; Harding, 1987; Harrison, MacGibbon, & Morton, 2001; Lincoln, Lynham, & Guba, 2011; Olesen, 2011). I viewed trustworthiness as striving to be faithful to participants’ intended meanings as I understood them, and in this process, being conscious of how my own beliefs, identity, and experiences may influence my interpretations.

In reflecting on the ethical and methodological challenges of doing “‘interested’” research on midwifery, Ivy Bourgeault and Margaret MacDonald (2000) argue that
because participants are the ones telling their stories, and have power over their narratives, the relationship between interviewers and participants is not “clearly nor consistently hierarchical.” In this sense, the “politics of representation” are negotiated by the researcher and participants (Bourgeault & MacDonald, 2000, p. 151). It is my view that this dynamic is, in some ways, evident in any research that depends on participants’ self-reported insights. However, when studying women’s experiences with midwifery and home birth in North America where these experiences have a history of being marginalized and misunderstood by others, there are perhaps greater implications for participant empowerment, that is, if the researcher accomplishes a trustworthy representation of their valuable insights.
FINDINGS

Introduction and Overall Analysis

Overall Frame

This study explores the process as well as the beliefs and values associated with women’s decisions to give birth at home with midwives. This process, which all of the women found to be profoundly challenging and significant was, at its core, dependent on a woman-centred perspective of birth. Despite important similarities in their access to resources that support informed decision-making (i.e., education, money, support of their partners or other family) and the elements of a midwife-attended home birth that appealed to them (the possibility of greater control, privacy, intimacy, comfort, and convenience), the women approached their decisions from unique starting places and envisioned their desired birth experiences differently.

Decision-Making Context

In Canada, as in many moderate- to well-resourced countries, there is tremendous cultural pressure on women to have a hospital birth, and in many cases, to have a physician as the primary care provider. This pressure stems from the dominant view of pregnancy and birth as risky events that require close medical management to prevent possible death and injury to the mother and baby. Expectations of childbearing women are normalized through seemingly endless channels: the media, medical professionals (whether the official position of medical organizations or the attitudes of women’s individual care providers), popular childbirth guidebooks, and the advice of family and friends. In this cultural context, where few women are aware of the possibility of home
birth or even the existence of midwifery, and the notion of a planned out-of-hospital birth is generally unconceivable, it is difficult to frame hospital birth as a “choice” for most women. Hospital birth is a cultural imperative. Regardless of the growing body of evidence demonstrating the advantages of midwifery for women and babies, and the safety of planned home birth for low-risk pregnancies, the notion of a midwife-attended home birth is widely perceived to be dangerous and irrational. Women who consider this “alternative,” where available, are frequently presumed to be selfish, ill-informed, and irresponsible mothers who foolishly prioritize their own “comfort,” “experience,” and “choice” ahead of the lives and well-being of their babies (Cheyney, 2008; Murray-Davis et al., 2012; Rushing, 1993; Van Wagner, 1992).

Central Finding

I found that the decision to plan a midwife-attended home birth was, for all of the women in this study, a challenging and transformative process. This was because of the scrutiny that all of the participants faced, the considerable efforts required of them to make an informed decision, and their need to confront and resist the pervasive cultural view of home birth as unsafe. From each woman’s narrative it was clear that this process involved significant personal growth and discovery. The women had to draw on their own strength, take responsibility for their decision-making, and trust that with the support of their midwives, and the love and encouragement of their partners or other support persons, they could have a satisfying and safe birth at home. As my analysis will show, this decision was intellectually and emotionally demanding because the women were making it in a cultural context where there is significant fear about childbirth, and where women’s knowledge and childbirth experiences are assigned a relatively low value.
Findings Overview

My analysis is presented in two parts and is structured around (1) the dimensions of participants’ decisions, that is, their resistance and relearning, and (2) participants’ woman-centred views of birth. In Part One (Chapter 4 and Chapter 5), I explore the transformative process that the women underwent as they progressed through their decisions. Central to this process was their questioning of dominant beliefs and assumptions, not only about midwives and home birth, but also about those who choose them. In all cases, women’s interrogation of what they ultimately came to view as myths and misconceptions resulted in them taking an active role in educating their partners or other support persons. This was a key step in gaining the support and confidence they needed to proceed with their plans for a home birth. Of equal importance to this learning was the way that the women challenged the authoritative knowledge of obstetric medicine. This involved substituting or supplementing medical knowledge with a variety of sources that they deemed trustworthy: their own experiences and those of other women who had had midwifery care or given birth at home; their intuition or embodied knowledge; the insights of their midwives and other childbirth educators (through books, online information, etc.) who had holistic, woman-centred views about birth; and empirical quantitative studies about the relative safety of home and hospital birth that distinguished between low- and high-risk pregnancies. Questioning the status quo of hospital birth and envisioning more woman-centred possibilities was inseparable from their own empowerment as knowledgeable decision-makers and active agents in their births.

In Part Two, having laid out the transformative process of participants’ decisions, I discuss two important beliefs and values that the women had or developed about
childbirth, and consider how these shaped their choices. First, (discussed in Chapter 6) was their view that pregnancy and birth are inherently healthy, normal processes, and that more than a means to an end, these are significant life experiences that include physical, emotional, social, and for some women, spiritual dimensions. Second, (discussed in Chapter 7) was their willingness to honour their desires for positive birth experiences according to their individual needs and those of their families. Analysis of participants’ beliefs and values serve as extended examples of how they resisted medical orthodoxies, specifically, the view of birth as a normally risky medical condition and the survival of the newborn and mother as the only criteria of a successful birth. Developing or strengthening their holistic, woman-centred perspectives of birth meant challenging the more fundamental cultural constructions of childbirth on which medicalized views are predicated; specifically, the notion of the woman and fetus as separate and in competition, and the conception of the female body as a flawed machine that must be fixed, and from which the fetus must be rescued. Both of these ideas are deeply misogynistic, characterizing the childbearing woman as untrustworthy, incapable of making rational decisions, and a passive object (a vessel). These conceptions also create false dichotomies between woman and baby, choice and safety, and experience and outcome, and moreover, may elicit fear and guilt among women, which may undermine their confidence. As the women I met with developed or reaffirmed their holistic, woman-centred views about birth, they came to see the rationale for compulsory hospital birth as false logic, and were able to confidently proceed with their plans for midwife-attended home births.
Although all of the women described their decisions as a gradual progression towards an informed decision, this process was not linear. The fluidity of their decisions had to do with their learning from various life experiences (not always related to childbirth) over extended periods of time, and with their ongoing need to negotiate with the norm of compulsory hospital birth. Even after becoming educated and assured of their decisions, each woman in her own way struggled with the skepticism, concern, and criticism of others. Participants also struggled with the more general cultural pressure that they had internalized from living in a society where medical knowledge and technology are trusted unconditionally. Given these realities and participants’ experiences, it is not difficult to see why their challenging and transformative decisions were personally and politically significant.
PART ONE

I knew when I first gave birth that the experience could be better and that I was missing something of what should be, but I didn’t have the words or courage to formulate what that was. But as time went on and I began to talk to other women (whether personally or through books and a study of history), I grew more confident in my ability to take control of the birth process and what would happen afterward. My husband was an important part of providing that confidence with his encouragement and support, but also with his own wisdom that said, our baby belongs in our home....Whatever the reason, we've had plenty of friends and family in our lives who think it odd or radical. I can only share with them my story and let time take them on their own road of discovery to what works best for their family. [Mary-Beth, mother of five]

The women in this study described their decisions to give birth at home with midwives as intellectually and emotionally demanding. A process of “unlearning and relearning” has been confirmed in other qualitative research (Cheyney, 2008, p. 256; Murray-Davis et al., 2012). For the women I met, unlearning involved questioning false information about midwives and home birth, and redefining authoritative knowledge. Relearning involved developing, or in some cases reaffirming, a holistic view of pregnancy and birth that respects a woman’s birth experiences, and trusts that possibilities other than hospital-based obstetric care can facilitate a positive experience and outcome. Through this challenging, transformative process of informed decision-making and resistance of medicalized birth the women were empowered as active agents in their births.
Chapter 4: Unlearning

Deciding to seek midwifery care was, for all participants, an important act of resistance against the hegemony of physician-managed birth. It facilitated many other meaningful childbirth-related choices and afforded the women the benefits of continuous care. However, it was their decision to give birth at home that appeared to be their more fundamental challenge to medicalized childbirth. Although the women acknowledged that a woman can benefit from midwifery care regardless of where she gives birth, their stories revealed the personal and political significance of place of birth. April explained:

I think a lot of people feel this way. You feel like you don’t know anything in a hospital. That all of these people around you, these doctors, these nurses are the experts that they know better than you. And I know myself, and I know that I would give myself over to the expert. So an expert telling me, “oh the baby’s heart rate’s this, so you need to have Pitocin to get your labour started,” or, “you need to have an epidural,” or “you need to have forceps.” I knew that I would give in to that. That I wouldn’t be strong enough to stand up to the expert opinion in the hospital.

Through these insights, April revealed an important connection between knowledge and power, and how, for some women, the possibility of feeling empowered in the birth process may be reduced in a hospital setting where surroundings are usually unfamiliar, rules must be followed, and where knowledge and decision-making are entrenched in an established hierarchy. Although April acknowledged how difficult it can be to challenge medical advice or directives in a hospital setting, the decision to give birth at home was not an easy one. The women recognized that home birth and midwifery might not appeal or suit all women; however, they emphasized the importance of women having these choices.

Despite their decisions being challenging, the women reflected positively on them. April, Sally, and Mary-Beth commented that after choosing midwife-attended home birth
they could not envision desiring a hospital birth or one attended by a physician. Felicia conveyed the magnitude of her decision: “It was probably one of the most important decisions I made in my life, and the fact that this was something that is available to us that I didn’t even realize before made me want to educate people when there was an opportunity.” In addition to emphasizing the personal impact of this decision, Felicia’s comments suggest its political significance. Had she and other participants been choosing midwifery and home birth in a social context where these are better understood and accepted, their decisions would likely not have stood out as so meaningful.

**Interrogating Myths and Misconceptions about Contemporary Midwifery and Home Birth in Ontario**

A central part of the women’s transformative decisions involved challenging some of their assumptions about home birth, midwives, and midwifery clients. Through this “unlearning” participants discovered that many of these assumptions were inaccurate or limited. Natalie explained, “[I had to] un-write some of the assumptions that I didn’t even realize I had made.” The most significant myth the women struggled with is that home birth is dangerous, or at least more risky than hospital birth. Another important misconception they grappled with was the perception that midwifery and home birth only appeal to certain “types” of women (namely, women in traditional communities or cultures, “modern day” hippies, and those involved other counter-cultural lifestyles).

Gaining an accurate and up-to-date understanding of contemporary midwifery and home birth practice in Ontario was central to the women’s unlearning and relearning. Felicia explained that “to be perfectly honest I knew what a midwife was. I knew that they existed. I had no idea they were part of sort of our current…I thought it was
something like they do in a Mennonite community somewhere you know?" April admitted that, "for me it was just getting over the image of home birth as being about, you know…hugging trees and being a hippie…so it’s about overcoming that image. Even of midwifery…” Once she encountered other midwifery clients, she realized her earlier assumptions were inaccurate:

I’ve never met anyone who looked like I thought they should look…if they are giving birth at home or using a midwife. So I think dispelling the whole image of home birth is really important. And putting out a modern look on home birth…When I went into the midwifery clinic the first time I still had that stereotype that there was certain people that accessed midwifery care so that was what I was expecting to see…. So maybe that’s why I noticed that wasn’t what I saw at the midwifery clinic. That there was a diversity of clients from everywhere around the world.

While the women I spoke with did not elaborate about the reasons or origins of their initial misconceptions (suggesting an area for further research), some possibilities are raised in the literature. A number of scholars trace present day myths and stereotypes about midwifery and home birth to efforts to establish a medical monopoly over maternity care (Biggs, 2004; Bourgeault, 2006; Burtch, 1994; Davidson, 1997; Ehrenreich & English, 1973/2010; MacDonald, 2004; Rushing, 1993; Witz, 1992). This depended, in part, on convincing the public that midwives (and in some instances general practitioners) offered old-fashioned care, second-rate to that available from modern obstetrics (Klein, 2011). Barbara Ehrenreich and Deirdre English (1973/2010) argue that medical efforts to discredit and malign their perceived competitors has resulted in a lasting “contamination” of the notion of midwife, while at the same time securing the authority of an emerging professional class of physicians (p. 32).

Margaret MacDonald (2004) notes how in the contemporary Canadian context the media plays a role in depicting limited, stereotyped notions of midwifery—even when
these depictions are intended to be flattering. Referring affectionately to the “Heritage Minute Midwife” portrayed in the “Part of Our Heritage” television vignettes broadcast in Canada the 1980s and 90s, MacDonald observes how this particular representation of the “traditional midwife” reflects a romanticized image of midwifery and home birth that has become part of Canadian popular culture, and one that tends to obscure the diversity of these practices over generations and across cultures and communities (p. 46). As evident in the comments of women I interviewed, associating midwifery and home birth with ways of the past may prevent these practices from being viewed as part of “modern” maternity care as a realistic health care choices.

Making a parallel argument as MacDonald, medical ethicist and past midwifery client Alice Dreger (2012) describes her experiences teaching American medical students where she has encountered some of the same stereotypes that some of my study participants initially expressed:

> When I ask my medical students to describe their image of a woman who elects to birth with a midwife rather than an obstetrician, they usually describe a woman who wears long cotton skirts, braids her hair, eats only organic vegan food, does yoga, and maybe drives a VW microbus. What they don’t envision is the omnivorous, pants-wearing, science geek standing before them.

Like the women in my study, Dreger does not shed light on the reasons for these assumptions, nor does she clarify whether they are intended as criticisms. It is my sense that stereotypes about midwifery and home birth raised by the women I spoke with (and Dreger’s students) stem from the association of contemporary midwifery practice with counter-cultural movements that were important and influential to the re-emergence of midwifery beginning in the 1970s (e.g., anti-war, civil rights, women’s movement) (Daviss, 2001; Van Wagner, 2004). Since many childbearing women are unfamiliar with how midwifery is integrated into the present day Ontario health care system, and may be
unaware of the diversity of midwives and their clients, it is not unreasonable to expect that myths and stereotypes might fill knowledge gaps.

Although misconceptions about the “types” of women who practice midwifery or receive midwifery care may be less fear inducing than those about safety, participants’ narratives demonstrated some of the ways that these may be problematic. Felicia’s comments illustrated how myths and stereotypes about the practice of midwifery in Ontario may prevent women from knowing that it is available to them as a regulated and publicly funded health service. April’s statements revealed how stereotypes may close off the possibility of midwifery care and home birth to women who do not identify with a narrowly (and inaccurately) defined “image” of midwife or midwifery client. Taking a more critical look at what the women came to see as outdated and limited views enabled them to envision midwifery and home birth as appealing choices for a broad range of women.

**Questioning Unconditional Trust in Western Medicine: Women and their Partners Learn Together**

The six women who were living with long-term partners at the time of being pregnant indicated the importance of having their partner agree with their decision to seek midwifery care and plan a home birth before proceeding with this decision. Corinne, for example, expressed, that “it was important that my husband was on board.” Participants described how their support persons’ concerns about the safety of home birth, like their own, shifted as they became more educated about midwives’ knowledge, skills, equipment, and the availability of medical backup, and as they became less mystified by medical technology. Natalie, for instance, explained that her partner’s trust in her
decision resulted from thinking critically about his pre-conceived notions: “There’s no like, I’m alone in the woods and like, ‘boil some water and rip up some bed sheets!’ Like the idea that I had really good care and that they were going to be paying attention.” April explained that her partner “was a little hesitant at first, because he felt…Like, ‘sure we can have a midwife, but we are doing it in a hospital’, you know?...‘The hospital is safe’…at the hospital you have all the machines that go beep!”

April’s satirical reference to “the machines that go beep!” from the Monty Python comedy sketch convey the false sense of security many people may feel in the presence of medical technology. Hanna’s comments confirmed this problem. She lamented: “There’s this blind faith in science. Like having equipment means nothing will ever go wrong!” Like the women I met with, scholars critical of medicalized birth problematize this over-confidence in medical technology and the assumption that it is a sign of the most evidence-based and advanced kind of care (Dreger, 2012; Klein et al., 2006). Dreger (2012) argues that both medical care providers and health care consumers tend to “confuse science with technology” and as a result, form misconceptions about what makes for safe maternity care: “They think that what it means to be a scientific doctor is to bring to bear the maximum amount of technology on any given patient” (p. 17). Dreger’s assertion sheds light on Hanna’s comment, which not only encourages critical reconsideration of the common assumption that having a lot of medical technology is a sign of “modern” and safe care, but also inadvertently demonstrates how even among educated, politically aware individuals, science and medical technology are often mistakenly seen as interchangeable.
The degree to which the women revealed or concealed their desires for a home birth demonstrated their awareness of the myths, misconceptions, and stigma associated with home birth (and to some extent midwifery). Sally, Natalie, and Corinne were quite open about their plans, but noted how this exposed them to discouraging advice and warnings about the risk of their choices. Felicia, Mary-Beth, and April were more measured in the extent that they shared their plans, but this did not prevent them from being questioned or doubted by some family and friends. With the exception of telling a few like-minded classmates from her women’s studies program, Hanna deliberately kept her plans from all of her family and friends. Not only did she want to avoid being judged for having what she thought some might view as a “failed home birth” if a hospital transfer occurred, but she also anticipated that her parents would be “horrified” by her decision. Managing their decisions (deciding who to tell, what to say, and how to defend their choices) required a solid understanding of the myths and realities of midwifery and home birth practice in Ontario.

**Redefining Authoritative Knowledge about Childbirth: Experience and Intuition**

In my study, the notion of authoritative knowledge, or *knowledge that counts* was at the crux of women’s decisions (Jordan, 1997). A critical part of women’s unlearning involved redefining authoritative knowledge. This was evident in the ways that women questioned the superiority of medical knowledge about childbirth and substituted or augmented it with other sources they deemed trustworthy.

Personal experience, whether related to previous births, parenting, family upbringing, education, or work, had a profound impact on women’s decisions to plan midwife-attended home births, and became trustworthy source of knowledge. So too did
the experiences of other women who had received care from midwives or given birth at home. Past interactions with the medical system were particularly influential for April, Mary-Beth, and Sally. Their experiences had the dual effect of raising some doubts about the credibility of medical authority in childbirth and the superiority of obstetric care for low-risk pregnancies, and increasing their confidence in more woman-centred possibilities. For about half of the women, influential experiences occurred long before they first sought midwifery care. For instance, April’s negative impression of obstetric care and the hospital environment stemmed from treatment following an ectopic pregnancy in her early twenties. She explained:

It’s not that they [medical care providers] did anything to make it a negative experience beyond treating me like…someone who needed to be fixed and get out….I guess because I was dealing with something so traumatic and I was in a very…not unstable, but…just a bad state. I kind of expected there to be…a grief counsellor or somebody to talk to me. And there was none of that. I remember when I was coming out of the anaesthetic—because they had to do emergency surgery—they were discussing where they were going to place me because they had no rooms or no beds available in the hospital that I gave birth in, or not that I gave birth, that I had surgery in, and there’s a maternity hospital right next door. And they were discussing putting me into this maternity hospital with all these babies being born, and I just thought, “please, please, please don’t put me in that maternity hospital. That’s not something I can handle right now.” Thankfully they didn’t…. I think those experiences, that’s what really shaped my decision to give birth away from the hospital.

There was a sense from April’s comments that what was already a traumatic event was made worse by an overextended institution and care providers who treated her insensitively. Hanna’s doubts about the medical model of pregnancy and birth evolved gradually as she became educated in social justice issues. She described a formative experience years before becoming pregnant with her first child:

The moment I decided to have midwives I was TA’ing [teacher’s assistant] a women’s studies class…like a thousand years ago and there was midwife who came in to speak to the students about the medicalization of women’s bodies. And I
listened to her speak, I thought, “yes, I will be doing that.” And I think I had nascent understanding.

It is noteworthy that although the women were critical of physicians’ often heavy-handed use of interventions, and their tendency to provide care that is not woman-centred, they respected the usefulness of medical knowledge and technology in situations when pathology arises. Sally, for instance, clarified that although she found obstetric care to be “really impersonal” and too reliant on interventions, she is “still a believer in Western medicine” overall. She gave examples of a diagnostic test she would be undergoing to investigate an ongoing health issue, and insights gained from witnessing her mother receive medical treatment for long-term illness as evidence of her faith in this model of care for managing diseases and disorders. Likewise, April expressed an appreciation of hospital-based obstetric care for women with serious pregnancy complications: “I understand that hospitals are very important and they are for women who are in high-risk pregnancies….I might need to give birth in a hospital someday. I don’t know. So I’m certainly not knocking hospitals for what they do.” Comments such as these were important because they challenge the myth that women who choose midwifery and home birth all generally distrust physicians and avoid medical care.

In addition to learning from their own experiences, women’s decisions were influenced by those of their friends, sisters, mothers, and grandmothers. For example, Natalie felt that her mother’s and grandmother’s birth “narratives” may have “played a factor” in her decision:

I’ve heard stories…maybe a good thing was my mom’s mom, her parents [Natalie’s grandparents] were from the Netherlands. And so she had her first baby over there…before immigrating to Canada in the ’50s. My mom’s older
sister was born...at home...they had a nurse who lived with them for...a week afterwards, and she had her baby in her own bed. And it was...this very positive experience for my grandmother, and immigrating to Canada my mom had told me again and again this story, and then when she was born she [Natalie’s grandmother] was...strapped to the bed and they shaved her and they knocked her out right before it was time to push. And all this stuff that was comparatively so horrific...And she was kind of like, “I know how to have babies, I’ve had them before.”

Natalie reflected on her mother’s labour with each of her children:

She got a huge episiotomy [with Natalie’s birth]. And she still has negative repercussions from it...[And later, with when giving birth to Natalie’s brother] She had this strong, strong induction and then it turned out he was...sideways or something...he went into distress and it was...an emergency. They had to knock her out and give her a caesarean. And with [Natalie’s youngest brother] they didn’t even give her a choice for a VBAC. It was just, “once a caesarean, always a caesarean”, and then after that they were like, “ok, you’ve had two caesareans, so it would be dangerous to have a third, so while we are in here, let’s...tie your tubes up so you can’t have any more babies.”

Throughout our conversations, participants consistently described stories of friends and family receiving medical treatment that was not woman-centred or that left women feeling fearful or ambivalent about birth. Undoubtedly, there are those who have positive experiences with physicians, and those who have disempowering interactions with midwives (Sharpe, 2004); however, among the women I interviewed, it seemed that negative experiences with physicians and hospitals left lasting impressions that influenced their interest in other maternity care possibilities. Stories such as Natalie’s, Hanna’s, and April’s highlight how a lack of woman-centred care may undermine women’s confidence in medical knowledge and care.

Women credited positive word-of-mouth from women who had had midwife-attended births, whether at home or in a hospital, as having one of greatest impacts
on their decisions. They encountered this word-of-mouth from their friends and close relatives, breastfeeding support/education networks, academic studies, and interactions with holistic health care and activities (massage therapy, naturopathy, yoga). Sally described how she first learned about midwifery through her family network following the birth of her first child:

It’s very likely it was from my sister-in-law…And I’m pretty sure it was one of her friends that had used a midwife for their second [pregnancy]….That was what pushed me further in that direction. I’d been considering it before. Now she [Sally’s sister-in-law’s friend] had had a hospital birth with an epidural the first time. The second time she had a hospital birth with no epidural, and that to me spoke volumes about the type of support and care you get with a midwife… I kept bugging her [Sally’s sister-in-law] here and there. And she was like me afterwards. She was convinced. She was like “oh, I’d never do any other way. It’s like amazing.”

In these comments, Sally conveyed some of the compelling qualities of experiential knowledge. It is immediate, tangible, and specific, and may resonate with women in a way that more abstract knowledge often cannot. For the few women who had friends who had given birth at home, positive word-of-mouth also allowed them to witness the possibility of safe home birth and to develop counter-narratives to the discouraging and frightening messages about out-of-hospital birth that they encountered from some medical care providers, the media, and certain friends and family. Corinne explained that being able to “really pick the brains of my friends who’d had home births” provided her with concrete insights into what it is like to have a home birth and helped her partner trust that it could be safe and offer other unique benefits. Corinne, like all of the other women, emphasized the importance of experiential knowledge originating from “like-minded” individuals, that is, those who share similar beliefs and values, especially about health,
childbirth, and parenting. She explained, “I guess we have these common ideas about
birth and being a woman.”

Mary-Beth’s decision, perhaps more fully than any of the other women I met with,
conveyed the empowering process of redefining authoritative knowledge, moving away
from the conventional notion of physicians as the authority on pregnancy and birth, and
toward ways of knowing that include embodied knowledge, intuition, and insights gained
through important life experiences.

**Mary-Beth: Honouring the Wisdom of Mothers**

Mary-Beth, a mother of five children, conveys deep respect for the work of
mothering. She feels that despite the skills and knowledge required, it “is not so much a
valued vocation anymore.” To illustrate her belief, she described a particular conversation
she once had with an educator:

> When I was in college getting my teaching degree, I had a Latin professor and
> I remember he talked to me once, and I said, “you know, I would really like
to be a wife and a mother.” And he said, “ah, no! No, no! You’re way too
> smart to do something like that!” And it just really offended me. Like do I not
> need to be smart to be a wife and a mother? What is invalid about this
> profession that I should not want to do that?

Mary-Beth observes that raising five children and teaching in her church community has
meant that she has “done plenty of teaching, just not in the public school system.”

After graduating from college, Mary-Beth married her husband, Thomas, and
became pregnant with their first child. Reflecting on this first pregnancy, she questioned
how realistic it is for women to be expected to “speak up” for themselves with their
doctors: “I look back at the time and I didn’t know *anything*. I didn’t know…what
questions to ask the doctor. You know they always say, ‘oh, ask your questions’, but you
gotta know what to ask. Or that you don’t *know* what to ask. I didn’t even know that I
didn’t know all this stuff.” She described her experience with medical care providers during her first pregnancy and birth:

I had this doctor that really didn’t explain much. When I delivered it wasn’t even the same doctor. When she was born, she wasn’t breathing and they whisked her off immediately to… the intensive care unit…. Apparently, she had pneumonia. We tried to ask questions about that—why she got it. And we were just given these short, quick answers that really didn’t satisfy you. But you feel intimidated by the authority and you don’t want to keep pressing when they are making you think, “why are you asking that? Why are you questioning me? I am the doctor. I know.” And as just… a small person… you feel intimidated.

Mary-Beth’s subsequent three births reflected similar physician-patient relations. Because the Andersons moved part way through her second pregnancy, Mary-Beth had three different obstetricians. As with her first birth, it was the obstetrician on call, someone she had not met before, who delivered her second baby. Mary-Beth received episiotomies for all four of her births, which made nursing and caring for her newborn uncomfortable.

By her fourth pregnancy Mary-Beth had been in touch with a long-distance college friend who had given birth at home in the care of midwives. She had also attended La Leche League meetings where conversations about doulas and home birth exposed her to the experiences of women who had benefited from having “another woman helping you out.” While she initially found her friend’s birth choices to be “pretty radical,” Mary-Beth was intrigued by what sounded like the kind of woman-centred care she had been looking for. However, she perceived barriers to accessing midwifery care:

I know you might think, “well if you really wanted to, you could have looked it up.” And you get distracted by your other children and by all the other concerns going on in your life and I already had a gynaecologist. And I did know there were some midwives downtown, but it was all in Spanish [it was her understanding that the clinic provided services primarily in Spanish/to the Hispanic community] and so I thought, “well I’m a little intimidated by that culture difference, because I don’t speak Spanish and these are the only midwives I know of.”
The obstetrician for Mary-Beth’s fourth pregnancy offered more information than her previous physicians, but his authoritative style undermined her confidence.

[He] took a long time at each appointment talking to me about all my concerns. But he was very, “I know what’s what. And you listen to me. I’ll listen to you, but I’m going to tell you what is, and if you don’t believe me well, go somewhere else.” You know?...Once again there’s the intimidation factor. This is a knowledgeable man. He’s got the degree. I don’t.

When Mary-Beth’s partner accepted a new job in the Toronto area, the Andersons temporarily relocated. Being pregnant with her fifth child and without Ontario health insurance, they were faced with the dilemma of either using their employer-funded health care benefits, which required medical evacuation to the United States for the birth, or paying out of pocket for physician and hospital-based care in Ontario. The prospect of being separated from their four older children, living in a motel near the border, and giving birth in an unfamiliar hospital and city was impractical and unappealing; and although they had savings to initially pay for medical expenses out of pocket, this option was inconvenient and potentially expensive.

Prior to her fifth pregnancy, Mary-Beth had begun homeschooling her children. She observed parallels between the decision to home school and her later childbirth choices: “home birth and home education go against the grain of society, and I believe, harken back to an inherent wisdom about families and parenting that we seem to have lost in this day and age.” As with her decision to home school, she felt her partner’s support was valuable in raising her confidence.

In the beginning when we first started having children, and heard about my friend having home births, he was like, “wow, that’s pretty out there, that’s pretty cuckoo. I don’t want you doing that”. And you know he had fears about that kind of stuff, but I think...because we did the home schooling first, and it was just a slow progression of learning through experience and wisdom that we can look outside the box and see. You know you just learn. You grow. And he had come to the point
too where he was able to say, “this is a good thing. Let’s try it. Let’s do this.” And with both things, homeschooling and the home birth, he became my biggest encourager.

Mary-Beth admitted that even as she progressed through her decision she continued to feel uncertain. Her friend who had given birth at home became an important source of emotional support, advice, and encouragement: “I called her…Rare for us, because mostly we chat through email. I called her specifically and we talked for a long time about it and she said the same thing with home schooling: ‘Once you do it Mary-Beth, you’ll get it. You can do this.’”

When Mary-Beth contacted her local midwifery practice she was disappointed to learn they were at full caseload. She came across the website of another practice in her area, which also had a waiting list but prioritized her care because she was an uninsured resident. She realized that had this detail not come up in her initial phone inquiry she may have missed the opportunity for midwifery care altogether. She feels destiny played a role in bringing her to this opportunity.

Mary-Beth appreciated her midwives’ communication skills and their practical knowledge and advice. Their approach satisfied her desire for personalized care that honoured the knowledge she had gained through pregnancy and parenting.

I was finding a good experience with these women. I could talk to them. They were interested in who I was as a woman, and my concerns as a woman. And they understood what it meant to be a woman. Not only that but you know I don’t know they just had more of an intimate knowledge of children and the birthing process and the after-process than it seemed the obstetrician had. He had a very clinical viewpoint, but they had a very practical, common sense, this is the way it really works viewpoint. And it was what I had always wanted and was looking for.

Although Mary-Beth was committed to planning a home birth, she had some safety concerns. Her midwives’ prenatal home visit, which involved demonstrating their
equipment and discussing emergency procedures, was important to setting her mind at ease.

There were fears. I wasn’t one hundred per cent confident. But there are always fears….I felt very calm when they brought over the stuff. Because it just shows me, “these women are prepared. They know where I live. They’ll be here. You know, they’ve got it together”…I guess even though they say words you want to see a little bit of evidence.

Mary-Beth gave birth to her fifth child in the comfort and privacy of her home with the support of her midwives and partner. She appreciated her midwives’ skills and patience in helping her birth without an episiotomy, the benefits of which she initially underestimated:

They didn’t give me the episiotomy and I was like, “this is taking a really long time. I don’t remember it taking this long to get the baby pushed out.” …And the reason, I realized afterwards, is because they take much longer to stretch the vaginal area so that you don’t have to have the tearing….At the time I thought, “oh who cares! Just cut and let me get this baby out!” But afterwards, I realized the wisdom of that because you heal so much faster. You feel so much better. You’re able to move around so much quicker to do the things you need to do to recuperate. So I was grateful for that.

During the post-partum period, Mary-Beth valued the woman-centred care she received from her midwives. She conveyed the positive impact of her birth on her family:

I spent the next day in bed just peacefully nursing her almost the whole time. And the kids came back the next day around noon, and they…liked to see her. But as my husband kept saying over and over again, the whole experience was so calming and peaceful and relaxed. And he was so happy with it and I was so happy with it that we were like, “why didn’t we do this before?! Four children ago. Why didn’t we do this before?!” And then I loved the way the midwives came over the course of the next week, to my house, to see me and the baby. Because you don’t feel like going out! No! And waiting in a doctor’s office and driving you know?…They came over. They talked. They took care of her. They were readily available should I need to call them. I loved my post-partum care…I didn’t want to leave them after six weeks! I was like, “I want to stay with you! Let me stay with you!” I mean I know you couldn’t. But you form a relationship with them. I knew at the last appointment I was going to tear up when I had to say goodbye….And I did.
Discussion

In recalling her decision, Mary-Beth reflected on the way that this process strengthened her beliefs about teaching, mothering, and the value of knowledge gained through women’s everyday experiences. She found that the advice of other women she trusted, especially her college friend and La Leche League members, to be particularly valuable: “what is the most helpful to me was not so much the books as it was my friend telling me from her own experience, ‘this is how to do it. Yes, you can do it.’ We need women talking to each other about it.” In addition to providing practical advice and encouragement, Mary-Beth’s friend raised the importance of embodied knowledge as a legitimate way of knowing.

It appeared that Mary-Beth’s earlier decision to home school her children helped prepare her for criticism or “social sanctioning” from friends, family, and others that may result when parents make unorthodox health or parenting choices (Cheyney, 2008, p. 264). She felt that both decisions involved “unlearning” the dominant cultural belief that parents’ knowledge is less credible and valuable than that of professionals. Mary-Beth did not seem to distrust or reject expert knowledge in general. She expressed appreciation for both her obstetricians’ and her midwives’ formal training and technical knowledge. However, whereas Mary-Beth observed obstetric knowledge as having a provider-centric, technicist approach—what she described as a “clinical viewpoint”—she saw midwifery knowledge as holistic and grounded in the “practical, common sense, this is the way it really works viewpoint” of everyday experiences, including the experiences of mothers. Having this mutual respect for practical, experiential knowledge facilitated rapport and trust between Mary-Beth and her midwives.
Early in her narrative Mary-Beth highlighted the value of a mother’s intuition as a legitimate way of knowing: “you have an intuition that says, ‘this is not right. Something could be better than this. This is not the way the experience should be.’” Later, she credited her intuition, along with other more concrete information and experiences, with reassuring her about her midwives’ clinical skills and judgment. The value of intuition also arose in conversations I had with several of the other women. Sally explained how after evaluating the information she had collected on home birth she ultimately had to trust her intuition when making her final decision:

Sometimes you just need to take a leap of faith. And put your faith in whatever you believe in, whether it be destiny, fate, God, whoever. And just say, “you know what if this is what it’s going to be, this is what it’s going to be.” I have, for my whole life, believed that everything happens for a reason and when my mom died I had to accept that.

Like Sally, Mary-Beth’s conception of intuition was connected with her spirituality. She expressed a strong sense that God or “destiny” had presented her with the opportunity to be cared for by midwives and give birth at home. In contrast, Corinne conveyed a secular notion of intuition. She described how, in addition to reading and consulting with health care providers to make an informed decision, she listened to what she felt in her “heart” and her “gut”—embodied interpretations of her intuition.

Robbie Davis-Floyd and Elizabeth Davis (1997) characterize intuitive knowledge as holistic, immediate, non-rational, and interconnected. These conceptions were consistent with those of participants in my study who found that “body knowledge” such as pain, energy, euphoria, and exhaustion, was an important source of information, for their decision-making and served as a valuable feedback during labour and in the early days as a new parent (p. 318). Similar experiences have been described by women who
had midwife-attended home births (Cheyney, 2008; Lindgren & Erlandsson, 2010). Several of Mary-Beth’s comments reflected her awareness of the marginal status of intuition and the experiential knowledge of mothers in contemporary North American society. Given that rational-analytic, mechanistic, and so-called objective knowledge dominates in Western society, it is not difficult to see why subjective and situated knowledge essential intuition is devalued or discounted. And yet, it was precisely intuition that empowered Mary-Beth and some of the other women I met with to consider possibilities other than obstetric care (Davis-Floyd & Davis, 1997). This reality suggests that these forms of knowledge ought to be acknowledged as powerful and valuable.
Chapter 5: Relearning

Among the women in this study, unlearning and relearning occurred in parallel. As they became more aware of midwifery and home birth, they set about gathering and evaluating different kinds of evidence that they felt would enable them to make an educated decision about where to give birth. Whereas experiential learning often occurred fluidly or unexpectedly, sometimes over a longer period of time, the women tended to describe their information gathering as more active, focused, and time-limited.

Doing Your Homework

Interestingly participants often used similar language to describe their deliberate, focused efforts to make informed decisions. The notion of “doing your homework,” your “research,” and your “due diligence” signified the intellectual and practical work involved. These efforts were essential to their resistance of the cultural pressure to have hospital births because they enabled the women to defend their choices to themselves and others, and helped them prepare for labour. Participants described this process of relearning as positive and empowering. All of the women, except Mary-Beth, began doing their “homework” once they were in the care of their midwives. This may because these women were making their decision in Ontario where the decision to seek midwifery care does not require the decision to give birth at home. In contrast, Mary-Beth’s decision-making was initiated when living in the United States where choosing direct-entry (non-nurse-midwife) midwifery care means planning a home birth (direct-entry midwives practice outside the mainstream health care system and do not attend hospital births).
The information that the women sought as part of doing their homework tended to fall into one of two categories: (a) books and other resources authored by childbirth educators, researchers, and health care providers who have holistic, woman-centred views of birth; and (b) empirical quantitative data comparing outcomes of low-risk, planned home and hospital birth, and evaluating the safety of other maternity care practices. For a list of resources women consulted with see Appendix A: Advice for Women and Midwives in Ontario to Promote Informed Decision-Making.

**Insights from Holistic Childbirth Advice Books**

All of the women I met with referred to information and advice in childbirth education materials as among the most influential in their decisions to seek midwifery care, and later to give birth at home. These resources included books, films, articles, and social media from a range of authors, including midwives, childbirth activists, academics, medical professionals, and parents. As with other dimensions of their decisions, they recognized the element of chance or luck in exposing them to the “right” kind of information to incite critical awareness, consider choices outside the *status quo* of physician-managed hospital birth, and advocate for choices in childbirth. Several participants implied that they found much of childbirth advice literature to be paternalistic or not that helpful. For example, Sally and Felicia criticized popular childbirth advice books for glossing over certain information and issues, or failing to adequately address the risks of many medical interventions. Sally referred to some of these as “almost like ‘pregnancy for dummies.’” Felicia felt that had she not been exposed to midwifery principles through her sister, she might have been influenced by
the “typical online information, about ‘What to Expect When You are Expecting.’” She remarked, “I hate that book.”

Several scholars provide critical analyses of popular childbirth education literature for parents in Western social contexts. These are relevant to insights made by participants in my study. Jane Pincus (2000) has found that childbirth advice books tend to align with one of two ideologies: an “expansion of options perspective,” which advocates for woman-centred birth informed by a philosophy of pregnancy and birth as healthy, normal events, or an “increasingly medicalized perspective,” which focuses on medical tests and interventions that women routinely encounter during pregnancy and childbirth, as well as potential complications (p. 211). As noted by the women I interviewed, Pincus observes that few books, even among those claiming to support choice and a holistic view of birth, succeed in communicating empowering messages, and that of those that do, most are authored by midwifery supporters. Other feminist scholars confirm these observations (Ehrenreich & English, 1978/2005; Kennedy et al., 2009).

The women I interviewed described gravitating toward childbirth education materials that promoted a holistic, woman-centred perspective, and that highlighted birth stories where women and their families were active participants. All of the women, except April, specifically mentioned the books of American midwife and childbirth activist Ina May Gaskin as having a significant impact on their choice of birthplace. Felicia explained that, “I think most of it was what I read. Honestly, I think Ina May Gaskin’s books had the most impact on me…I just read all these beautiful stories of people’s experiences…and just…wanted to be as relaxed and open about the whole thing
as possible.” Similarly, Natalie felt Gaskin’s book was instrumental in transforming her
view of labour and birth:

So Ina May’s *Guide to Childbirth* really was what did it for me. Because reading all the birth stories…it totally shifted me from being like afraid of
birth to being like, “wow, I wonder what mine’s going to be like.” Because each story was so different but ultimately the end was the same, in that…
moment, when it’s your baby, and you did it, and the accomplishment, and …the love and all that.

Positive birth stories in Gaskin’s and others’ books provided counter-narratives to what women often referred to as “horror stories” and “fear-mongering” that they encountered from home birth skeptics in the medical profession, the media, and friends and family. Women also emphasized the value of authors’ discussions of published research about the safety and effectiveness of various childbirth practices, from birth in various settings, to medical interventions, and as well advice for home remedies, labour pain coping strategies, and newborn feeding and care. Having a well-rounded view of pregnancy and birth from these sources complemented women’s experiential knowledge, enhanced their confidence as birthing women and prepared them for labour, and supported their resistance to alarmist information they encountered elsewhere.

**Empirical Quantitative Studies about Home Birth Safety**

In addition to learning from books, websites, films, social media, and other resources providing descriptive and experiential information framing midwifery and home birth as realistic possibilities, participants sought empirical quantitative data to inform and defend their decisions. Their confidence in scientific evidence seemed to stem, in part, from their perception of it as more trustworthy than medical knowledge (knowledge of physicians). For example, some of the women (Hanna, Corinne, April) suggested that physicians’ opinions about various childbirth practices may be skewed by
their personal preferences, convenience, comfort level, and view of birth as inherently risky. In this sense, scientific evidence was a convincing source of authoritative knowledge, and important tool for resisting normative medicalized childbirth practices (Jordan, 1997; Rushing, 1993). Scientific evidence was also valuable because it was useful; empirical studies provided practical, measurable, and generalizable information to quantify risks and benefits of various childbirth practices, and enabled them to put these risks into perspective (understand the odds). Whereas more qualitative, narrative information from other women who had given birth at home with midwives (whether from their personal networks or books or other educational material they read) revealed the experiential benefits of midwifery and home birth and demonstrated good birth outcomes on an individual basis, empirical quantitative studies confirmed the likelihood of good outcomes on a broader scale.

Most of the women did their “homework” about scientific evidence by reading childbirth advice books and other web-based sources that referenced this kind of information. Hanna and Corinne, however, described looking up studies directly to scrutinize methodologies used, and to verify that findings that not been misquoted or overstated in childbirth advice literature for parents. Hanna’s narrative illustrates the empowering process of “doing your homework” as part of making an informed decision.

**Hanna: Learning a Language of Choice**

Hanna recognizes that complex cultural, family, and personal factors may shape a woman’s childbirth knowledge and choices, as well as her broader identity and worldview. She explains how this applies to her own life:

I come from a really traditional background. So I’m a really ardent feminist, but at the same time I have this real conservatism that’s not from myself necessarily, but
this sense of like wanting to placate my parents. And so I think that there’s a lot going on there.

Hanna’s family is Arabic and Jewish. Her parents and older sister left their home country as refugees, and after living in Israel, immigrated to Canada where Hanna was later born. Hanna contrasted some of the ways that women have given birth in her family over the course of only three generations, and how this has influenced her views on pregnancy and birth:

My parents were born at home with midwives because…that’s what you did…Midwives were more like obstetricians if anything. They had a really high level of knowledge because women would not go…to male doctors for gynecological issues…. my father’s distant cousin was one of the midwives… she dealt with complicated cases…When my grandmother went into labour, she delivered my mom…On the one hand, we kind of revere her; [and] there’s this sense that you did that…in the old country and it’s kind of this backward way….

My mother I know, [when giving birth to Hanna’s older sister], laboured in an open [hospital] ward with 10 other women in the room and everyone was just writhing and it was just horrible and scary and loud and overwhelming and humiliating. And that…was meant to be somehow progress. And then with me she had an epidural. And so as far as she was concerned this was, you know, the sort of the steps of progress…. I think when I initially chose midwifery my mother was horrified because I think she…saw it as a backward choice….

I have a…sister who is nine years older than me and who struggled a lot with very serious infertility problems that she knew about even as a young person because it affected her experience through puberty so that’s also a big lens. She was pregnant with twins at 41… it took so much to get her pregnant…she wanted it to be as medicalized [as possible] and so she had a [caesarean] section at 34 weeks and the twins are fine and she had another baby when she was 44. And had a subsequent [caesarean] section. She was in a high-risk practice the whole time…. So there’s a lot of anxiety around that.

In reflecting on her sister’s and her own pregnancies and births, Hanna noted how they “could not have been more different.” Hanna felt that given this history within her immediate family, “fertility and reproduction [is] this very loaded area.”
During her graduate studies Hanna was introduced to the philosophy of contemporary midwifery in the West, and its roots in social justice:

I’ve always been…in one way or another a social justice advocate. I never had the language to explain that because that’s just not where my family of origin began. …I just thought, of course, everyone should be treated fairly. And slowly, slowly through university and graduate school I started to realize there are actually words for this and became informed and more educated about what those words are.

Shortly after completing her undergraduate studies, Hanna met and married her partner Ben. When she became pregnant with her first child she contacted midwives. Hanna appreciated that the midwives tracked down information about a dietary concern she had even before she was accepted as their client, and she reflected on how this positive first impression, and her lack of a primary care provider, shaped her decisions over the long run:

I suppose if I had a family practitioner who I liked well enough I might have gone to them with that question and it might have sent me on a completely different trajectory….We were outside of their [midwives’] catchment, and once they bent to let us into their catchment…and answered my questions so nicely I felt like it was a good point of entry. But part of it was I’ve never had a stable family doctor, so I’ve had stable midwives for a decade but I’ve never had a stable family doctor.

Hanna explained how she decided on a hospital birth during her first pregnancy: “So I decided that I wanted midwives but I think like many women, I didn’t know a ton about birth and I thought the hospital seems safer—wasn’t really sure—and I didn’t have any major trauma around hospitals…It didn’t seem like a scary thing to me. So for the first birth that was where we ended up.” Hanna’s labour progressed quickly and was uncomplicated. She arrived at the hospital at about eight centimetres dilated and left a few hours after giving birth.

Hanna began considering a home birth late into her second pregnancy. Initially it was some of the practical advantages and a lack of comparable childbirth experiences
among her friends and family (i.e., less medicalized birth experiences with midwives) that raised her interest in this possibility.

I had every intention with the second of following it up with a second hospital birth. It had been reasonably positive….The thing that actually compelled me to change my mind…was worrying about my eldest…because I couldn’t figure what I was going to do with him, and everybody else I knew who was having a subsequent child…was having either an induction or a scheduled [caesarean] section because they’d already had a [caesarean] section with their first baby. I’m talking about a whole group of women who did not pick midwives obviously so I had no template for what you do.

Her partner was also quite supportive of this possibility. His awareness of other parents’ negative experiences with obstetric care had sparked doubt the efficacy of the medical model. Hanna began reading books and online information about home birth. She explained how blogs, among the many sources of “qualitative” information she gathered, ultimately had the greatest effect on her emerging interest in a home birth.

Blogs are the biggest thing for me. They always have been….They have really transformed my life [in ways other than related to childbirth]. And I think that finding bloggers who had had successful home births and also reading all…these bloggers who had medicalized births and they were all just sub-par. And even the ones that were positive birth stories where nothing actually went really awry they were still kind of like, “meh—.” You know? “This is not what I wanted. There’s got to be something better than this?…Why would I pick that?”

Hanna felt that in order to confidently plan a home birth, and be prepared to defend this controversial choice, she needed to make an informed decision based on available empirical studies:

Because I’m a researcher and because I’m a scholar, and because my partner who, as I say wanted a home birth from the first one, was also a little bit anxious and I needed to put my mind to rest that if anything went awry that I had done my homework I guess. So I went and looked up about 10 different studies and I had a little folder that I sort of willed to other women since then of…good studies that discussed home birth, and I looked up a whole bunch of studies that Ina May’s Guide to Childbirth cites…myself rather than reading her interpretation of them…I had the experiential, I had the sort of affirmative qualitative version. I wanted to really be able to say with confidence there’s no difference in outcomes here…
Having quantitative and qualitative information gave Hanna the well-rounded evidence that she felt was necessary to trust that she could give birth safely at home with her midwives. Moreover, it enabled her to question and resist the “false logic” that she feels drives fear and hostility toward home birth.

It wasn’t that I thought it was foolproof…. the conclusion that I finally drew is that babies die sometimes and you don’t know which risk you are facing. And when babies died at home it’s because their parents are foolhardy…and it’s the plan…but if the babies died in hospital it is merely tragic. But the truth is statistically babies are just as likely to die wherever they are and once I could confidently say that, I put it to rest, and as they say, prepared for this home birth.

Looking back at the circumstances of her first hospital birth, she further questioned the conventional wisdom that hospitals universally protect against risks:

It just seems so silly. Especially since our [oldest] son was born during SARS. Because everybody wanted a home birth right then. I mean the midwifery practices—their phones were ringing off the hook with people in their ninth month wanting to switch to a midwife because they were so frantic. And so in many respects the riskiest birth statistically speaking was the first one. The obstetrics ward [at the hospital she first gave birth in] closed four days after he was born.

Although Hanna felt that the “convenience” aspects of her home births enabled her to have low-stress and positive experiences she desired, she maintains that having a midwife has always been more important than where she gives birth. Hanna’s plans for a home birth proved to be practical; her second labour progressed extremely quickly (less than half an hour). She felt that had she travelled to a hospital she would have given birth in the car or an ambulance, which she did not view to be desirable situations even if they were likely to result in good outcomes.

During her third pregnancy Hanna felt it was a “foregone conclusion” that they would prepare for another home birth. As with her second birth, to avoid scrutiny and potential negative judgment from some of their friends and family, she and her partner
decided to keep their plans to themselves: “We kinda didn’t tell anybody. A couple of friends and that was it. Also because I had some weird pride issues about feeling like if it ended up with a transfer of care I didn’t want it to be anybody’s business that I planned to labour at home and that it didn’t ‘work.’” Partly their decision stemmed from Hanna’s fear that planning a home birth would further provoke her mother’s anxieties about her decision to forgo traditional obstetric care. Hanna observed how despite her mother’s ambivalence about childbirth in general, her mother’s attitudes toward midwifery have shifted dramatically: “Now she’s quite a strong advocate of midwifery and after [Hanna’s] births [she] met the midwives when they’d come to do the [home] check-ups after the births…So she raves about it to other people, which is shocking to me. She’s come a very long way!”

Hanna expressed concerns about the accessibility and sustainability of what she views is a model of safe and empowering health care. For this reason, she described midwifery in Ontario as being at “a bit of a crossroads,” where woman-centred care may be more attainable for comparatively privileged women who have the resources to educate themselves about these choices, and the “class confidence” to pursue them:

One of the things that makes me so sad is when I hear other women…in obstetric care say, “oh at this stage you do this, or you have to do this test at this point,” and I think you don’t have to do any of that. But the whole way of shifting the language…I wish that we had four times as many midwives. I guess that’s the biggest thing….on a policy level we actually have to believe that this is a good choice for everybody….I mean I can’t tell you the number of women I’ve talked to about this, who I’ve suggested midwifery, but they are understandably ambivalent. They just found out they are pregnant. There’s that emotional stuff. They don’t call [midwives] until they are eight weeks, until they are 12 weeks. Well, you know what? That decision is taken away from them at that point….It’s interesting for me to articulate all this. Because I don’t realize how strong my opinions are until I’m forced to put them into words.
Although Hanna acknowledged that efforts from within the midwifery community have helped address equity issues in the provision of midwifery, she is frustrated by what she views as a lack of political will to make it an accessible and normal choice for most women in Ontario.

Ultimately, Hanna looks back on her decision positively with a sense that it is meaningfully interwoven with other significant aspects of her life: her vocation, relationships, identity, and social justice principles:

I didn’t have the language for this. I didn’t know that midwifery existed. Again, it’s because I didn’t grow up like this. Right? I didn’t grow up in this…consciousness-raised, politicized…culture….That’s not at all how I was brought up, and so I didn’t know what a professor was until I went to university, which is why this still feels so bizarre to be here [be an academic]. And I didn’t know that you could have a midwife because I didn’t understand what midwives were, and so as a teaching assistant, as I was doing my first grad degree, I was lucky enough to bump into this [exposure to midwifery] and that gave me the language of choice…that I just wouldn’t have had…and that my kids will always have…because they were here for this. So, that feels like it is such a gift to have the cultural capital, to have an awareness of this model, because it’s still so under the radar for some people.

**Discussion**

Hanna’s story highlights how the decision to give birth at home with midwives can be consciousness-raising both personally and politically. Among the women I interviewed, Hanna seemed to be most aware of the political significance of choosing midwifery in a social context where it is marginalized and where access uneven.

Hanna’s transformative decision, which began through serendipitous exposure to midwifery years before she first became pregnant, involved considerable information gathering, analysis, and self-reflection. Her mother’s and sister’s ambivalence about their respective birth experiences, and her emerging feminist principles were important factors behind her skepticism about the superiority of medical knowledge. Encountering
empowering birth stories through social media and childbirth advice books, about women’s experiences with midwifery and home birth, became an important source of experiential knowledge that she lacked from her own personal experiences or those of her friends and family. Empirical quantitative studies demonstrating the safety of home birth ultimately solidified her trust in midwife-attended home birth as a safe choice. Additionally, these studies broadened her critical awareness—in particular, other social norms and expectations that may be disempowering to parents, especially mothers:

How much of this [these dominant cultural beliefs] is just common sense and not logic? In the same way that people who have babies at home have dead babies? And people who have babies at home are selfish, ignorant people? And so being able to do the homework on this issue [choice of birthplace]…and see with my own eyes that this is false logic, has allowed me to extend that analysis to other areas where common sense truths dominate and I don’t necessarily think they should.

Hanna remarked that the confidence gained through this decision-making process and from experiencing midwifery care has impacted the way she teaches, advocates for social change, and parents:

I think it’s shifted how I parent. You know in terms of…trying not to parent from this position of anxiety the idea that if birth’s not a three alarm fire then maybe parenting doesn’t need to be either all the time, you know? Maybe my children aren’t these precarious vessels, I mean just starting from this premise that babies are hearty, and I feel like midwifery emphasizes this to some extent. Those are a really good way to begin.

Like Hanna’s, Corinne’s narrative, highlights the potential value of empirical quantitative data in women’s informed decision-making, and the role that informed decision-making can play in women’s empowerment in their births. Her desire for a home birth following a caesarean delivery sheds light on potential complicating factors in a woman’s choice of birthplace.
Corinne: Disappointment, Resistance, and Healing

Until her friends began having children, Corinne was unaware that midwifery existed. She considers this ironic given that she studied sciences at one of the three universities offering the Ontario Midwifery Education Program, at the same time that the first class of midwives graduated. After completing an undergraduate degree, Corinne trained as a massage therapist. She learned about midwifery through colleagues who had served as labour support persons at midwife-attended births, and through friends who had received midwifery care. Her family doctor was also positive about midwifery care:

Our doctor teaches obstetrics…So he has a family practice but he does labour and delivery. That’s part of his practice. So when we were thinking about being pregnant, I said, “Doc? Tell me about midwives?” and he said, “if you have the chance to be with a midwife, go.” He said, “you will get far more intimate care than you ever will with me. And if it’s an option that you are interested in I would totally recommend that you go and be cared with a midwife.” And I was like, “ok, really?” So my doctor’s telling me to be with a midwife. So we were with the midwives.

When she became pregnant with her first child, Corinne contacted midwives right away. She found it odd and “amusing” that despite her family doctor’s endorsement of midwifery, he was firmly against out-of-hospital birth. Through reading, speaking with friends, and talking with her midwives, Corinne became confident that home birth was a safe choice and could facilitate her desired birth experience. The insights of fathers whose partners had given birth at home reassured her partner, and he soon became supportive of Corinne’s interest in a home birth.

Corinne’s labour progressed quickly. When she received her first vaginal exam, her midwives discovered that she was already 10 centimetres dilated and that the baby was in frank breech presentation (buttocks down). In Ontario breech presentation is an indication for hospital birth, and at the time of Corinne’s first birth the Society of Obstetricians and
Gynaecologists of Canada (SOGC) held the position that all breech births be delivered by caesarean section. She felt this policy guideline greatly influenced her midwives’ approach. Corinne was quickly transferred to hospital where a caesarean was performed. The obstetrician criticized Corinne for attempting to give birth at home and questioned her midwives’ ability to identify breech births.

In hindsight, Corinne was disappointed that her capacity for informed choice was undermined, at least to some degree, by what she perceived as her midwives’ and the obstetrician’s lack of confidence in vaginal breech birth:

My frustration comes from the fact that my circumstances were perfectly aligned for attempting the breech delivery. [The] baby was frank breech, there was no maternal or fetal distress, and the OB that did the surgery was in fact skilled in vaginal breech delivery…and my midwives are trained in vaginal breech delivery.

Whatever the layers were around it, certainly the SOCG guidelines were that [caesarean sections were recommended for breech birth]…I think personally that the midwives, the one that was with us, it was her personal opinion that it was safer to do it, but part of being a midwife is that it’s not your place to make the decision, it’s your place to inform your client to make the decision.

Corinne’s frustration increased when two months later the SOGC changed its position on breech delivery, indicating vaginal breech birth to be a safe possibility.

Corinne described a difficult post-partum experience: it “mentally and emotionally sucked” and was “physically terrible.” Recovering from surgery made breastfeeding uncomfortable, restricted her ability to perform household chores, and prevented her from being physically active, something that had always been a great source of enjoyment. Because she felt it was difficult to “let go” of this negative birth experience, she enrolled in a workshop based on a childbirth education book she had found helpful. This workshop played an important part in her emotional healing.
I bawled the whole time. It was so cathartic and I was like, “that’s what I needed to heal”….It was so far from what I wanted my birth experience to be that it sucked, you know? And there was so much intervention and so much…that I didn’t have power over. And I’m a total control freak on a good day. So…to have lost control: “Ok, now it’s in a hospital. Ok, now it’s with a doctor. Ok, now it’s a caesarean. Ok….Be gone with you.” And then there’s no follow up from the physician. And…caesareans aren’t [midwives’] thing…. So that [workshop] was a really healing thing for me to go through.

When she became pregnant with her second child, Corinne hoped she could give birth vaginally and at home. She spoke with her midwives, one of whom had been her midwife for her first pregnancy, about her concerns and desires. She also reviewed relevant empirical quantitative studies:

So “ok, I want to try to birth at home…. but then there’s the VBAC idea….That’s what I want because it [the last birth experience] sucked. Now let’s be rational about it.” So I went and read whatever I could….The science geek that I am, I’m Medline-ing “home birth” and “evidence-based medicine.”

Despite her fluency with scientific research and experience working in health care, Corinne encountered conflicting information and inconsistent policies and practices among health care providers. For instance, she was aware that planned elective repeat caesareans were still the norm even though there was evidence indicating vaginal birth after caesarean (VBAC) could be safe and potentially avoid risks associated with repeat caesareans (e.g., placental issues in future pregnancies, infections, hemorrhage) (AOM, 2011). She also discovered that clinical practice guidelines around VBAC and home birth varied across midwifery practices. To develop a well-rounded perspective, Corinne supplemented her analysis of scientific studies and medical policy statements with information in childbirth advice books that she felt was consistent with her holistic view

21 Medline is an academic database of medical and other health care-related publications.
of pregnancy and birth and that encouraged informed decision-making and woman-centred care.

As per her midwives’ practice guidelines for clients desiring a VBAC, Corinne was referred for a consultation with an obstetrician late in her pregnancy. Here, Corinne was sternly lectured for her interest in VBAC and home birth. Feeling “shell shocked” for days after and with her confidence shaken, Corinne felt compelled to reconsider her decision.

_Uterus rupture. Nasty. If the mother dies, it’s terrible. God forbid if the baby dies._ And so I cried for…three days after and thought I was an asshole parent and really…vacillated about my decision. And my husband was like, “what do you think? Is what he has to say, does it really change your opinion?” So we sat down and I was like, “no, my heart is saying it should really be at home.” And it’s not just like a heart decision. Like in my gut, my gut is telling me that the best place for this baby to come out is at home. You know? How labour would progress the best is in the comfort of my home. So, uh, when we went into labour, we stayed at home.

Corinne’s midwives supported her plans for a VBAC at home. She experienced a straightforward labour and gave birth to her son in her home in the care of her midwives, partner, and close friend. Two years later, and with one of the same midwives, Corinne had another successful VBAC at home. Corinne agreed with her midwife that each of these two VBACs at home held unique meaning:

The first one is like, “wow, now I know what I missed.” You know? Like all of that stuff that I…It was very healing. And it was interesting because the midwife put it like that to me…. I just wanted to climb on top of a mountain and beat my chest or something. And with [her youngest daughter] it was just about the birth.

Corinne feels a key part of her decision to initially plan a home birth, and later to attempt VBACs at home, originated from her overall outlook on pregnancy and birth:

As much as I’m scientific and all about evidence-based medicine in whatever practice you choose to practice…one of the things that kind of resonated with
me is the idea that pregnancy is not a disease, right?...Like having a baby is amazing. It’s not about being sick or diseased or any of that, and it’s not pathology. It’s a state of existence, right? So I think I felt that, that was something that influenced me kind of in my approach to things.

Although Corinne appreciated that her eldest child was born healthy via caesarean and that she recovered smoothly from surgery, she was disappointed with the experience and identified her need to heal from it. She was proud of her ability to make an informed decision with her second birth and that she was able to experience the vaginal birth at home her had desired. Shortly after her third birth, a student midwife in her practice group asked: “how did it go?” Corinne recalled her response: “oh, amazing, empowering, vulnerable, and healing.”

Discussion

Among the women I interviewed, Corinne’s initial decision to plan a home birth appeared the most straightforward. She thoughtfully weighed the risks and benefits of home and hospital birth; however, she came to her decision relatively early in her pregnancy and did not seem to struggle as much with the myths and stereotypes that some of the other women described. Corinne’s disappointment with her unexpected caesarean birth, and her frustration with the possibility that it may have been avoidable had clinical policies been different reaffirmed her desire for a vaginal birth, and ideally one at home, for future pregnancies. Making this decision a second time required consideration of multiple factors—what Corinne described as “layers”—and complicated the process. The lack of consensus within the literature and health care professionals, for example, about the safety of VBAC versus planned repeat caesarean, and VBAC at home versus in the hospital, made doing her “homework” more challenging. She explained this in the context of the debate over VBAC versus planned elective repeat caesarean section:
The evidence-based medicine is all like EFM [use of continuous electronic fetal monitoring] is the golden standard for VBAC… Because the fetal heart rate will do a decel [deceleration] and consistent deceleration prior to the uterine rupturing. I don’t know how they figure that out. Like in retrospect or something…. And then I’m reading Pam’s [Pam England, author of *Birthing from Within*] stuff and it’s like EFM with your feet in stirrups is the least likely way to get labour to progress normally. You need to be up and you need to be moving…

Corinne also found that available empirical quantitative studies and clinical guidelines sometimes conflicted with her own embodied knowledge. This was the case with evidence-based recommendations for monitoring VBACs: “I’m not lying on my back [for continuous EFM]. I’m not pushing with the baby on my back. Like that was just my body’s way of wanting to get the baby out at all. I never laboured on my back.”

Corinne’s first birth reflected the reality that even when multiple ways of knowing support a woman’s preferences, the authoritative knowledge of obstetric medicine often dominates. It may be enforced through institutional policies or by health care providers’ attitudes or confidence, and may limit women’s informed decision-making. Her encounter with a disapproving obstetrician late into her second pregnancy further contributed to the challenging nature of her decision. The physician’s use of alarmist language—“do you know how tragic it is if the mother dies during birth?...Are you kidding?...Do you know how tragic it is if the uterus ruptures and the baby’s arm is sticking out of the wound?”—made her feel guilty and fearful and led her to question her judgment and worth as a parent. In retrospect, Corinne reflected on the irony of this:

I think of myself as educated scientifically around birth, about medicine around birth. I do my due diligence around EFM [electronic fetal monitoring] and home birth and home birth safety….And he might has well have said, “you don’t love this baby enough because you want to birth at home and the baby’s going to get hurt and you’re going to die.”

Corinne’s experience underscores the negative effects that social sanctioning may have on a woman’s confidence and on her ability to make informed decisions. Regaining her
confidence required the support and trust of her partner and midwives, careful consideration of the information she had gathered, and great personal strength. Ultimately this knowledge enabled her to make a decision with which she felt comfortable. Her decision to have a VBAC appeared to be worth the effort, as she emphasized that her birth experiences and outcomes were healing and empowering.

**Findings Part One: Reflections**

For the women in this study, a combination of experiential knowledge and more focused information gathering appeared to be of equal importance to the “unlearning and relearning” that was central to their transformative decision to give birth at home with midwives (Cheyney, 2008, p. 258; Murray-Davis et al., 2012). The different types of evidence participants gathered became a valuable body of authoritative knowledge that empowered them to resist the dominant cultural metanarrative that labour is normally messy, dangerous, and unbearably painful. Participants’ commitment to take responsibility for their decisions and to devote considerable time, effort, and careful thought to this process demonstrated their decisions were complex and significant. The process of unlearning and relearning enabled the women to see themselves as competent and trustworthy decision-makers, and to challenge the dominant perception of women choosing home birth as misinformed, selfish, and irresponsible.
PART TWO

I think that how mothers feel about how they birth is profoundly important. But I don’t think that it’s more important than live babies. And I don’t think that anybody in this field does. And that’s the irritating thing that when everybody says you know, “you’ve got a healthy baby that’s all that matters.” Well, no that’s an important thing and that does matter, but it’s not all that matters. How you got to that healthy baby matters. That matters a lot. So if you can have both, why wouldn’t you try to have both? [Hanna, mother of three]

Having laid out the dimensions of participants’ challenging, transformative decisions to plan midwife-attended home births, I discuss two key beliefs and values that all the women developed or reaffirmed about childbirth, and consider how these influenced their choices. First was their view that pregnancy and birth are healthy, normal processes that, in addition to being means to an end, are significant life events for women and their families. Second, was their willingness to honour their desires for positive birth experiences according to their individual needs and priorities. Exploration of participants’ holistic, woman-centred views of birth serve as extended examples of how they challenged medical orthodoxies, particularly the conception of birth as a risky medical condition and avoidance of fetal and maternal death as the only criteria for a “good outcome.”
Chapter 6: Birth as a Healthy, Normal Process

For the women in my study, the decision to seek midwifery care, and especially to plan a home birth, required a view of pregnancy and birth as healthy, physiologic processes. In fact, this “trust in birth” and in women’s bodies to give birth safely, appeared to be the most critical factor in their decisions (Dahlen, 2010, p. 156). It enabled them to resist the fear-inducing medicalized view that rationalizes compulsory hospital birth for low-risk pregnancies and many routine used medical interventions. The importance of this confidence in birth as inherently normal has also been identified by participants in many other studies that explore women’s motivations for choosing midwife-attended home birth (Abel & Kearns, 1991; Bastien, 1993; Boucher et al., 2009; Catling-Paull et al., 2010; Cheyney, 2008; Dahlen, 2010; Godfrey, 2010; James, 2011; Klassen, 2001; Lindgren et al., 2004; Madi & Crow, 2003; MacDonald, 2007; Morison et al., 1999; Murray-Davis et al., 2012; Sharpe, 2004).

The tendency for the women I met with to describe birth according to what they perceived it is not—“not a medical condition” (Felicia), “not a medical experience” (Sally), “not about being sick or diseased or any of that, and it’s not pathology” (Corinne)—suggests that they were aware that their views ran counter to the dominant paradigm. In addition to these attitudes towards birth, the women also conveyed a shared belief that birth is a significant life event with emotional, social, and for some individuals and families, spiritual dimensions. Their holistic perspective corresponded with principles set out clearly in the College of Midwives of Ontario’s Philosophy of Midwifery Care:

Midwifery is based on respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman’s life. Midwifery care respects the diversity of women’s needs and the variety of personal and cultural
meanings which women, families and communities bring to the pregnancy, birth and early parenting experience (CMO, 1994).

Related to women’s wellness-oriented views, were their concerns about a potential *cascade of interventions* that may result in a hospital setting where interventions have been shown to be more common (Hutton et al., 2009; Janssen et al., 2009a). All of the women emphasized that having midwives as their care providers was the most important factor to reducing the likelihood of unnecessary interventions and potential iatrogenic complications. However, the women also raised concerns that more subtle restrictions (such as reduced privacy, reduced/lack of access to certain comfort measures), which they perceived as reality in hospitals, might inhibit effective labour, and undermine their desires for births with few or no medical interventions. Ultimately, these concerns became important factors in their decisions to plan home births.

As discussed in Chapter 5, some of the women’s concerns emerged or were reinforced after reading research studies and childbirth advice books, watching films, talking to past midwifery clients, and critically considering the experiences of women they knew who had had physician-managed births or delivered in hospitals (sometimes, but not necessarily in present-day Ontario). Developing trusting relationships with their midwives also increased their confidence that they could expect less interventionist and more holistic care from midwives. As an illustration of this view, Sally compared her two birth experiences:

[With the first obstetrician-attended birth] I didn’t have the medical involvement because it wasn’t necessary [because her birth progressed quickly]. I had made a list of the progression if necessary…I would have preferred to have a vacuum delivery before I would have chosen forceps or an episiotomy. I mean I had a progression…. it was all based on talking to friends who’d had previous experiences, doing some reading in books and research online about outcomes, and deciding that the pros and the cons of certain things were outweighed, which is why
they went higher on the list…But sort of going forward with a midwife and a home birth I was like, “I don’t have to worry about those things because they’ll tell me, and I will trust them if I need to go to the hospital.”

It is possible that being inexperienced with labour contributed to Sally’s greater degree of preparation during her first pregnancy. However, there was also a sense from her comments that being vigilant about advocating for herself was something she felt was more critical when receiving care from an obstetrician than with a midwife. She highlighted how the likelihood of woman-midwife relationships where power is shared may foster trust among midwifery clients:

I love the option of having the choices to do any of the testing. That there was nothing that they just handed you a sheet [about] and said, “go do it.” You could ask why, you could ask what, you could ask how, and if you decided not to do it, there was no judgment whatsoever. And if you decided to do it, there was support. And at the same time [the midwives would say]: “tell me a little about yourself.” You know? “I want to meet your other child. I want to meet your husband. I want to meet your parents!” It’s like they express a genuine interest in who you are as a person not only the experience you are going through. And having heard that from so many people,…[and] thinking about having a second child I was like, “I’m so going with a midwife the next time!”

Similarly, Hanna explained how her trust in her midwives’ clinical judgments resulted from her perception of midwifery care as woman-centred (as opposed to provider-centred):

The priority was having woman-centred care and having advocacy and feeling like I had actually informed choices and also feeling if they said “we need to transfer, you need a section, this is what is going on,” that I had absolute confidence that that really was true other than it was…fear mongering or that it was to make anybody’s schedule easier.

April saw midwifery care, and especially birth at home, as a way of avoiding pharmacological pain management and its associated risks:

I knew all along I wanted to go drug-free, and one of the other things that played into our decision to have a home birth was the fact that there was going to be zero access to drugs. So I couldn’t halfway through, “no, get me the epidural!”…I had
read a lot about the effects of epidurals and the dangers of epidurals, it just wasn’t something I wanted to do. So the more research I did and the more reading I did, the more I became convinced that I didn’t want to be in a hospital. I started reading about experiences where women had gone in to do this in a hospital,…and give birth naturally…all of these interventions start happening and all of a sudden are escalating, and the next thing you know they are in a c-section.

Although it is possible that a new orthodoxy is emerging among women who choose midwifery care, where clients substitute the expertise of one type of care provider (physicians) with another (midwives), it seemed from my conversations with the women that their greater confidence in midwives compared with obstetricians stemmed from their woman-midwife relationships where there was shared power and views about birth, more than from their perception of midwives as “experts” and authority figures.

**Shared Beliefs, Different Starting Places for Decision-Making**

Although the women shared holistic views of pregnancy and birth, these views emerged differently from the women’s life experiences, and each approached her decision from a unique starting place. For example Hanna’s view evolved gradually during graduate studies and as she read more about woman-centred birth. She explained, “I was never terribly spooked about birth, but I wanted to read about positive, healthy, celebratory, strong, empowering stories.” Felicia’s wellness-oriented view of birth was established well before she became pregnant. Her narrative sheds light on how this may shape women’s childbirth choices.

**Felicia: Staying Balanced, Staying Calm**

Felicia grew up in a close family with three younger sisters. Although she wanted to have children for a long time, she deferred parenthood because her long-term partner had not felt ready. She became pregnant, but had a traumatic early loss. Shortly before
discovering she was pregnant second time, she separated from her partner. Not wanting to “upset the balance of what was going on in [her] body,” she decided not to inform him about her pregnancy until the end of the first trimester. Felicia has coped with family violence, first through learning that her father had abused her mother during their marriage, and more recently from her ex-partner. She reflects on her experience: “it’s so weird though that I kind of watched my mom and here I am in the same situation.”

Felicia is committed to leading a healthy, balanced lifestyle, which for her includes regular exercise, a healthy diet, and the use of holistic therapies. She recognizes that maintaining this approach with a full-time career and a young child can be challenging:

It’s hard to do that. It can be expensive. But I try to make choices and prioritize like the things that are highest on the list of pesticides and contaminants. I try to avoid them and buy organic. He [her son] doesn’t eat anything that’s not organic. Except, to date, things that other people have given to him that I have no control over… I try to do things to sort of rebalance myself like yoga, or you know, there’s not a lot of time for quiet meditation in my life anymore, so if I can get to a yoga class that’s good for me. If I can play a round of golf sometimes or be in the fresh air with peace and quiet, that’s good.

Felicia’s youngest sister is a naturopathic doctor, which has familiarized her with health care approaches other than the Western biomedical model. She and her sister “have a similar philosophy in terms of holistic health care,” which, in her view, means taking personal responsibility for one’s health, practicing preventive measures, and avoiding invasive treatments when possible.

Felicia became aware of midwifery through another sister who explored midwifery care during her own pregnancy. She provided Felicia with childbirth education books that discussed midwifery, including several by midwife and childbirth activist Ina May Gaskin. These resources were instrumental in attracting
Felicia to midwifery. During her first pregnancy, Felicia was waitlisted for midwifery care. She persisted during her second pregnancy: “I phoned as soon as I knew and I followed up like every day for four days, like, ‘I need to know, I need to know,’ and they were able to take me, which was fabulous.”

Initially Felicia was undecided about where she wanted to give birth: “I wasn’t one hundred per cent sure about it yet. I knew I wanted a midwife. And I think that a big part of me really wanted a home birth, but…I needed to feel comfortable with the idea for various reasons.” A trusting relationship with her midwives, who Felicia felt were knowledgeable about the benefits and risks of available birth settings, increased her confidence in home birth:

They answered all my questions….They were really, really good at offering information and making sure that I had all the tools to make the right decision. A lot of my questions were just sort of the what ifs: what if something happens? What if this and what if that, and what if the other thing? And I think once they had explained to me that if I was in a hospital—I think this was the turning point for me—if I was in the hospital and there was a complication, by the time anybody prepped and O.R., got me prepped, and got me down…it would take the same amount of time for them to prep me here, call an ambulance, start the IV, and transport me anyway while they are prepping an O.R. there. So I thought, “well?”…So for me that was sort of the decision changer for sure. That was the thing that sort of put me on one side of the fence, because I was sitting for a while.

Felicia attended a home birth information night at her midwives’ practice where she met families who had planned home births and learned about the equipment midwives bring to women’s homes. Reading the birth stories of women who had received midwifery care or given birth at home reaffirmed her desire for a home birth and helped her prepare for her own birth:

So I had to go into this with absolutely no expectations. And I had to just go with it, because however it was going to be for me and my body and my child was how it was going to be. And if I started to have expectations and I had set
in my head that it was supposed to be a certain way and it didn’t go that way, I didn’t want to get stressed out about it. And I thought you know this is something that I am supposed to be relaxed about because it’s a normal process; it’s a natural process. You know people don’t coach a cat when it’s giving birth or a dog or a whatever. Animals just know. They don’t freak out and moan.

To cope with the pain of labour, Felicia relied on the support of her midwives and youngest sister who was present for the birth. She also used homeopathic remedies and visualization and breathing techniques she had learned from childbirth advice books. Felicia was surprised to find that her contractions felt less painful than when she experienced the early loss. This confirmed her belief that a woman’s emotions and state of mind have a significant impact on her perception of pain.

The miscarriage was far more painful than my birth was….afterwards, I thought: “you know it’s probably because when I was miscarrying I was completely resisting it. I didn’t want it to happen”. And when I was giving birth anything that felt remotely like a contraction I was like, “oh yes”, because I wanted them to come. “One more contraction is one more step to meeting my baby.” And I was waiting for them to start happening because they weren’t for a while. So I think that had a lot to do with it. I think mind over matter plays a really big part of how it all plays out for you.

While Felicia understands why women may choose pharmacological pain management and believes women should choose the birthing conditions that make them feel safe, she was concerned that an epidural might disrupt the natural progression of her labour and interfere with her ability to “feel in control.”

Similarly, she felt giving birth in a hospital, with its rules and restrictions, could undermine her ability to relax and focus.

Following the birth of her son, Felicia was well supported by her mother and sisters. She also greatly appreciated her midwives’ home visits where breastfeeding
education, emotional support, and insights about normal newborn behavior (including when to be concerned) were accessible and personalized:

The after-care…really surprised [Felicia]. The coming back to your home and checking up on you. And that for me, that was a big deal. That was a big deal. And that as a brand new mom, a first-time mom, that really helped to feel comfortable, you know? Or the little things they said, like “you know newborn babies really…they are still learning how to breathe and they breathe really funny and sometimes it might sound like he’s gasping.” Because if somebody hadn’t told me that, I probably would have freaked out and called 9-1-1! So those little things really helped me to feel at ease.

**Discussion**

Felicia’s decision to seek midwifery care and plan a home birth emerged, in part, from her desire for a care provider who shared her holistic view of birth, and who she felt would facilitate a calm and relaxed environment for labour. This priority was conveyed through recurring language and imagery in her narrative (her desire to remain “calm,” “relaxed,” and “balanced” during labour). Her references to the ways that other mammals give birth, guided by intuition and instinct, reflect her view of labour as a physiologic or “natural” process that progresses best with minimal disruption. Similar imagery has been used by participants in other studies examining women’s home birth experiences. Like Felicia, women interviewed by Pamela Klassen (2001) used analogies of animal birth to normalize and make sense of labour pain. This view of productive pain seemed to help some of the first-time mothers in my study (Felicia, Natalie, April) prepare for childbirth and cope with labour pain. Their holistic perspectives countered the dominant view of labour pain as an unpleasant “side-effect” of childbirth that ought to be feared and eradicated, and that frames women who avoid drugs for pain control as “suffering” foolishly and unnecessarily.
It is important to acknowledge that the idea of “normal” or “natural” birth may give rise to potentially narrow expectations about how women ought to give birth (MacDonald, 2007; Sharpe, Rudel, & Turner 2009). These views may reflect gender and racial stereotypes: for example, the selfless and saintly mother; the female body as constrained by biology, “closer” to nature, more animal-like, or more “naturally” inclined to cope with the pain of labour. These expectations may also inform judgmental views about what it means to be a “good” or “natural” mother or woman (MacDonald, 2007; Nestel, 2006). Since the women in this study arrived at their particular conception of birth as a healthy, normal process in active and empowering resistance to its conception as an illness, the potentially limiting stereotypes that may be associated with “natural birth” were less restrictive. Moreover, instead of being motivated by fear or guilt arising from the dominant cultural message of “all the things that can go wrong” during childbirth, their views of childbirth as normal life events enabled them to feel comfortable and confident giving birth.

For Felicia, a holistic view of birth fit within her broader pre-existing philosophy about health and the body. She explained:

I tend not to go to doctors or hospitals unless I really need it. So I don’t see a family doctor regularly. And very rarely. I think over my adult life I have started to educate myself about lots of things and there’s a lot of information out there that wasn’t available to us 20 years ago, in terms of proactively managing your own health. So that’s important to me and in doing that I have started to see a naturopath regularly. I’ve gone to chiropractors and physiotherapists and tried to manage my health holistically. And recognizing there’s a place for modern medicine. But if I don’t need it and I can find an alternative, I prefer to look for the alternative first before resorting to that…. So I think that’s sort of why for me the midwives, midwifery care just resonated with me. Because it sort of falls under this holistic kind of health care.
Felicia drew an explicit connection between midwifery principles and holistic health care, which she feels empowers individuals to be active participants in their health. Corinne and Sally expressed similar views. In contrast, Natalie’s perspective changed dramatically after a transformative experience. Her narrative highlights the potential impact of this kind of experience on a woman’s childbirth decisions.

**Natalie: Birth Becomes Beautiful**

Natalie grew up in a small town, the older sister to five brothers, three of whom were cousins adopted after the death of her aunt. Although Natalie “dreamed of the Big City” growing up, as an adult she finds a sense of relief and familiarity in the countryside. After attending university, she travelled abroad, met her partner Ravi, and settled in Toronto.

Natalie became a yoga instructor and became interested in teaching prenatal students: “I always thought that there was something amazing about pregnant women and loved the idea of getting to be around that. So I thought, ‘oh wouldn’t it be cool to teach prenatal yoga.’ But I didn’t really know about that whole world. Like I wasn’t having kids yet myself.” Until this point Natalie was not familiar with midwifery or childbirth options outside of the medical model. Her mother experienced three difficult births, including two caesareans, which Natalie believed had caused her to be fearful about childbirth.

Natalie enrolled in a training program facilitated by a yoga educator and doula, where she was presented with an unexpected opportunity to reflect on her beliefs about childbirth. She describes this training as consciousness-raising:

I was expecting to go and be taught, “so you can’t do these poses and do these ones instead.” And I was looking at a very superficial and pragmatic way, like
having to work with pregnant women. But she [the instructor] thought it’s really important as a teacher to examine your own assumptions about birth and pregnancy, because even if you don’t mean to, those are going to inform the way you are going to interact with your students. Like those will be in the room whether you intend them to be or not. So she had us all...brainstorm: “so birth—what comes to mind? What does that word mean to you? And here’s some coloured pencils and what not.”

Natalie recalled being taken aback by her drawings:

So I wound up scribbling all over this page and...a lot of the stuff that kind of came up was kind of shockingly dark and negative and I sort of wrote PAIN in big black letters. And I was just like, “ah” and there wasn’t even anything about like love. It was just all this fear, all of a sudden like looking back at me from the page. And I was like, “Oh! I had no idea I even felt this way!”

Later, when the facilitator demonstrated ways supportive touch can be used to help a woman cope with the pain of labour, Natalie saw birth in a drastically different way:

So the partner was like standing up and she was like holding on and kind of rubbing her shoulders and leaning down. There was this kind of intimacy.....And I had this moment of like being. And I thought that the way that you gave birth was like you see in the movies. Like with your feet in stirrups, screaming in a hospital. And that was all I’d ever been exposed to. And so seeing that it could be this thing, like, “oh you mean you can move around? And your partner can be there and you can like?” And just seeing that moment. And so afterwards she asked, “what kind of struck you guys about that?” And I just tried to explain that and I just started to cry. It was just so beautiful. I didn’t know that birth could be beautiful. So that was a moment that shifted...like started to...open my eyes to this whole other way it could be.

As part of the workshop, the instructor invited a midwife to present to the class. This presentation reinforced Natalie’s revelation that “birth is normal” and “beautiful.” She recalled going home and bookmarking the midwife’s practice website thinking she might seek their care in the future.

A year later, when Natalie became pregnant, she contacted this midwifery practice. Recognizing that many women seeking care are waitlisted, she felt that
she “lucked out” when she learned she could be accommodated. Even though she was set on midwifery care, she appreciated that her midwives encourage prospective clients to ask questions and leave the decision to proceed with care open-ended at the first appointment.

After the option of giving birth at home was presented in routine clinical care Natalie contacted a good friend who had given birth at home to ask her about her experience:

I remember thinking like, “I didn’t know you could even do that. You can choose that, really?” and as an idea it really appealed to me because you know I’ve never really felt really comfortable in hospitals and it’s like, it just seemed like not the warmest environment, and like a lot more would be out of my control there. It’s the idea that you could just be home. And I was like, “really? But is it safe?”

Natalie found that having her questions answered by her midwives, reading information online and books recommended by her friend strengthen her view of birth as a healthy, normal process, and increased her interest in home birth:

[Reading] totally shifted me from being like afraid of like birth to being like, “wow, I wonder what mine’s going to be like.” Because each story was so different but ultimately the end was the same, in that like moment, when it’s your baby and you did it and the accomplishment and like the love and all that. And so some of the more like longer or shorter or more challenging or you know? And each one the details are so different but like they all did it, so I found that so empowering like, “ok, well I could do it too, and I wonder what mine’s going to be like.” So I started getting excited about it.

Although Natalie’s partner was initially hesitant about the safety of home birth, as he learned more, he soon became a strong supporter of her decision. Natalie openly shared her intentions to give birth at home with her colleagues, friends, and family, and while she accepted their curiosity, she found their childbirth “horror stories” and second-guessing of her decision was “profoundly unhelpful.” She lamented that as a pregnant
woman “suddenly you have this big target painted on you for everyone’s advice.” Being able to read about home birth and ask questions of her midwives and friend enabled her to resist what she described as “fear mongering” from others and trust that she was making a good decision.

On New Year’s Eve Natalie’s membranes ruptured while she was in her hometown celebrating with her family. Amidst the excitement, Natalie called her primary midwife to discuss the plan. Because her pregnancy was a few days short of being full term (pre-term labour is one indication for planned hospital birth), her midwife informed her that she had the choice to go to the hospital to be examined. She also informed Natalie that once in hospital she would likely be asked to remain there to give birth. Natalie’s midwife encouraged her to make her decision based on her comfort level. She decided to proceed with their planned home birth.

Natalie, her partner, and mother said their “Happy New Years” on a country road as they drove back to Toronto. She gave birth to her son at home on New Year’s Day in the care of midwives, partner, and mother. She looks back on her birth as an “incredible accomplishment,” and recalls feeling “high for days” afterward. As a new mother who was anxious about caring for a newborn she appreciated the in-home visits she received in the immediate post-partum period. She felt midwifery care and giving birth at home not only helped her bring forth a new life in a safe and satisfying way, but helped build her confidence as a mother:

I came across a quote recently that had something to do with: birth isn’t just about making babies, it’s about making mothers… it’s really like making strong, confident mothers, and it’s true, like because it is such a profound experience and it’s gonna have a huge impact no matter how you have your baby….People remember that day for the rest of their lives…and so for us I’m so grateful that that impact was profoundly positive…because it’s so
overwhelming in the early days with a newborn, but if you’re just like, “I just had my baby! I just had my baby right there! [pointing to dining room] I can do anything.”

Discussion

Like Felicia, Natalie described the process of learning about woman-centred birth as “eye-opening.” However, Natalie’s awareness emerged more dramatically and became an important starting place for her decision to seek midwifery care and later, to plan a home birth. Prior to Natalie’s transformative experience during the yoga instructor workshop, she associated birth with pain and risk. Her impression of childbirth was dominated by the stereotypical image of the labouring woman in a hospital, legs up in stirrups, and screaming. This image plays into the overarching cultural metanarrative of childbirth as terrifying, out of control, and excruciatingly painful. This common impression of birth is driven by and sustains the dominant medical view of birth as an illness and pain as an indicator of dysfunction. In the case of the women in my study, overcoming fears about birth—or not being fearful of birth in the first place—were empowering and confidence-building.

A perception conveyed among participants was that their midwives’ involvement in low-risk birth made them the appropriate care providers for those with “normal” pregnancies, and qualified them to accurately differentiate between the normal pregnancies and those that would benefit from physician involvement. Felicia explained how this increased her confidence:

They see so much normal then if something’s not going according to plan, they know when they need to transfer. They know when they need to involve somebody else, and I think that’s a really good thing to take into consideration.

22 The quote Natalie referred to is attributed to Barbara Katz Rothman, 1989.
when people are concerned about what if, what if, what if? Well, they know when it’s not ok. So it was good.

Although each woman’s perspective on birth emerged uniquely, all were confident that women’s bodies *can* give birth safely, and that when supported and encouraged by equally confident care providers and support persons in a comfortable and safe (emotionally, physically, etc.) environment, the likelihood of this happening is greater. The women’s “trust in birth” was nurtured through woman-centred midwifery care and was critical to their decisions to give birth at home (Dahlen, 2010, p. 156).
Chapter 7: Birth Experiences Matter

In addition to viewing pregnancy and birth as healthy, normal processes, participants’ “paradigm of birth” involved them seeing these processes as more than a means-to-and-end (Dahlen, 2010, p. 156). This holistic perspective radically challenges the dominant product-focused view central to medicalized birth, in which women’s and families’ experiences have a relatively low value. In this medicalized view, interventions and iatrogenic complications are often accepted as collateral damage necessary for a “good outcome” to a normally risky event. Pain and discomfort for the woman, elevated risks of complications in future pregnancies or impacts on fertility, lengthened recovery, emotional stress, financial costs, and disruption to breastfeeding and family bonding are comparatively trivial when fetal and maternal death or disability are perceived to be likely possibilities without medical management. For participants in this study, resisting this end-justifies-means view of childbirth empowered them to envision the possibility of both a good outcome and good experience based on their individual needs and priorities. In doing this, they also called into question the dichotomous view of woman and fetus as separate and in competition, and were able to deflect some of the guilt and fear that proliferates in a culture where women seeking less medicalized birth experiences are judged as selfish and irresponsible.

Mary-Beth’s and Sally’s stories from their previous obstetrician-managed births highlighted some of the shortcomings of the medical model that tends to downplay or overlook the psycho-social needs of women (and families). Over the course of 10 years, Mary-Beth gave birth in various hospitals and received care from more than six obstetricians. Her descriptions of these births were remarkably similar. They included
impersonal, fragmented care; many interventions during labour; routine separation from her baby after birth; and the use of infant formula by her newborn’s care providers despite her desire to exclusively breastfeed. Although she gave birth to four healthy babies and succeeded with breastfeeding, she emphasized that her experiences were “pretty pathetic”:

As for the nursing [soon after giving birth to her second baby] you know they didn’t put him on my chest again either. I don’t know why they took him right away because he had no health problems. But they would keep him in the nursery and, I’d be like, “where’s my baby? Can you please bring my baby to me? I want to go get my baby.” And it would…be a few hours and they’d say, “ok, we’re coming.” And another couple hours would pass and I still wouldn’t have him. And in the mean time, I was also willing to sleep. My body was tired, but the thing is I really needed to be sleeping with the baby attached to my breast and I didn’t know that, and I didn’t understand that. So even though I was once again successful, and I breastfed him for over a year, it just didn’t start out the best way it could have started out.

One of the most important reasons behind Mary-Beth’s decision to seek midwifery care, in spite of the barriers she encountered, was to have a better birth experience. Her description of her fifth delivery at home in the care of midwives highlights some of the differences between a birth that is woman-centred and one that is not:

[My husband] was like, “I’m so excited. We’re going to have a baby again!” We lay on the bed together while the contractions got stronger, waiting for my midwife to come over. It was such a close bonding time for the two of us. So much more than it had even been in the hospital. This was, I mean the bed we had conceived our child in and I was going to give birth to her in the same bed…You know giving birth with your partner, your husband there is just the most close time you can feel to this person to me. And the fact that we had no people coming in to sweep the floor, or to check my blood pressure, or to rearrange this, or…Because that’s what happens at the hospital. You have 15 people coming in! I had a shift change one time and the janitors were there and I’m like sitting there with, you know, my legs spread apart doing an episiotomy while the janitor’s sweeping the floor. I didn’t have that at home. It was so peaceful. And they [the midwives] were just gentle, quiet. The whole place was quiet. I could focus.
Mary-Beth’s comments highlight the failings of a model of birth that places little to no value on a woman’s experience and that of her partner, newborn, and other children. Even if the outcome is “good,” a woman’s experience may be uncomfortable, inconvenient, and in some instances, traumatic. Fundamental to Mary-Beth’s and the other women’s choice of midwifery, and especially home birth, was a strong belief that their birth experiences mattered and were not necessarily at odds with a safe outcome for their newborn.

**Appealing Qualities of a Home Birth**

Participants’ comments often conveyed that having a midwife was a priority, above and beyond where they gave birth. Hanna was particularly emphatic, reiterating at several points in her narrative that she was less concerned with “venue” than with having “woman-centred care.” As women considered the qualities of hospital and home birth in greater depth, certain appealing qualities of a home birth became more apparent. Hanna explained how having a home birth afforded her unexpected experiential benefits:

Now my daughter was born extremely quickly. She got here 20 minutes after the midwives arrived. And if I tried to go to the hospital with her in the end analysis I would have had her in the car. So I’m very relieved that we were prepared for a home birth because we would have gone very much awry. I mean I think it would have been a safe and healthy labour but it would have been a very unpleasant experience…And in the end it was a bit of a circus. The lights went out. Her brother woke up…But it was a beautiful event. It was really lovely to have her at home. And to just, you know, come upstairs, and eat a bowl of Cheerios, and take a shower in my house, and then get into my own bed and then just…call it a night. It was a very positive experience.

Hanna’s comments clearly highlight that a good experience is generally not required for a good outcome if this good outcome is solely defined as the survival of the mother and baby. However, her realization that it is possible for women to have a satisfying *and* safe
birth experience at home influenced her to reflect on what she saw as “false logic” behind compulsory hospital birth for women with low-risk pregnancies. Hanna’s insights, and those of others I spoke with, also suggested that what made their births “beautiful event[s]” stemmed from certain appealing qualities—increased control, intimacy, privacy, comfort, and convenience—that they felt could be more fully accomplished at home.

Although the women I met with were attracted to home birth for many of the same appealing qualities (comfort, privacy, control, etc.), and were wary of hospital birth because they perceived it to be a provider-centred environment, each woman envisioned these appealing qualities of home birth differently depending on her needs and priorities. Sally’s and April’s narratives highlight these particularities especially clearly.

**Sally: Creating a Meaningful Family Experience**

Early in their relationship, Sally and her partner David knew they wanted to marry and have children. She credits their Jewish faith and family-focused upbringing for instilling in them a deep commitment to tradition and parenting. Sally’s mother passed away when she was a young woman, which she feels has shaped her perspective on relationships with loved ones. She and her husband take pride in their parenting approach, which involves being flexible, honest, and open-minded:

We are very easy going as parents, and very laid back, while still maintaining discipline where necessary. We’re very not neurotic people. We don’t coddle our children. We don’t believe in that. I believe in exposing your children to things that are bad….grief, jealousy…. You know my daughter’s five and she’s been to like three funerals. It’s difficult to explain. But I lost my mom 14 years ago. And she [her five-year-old daughter] knows that it’s my mom. And she knows that even though she’s gone she still loves us, and we can still think about her and have happy memories and look at pictures….We want to keep things as real as possible. I don’t ever want to lie to my kids about things
like that. If I don’t know the answer I just tell her that. I say, “I really don’t know what to tell you.”

During her first pregnancy, Sally had to take 10 weeks off work and be hospitalized twice for acute nausea and vomiting. Although the obstetrician she sought care from came highly recommended and was head of obstetrics at the hospital she delivered, she was disappointed by the lack of empathy she received: “I wasn’t concerned about the pregnancy. I wasn’t even really concerned about my health. I just wanted someone to just say something like, ‘it sucks.’” Despite a difficult pregnancy, Sally’s first birth was uncomplicated. After labouring for a relatively short time she arrived at the hospital and was shocked to learn that she was nine centimetres dilated. She gave birth minutes later into the hands of the obstetrician on call. Although she had read up on various medical interventions, and prepared a birth plan outlining her preferred progression of interventions, she was relieved that her labour proceeded quickly without any. Sally was disappointed that despite an uncomplicated labour she was not given immediate skin-to-skin with her newborn and that her family members were not able to be present for her birth.

Sally recalled her overnight stay in the hospital with her new baby as adequate:

My big thing was if I didn’t have to stay I didn’t want to. There was no private room available even though we were willing to pay for it…I had a very nice roommate. It was fine. I mean no crying babies or anything. It was fine. No relatives in the room. That wasn’t the issue. The issue is there’s no reason to stay.

Because Sally had read that doctors and nurses may become anxious if breastfeeding is not established quickly and encourage the use of infant formula, she felt more comfortable seeking help, if it became necessary, from her local public health department’s breastfeeding clinic. Sally did have breastfeeding challenges and found
herself travelling back and forth between her public health unit, paediatrician, and family doctor to be diagnosed and treated for thrush. Despite several months of pain and medication, Sally persisted with breastfeeding.

Sally started hearing a “buzz” about midwifery from women in her social network who had had midwife-attended hospital births. As soon as she confirmed she was pregnant for a second time, she sought care from her local midwifery practice. Her midwives’ willingness to get to know her, and their prompt compassionate response to her severe nausea and vomiting were two aspects of her prenatal care that she appreciated most. She observed some of key distinctions of woman-centred care:

The biggest thing I tell people when they ask what the main difference is [between midwifery and medical care]...is the personal level of care and attention is unparalleled. You can’t get that anywhere else. You know to have them know you by name before you come in the door….They are genuinely happy to see. They don’t make you feel pushed out the door. Like any question you ask is silly or stupid. They are supportive in a way that a sister is or a mother. And while you might have a great relationship with your doctor, your doctor is not necessarily going to be there for your delivery. And you know with a midwife you still have options. That’s the other thing. When you are with a doctor you don’t often get to make a lot of choices about your medical timeline. You know? This is when we do these tests? Here’s your lab order. This is when we do these tests. Here’s your lab order. This is when…you go from here. If you don’t want to have an ultrasound when you are pregnant and you are with a midwife, you don’t have to….Whereas with a doctor you don’t get that option. You don’t get the option to be involved in your own medical care. And for me that just is really a no brainer.

Although Sally’s midwife indicated that she could be a “perfect candidate” for home birth, she initially rejected the idea: “I brushed it off, I was like ‘I’m not doing it at home…Forget it.” However, as time passed, Sally became drawn to its practical benefits. Her midwives answered her questions, and referred her to their practice’s home birth night where she learned first-hand from parents who had planned home births:
I maybe asked [Sally’s midwife] one question and then the next time I’d ask a different question and then later on when I was starting to see them more often they were like, “oh, we have a home seminar where we have someone who had a home birth come in and talk about their experience and it’s an open floor for questions. So why don’t you come?” So I signed up for it. I was nervous because it was in February and I was due in March. We ended up making it, and it made a big difference to hear from another person…who’d been through it as opposed to hearing it from a midwife. Or even a friend personally.

Having had a quick and uncomplicated first birth, and knowing that she would have the continuous support and expertise of her midwives, Sally became confident that she could give birth at home safely and could manage the pain of labour.

David was supportive of Sally’s decision; however, several of her friends and family were skeptical. She explains why this was problematic for her:

I wanted my family to be supportive of my decision. I didn’t want anyone to feel uncomfortable because I wanted them to be here and be here 100 per cent. I didn’t want them to worry. I wanted them to be involved as I wanted them to be. Because I don’t have my mom, my sister and I are really close and I’m also close with my dad. I wanted him…in the delivery room while I was delivering…[but only able to see her] from the waist up!

Sally’s midwife encouraged her to invite her father and stepmother to a prenatal appointment. Here, Sally’s midwife showed the equipment midwives bring to women’s homes, described how midwives monitor and care for women during labour and delivery, and explained why and how hospital transfers occur. In addition to allaying her father’s fears, this became another opportunity for Sally to learn, and deepen her trust in midwives and her ability to give birth safely at home.

I was fascinated that midwives are considered to be a level one hospital on wheels. And that’s how she explained it to my dad. And I was like, “really?” And she was like, “yeah, we carry like three duffel bags full of medical equipment” and I’m thinking, you think of midwives, you think like they come with a little bag with like a stethoscope and whatever, and she goes, “no, we come with three or four bags.”
Sally recalled her and David’s excitement in the weeks leading up to her due date: “it was fun getting all the supplies together and thinking that it’s going to happen in my house.” When her labour began she used breathing techniques, distraction methods, a birthing ball, a warm bath, and emotional support to cope with the pain. She gave birth to her daughter in her bathtub surrounded by her midwives and partner, and with her father, step-mother, daughter, sister, and in-laws in her home.

Sally wanted her close family to be present for the birth, and for other friends and relatives to be able to visit soon after. With the encouragement of her midwives, she invited David to catch the baby:

When she came they said, “go get your baby.” He was the first one to touch her. They actually—I shouldn’t say that—when her head was out, the student midwife checked to make sure there was no cord wrapped around her neck. …So that was the only person who touched her beforehand. And when she was fully out he picked her up and put her on my chest.

Knowing that her father had witnessed her mother’s difficult birth years ago and that this may be his last grandchild, Sally offered her father the role of cutting the umbilical cord, a moment she describes “was very special.” As soon as Sally was settled into bed with her newborn, her older daughter, Elise, and other loved ones were invited in to meet their newest family member:

I was like, “give the baby to David so that Elise can go meet her.” So there’s pictures of them, with her all wrapped up with her hat in the receiving blanket and Elise’s looking at her and giving her kisses and they are kind of having their first meeting. It’s really sweet. And so she was literally there minutes after and then once they had her unwrapped and had her on me, I let everyone come in. And then I was like as long as I’m covered, and I didn’t even care about my breasts as much to be honest. I was like “come in.” It was all nice and cozy.
Sally enjoyed the comfort of being at home, the relaxed atmosphere, and the impact this had on early bonding with her baby.

David made me peanut butter on toast and you know I was comfortable at that time I was kind of sitting up while the baby was at the bottom of the air mattress getting her once over by the midwife...And then later on she gives her back to me, skin-to-skin again,...and people were taking pictures and whatever, and I’m holding her and I guess because I was half sitting up half reclined she was kind of sliding to the side and at one point I looked down...She was nursing.

Sally recognized that her decision to give birth at home with midwives was greatly motivated by her desire for a meaningful family experience. This meant avoiding the disruption of daily life, especially for her young daughter, and enabling her loved ones to witness and celebrate her birth in the comfort of her home.

A huge factor for me, believe it or not, was the disruption of Elise’s life. And some people you know really didn’t see that from my perspective...Everyone was relatively close by, that if my labour was going to be so super-fast, everyone would get here...That was the other thing. Everyone missed my birth the first time. If I have to take the time to labour at home and then go to the hospital even if I called people on my way to the hospital they could miss it depending on where they were coming from. So there were just so many appealing things about it. But the biggest thing was really just disruption of daily life. She just kind slid in where it was convenient for us. It was over the dinner hour. Nobody was disrupted. It wasn’t the middle of the night. It wasn’t anything! It was just like the perfect end to a day.

**Discussion**

When I met Sally in her home, it became clear to me how her family and traditions shape her identity, and why incorporating these values in her birth experience was a priority. The walls of her home were decorated with dozens of photographs of her children, her and her partner, their wedding, and other gatherings with relatives and friends. After our interview, Sally invited me into her daughters’ bedrooms to look in on them sleeping. She showed me a portrait
honouring her mother. I appreciated this glimpse into her family life, which reiterated for me why birth at home appealed to her.

Sally’s desire for comfort, privacy, intimacy, control, and convenience motivated her to seek midwifery and give birth at home. For her, these principles meant having a relaxed birth environment in the presence of extended family. There was a sense from Sally’s comments that until she gave birth at home, she underestimated the impact that this choice of birthplace could have on her experience. Establishing breastfeeding without the perception of time pressures, minimal disruption of daily life or separation from her partner, the ease in which family and friends could visit her at any time she wished, and access to all the comforts of home, made for a very satisfying birth.

I had infinite changes of clothes. I had laundry. I had...all these things at my finger that I may not have been able to have, and I would have likely been on my own because I had another child at home. My husband, he didn’t stay [in the hospital] when our first was born because I insisted he go home and get a good sleep because I knew it would be his last one for 18 years….Because everyone knew I gave birth at home I feel like it was even more relaxed in the sense that—like I gave birth on a Thursday, I had about 15 people come in and out on that Sunday.

Although both of her pregnancies were difficult and both births were uncomplicated and resulted in good outcomes, Sally’s second birth illustrates some of the ways midwifery and home birth may facilitate a positive experience based on a woman’s desire for family togetherness, without compromising safety. Some similar priorities were raised in April’s story.
April: Intimacy and Relationship

After moving to Ontario at age 19, April was unsure of her direction in life. She entered university thinking she might become a math teacher, but found she disliked her courses. Reluctantly, April followed a friend’s advice and took a women’s studies course taught by a well-liked professor: “So I took the course and it totally changed my life. So I changed my major to women’s studies and started getting into social justice issues. It completely changed the path my life was going to take. So that was sort of my wake up call to women’s issue in general.” After graduation, April found meaningful work with non-profit agencies, and began a master’s degree.

During her first marriage in her early twenties, April experienced two traumatic pregnancy losses. She described her negative experience with medical care providers in the hospital:

I had gotten pregnant with my ex-husband and we had a fairly traumatic loss. I had an ectopic pregnancy and then following the ectopic pregnancy we had a miscarriage....Those experiences dealing with the health care, the health system, so dealing with an OB...and then just dealing with the hospital, and my feelings around that made me realize later that that wasn’t an experience I wanted to have again. So when we found out we were pregnant this time, it’s not just that it was unexpected. I knew immediately that I didn’t want go through that...hospitals for me always held...a trauma element to them.

After re-marrying April became pregnant unexpectedly. She and her partner Kyle sought care from midwives.

I don’t actually know when I came to the realization that midwifery care was available and something that I was interested in. I think it was probably sort of part of that whole opening up to women’s studies and social justice issues and things like that. I think it just sort of became my worldview, my consciousness. Like it wasn’t something that I really looked into, but it was something that I became aware of.
Having a close and trusting relationship with her care provider was something that April felt was special about midwifery.

I think having the right midwife made all the difference as well, because you really have to connect with somebody, especially when it comes to birth and that wasn’t something I’d realized before either…before I came to know about midwifery and midwifery models of care, birth was about um just the doctor, you know, five minutes with this doctor every month telling you, “ok what’s new? Come back to me when the baby is ready to come out,” sort of thing. It wasn’t really about developing relationships.

April credits her partner Kyle for her instilling in her an appreciation of close relationships with others. She described their small, personalized wedding as emblematic of the kind of relationship they strive for:

When we decided to get married…we wanted to have a lakeside wedding at his aunt’s and uncle’s cottage with our closest family and friends there….We wrote our own vows and we included all of those people that we had invited to be a part of that moment with us. Those really important moments in people’s lives, especially with weddings…people look at it as a performance—and with my first wedding it was certainly a performance—and forget that it’s about building a relationship.

Initially, April was adamantly against planning a home birth, mostly because she associated it with a countercultural lifestyle that is very different from her own. Choice of birthplace was an option left open-ended by her midwife. April cannot remember precisely when she changed her mind, but recognized that part of her change of plans involved overcoming “that whole image of home birth as a hippy sort of idea.” Being “a researcher at heart,” she watched films, read books, and searched online for information and birth stories to inform her choice. Knowing that her midwives were skilled and prepared to handle emergencies and that her home was a short distance from the hospital where her midwives had privileges, increased April’s confidence that she could give birth safely at home. These
realities also put Kyle’s initial concerns to rest. Much of April’s decision resulted from her vision of a quiet, gentle, private birth experience in a familiar space.

Like I said, my husband and I have always been about relationship and about intimacy, and I started thinking about that moment that she [her daughter] would be born and I started thinking, “ok, what do I want that experience to be like?” And I couldn’t imagine… I just, to me a hospital setting didn’t speak to me for that moment, when I started really thinking about the birth and that moment that she would be there. I would give birth, and they would put her on my chest. I couldn’t imagine that being held in a sterile, white hospital room. I just wasn’t…it was an image that wasn’t jiving for me at all. Um, so then I really had to start grappling with the idea of having her in my home, you know? Having the birth at home. In a space where I am very comfortable where I can um, be completely at ease in my own space.

Despite encountering mixed reactions from family and friends, April proceeded with their plans for a home birth: “And as soon as we made the decision, it made complete sense. I could not imagine giving birth in a hospital now.” During much of her pregnancy, April and Kyle commuted from Kyle’s hometown to Toronto so they could attend prenatal appointments while still completing their work and graduate studies back home. They moved to Toronto permanently before April’s due date. One of the pleasures of anticipating a home birth involved planning the special details to make the experience as comfortable as possible.

It’s funny because once we embraced the whole home birth idea, we had developed these grand visions of what it was going to be like, and I’m sure a lot of people do around their births, they have ideas of what it’s going to be like. But my husband is a foodie so he kept promising the midwives, “oh I’m going to lay out a full spread for you.” He had a whole spread laid out for them. We rented a birth pool and all of that. The birth pool was amazing. It was very nice to have…. I had this vision of climbing into freshly laundered sheets, so as soon as labour [started]…he did laundry and made the bed.

April laboured for 12 hours and pushed for another two. She gave birth to a nine-pound baby girl with the support of her midwives and partner. She recognizes that had she given birth in a hospital she would have accepted an epidural, something
she had hoped to avoid. Her labour was long and challenging; however, she felt relieved to have been able to give birth without pain medication, which she had hoped to avoid.

So it was really, really, really tough. But in retrospect looking back on it, it was the perfect birth experience like even my midwife said, “it was a beautiful birth experience.” My husband had the food spread out there. We had the music going and it was evening because I had said, “I really want, I really want to labour through the evening and the night because I prefer it to be darker and it’s so bright in here during the day”…. I got really mad when daylight came and was like, “wait! It’s not supposed to be this bright! How is this child not here yet?”

After the birth of their daughter, April and Kyle appreciated an uninterrupted period of private bonding as a family. Being able to control who entered their birth space was something that April recognized would not have been possible in a hospital setting.

We climbed into this freshly laundered bed with our new baby and made phone calls and shut the world out. And that’s what I wanted it to be. I wanted it to be just quiet and intimate and just us and not the machines that go beep and not the doctors and not the intercoms and not you know that whole hospital feel.

April and Kyle recently shared their birth experience at their midwifery practice’s home birth information night. She explained that while she understands that giving birth at home or with midwives may not be feasible or appealing for some women, she could not envision a better experience for herself and her family.

Midwifery for me was about developing in a relationship and we knew that, I think…a lot of it has to go back to my relationship with my husband as well….Kyle and I have always been about intimacy and relationship. So he introduced me to a lot of those concepts about building relationships. And having close intimate relationships with people, so I think that it…probably also led to our decision to go with midwifery rather than an OB, because midwifery is about relationship. It’s about developing that closeness.
Discussion

April’s story reflects the way that unexpected events may change the course of one’s life, and how the desire for close and meaningful relationships may influence a woman’s childbirth choices. Her decision to plan a home birth was a significant change. Like many of the women I spoke with, earlier experiences, sometimes occurring serendipitously, shaped her belief system, and later exposed her to a model of maternity care that would enable her to honour these beliefs and values. At several points in her narrative, April emphasized the importance of intimacy and relationship as giving meaning to social relations and significant life experiences. For her, these concepts were most achievable in a familiar, private birth setting. This importance intimacy and continuity of care during birth have been described by women in other studies exploring the decision to give birth at home with midwives (Abel & Kearns, 1994; Cheyney, 2008; James, 2011; Klassen, 2001; Murray-Davis et al., 2012).

The prospect of having greater control over their birth spaces was something that both Sally and April raised as important to their decisions. Felicia and Mary-Beth also emphasized this as a priority. For Sally, this meant being able to invite as many friends and relatives as she desired to her birth, and welcome guests into her home soon afterwards. For April, being in control meant being able to “shut the world out” so that she could spend the first few days alone with her partner and newborn. In both cases giving birth at home fulfilled their visions of an intimate and family-centred birth, in ways that would have been difficult, if not impossible, in a hospital setting.
Sally’s comment that some people did not understand why her desire to minimize disruption to her older daughter’s routine factored into her decision was significant. It demonstrates the relatively low value placed on women’s and families’ experiences in the social context in which the women were making their decisions. Likewise, when April described some of the features of her desired birth environment—soft music, a carefully prepared meal, freshly laundered sheets—I was struck by the way it resembled a romantic evening more so than what one might envision for a long and exhausting first labour. Within the dominant medicalized paradigm of childbirth, where delivery is a potential crisis to be managed and where labour is understood to be messy and exceedingly painful, the notion of women having “grand visions” for a calm and intimate birth may be viewed as naïve, trivial, and unrealistic. And yet, as participants in this study demonstrated, being able to “choreograph” their birth experiences in ways that would have been more difficult or impossible in a hospital setting (with the exception of a planned caesarean) was something that they found attractive about home birth (Janssen et al., 2009a, p. 297; Van Wagner, 2004b). For all the women I met with their willingness to honour their desired birth experiences was a critical part of their decision to plan a midwife-attended home birth.
CONCLUSIONS

Chapter 8: Choosing Midwife-Attended Home Birth in Ontario: The Personal is Political Revisited

The women in this study testified to the challenging, transformative process of choosing midwife-attended home birth in a cultural context where there is significant fear about birth and where women’s childbirth experiences are assigned a relatively low value. To make this choice, the women had to draw on their own strength, resist the dominant cultural metanarrative that home birth is unsafe, and trust that with the support of their midwives and the love and encouragement of their partners or other support persons they could have a positive birth experience and positive outcome at home. As the women resisted medicalized birth and envisioned more woman-centred possibilities, they were empowered as active agents in their births.

Participants’ narratives shed light on the significant amount of time and effort that was involved in gathering and evaluating the evidence they felt was necessary to make an informed decision about where to give birth (and to a lesser extent, their choice of care provider), as well as the varied ways this decision unfolded—often unexpectedly—from their particular life experiences. Participants’ stories also conveyed how even after becoming educated and assured of their decisions they often faced criticism and other forms of “social sanctioning” that was intended to make them feel guilty or fearful and convince them they were making selfish, misguided, and irresponsible choices (Cheyney, 2008, p. 264).

As the women in this study progressed through the intellectually and emotionally demanding process of choosing midwife-attended home birth, they confronted and
resisted two key presumptions that are central to dominant notions of birth, and that lead to the widespread negative perception of home birth. First, is the view that pregnancy and birth are by nature risky medical events that must be managed in a hospital to avoid a bad outcome. Second, is the narrow view of successful birth defined solely as the survival of the newborn and the mother. Central to their transformative decisions was their development or affirmation of woman-centred views of birth, in which women’s and families’ experiences are understood to be compatible with more narrowly defined good outcomes. This woman-centred perspective depended on a view of pregnancy and birth as healthy, normal processes, involving physical, emotional, social, and for some women, spiritual dimensions.

Although the women began their decision process from different starting places, and envisioned their desired birth experiences differently, there were some key similarities about their decision-making. All of the women interrogated common myths and misconceptions about midwives and home birth. Efforts to “unlearn” dominant beliefs translated into the education of their partners or other support persons and were key to women gaining the solidarity and encouragement they needed to feel confident about their unorthodox choices. Of equal importance was the way that all of the women came to challenge the authoritative knowledge of obstetric medicine. This involved calling into question the pervasive unconditional acceptance of physicians as the experts in pregnancy and birth, and their knowledge as superior. As participants redefined and expanded their conception of authoritative knowledge in childbirth they relied on a variety sources they deemed trustworthy, among them: experience, intuition and embodied knowledge, the insights of childbirth educators and care providers with holistic
views about birth; and empirical quantitative studies comparing the relative safety of home and hospital birth, and other childbirth practices.

**Concluding Reflections**

Midwifery has been described as “feminist praxis,” because as Barbara Katz Rothman (1989) rightly asserts, it actively “works with the labor of women to transform, [and] to create the birth experience that meets the needs of women” (p. 170). I see midwifery as embodying core feminist principles of holism and of shared power, and for these reasons, a woman’s choice of care provider and birthplace as personally and politically significant. The women in this study demonstrated that the decision to seek midwifery care and give birth at home can be empowering and transformative, not only as related to pregnancy and birth, but also for women in their roles as parents, partners, teachers, health care providers, students, leaders, and advocates. Increased confidence—in many facets of their lives—was the most important legacy of participants’ decisions.

Toward the end of our conversation, April offered advice to childbearing women, which eloquently synthesizes the most important messages that emerged from participants’ narratives. Concluding this study with a participant’s insights highlights the wisdom gained through women’s experiences. It also emphasizes the personal and political significance of women resisting dominant expectations of how they ought to give birth, and choosing more woman-centred possibilities:

When you make the decision about who’s going to provide your care, understand that that decision does either open up or shut down your birth choices. And that was something I didn’t really realize when we made the decision to go with a midwife. Like I said, I didn’t know anything about the idea of birth choices. I didn’t know. I didn’t really even understand the concept of the medical management of women’s bodies in birth. That was something I came to as I was reading about birth and that sort of thing. That decision to either go with an OB or a midwife sets your birth
choices for you. So it’s a decision you have to make very carefully even though you might not know what type of birth you want to have. Whether you want to have a hospital or a home birth, allowing yourself to have those options is really important. There’s so much to be said for women having choices over their own bodies and what happens to their own bodies and how it happens, especially in birth. Because birth is so managed in the medical model that having choices is very liberating. You know there’s something about being able to make the choice, to say, “I’m not going to let you do that to me. And I’m going to have my child at home. And I’m going to reject that whole medical establishment and do it my way.”
Postscript: Areas for Further Study

My exploration of women’s decision-making highlights the need and importance of further research on this topic. In addition to facilitating informed decision-making among women and supporting midwifery practice, qualitative research on women’s decision-making experiences may broaden the dialogue about midwife-attended home birth from a narrow debate about important but limited notions of safety (i.e., outcomes) to a holistic understanding of the factors involved in positive birth experiences (e.g., good outcomes, physical and emotional wellbeing of the woman and baby, family bonding, community healing). Some areas for further research are identified below. Advice for women and midwives to support informed decision-making is included in Appendix A.

Deepening Analysis of Women’s Decisions through the Inclusion of Insights from a Broad Range of Participants

Of the many possible reasons for choosing midwifery and home birth, it seemed that the women I interviewed shared a powerful sense of their home birth decision-making as empowering and transformative. With more resources than were available in a Master’s research project, it would be interesting and important to develop a deeper understanding of women’s decisions by exploring the experiences of more diverse women. This could be achieved, in part, through purposive sampling for a broader range of participants.

All of the women in this study were middle-class, educated, Canadian-born, English-speaking, and somewhat older mothers (ranging in age from late 20s to early 40s at the time of our conversations). They had all completed some post-secondary education (two also had graduate-level degrees). Being well educated likely contributed to their
skill and comfort “doing their homework” about home birth. Two of the women specifically mentioned their fluency with technical or scientific information and how this supported informed decision-making. Accessing and making sense of childbirth-related information, especially that which challenges dominant views about pregnancy, birth, and women’s bodies, requires health, language, and computer literacy; the time to search for and read information; and the money to purchase books and other resources when they are not available free of cost.

Perhaps more important than the practical advantages of being well-resourced is the extent to which these privileges may empower women to question authority figures who may be disapproving, such as physicians and family members, and resist the more general cultural pressure to have a hospital birth. Vicki Van Wagner (2004a) has argued that in Ontario, midwifery has been strengthened by regulation, not only because it laid the groundwork for affordable midwifery care for diverse women (through public funding), but also because it has made midwifery a more appealing possibility for women who may lack the education or confidence to pursue a model of care that prior to regulation was greatly marginalized within the health system (and of which much of the public was unaware). While it is likely that midwifery has become more accessible, the effect that a “class confidence” may have on a woman’s choice of care provider and birthplace warrants further exploration in the current Ontario context. It would be worthwhile interviewing women who have fewer resources, especially education, family support, and financial means, to explore the ways and to what extent certain resources (or their absence) may facilitate or limit decision-making, and the ways it may enable or prevent
women from having their choices respected by others (e.g., health care and social service providers).

Of particular interest are the experiences of uninsured women in Ontario, who must pay for hospital, laboratory, and (usually) physician fees out-of-pocket, and for whom the decision to have a midwife-attended home birth may be motivated, in part, by the need for affordable care.\textsuperscript{23} With recent cuts to federal programs that previously provided interim health coverage to immigrants and refugees awaiting provincial health insurance, and the cultural landscape in Ontario, which includes large immigrant populations, the question of health care equity as related to choice of care provider and birthplace is an important area for exploration (Wilson-Mitchell, 2013). Of related interest are the perspectives of women who have immigrated to Ontario from cultures where midwifery and home birth is more common or differently perceived (e.g. more positively, or negatively but for different reasons), and where women may be viewed as the authority on pregnancy and birth (Jordan, 1997; Murray-Davis et al., 2012).

In their interviews with informants serving or identifying with historically oppressed groups, Ann Rochon Ford and Vicki Van Wagner (2004) found that women who have a history of being marginalized in the medical system in Ontario (i.e., Aboriginal women, immigrants and refugees, LGBTQ community members, women with disabilities, teenaged women, women who are incarcerated, religious minorities, Francophone women) may perceive midwife-attended home birth to be more appealing.

\textsuperscript{23} In Ontario, midwifery services are funded by the Ministry of Health and Long-Term through different payment models than fee-for-service physicians. This enables uninsured women (e.g., women who have yet to complete the three month waiting period before OHIP coverage is granted, undocumented women, etc.) to receive midwifery care free-of-charge in the same way that insured residents do. Uninsured women who have midwife-attended hospital births must pay out-of-pocket for hospital-based care, lab tests, and consultations with fee-for-service physicians.
than obstetric care and/or hospital birth. For example, Aboriginal women who want to give birth on their own land attended by members of their own cultural community, may view midwife-attended home birth as practical, family-centred, potentially healing (AOM, 2012; Ford & Van Wagner, 2004; Simpson, 2006). Likewise, for religious women who, for reasons of modesty or otherwise, do not want to be seen by male care providers, midwife-attended home birth may be appealing. Also, home birth may be more conducive than a hospital setting for performing certain religious or spiritual practices that have been identified as part of culturally sensitive care (AOM, 2012; Klassen, 2001).

Unfortunately, women from some marginalized groups may face greater barriers to midwifery (e.g., they may be unaware of or less educated about it, may be led to believe they are not safe candidates, etc.) and home birth (e.g., may lack safe housing and privacy or support from partners/family members) (Ford & Van Wagner, 2004). Also, women identifying with disenfranchised groups may be less willing to make unorthodox health care choices for fear of being punished by authorities (e.g., fear of being refused medical care by providers who disagree with their choices; fear of having their newborn taken from them by child welfare; fear of being reported to authorities if undocumented immigrants) (Ford & Van Wagner, 2004). These types of social sanctioning (whether real or perceived) may prevent marginalized women from advocating for their rights and preferences.

In addition, purposive sampling for women with less positive midwifery and birth experiences would deepen our understanding of women’s decisions. Finding women with these perspectives may prove difficult because they may be less likely to volunteer for a study where the researcher has acknowledged her support for woman-centred midwifery
principles, including choice of birthplace (Murray-Davis et al., 2012). Nonetheless, this is an important avenue of exploration to ensure diverse women’s experiences are reflected in studies on these childbirth choices.

**Further Exploring the Basis of Trust in Woman-Midwife Relationships**

Also requiring further exploration (and as raised in Chapter 6) is the question of whether a new orthodoxy is emerging in Ontario, in which women who are dissatisfied with some aspects of obstetric care may transfer unconditional trust or confidence from one group of experts (obstetricians) to another (midwives) without critically questioning the client/patient-care provider hierarchy. Among the women I interviewed this did not seem to be the case. Their comments suggested that their trust emerged from their close woman-midwife relationships and shared values more than from their perception of midwives as authority figures. Nevertheless, the possible emergence of a new orthodoxy of authoritative knowledge in childbirth warrants further examination especially as related to choice of care provider.

It would also be interesting to explore whether and in what ways women may or may not assert themselves to their midwives (or potentially other support persons) during a home birth. The assumption that a woman will be more confident advocating for herself at home (James, 2011) must be examined further from the standpoint of women’s experiences giving birth at home.

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24 As part of creating a safer space for women to share their decision-making stories, I communicated my support for midwifery principles, including choice of birthplace, in my information letter to participants (see Appendix D: Information Letter for Prospective Interview Participants). In all of my correspondence with prospective participants, I made clear that I welcomed participants with positive, negative, and/or mixed experiences.
Expanding Choice of Birthplace: Birth Centres in Ontario

The advent of midwife-led birth centres in Ontario opens up another important avenue of study related to choice of birthplace. For women who are interested in having an out-of-hospital birth, but for whom home birth is not appealing or feasible (e.g., because of unsupportive family, lack of safe housing or privacy in their homes, long distances from hospital back up), a birth centre may be an excellent alternative. Rogers and Haque’s (2012a, 2012b) recent studies in Ontario suggest that women may view a birth centre to be a “happy medium,” a “best of both worlds,” or a “middle ground” between a midwife-attended hospital birth and midwife-attended home birth (2012a, p. 14; 2012b, p. 23). Qualitative data from these surveys suggest that these views may stem from the presumption that birth centres share the perceived safety advantages of hospitals (e.g., more technology, medical specialists on site), but with continuity of care and more home-like surroundings (Rogers & Haque, 2012a, 2012b). The question of whether these beliefs may deter some women from home birth who might otherwise choose it warrants exploration. Further study may also confirm the need for greater public education about birth centres, especially given that the public may not be aware that birth centres will be available to the same cohort of clients eligible for home birth (i.e., low-risk pregnancies), will have the same equipment as brought to women’s homes, and will afford a similarly low intervention approach (e.g., no epidurals, oxytocin for induction) as is available at home births (Darling & Gagnon, 2013).

Clearly, there are many interesting questions and issues related to midwifery and home birth in Ontario that warrant further study. Efforts to deepen and broaden this exploration may enable new connections to be made and support meaningful woman-centred childbirth experiences for diverse women and families.
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APPENDICES

Appendix A: Advice for Women and Midwives in Ontario to Promote Informed Decision-Making

Toward the end of our interviews, I asked participants if they had advice for women who may be deciding on a care provider or setting for birth, and midwives who want to support informed choices among their clients. The following recommendations are based on their responses and my analysis of relevant comments from elsewhere in their narratives. Advice is written in plain language with readers of varying literacy levels in mind.

PART I: Advice for Women in Ontario

Advice for childbearing women considering a choice of care provider: midwife, obstetrician, or family doctor/general practitioner (note: not all family doctors provide maternity care)
- Choose a care provider who you think will support your beliefs and values about birth.
- Depending on the amount of time and other resources you have, learn about the choices available and/or not available when women receive care from the various care providers available. Take into consideration the beliefs and values of the information source.
- For women who have had prior caesarean sections (c-sections) consider what birth choices will be available to you, and how well you think these choices will be supported.

Suggested sources of information: books, articles, social media, other people you trust, health care providers, past midwifery clients, past patients of doctors, documentary films, academic journals (some provide summaries in plain English), organizations representing health care professions.

Childbirth education resources recommended by participants in this study:
- *The Birth Partner*, a book by childbirth educator Penny Simkin
- *Ina May’s Guide to Childbirth* by midwife and childbirth educator Ina May Gaskin
- *Birth Matters: A Midwife’s Manifesta*, by Ina May Gaskin
- *Birthining from Within*, a book by midwife Pam England and psychologist Rob Horowitz
- *Magical Beginnings*, a book by physician Deepak Chopra
- Books written by La Leche League (breastfeeding advocacy and support network)
- *The Midwifery Option: A Canadian Guide to the Birth Experience*, by health writers Miranda Hawkins and Sarah Knox (although this guidebook was not mentioned specifically by women, they did express the need for childbearing women having access to Canada-specific information, so it has been added to this list)
- *The Business of Being Born*, a documentary film directed by Ricki Lake and Abby Epstein

Scientific studies comparing outcomes of planned home and hospital births for low-risk women and attended by trained care providers
Websites, professional guidelines, and social media
- Association of Ontario Midwives (AOM) website http://www.aom.on.ca
- Canadian Association of Midwives (CAM) http://www.canadianmidwives.org
- College of Midwives of Ontario (CMO) http://www.cmo.on.ca
- Society of Obstetricians and Gynaecologists of Canada (SOGC) website http://sogc.org
- Individual midwifery practice websites
- Blogs discussing child birth options and mothering, especially those that examine social justice issues and issues of choice as related to women’s life experiences

Choose a care provider who you think will support the pregnancy, birth, and post-partum experience you want. Some factors to consider:
- Choices available related to:
  - Prenatal testing – including the option to refuse tests or seek additional tests
  - Where you can give birth – if planning for a hospital birth, when you can return home, whether a support person can stay overnight in your room
  - Medical interventions during labour and delivery – such as pain relief and comfort measures, induction, fetal monitoring, freedom of movement, eating and drinking, vaginal delivery for breech presentation, reasons for using forceps, vacuum assistance, c-section, VBAC, and episiotomy
  - Involvement of support persons who can be with you during labour – partners, family members, doula, community elders
  - After-birth care – options for delivery of the placenta (active versus expectant management), vitamin K injections for newborn, antibiotic eye ointment for newborn, newborn screening, immediate skin-to-skin between mother and baby, likelihood of infant formula being offered, rooming in with newborn
- Length of prenatal and post-partum visits and access to your care provider outside of visits (to ask questions, seek advice)
- Content and style of prenatal classes (if offered)
- Typical wait times at clinic visits, travel time to care provider, whether alternatives to clinic visits are possible (e.g., for accessibility or safety reasons)
- Likelihood of your chosen care provider being present at your birth
- Roles for support persons during labour (e.g., restrictions on number, expectations of support person involvement)
- Whether your care provider will accommodate any cultural, religious, or familial customs or traditions that are important to you during your pregnancy, birth, or post-partum
- Degree of education and support for breastfeeding (and/or other ways of feeding) and newborn care
- Whether and how post-partum visits are provided, especially in the first few days after birth (for example, participants in this study emphasized the benefits of receiving good support during the first few weeks with a new baby)

Advice for women who are considering midwifery care
- If you are interested in midwifery care (even undecided), contact your local midwifery practices (multiple practices if possible) as soon as you know you are pregnant. There are currently more women who want midwifery care than there are midwives to serve them. The AOM website lists all midwifery practice contact information in Ontario.
- You do not need a referral from a doctor to get a midwife.
- You do not need to pay for midwifery care in Ontario. It is covered for women who have Ontario health insurance (i.e., OHIP) and those who are uninsured.
- Use your first midwifery visit to see if it is right for you. You do not need to decide on whether you want to go with a midwife before the first meeting.

Advice for midwifery clients deciding where to give birth
- Choose a birthplace where you think you will feel safest and most comfortable (calm, relaxed, supported). Some clients:
  - Plan to labour at home and give birth at home
  - Plan to labour at home and move to the hospital shortly before the birth
  - Plan to have most/all of their labour and birth take place in the hospital
1. Plan to labour and/or give birth in other out-of-hospital settings (e.g., midwifery clinic), if available
2. Decide where to give birth once in labour

- There are instances where a transfer to hospital/change of planned birthplace from home is (during pregnancy, in labour, after the birth). A midwife can explain these scenarios. Information is also available on the AOM website.

**PART II: Advice for Midwives in Ontario**

Participants offered advice for midwives in everyday practice and to the profession. Some participants also made recommendations for other health care stakeholders (e.g., policy makers, medical care providers). Recommendations are offered under the assumption that they are intended for women who are candidates for home birth.

**Recommendations for midwives in everyday practice:**

- **Introduce all clients to home birth (and other out-of-hospital birth option if available) as a possibility as opposed to only women who express a preference for it.** Some approaches discussed in this study include: informal dialogue in routine prenatal care (not necessarily only when discussing choice of birthplace), at prenatal classes (not just home birth information sessions), and in handouts given to all clients.
- **Allow the decision about where to give birth to be a fluid one as opposed to expecting that clients will have made their decision by a certain point, especially early in prenatal care.**
- **Work to dispel the myth and that home birth appeals only to a narrow range of women.** Some of the stereotypes cited by participants include: “hippies,” “tree-huggers,” “radicals,” people who live in traditional communities, people who adhere to a particular style of parenting, and people who reject Western medicine in general. To help dispel these myths and stereotypes promote literature and other resources (e.g., films) that represent diverse clients/families who planned home births.
- **Communicate the practical (social, logistical) advantages of home birth especially for the immediate postpartum period, as part of supporting informed decision-making.** Women may be unaware of practical benefits such as not having to travel during labour or shortly after giving birth; minimal disruption for older siblings; being able to control who comes into the birth space (including family and friends); having immediate and unlimited access to all personal items, clothes, food and drink, comfort measures; some decreased costs (parking, hospital room surcharges, take-out meals); comfortable beds and other furniture for breastfeeding and for support persons; ideal conditions for bonding with a new baby; and a general sense of increased control and comfort in the birth setting.
- **Communicate that home is often the site where midwifery principles (e.g., choice, comfort, intimacy, relationship) can be most readily experienced.** These are often principles that attracted women to midwifery care.
- **Provide opportunities for women to learn about home birth experiences from other women/parents.** Women may relate better to other parents’ personal experiences and may view their advice as more objective than health care providers.
- **Display standard midwifery equipment that is brought to women’s homes during labour (regardless of whether they plan for home birth or not) and explain how and when equipment would be used.** Avoid reserving show-and-tell for women who have expressed a definite interest in home birth. All clients can benefit from seeing it and learning about how midwives are prepared and skilled regardless of their planned place of birth.
- **Make evidence-based information accessible to women** (e.g., scientific studies demonstrating safety of home birth in Canadian/North American context, AOM, CAM, CMO, SOGC position statements and resources). Make comparable information about other relevant choices available (e.g., around prenatal testing, VBAC, breastfeeding, various medical interventions, and comfort measures). Where applicable, highlight any correlations between choice of birthplace and these other choices or impacts on care. Participants suggested printing out and displaying this information in clinic waiting rooms, giving web links and reference lists in client information packages, and handing out information at prenatal classes.
Communicate how midwifery fits within the health care system (e.g., skills and equipment midwives have compared with what is available in hospitals of varying levels). To put this information into further perspective, describe what type/level of hospital most Ontario women give birth in.

Explain how hospital back-up works and what hospital transfer would likely entail, how long it would take, and how these scenarios would compare to women labouring in hospital (e.g., the “decision to incision time”). To put this information into further perspective, describe the likelihood of these scenarios arising, from the least to most urgent.

Encourage clients to bring support persons (including parents) to prenatal visits to ask questions about midwifery care and home birth if they are skeptical about safety or have other concerns.

Work to reduce material barriers to choosing home birth, such as by: offering free/low cost home birth supply kits for women with low incomes; dispelling myths that many/costly supplies are needed; allowing women to labour and give birth in midwifery clinics (and birth centres as available); addressing concerns about neighbours, siblings, relatives, and pets; resolving concerns about home birth requiring a lot of space, being unsanitary, or resulting in a lot of clean up and laundry.

Recommendations for the midwifery profession in Ontario

- Information about midwifery—from how to get care, to awareness about the midwifery model, to resources that dispel common myths—should be more accessible to diverse women. Unless women know the specific sources where this information can be found (which they often do not) or have the information given to them by other women (e.g., books about midwifery, social media, word-of-mouth advice), they have difficulty knowing where to go to get timely, credible, and practical information, or information in languages other than English and French. Since participants often noted that they came across midwifery and home birth by chance, they worried other women are missing out on what it’s like to experience the benefits of midwifery care.

- The AOM or other midwifery organizations should develop resources illustrating the diverse range of women who choose home birth to help dispel the myth that only a narrow range of women choose it. Midwives should make home birth a realistic, normal, and appropriate possibility and one that diverse women can identify with. Out-of-hospital birth should be framed as part of a modern, woman- and family-centred maternity care system. Some participants described the need for home birth to be “rebranded” to appeal to the fullest range of Ontario women. A video like the AOM’s Ontario Needs Birth Centres was one specific suggestion of a resource that could support this end.

- Home birth and midwifery should be normalized by presenting these possibilities to people of all walks of life and across the lifespan, not just childbearing women. Some opportunities could include: high school health and sex education; sexual health clinics; routine medical care provided by family physicians; hospitals, labs, medical clinics; breastfeeding clinics; public health units; public education campaigns; various media; and university and colleges; parenting groups; social service agencies.

- Increased effort should be made to increase equitable access to midwifery and out-of-hospital birth to communities or populations who have a history of being marginalized in the medical system or who may not see themselves as candidates for midwifery or home birth (e.g., older mothers, women with disabilities).

Recommendations for other health care stakeholders

- Government decision-makers must commit to make midwifery a realistic choice for as many Ontario women as possible (recognize that otherwise it remain inequitable). They must decide whether they are committed to supporting and funding the infrastructure to support cost-efficient, evidence-based, safe, satisfying care that is a model for many other jurisdictions to follow, or allow midwifery and out of hospital birth to remain on the periphery (“under the radar”) of mainstream health care. This involves many strategies including:
  - Educating more midwives and reducing barriers to education for diverse candidates
  - Reducing barriers to midwives getting hospital privileges
  - Supporting interprofessional relationships; supporting out-of-hospital birth (e.g., birth centres, home birth); encouraging midwifery as the standard of care (most appropriate, cost effective) for
low-risk pregnancies; ensuring good medical backup (supply of specialist physicians, other perinatal care providers).
- Reducing barriers to access to midwifery care (social, material, attitudinal, geographic, etc.)
  - **There must be more opportunities for physicians, nurses, and other health care providers to receive in-depth exposure to the midwifery model (in addition to in the everyday hospital setting).** This would enable medical care providers to have a better understanding of birth as healthy and normal and of low-intervention care. Participants recognized some skills (like delivering breech babies vaginally) are being lost in the obstetric community. Greater exposure to midwifery could also improve their understanding of home birth and dispel myths about it. Participants suggested having medical residents take rotations in midwifery practices as one way to help accomplish this.
  - **The government should ensure that midwifery and home birth remain available to uninsured women.** The availability of midwifery and out-of-hospital birth should be communicated to uninsured populations (e.g., new Canadians, temporary residents) through accessible channels (e.g., in various languages, community networks, employers).
Appendix B: Interview Guide

Introductory questions:
- Tell me a bit about yourself (hope to hear about their age, current occupation, interests, background, education, maybe where they were born and places they’ve lived, areas of past work or study, or important lived experiences)
- Tell me a bit about your family and/or social network (hope to hear about their partner and their occupation, other children, family background, cultural/ethnic/religious, a bit about their social network, or material conditions)
- Tell me when your child(ren) were born (if any were adopted)/how old children are, who their health care providers were for these pregnancies/births, where they planned to give birth, and where they actually gave birth
- If comfortable, could you tell me how old you are? And how old you were when you gave birth for each/any birth experiences?
- Is there anything else you want to share about yourself, family, or social network that they feel is important to your identity?

Primary questions:
1. Could you tell me about how and why you decided to give birth at home with midwives? (See supplementary questions below).
2. Is there anything else you want to share about your experience of making this decision?
3. Do you have any advice to share with women thinking about giving birth at home with midwifery care?
4. Do you have any advice for midwives so they can help women make informed decisions about where to give birth?

Supplementary questions:
Relationships
- Did any people who are important to you have an impact on your decision to give birth at home with midwives (for example: your partner, close friends, relatives, others)? If yes, can you tell me in what ways?
- Did your knowledge of others’ pregnancy or birth experiences influence your decision? If yes, can you tell me how or share any examples or stories illustrating this?
- Can you tell me about how people in your life responded when they learned you had decided to give birth at home with midwives (or were thinking about this option)?

Health care providers, the health care system
- Can you tell about whether any health care providers impacted your decision to give birth at home with midwives? If yes, in what ways?
- What influence, if any, do you think your own knowledge and/or previous experiences of hospital birth, the medical system, midwifery, home birth, etc. had on your decision?

Pregnancy, birth, and parenting
- [For women who have been pregnant or given birth before] What influence, if any, did your past experience being pregnant, giving birth, and/or parenting influence your decision? Can you share with me any specific examples or stories illustrating this?

Beliefs and values and other sources of knowledge/information
- Would you tell me about some stories from your life that might illustrate some of your beliefs and values when it comes to making decisions? In what ways do you feel these beliefs and values shaped your decision to give birth at home with midwives?
- Were there any sources of information (for example: books, internet resources, television, films) that influenced your decision to seek midwifery care or give birth at home? If yes, can you tell me more about these sources and how they influenced your decision?
Appendix C: Study Overview for Midwives

I am a graduate student at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). I am working on a master’s thesis exploring why and how women choose to give birth at home with midwives. I would appreciate your help in circulating information about my study (the Information Letter for Prospective Interview Participants enclosed separately) to past clients who may be interested and eligible to participate in it. I am a former midwifery client and supportive of the principle of choice of birthplace for childbearing women. Dr. Mary Sharpe, Director of the Ryerson Midwifery Education Program, is a member of my thesis committee.

I am conducting a qualitative research study, which involves in-depth individual interviews with five to eight women living in the GTA who recently chose midwife-attended home birth (gave birth in the last two years). Interviews will last between one and two hours and will be tape-recorded. My approach (described below) will ensure the confidentiality and privacy of participants.

To be eligible to participate, women must have chosen midwives as their primary care providers, have decided to give birth at home by the onset of labour, and have been eligible for home birth according to midwifery clinical guidelines. Women who required intrapartum transfer to hospital and/or to a physician specialist are still eligible to participate.

My study may ultimately benefit other women considering home birth, midwives supporting women’s informed choices, and other members of the health care community seeking to better understand women’s childbirth decisions.

Participant privacy, confidentiality, and informed consent:
I am taking the following measures to ensure women’s participation does not impact potential future midwifery care and to promote past client privacy:

- I will not ask you to disclose any personal information regarding past clients to me.
- I will not ask for your involvement in recruitment beyond sending initial information letters to prospective participants.
- I will not inform you of which past clients I interviewed (if any).
- Additional measures to ensure confidentiality and privacy will be explained to prospective participants (e.g., use of pseudonyms in interview transcripts, removal of personal identifiable information in thesis write-up).

If prospective participants contact me, I will provide them with more information about the study, the time commitment, and will answer any questions they have. If they agree to participate, they will be provided with informed consent forms to sign and return to me.

Past midwifery clients’ participation in this study is voluntary. Women may withdraw from the study without penalty at any time. They are free to decline answering any questions they wish. My project has been approved by the University of Toronto’s Office of Research Ethics (Protocol #27729).

Continued…
If you are interested in assisting, please feel free to forward the Information Letter for Prospective Interview Participants or contact me if you have any questions or would like more information. You may also contact my thesis supervisor, Dr. Angela Miles.

Shawna DiFilippo  
M.A. Candidate, Adult Education and Community Development  
OISE/UT  
Email: shawna.difilippo@utoronto.ca

Dr. Angela Miles  
Professor, Adult Education and Community Development  
OISE/UT  
Tel: 416-978-0809  
Email: angela.miles@utoronto.ca
Appendix D: Information Letter for Prospective Interview Participants

June 2012

Dear Past Midwifery Client:
My name is Shawna DiFilippo, and I am a graduate student at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). I am working on my master’s thesis exploring why and how women choose to give birth at home with midwives. I am seeking to interview women who have given birth in the last two years and chose to give birth at home with midwives, whether or not these births actually took place at home. I am also a past midwifery client and support the midwifery principle of choice of birthplace.

If you are eligible, I hope you will consider being interviewed after reading the information below. If you would like more information or wish to participate, please contact me at the telephone number or email address below. You are also welcome to contact my thesis supervisor (my professor), Angela Miles, at OISE/UT.

In an interview lasting between one and two hours, I will ask you general, open-ended questions about your decision-making process and the factors you feel shaped your choice to give birth at home with midwives. If you decide to participate, we will set up a convenient time and place for the interview, which I will tape-record and later transcribe (type up).

Your privacy is very important. Throughout my research project I will take all efforts to ensure any information you share with me is kept confidential. I will keep all tape recordings and transcripts in a secure location. Only my thesis supervisor and I will have access to these materials. In writing up this research I will also do everything possible to protect your identity (e.g., by using pseudonyms, by removing or disguising any information that could identify you). However, you should know that I cannot absolutely guarantee that you will not be recognized by people who know you. I will be happy to provide more information about this or any other matters you may have questions about.

Your participation is completely voluntary and you may withdraw from the research project at any point without any negative consequences. Your past midwife who sent you this letter will not be made aware of whether or not you choose to participate.

I welcome women who have positive, negative, or mixed experiences of making the decision to give birth at home with midwives. The insights women provide to me may benefit others who are considering home birth and/or midwifery care. They may also help midwives better support women in Ontario as they choose where to give birth.

If you are interested in receiving more information or would like to be interviewed please let me know as soon as possible. Thank you for considering my request.

Sincerely,

Shawna DiFilippo
M.A. Candidate, Adult Education and Community Development
OISE/UT
Email: shawna.difilippo@utoronto.ca

Dr. Angela Miles
Professor, Adult Education and Community Development
OISE/UT
Tel: 416-978-0809
Email: angela.miles@utoronto.ca
Appendix E: Consent Form for Interview Participants

July 2012

I understand that Shawna DiFilippo is a graduate student doing research for a master’s thesis at the University of Toronto. Her research is examining why and how women choose to give birth at home with midwives. I understand that by participating in her study I will have a taped face-to-face interview with Shawna at a place of my choosing that will last up to two hours and that will later be transcribed.

I understand that my privacy and confidentiality will be protected. Any details from the interview that could identify me or other people, places, communities, and institutions will be excluded or modified in the interview transcript and write-up of the research to ensure anonymity. I understand that there are usual limitations to confidentiality in this study. These limitations include suspicion of a child at risk for harm and the risk of participant self-harm or harm by another person.

The tape, transcript, notes, and my contact information will be stored in a locked filing cabinet in Shawna’s home. Only the researcher, Shawna DiFilippo, and her thesis supervisor, Angela Miles, will have access to these materials. Following completion of the project I will be given the opportunity to indicate whether:

- I wish to have the tape recording of my interview returned to me or destroyed.
- I wish to give Shawna permission to keep the transcript of my interview (with my identity disguised) for use in possible future research or wish it destroyed.

I understand that:

- My privacy and confidentiality will be protected.
- My participation will have no impact on any potential future clinical care from midwives.
- My participation is voluntary and I may withdraw from this study at any time.

By signing below I consent to participate in the study as it has been explained above.

Name:

Signature: Date:

A copy of this form will be given to you for your records.

Would you like a summary of the findings of the study upon completion? Yes [ ] No [ ]

Shawna DiFilippo
M.A. Candidate, Adult Education and Community Development
OISE/UT
Email: shawna.difilippo@utoronto.ca

Dr. Angela Miles
Professor, Adult Education and Community Development
OISE/UT
Tel: 416-978-0809
Email: angela.miles@utoronto.ca
I am a graduate student at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). I am working on a master’s thesis exploring why and how women choose to give birth at home with midwives. I am seeking the opportunity to attend one or more prenatal classes and/or home birth information sessions led by your practice group and available to your clients. I am a former midwifery client and supportive of the principle of choice of birthplace for childbearing women. Dr. Mary Sharpe, Director of the Ryerson Midwifery Education Program, is a member of my thesis committee.

I am conducting a qualitative research study, which involves in-depth, semi-structured interviews with five to eight women living in the GTA who recently chose midwife-attended home birth (gave birth in the last two years). I would also like to attend two or three midwifery practice-led prenatal classes/home birth information sessions, as these may shed light on some of the information some women may have when they make this decision. When sitting in on these classes/sessions, I would listen and take notes on material discussed. I would not ask questions or intrude on group discussion; however, I would be happy to provide more information about the study to any interested participants or midwives in your practice group if requested.

Participant privacy, confidentiality, and informed consent:
I am taking the following measures to ensure my attendance at prenatal classes/home birth information sessions does not impact current or potential future midwifery care of clients and to promotes participants’ privacy:

- I will not ask you to disclose any personal information about prenatal class/home birth information session participants.
- I will not record any participants’ names or personally identifiable information in my notes taken during my attendance of classes/information sessions.
- I will provide your practice group with an administrative consent form to sign that outlines privacy and confidentiality measures taken in my study as well your right to withdraw participation at any time.
- I will seek written informed consent from all prenatal class/home birth information session participants with a consent letter to sign that outlines privacy and confidentiality measures taken in the study as well as their right to withdraw participation at any time (i.e., I would leave if the class if at any point a participant requests this).

My project has been approved by the University of Toronto’s Office of Research Ethics (Protocol #27729).

If you would like more information or would be willing to allow me to attend one or more of your classes/sessions, please contact me. You may also contact my thesis supervisor, Angela Miles.

Shawna DiFilippo
M.A. Candidate, Adult Education and Community Development
OISE/UT
Email: shawna.difilippo@utoronto.ca

Dr. Angela Miles
Professor, Adult Education and Community Development
OISE/UT
Tel: 416-978-0809
Email: angela.miles@utoronto.ca

Thank you for considering my request.
Appendix G: Administrative Consent Form for Midwifery Practice Groups

July 2012

I understand that Shawna DiFilippo is a graduate student doing research for a master’s thesis at the University of Toronto. Her research is examining why and how women choose to give birth at home with midwives. By consenting, our practice group allows Shawna to seek permission from participants to attend one or more (as listed below) prenatal classes and/or home birth information sessions to gain insights for her project.

I understand that Shawna will take notes while sitting in on the classes/information sessions. Notes taken will be stored in a locked filing cabinet in Shawna’s home. Only the researcher, Shawna DiFilippo, and her thesis supervisor, Angela Miles, will have access to these notes. Notes will not include participants’ names or personally identifiable information. Unless anyone in the class requests that Shawna destroy her notes of the class after the thesis is complete, Shawna will keep them (without any identifiable information about the class, facilitator, or participants) for possible future research.

I understand that:
- Shawna will seek the informed consent of class participants before attending.
- Our midwifery practice group/class facilitator/class participants may decide to withdraw from this study at any time. Shawna will be asked to leave the classroom and will destroy any notes she has made up to that point.

By signing below I consent to Shawna attending the following listed prenatal education classes/home birth education sessions if participants give their consent.

Midwifery Practice Group Name:

Name of Midwifery Practice Group Representative:

Signature: Date:

Date(s) of prenatal class(es)/home birth information session(s) to be attended:

A copy of this form will be given to you for your records.
Would you like a summary of the findings of the study upon completion? Yes [ ] No [ ]

Shawna DiFilippo
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Dr. Angela Miles
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Appendix H: Consent Form for Prenatal Class/Home Birth Information Session Participants

July 2012

I understand that Shawna DiFilippo is a graduate student doing research for a master’s thesis at the University of Toronto. Her research is examining why and how women choose to give birth at home with midwives. By consenting, I am accepting Shawna’s attendance at today’s prenatal class/home birth information session to gain insights for her research.

I understand that Shawna will listen and take notes while sitting in on the class/information session. Shawna’s notes will be stored in a locked filing cabinet in her home. Only the researcher, Shawna DiFilippo, and her thesis supervisor, Angela Miles, will have access to them. Unless anyone in the class requests that these notes be destroyed when the thesis is complete, they will be kept for possible use in future research.

I understand that I or anyone else in the class may withdraw their consent at any time and Shawna will be asked to leave the class and all notes up taken up to that point will be destroyed.

By signing below I consent to participate in the study as it has been explained in the letter above.

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A copy of this form and your signatures will be given to your course/information session facilitator for her records.

Shawna DiFilippo  
M.A. Candidate, Adult Education and Community Development  
OISE/UT  
Email: shawna.difilippo@utoronto.ca

Dr. Angela Miles  
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