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Resistance and Relearning: Women's Experiences  
Choosing Midwifery and Home Birth in Ontario,  
Canada

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# RESISTANCE AND RELEARNING: WOMEN'S EXPERIENCES CHOOSING MIDWIFERY AND HOME BIRTH IN ONTARIO, CANADA

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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 learning in their challenging, transformative decisions to give birth at home with midwives in Ontario, Canada. Semi-structured interviews were conducted with women who had recently planned midwife-attended home births to shed light on how they learned about these childbirth possibilities and gained the confidence to plan a home birth. Participants' narratives revealed that to make these choices, they had to become active and informed decision makers and resist the dominant view of birth as inherently risky and of women's birth experiences as unimportant and incompatible with the birth of a healthy baby. Replacing myths and misconceptions about midwifery, and especially about home birth, with more current and evidence-based information was critical to participants' resistance and relearning, as were their own life experiences and those of women they trusted.*

## Résumé

*Avec une approche critique féministe et à la lumière des expériences de vie générales des participantes, cette étude qualitative explore l'apprentissage de sept femmes dans leur prise de décision, difficile et transformatrice, d'accoucher à la maison avec des sages-femmes en Ontario au Canada. On a mené des entretiens semi-structurés avec des femmes qui avaient planifié leur accouchement à domicile avec des sages-femmes afin d'illustrer la manière dont elles se sont renseignées de ces possibilités d'accouchement pour avoir la confiance de planifier un accouchement à domicile. Les récits des participantes signalent que pour prendre de telles décisions, ces femmes ont dû devenir des décideuses actives et informées. Elles ont également dû résister à la perception dominante selon laquelle l'accouchement est dangereux par nature et l'expérience d'accouchement des femmes est insignifiante et incompatible avec la naissance d'un bébé en bonne santé. Ce qui est crucial dans la résistance et le réapprentissage des participantes, c'est de remplacer les mythes et les idées erronées sur les sages-femmes, et en particulier à propos de l'accouchement à domicile, par des informations actuelles fondées sur des preuves. Leurs propres expériences de vie ainsi que celles des femmes en qui elles ont confiance sont également importantes.*

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### Introduction

Using a critical feminist approach, and with attention to participants’ broad life experiences, this qualitative study examines women’s learning in their choosing to give birth at home with midwives in Ontario, Canada.<sup>1</sup>

In Canada, as in many countries where health care practices and conceptions of the body are dominated by Western medicine, it is expected that women<sup>2</sup> give birth in hospital under the supervision of a physician. This is the case in Ontario, where almost 98% of women have hospital births and where specialist-physicians (obstetrician-gynaecologists) who are trained in the management of high-risk pregnancies attend the births of approximately 80% of women, many of whom have low-risk pregnancies (Better Outcomes Registry & Network Ontario, 2013). In Ontario, these childbirth norms exist despite the provision of regulated, government-funded midwifery care, in which women with low-risk pregnancies are offered a choice of birthplace: home, hospital, or, where available, a midwife-led birth centre.<sup>3</sup>

The medical framing of birth as an illness, a risky event that requires close medical management to avoid possible death or serious injury to the mother and especially the fetus, rationalizes the perceived need for physician-led care for all women and compulsory hospital birth (Davis-Floyd, Barclay, Daviss, & Tritten, 2009; Declercq, DeVries, Viisainen, Salvesen, & Wrede, 2001, p. 9; Klein et al., 2006). Regardless of the growing body of evidence demonstrating benefits of midwifery care (Renfrew et al., 2014; Sandall, Soltani, Gates, Shennan, & Devane, 2013) and the safety of planned home birth for low-risk pregnancies (de Jonge et al., 2009; Hutton, Reitsma, & Kaufman, 2009; Janssen et al., 2009; Olsen, 1997), the notion of midwife-attended home birth is widely perceived to be dangerous—or more risky than hospital birth. Women who consider this alternative, where it is available, are frequently judged 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; Rushing, 1993; Van Wagner, 1992).

It can be difficult for women interested in midwifery care and out-of-hospital birth to find current, accurate, and relevant information. Childbearing women and the public in general are likely to be exposed to highly medicalized depictions of childbirth (e.g., with many medical interventions, emphasizing possible risks and complications) in popular media and childbirth advice literature, both of which have been cited as common sources of information for women (Kennedy, Nardini, McLeod-Waldo, & Ennis, 2009; Klein et al., 2006; Murray-Davis, McDonald, Reitsma, Coubrough, & Hutton, 2014; Pincus, 2000).

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- 1 In this study, the term *midwife* refers to regulated, professionally trained midwives, and *home birth* to planned home births attended by qualified health care providers. Unplanned out-of-hospital births and home births without a health care provider present are outside the scope of this research.
  - 2 The term *woman* is used throughout this study because this is how study participants identified themselves and because the female subject is used widely in relevant literature. I acknowledge, however, that some childbearing individuals may not necessarily identify as women (e.g., trans men).
  - 3 At the time of this research, the option of giving birth in a midwife-led birth centre was available in one Ontario community only. Birth centres have since been established in two others.

These sources may also present inaccurate or unrealistic depictions of midwifery and out-of-hospital birth, if presented at all.

Medical care providers (physicians, nurses, etc.) on whom women may rely for health advice may be unfamiliar with the findings of current, methodologically sound research comparing the outcomes of planned home and hospital births for low-risk pregnancies. They may be unable to provide balanced perspectives on home birth because they do not attend them, may only be exposed to home-to-hospital transfers, may provide care to a greater percentage of women with higher-risk pregnancies who may not be suitable candidates for out-of-hospital birth, and may be increasingly unfamiliar with low-intervention birth in general (Dahlen, 2010; Klein et al., 2011; Liva, Hall, Klein, & Wong, 2012; Vedam et al., 2014).

Well-designed empirical studies on the safety and potential benefits of midwifery care and planned home birth may help women make informed decisions; however, women may be unaware of these studies, may have difficulty accessing them or appraising their quality, or may be skeptical of their findings if they have, like most of the general public, been socialized to believe that physician-led hospital birth affords women the safest and most modern model of care.

In addition, since most women in Ontario do give birth in hospital, and the majority under the care of a physician, many women may have few opportunities, if any, to learn about the realities of midwifery care and home birth from women they know personally. This lack of access to experiential knowledge is particularly problematic since, as my findings will show, women may find it to be especially compelling and useful.

### Study Rationale

This research was driven by my curiosity about how and why, despite great cultural pressure to have a hospital birth and, to a lesser extent, physician-led care, and despite barriers to informed decision making, some women choose to give birth at home in the care of midwives. What life experiences, sources of knowledge, or other factors shape their learning? How do their decision-making processes unfold?

There is a need for research that sheds light on women's experiences of choosing midwifery and home birth—and there is particular need for this in the context of Ontario, where the body of qualitative research examining these choices is small (Murray-Davis et al., 2014). This study contributes to these efforts by presenting insights from seven women in Ontario who recently planned midwife-attended home births. Knowledge about these women's experiences may contribute to a greater understanding of the choice of midwife-attended home birth and the potentially transformative learning process involved, and may empower childbearing women and others to think critically about the various choices offered (or not offered) in the models of maternity care (i.e., midwifery, medical) in Ontario. This study may also support midwives as they promote informed decision making among their clients (Murray-Davis et al., 2012; Sharpe & Gold, 2011), and may be useful to others desiring a more nuanced understanding of this uncommon and potentially complex health care decision.

### Midwifery and Home Birth in Ontario: An Overview

In Ontario, registered midwives are regulated primary health care providers for women with normal (low-risk) pregnancies, and their newborns, from conception until six weeks post-partum. In 1994, Ontario was the first province in Canada to regulate and fund midwifery services. As of 2013, there were more than 700 midwives in practice (Association of Ontario Midwives [AOM], n.d.-b). Midwives provide primary care to more than 10% of pregnant women (AOM, n.d.-b). However, demand for midwifery services greatly outstrips the supply of midwives. Currently, 40% of women who seek care cannot be accommodated because there are too few practising midwives (AOM, n.d.-b).<sup>4</sup>

Women self-refer to midwifery care and are seen by the same midwife (or small team of midwives) for their entire course of care. This *continuity of care*, which is intended to facilitate a supportive and trusting client-provider relationship; *informed choice*, where the woman is the primary decision maker; and *choice of birthplace* are the three tenets of the Ontario midwifery model (College of Midwives of Ontario [CMO], 2014).

About 25% to 30% of midwifery clients plan home births; others plan hospital births (AOM, n.d.-a). Approximately one in four home births involves intrapartum transfer to hospital (AOM, 2010), usually for non-urgent reasons such as prolonged labour, maternal request for pain relief, or newborn instability (Darling & Gagnon, 2013). About 3% of out-of-hospital births involve more urgent transfers, such as for abnormal fetal heart rate (Darling & Gagnon). Screening to determine good candidates for out-of-hospital birth and the availability of hospital backup when transfers are needed contribute to the safety of planned home birth (AOM, 2010). Midwives are also prepared to respond to complications at home and to ensure prompt hospital transfers when they are necessary. They are trained in emergency skills, carry 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, 2010). Midwives may continue to provide primary care after a hospital transfer, sometimes in consultation with medical specialists, while in some scenarios a transfer of care may occur (AOM, 2010).

Midwives believe that women should be knowledgeable about the advantages and disadvantages of all available birth settings as part of making an informed choice of birthplace (CMO, 2014). In Ontario, 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 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.

### Literature Review

#### *The Medical Model of Childbirth and its Implications for Childbearing Women*

Many scholars have examined the dominant social construction of childbirth as a medical condition and have considered the impact on women (Cheyney, 2008; Davis-Floyd, 1992; Daviss, 2001; Declercq et al., 2001; DeVries, Salvesen, Wiegens, & Williams, 2001;

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4 Lack of funding and other factors account for this shortage.

Ehrenreich & English, 1973/2010; Jimenez, Klein, Hivon, & Mason, 2010; Jordan, 1997; Martin, 1987/1992/2001; Oakley, 1984; Rothman, 1989). It is widely accepted that medical interventions can offer lifesaving benefits during pregnancy and birth when certain complications arise and that medical specialists' knowledge and skills are valuable and useful in these situations. However, important criticisms of this model have been raised. Some health care experts contend that various obstetric practices are overused, especially in low-risk pregnancies, and/or are not sufficiently evidence-based, which can translate into increased risks for women and babies (Enkin, 1995; Enkin et al., 2000; Klein et al., 2006). Also, feminist and other critics have observed the tendency for maternity care based on the medical model to be paternalistic and fetocentric, ultimately undermining women's control and active participation in pregnancy and birth. In her analysis of key obstetric texts, Emily Martin (1987/1992/2001) has observed 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). 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. Melissa Cheyney (2008) has argued that the medical paradigm 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). Consequently, those who resist these metanarratives by choosing out-of-hospital birth and care from providers other than physicians may find this decision to be a challenging one.

### ***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. A recent Ontario survey (Murray-Davis et al., 2014) identified and compared midwifery clients' reasons for wanting to give birth at home or in hospital in their upcoming births. This study did not, however, look at the learning process associated with respondents' expressed preferences. Another recent study (Murray-Davis et al., 2012) used qualitative methods to explore and compare both the motivating factors and decision-making process by which women in Ontario and in British Columbia chose to give birth at home. In these studies and other literature, motivators for choosing home birth include a view of birth as a normal physiologic process; a desire for greater control and choice (e.g., for comfort, privacy, and intimacy; to incorporate cultural or spiritual practices); an assurance of having a known care provider; a desire to avoid birth interventions; concerns 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 (Abel & Kearns, 1991; Bortin, Alzugaray, Dowd, & Kalman, 1994; Boucher, Bennett, McFarlin, & Freeze, 2009; Catling-Paull, Dahlen, & Homer, 2010; Cheyney, 2008; Godfrey, 2010; Klassen, 2001; Murray-Davis et al., 2014; Murray-Davis et al., 2012; Soderstrom, Stewart, Kaitell, & Chamberlain, 1990). Many of the motivators discussed in the literature were also raised by participants in my study.

Because most research on women's decisions to give birth at home has been conducted in settings outside of Canada where midwifery and home birth may be differently regulated (e.g., countries where home birth occurs outside the formal health care system; countries

where a greater percentage of women are attended by midwives), findings from these studies cannot be presumed to apply fully to Ontario.<sup>5</sup> Also, fewer studies looked at the learning processes involved in women's decisions. This reinforces a need for current, qualitative research shedding light on women's unique motivators and decision-making processes in the Ontario context and through the lens of adult learning theory.

### Theoretical Framework

Adult education theory recognizes informal learning as a valid and meaningful avenue for both personal and social transformation (Hall, 2006). Informal learning can occur in many contexts, including outside formal education settings and independently by an individual or group. Learning in order to resist is of principal concern and is connected with personal and social transformation. As argued by Griff Foley (1999), this *emancipatory learning* involves an unlearning of dominant beliefs and a learning of those that resist the status quo. From this perspective, transformative learning involves a "perspective transformation": seeing the world in a new way and so that new realities—whether personal or social—can be attained (Scott, 2006, p. 153).

My qualitative study uses a critical feminist approach to explore women's informal learning as it relates to their childbirth decision making, particularly their decision to have a midwife-attended home birth. A critical feminist approach recognizes and explores non-dominant knowledge and ways of knowing (Harding, 1987; Smith, 1990). In the case of childbirth, which is dominated by the "authoritative knowledge" of Western medicine (Jordan, 1997), a critical feminist approach recognizes women's lived experiences as valid sources of knowledge (Smith, 1990) and as a fundamental context for informal and potentially transformative learning.

### Method

As a critical feminist researcher, my methodological and 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, like some other feminist midwifery researchers (Burton & Ariss, 2009), referred to our interviews as "conversations" to reflect the shared effort of knowledge creation in this study (p. 8). Also, in keeping with feminist principles of shared power in research (Harding, 1987; Oakley, 1981), I aimed to create a respectful and welcoming space for study volunteers; for example, by using inclusive language in recruitment materials, by encouraging participants to take the conversations in the direction they desired, and by inviting each participant to review the typed transcript of our conversation and to amend it if she desired. Nonetheless, I acknowledge that, to some extent, uneven power relations remain. For example, I was fully responsible for the study design and had final say over how women's narratives were represented in study findings.

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5 Regulation and public funding of midwifery are not consistent across Canada (see Canadian Association of Midwives [2013] for an overview of midwifery regulation by province and territory).

### *Data Collection*

Data were collected from June to September 2012 through single, one-on-one, semi-structured interviews with seven women who had planned midwife-attended home births in the Greater Toronto Area of Ontario, Canada.

### *Participants*

To be eligible to participate, a woman had to have given birth in the last two years; been receiving midwifery care at the beginning of labour; been a candidate for home birth based on Ontario midwifery clinical guidelines; and chosen to give birth at home by the time she was in labour. Participation was open to those who had positive and those who had negative (and/or mixed) experiences with midwifery and home birth. Women who had planned midwife-attended home birth but who transferred to hospital during labour, including those whose care was transferred to an obstetrician, were eligible to participate.

From the 21 women who contacted me and met my inclusion criteria, I selected seven participants of varying backgrounds (e.g., age, parity, occupation) who were served by different midwifery practice groups, with the hope of interviewing individuals with diverse experiences. At the time of being interviewed, participants ranged in age from late 20s to early 40s and had between one and five children. Two participants<sup>6</sup> (Mary-Beth, Sally) had one or more previous physician-attended hospital births; one (Hanna) had a previous midwife-attended hospital birth; one (Corinne) had a previous planned home birth that involved an intrapartum transfer to hospital for caesarean birth, followed by two subsequent vaginal births at home; and three (April, Felicia, Natalie) were first-time parents with home births only. Participants were welcome to discuss any of their birth experiences (not just home births and/or the most recent births).

Based on their comments, all participants appeared to be educated, middle-class, and heterosexual. 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, interviews revealed participants' richly diverse histories, including experiences with immigration, divorce and separation, family violence, parental loss at a young age, the experience of seeking health care as an uninsured resident (no provincial health insurance), pregnancy loss, difficulties with breastfeeding, caesarean birth, and vaginal birth after caesarean (VBAC) and at home. The women drew on their own life experiences as they discussed their decisions to seek midwifery care and home birth.

### *Analysis*

My analysis involved close reading and rereading of transcripts and listening to interview recordings to identify and interpret important themes and ideas. Close textual analysis enabled me to interpret women's language and tone as well as to identify patterns in 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. When presenting my findings, I sought to avoid reducing women's narratives to a list of reasons why they chose midwifery and home birth, as I believe this may oversimplify their decision

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6 Pseudonyms were assigned to protect participants' privacy.

making and their significant informal learning. I have, rather, expanded their complex health decisions within the circumstances of each woman's life, learning, and social context.

### Findings and Discussion

I found that the decision to plan a midwife-attended home birth was, for all study participants, a challenging and transformative learning process. This was because of the scrutiny that they faced and their need to confront and resist the pervasive cultural views of home birth, and childbirth in general, as unsafe and of women's childbirth experiences as having a relatively low value. From each woman's narrative, it was clear that her learning process involved significant personal growth and discovery. The women had to draw on their own strength, become active and informed decision makers, and trust that with the support of their midwives, and the encouragement of their partners or other support persons, they could have a satisfying *and* safe birth at home.

Findings from my study are presented in two parts. First, I focus on participants' resistance, or what home birth researcher Melissa Cheyney (2008) has described as "unlearning" of what they initially believed about midwifery and home birth and about pregnancy and childbirth more broadly (p. 256). Next, I focus on participants' "relearning," a process that involved replacing initial impressions, misconceptions, and fears with new insights and information that ultimately gave them the confidence to plan home births (Cheyney, p. 256). This process of unlearning and relearning relates back to adult learning theory, in which it has been identified as necessary for challenging the status quo (Foley, 1999).

Although for analytic purposes I present this decision-making process in two phases, for the most part, participants' resistance and relearning occurred simultaneously and fluidly, and for each woman, in her own unique way. This individualized and sometimes unexpected learning reflects identified characteristics of informal adult learning (Hall, 2006).

### *Resistance*

#### **Interrogating myths and misconceptions about midwifery and home birth in Ontario.**

A central part of participants' transformative decisions involved challenging some of their initial assumptions about home birth, midwives, and midwifery clients. Through this "unlearning," they discovered that many of their beliefs were inaccurate or limited. One participant, Natalie, articulated this early step in her learning process particularly clearly: "[I had to] un-write some of the assumptions that I didn't even realize I had made."

The most fundamental misconception that the women came up against is that home birth is dangerous—or at least more risky than hospital birth. Critically reexamining the widespread unconditional trust in physicians and medical technology and becoming informed about midwives' training, scope of practice, skills, and equipment were essential to participants' rejection of the dominant view of hospitals as the only safe setting for childbirth and of physicians as superior care providers at all births.

As part of their unlearning, the women took an active role in educating their partners and, in some cases (Felicia, Sally), other family members whose support they desired. Several women emphasized that these shared learning experiences, and the resulting support and solidarity that they received, were critical to them becoming confident to resist the pressure

to have a hospital birth. Corinne, for example, expressed that “it was important that my husband was on board.” Mary-Beth recalled:

In the beginning when we first started having children, and he [Mary-Beth’s husband] 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 ... and he had come to the point to where he was able to say: “This is a good thing. Let’s try it. Let’s do this.” ... He became my biggest encourager.

Several women described how their partners’ or family members’ concerns about home birth safety, like their own, shifted as they learned about the realities of midwifery care and as they became less mystified by medical technology. Natalie explained that her partner’s trust in her decision resulted from thinking critically about his preconceived 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 recalled that her partner “was a little hesitant at first, because he felt ... ‘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!”

Another important misconception that some participants reconsidered is that midwifery and home birth appeal only to a narrow range of women: those in traditional communities or cultures, modern-day hippies, and those with otherwise countercultural lifestyles or beliefs. Some participants also initially assumed this of midwives. Becoming familiar with the diversity of midwives and their clients, and their formal status in the health care system, helped dispel these misconceptions. Felicia explained, “To be perfectly honest I knew what a midwife was. I knew that they existed. I had no idea they were part of ... our current [system] ... 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 ... hugging trees and being a hippie ... so it’s about overcoming that image. Even of midwifery.” April explained how her views shifted once she attended prenatal appointments:

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.

Participants did not elaborate about the reasons or origins of their initial assumptions that home birth is less safe than hospital birth or at odds with modern maternity care (suggesting an area for further research). However, I suspect that these stem from the dominant cultural belief that childbirth is inherently dangerous, that life-threatening problems frequently arise without warning, and that without the supervision of a physician and immediate access to all available medical technology, a poor outcome is likely. Several participants’ comments suggested a conscious reconsideration of these commonly taken-

for-granted assumptions. April's satirical reference to "the machines that go beep!" from the Monty Python comedy sketch and Hanna's frank observation—"there's this blind faith in science. Like having equipment means nothing will ever go wrong!"—both highlight a critical awareness of a false sense of security that people may feel in the presence of medical technology.

Like participants in this study, scholars critical of the medical management of low-risk pregnancy and birth also problematize the common assumption that a heavy-handed use of technology and routine medical interventions represent the most advanced kind of maternity care (Dreger, 2012; Klein et al., 2006). Medical ethicist Alice Dreger has argued that this confusion of "science with technology" not only occurs among patients and clients, but also medical care providers. She has explained how she encourages critical reconsideration of these beliefs among the medical students she teaches because "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).<sup>7</sup>

Some scholars trace present-day myths and stereotypes about midwifery and home birth to earlier efforts by the medical profession to establish a monopoly over maternity care (Biggs, 2004; Bourgeault, 2006; Davidson, 1997; Ehrenreich & English, 1973/2010; 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. Barbara Ehrenreich and Deirdre English (1973/2010) have argued 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). The initial assumptions of several women in my study—that midwives are unprepared, lacking training or appropriate equipment for safe home births—lend support to these scholars' arguments.

The recurring associations of midwifery and home birth with "hippies" among several women I interviewed (April, Sally, Corinne) and examined elsewhere in midwifery literature (Dreger, 2012; MacDonald, 2004) suggest that some stereotypes about midwifery and home birth may also stem from the association of contemporary midwifery with countercultural movements (e.g., anti-war, civil rights, women's movement) that influenced the emergence of professional midwifery in the United States and Canada beginning in the 1970s. While some principles from these movements (e.g., reproductive rights for women, reducing social inequality) are reflected in the philosophy and practice of present-day midwifery in Ontario (Burton & Ariss, 2009; Daviss, 2001; Van Wagner, 2004), presumptions that all or most midwives and midwifery clients identify with countercultural lifestyles or beliefs (whatever these may be, and there was no clear consensus from the interviews I conducted) downplay the increasing diversity of midwives and midwifery clientele in Ontario (Van Wagner, 2004).

It is also likely that a fear of the unknown may contribute to skepticism about the safety of home birth and midwifery care and may enable stereotypes about midwives and their clientele to persist. When a model of care and birth setting are unfamiliar, which is still the case for many people in Ontario (including many health care providers), it seems reasonable that myths, stereotypes, and outdated assumptions are likely to prevail unless

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7 Hanna's reference to *equipment* and *science* as interchangeable terms reinforces Dreger's assertion that technology and science are often mistakenly seen as the same.

individuals, like the women I interviewed, are motivated to actively educate themselves about the realities.

**Lived experience as a source of knowledge and resistance.** In my conversations with participants, it was clear that their own experiences and/or those of women they knew (family, friends, colleagues) profoundly impacted their learning and childbirth decisions, whether by raising doubts about the safety advantages of hospital birth for low-risk women and the quality of experiences that may be had in a hospital or in the care of a physician, or by inciting curiosity about possible benefits of midwifery and home birth, or both.

For some women, experiences unrelated to childbearing became important learning opportunities that set the stage for their future childbirth decisions. Hanna described a formative experience during her academic training:

I decided to have midwives [when] I was TA'ing [acting as a teacher's assistant for] a women's studies class ... like a thousand years ago and there was a 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.

Mary-Beth described her decision to home school her children as a pivotal experience that influenced her later choice of a home birth:

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 ... 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*."

Participants also learned from the experiences of their friends, sisters, mothers, and grandmothers. For example, Natalie commented that her mother's and grandmother's birth "narratives" may have "played a factor" in her decision:

I've heard stories ... my mom's ... parents [Natalie's grandparents] were from the Netherlands. And so she [Natalie's grandmother] 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, ... [how when Natalie's grandmother gave birth to Natalie's mother], she 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."

Most participants also credited positive word of mouth from other women who had had midwife-attended births, whether at home or in a hospital, as being integral to their learning and having one of the greatest impacts on their decisions. They encountered this word of mouth from their friends and close relatives, breastfeeding organizations, academic

work, and interactions with holistic health care and fitness providers (massage therapists, naturopaths, yoga instructors). Sally described how she first learned about midwifery through her family 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 here and there. And she was like me afterwards. She was convinced. She was like "oh, I'd never do it any other way. It's like amazing."

In these comments, Sally conveyed some of the compelling qualities of experiential knowledge and the impact it may have in informal adult learning. It is immediate, tangible, and specific and may resonate with individuals in ways that more abstract knowledge (learned from books, experts) may not. The few women (Mary-Beth, Corinne) who were able to witness second-hand the possibility of safe, satisfying out-of-hospital birth through friends who had had home births drew on these experiences to develop counternarratives to the discouraging and frightening messages that they encountered from the media, skeptical friends and family, and, in some instances, medical care providers. Mary-Beth in particular emphasized the value of women educating and supporting other women: "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." Similarly, Corinne explained that being able to "really pick the brains of my friends who'd had home births" provided her with concrete realities about what it is like to have a home birth.

Exposure to positive experiences with more woman-centred midwifery care and, in some instances, negative interactions with obstetric care helped the women resist another key belief in the dominant medical model of birth—that women's birth experiences are relatively unimportant and potentially incompatible with the birth of a healthy baby. April, for instance, described forming a negative impression of obstetric care and the hospital environment when being treated for an ectopic pregnancy in her early 20s:

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 ... 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 ... They were discussing putting me into this [neighbouring] 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.

Similarly, Mary-Beth, who sought midwifery care for the first time during her fifth pregnancy, recalled experiences with various obstetricians and hospital staff over the course of her first four births that left her feeling unsatisfied despite being initially unaware of any alternatives. She explained: “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.’” Mary-Beth recalled how a lack of continuity of care (different obstetricians at her births than who provided prenatal care), breastfeeding support (extended separation from her newborns after birth and babies given formula without her permission), and informed choice (interventions performed routinely or without her input), along with her providers’ authoritative styles, contributed to her disappointment.

Hanna, more overtly than any other participant, critiqued what she saw as “false logic” behind the prevailing assumption that a live baby is the only priority in a “good” birth:

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?

Participants’ lived experiences and those of others they knew and trusted enabled them to reject what they came to see as false dichotomies—between woman and fetus, choice and safety, and experience and outcome—that are central to the medical model of pregnancy and birth. Their experiences and those of women they knew validated their beliefs that pregnancy and birth are healthy, physiologic processes. The tendency for the women 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.

It is noteworthy that although participants were critical of the often heavy-handed use of interventions in obstetric care and the tendency for care to be provider- rather than woman-centred, they recognized the usefulness of physicians’ knowledge and the need for certain medical interventions (e.g., caesarean section) in some situations. 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. Likewise, April expressed an appreciation of hospital-based obstetric care: “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 distrust physicians, disapprove of birth interventions, or generally avoid medical care.

### **Relearning**

**Doing your homework.** Among the women in this study, unlearning and relearning occurred in parallel. An important part of participants’ learning involved gathering and

evaluating different kinds of evidence that they felt would enable them to make informed childbirth decisions, including about where to give birth. While participants' experiential learning often occurred fluidly or unexpectedly, sometimes over a long period of time, they tended to describe their information-gathering processes as more active, deliberate, and time-limited. Several participants used similar language to describe this aspect of their learning—"doing your homework," your "research," and your "due diligence." This language is important because it signifies the intellectual and practical work involved in gathering and evaluating information. This "homework" not only helped women decide where to give birth, but also enabled them to defend their choices when challenged by critics and skeptics and helped them prepare for labour. This was one of the ways that their learning proved transformative: not only did it enable women to see new childbirth possibilities for themselves, but it also empowered them to resist the fears and disapproval of others when they encountered it. Most participants began doing their "homework" about home birth once they were already in the care of midwives, reflecting the two-part nature of their decisions for most of the women—first, to seek midwifery care; second, to plan a home birth.

The information that the women found useful and persuasive tended to fall into one of two categories: (1) books and other resources that depicted birth as a normal physiologic process and that advocate for a woman-centred birth, and (2) empirical quantitative studies comparing outcomes of planned home and hospital births for women with low-risk pregnancies and evaluating the safety of other common maternity care practices (e.g., interventions).

**Insights from holistic and woman-centred childbirth advice literature.** Participants referred to information and advice in childbirth education materials—books, films, articles, and social media authored by midwives, childbirth activists, academics, medical professionals, parents, and others—as among the most influential to their decisions. As with other dimensions of their learning, they recognized the element of chance or luck in exposing them to the "right" types of information. Participants described gravitating toward childbirth education materials that depicted pregnancy and birth as healthy, physiologic processes in most cases (i.e., had a holistic view of birth), that presented birth stories where women and their families were active participants, and that honoured women's experiences as important alongside healthy outcomes for mother and baby.

Several participants indicated that they found a lot of the childbirth advice literature to be paternalistic or not that helpful. 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 (e.g., informed choice, woman-centred, evidence-based birth) through her sister, she might have been less inclined to critically evaluate what she referred to as the "typical online information, about 'what to expect when you are expecting' ... I hate that book."

Hanna explained how social media served as a valuable source of "qualitative" information that provided the insights and knowledge that were unavailable from her peers who had all given birth under the care of obstetricians and with many medical interventions:

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?

Positive, empowering birth stories in childbirth advice literature that presented woman-centred, holistic perspectives provided counternarratives to what women often referred to as “horror stories” and “fear-mongering” that they encountered from those who were unsupportive of their choices. In addition, participants emphasized the value of authors' discussions of published research about the safety and effectiveness of various childbirth practices, as well as advice for home remedies, labour pain coping strategies, and newborn feeding and care as useful information in the literature. These resources enhanced their confidence by helping prepare them for labour and by supporting their resistance to alarmist information that they encountered elsewhere.

**Empirical quantitative studies about home birth safety.** Participants sought empirical quantitative data, what they often referred to as “scientific evidence,” to inform and defend their childbirth decisions, particularly their decisions to plan home births. Their confidence in scientific evidence seemed to stem, in part, from their perception of it as objective, or more objective than the views of health care providers and others (e.g., authors of childbirth advice books). For example, Hanna, Corinne, April, and Sally raised concerns that the opinions of physicians in particular may be skewed by their training, personal preferences, convenience, comfort level, and view of birth as inherently risky, whereas systemically collected data may be less subject to these biases. Sally and Corinne also raised the possibility of bias among midwives. This motivated them to review scientific evidence and seek out the insights of past midwifery clients, as well as the advice of their midwives, when making their decisions.

Participants also found scientific evidence to be useful because it could provide practical, measurable, and generalizable information to quantify risks and benefits of various childbirth practices and enable them to put these risks into perspective (understand the odds). Whereas qualitative, narrative information from other women was useful in that it shed light on possible experiential benefits of midwifery care and home birth and tangibly demonstrated the possibility of good birth outcomes on an individual basis, empirical quantitative studies confirmed the likelihood of good outcomes for broader populations of women with low-risk pregnancies.

Most of the women described doing their “homework” by reading childbirth advice books and other web-based sources that presented quantitative data comparing low-risk birth at home and in hospital settings as well as risks and benefits associated with other childbirth interventions and practices. Hanna and Corinne, however, described looking up studies directly to scrutinize the methodologies used and to verify that the findings had not been misquoted or overstated in childbirth advice literature intended for laypersons. Hanna explained:

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 ... 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 ...

After giving birth via caesarean for her first birth, Corinne hoped she could give birth vaginally and at home. She conveyed the value of reviewing quantitative information when weighing her options:

So, okay, 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<sup>8</sup> "home birth" and "evidence-based medicine."

Despite her fluency with scientific research from her undergraduate studies in the sciences and work as a health care provider, Corinne described her decision as an intellectually and emotionally challenging one because of her previous caesarean birth.<sup>9</sup> To develop a well-rounded perspective, Corinne supplemented her analysis of scientific studies with medical policy statements and with information in childbirth advice books that she felt were consistent with her holistic view of pregnancy and birth and that encouraged informed decision making and woman-centred care.

Critical thinking was inseparable from participants' resistance and relearning. As noted by feminist writer and activist Jane Pincus (2000), "Informing women does not necessarily mean empowering them" (p. 210). This was evident among the women I interviewed. Although gathering evidence-based, woman-centred information was critical to their learning, participants' willingness to think critically and to take responsibility for their decisions was of equal importance when resisting the cultural pressure to have a hospital birth. Hanna's comments highlight the potential connection between critical thinking, informed decision making, and empowerment and how together there may be a broader impact on an individual's life and worldview:

How much of this [popular health and parenting 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.

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8 Use of Medline, the academic database of health care-related research publications.

9 Perspectives, policies, and practices about the relative safety of elective repeat caesarean section and VBAC vary among health care professions and individual providers and are shaped by medico-legal pressures, place of birth, and other factors (AOM, 2011; Kotaska, 2009).

### Conclusion

The women in this study testified to the challenging learning process associated with choosing midwife-attended home birth in a cultural context where there is significant fear about childbirth and where women's pregnancy and birth experiences are assigned a relatively low value. Participants' narratives shed light on the significant amount of time and effort involved in gathering and evaluating the evidence that they felt was necessary to make informed decisions about where to give birth and, to a lesser extent, whom to select as their care provider. Participants' narratives also highlighted some of the ways that these decisions may unfold—often unexpectedly and over extended periods of time—from personal experiences and from those of other women and demonstrated the often fluid, serendipitous, and relational nature of informal adult learning. Even after becoming educated and assured of their decisions, the women often faced criticism and other forms of what Cheyney (2008) has called “social sanctioning”; that is, efforts to convince women that they are making selfish, misguided, and irresponsible choices and are violating “social parameters of what constitutes a good mother” (pp. 264, 260). Developing the confidence to resist this pressure was critical to participants' personal growth and empowerment and was indicative of their transformative learning.

Despite important similarities in their access to resources (i.e., education, supportive partners or other family) that may support informed decision making and their common interest in features of a midwife-attended home birth—the possibility of greater control, privacy, intimacy, comfort, and convenience—participants approached their decisions from unique starting places and envisioned their desired birth experiences differently. In further research it would be worthwhile to develop a deeper understanding of women's learning processes and decisions by exploring the experiences of more diverse participants. This could be achieved, in part, through purposive sampling for a broader range of participants, particularly those who have a history of being marginalized in the health care system (e.g., Aboriginal women, immigrants and refugees, LGBTQ individuals, teenaged women) (Ford & Van Wagner, 2004).

This study has useful implications for the adult education field, particularly those approaching informal and lifelong learning from a critical feminist perspective where the impact of power relations on women's lives is of principal concern. From this perspective, personal experiences are viewed as fruitful starting places for individual and social change.

Midwifery has been described as “feminist praxis,” because as Barbara Katz Rothman (1989) has rightly asserted, it actively “works with the labor of women to transform, [and] to create the birth experience that meets the needs of women” (p. 170). The women in this study demonstrated that the learning process involved in deciding 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 an important legacy of participants' decisions and highlights the way in which this particular decision-making process became a significant example of lifelong learning for the women in this study.

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