PREFER TO PUSH: A STUDY OF FACTORS THAT SHAPE WOMEN’S MOTIVATION FOR NATURAL CHILDBIRTH

by

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BSc, Simon Fraser University, 1997

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ABSTRACT

Among the many factors that affect a woman’s plans for childbirth, her attitudes and beliefs about birthing play an important role. This exploratory study examines attitudes and beliefs about childbirth among nulliparous pregnant women who are committed to natural, unmedicated childbirth. This study also examines the factors that motivate women to desire natural childbirth in a culture where obstetric interventions are normative. A dominant theme of ambivalence is presented within a conceptual analytical framework that demonstrates a number of factors held in tension in women wanting natural childbirth. These opposing factors coexist within women, both pulling her to trust and desire natural childbirth and creating fear and uncertainty about natural childbirth. These tensions are examined through a discussion of two main influencers that shape women’s perceptions and plans for birth: the dominant medical paradigm of childbirth, and a reflection on the power of personal stories.
To Quinn and Nova
ACKNOWLEDGEMENTS

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The women I interviewed, who were about to give birth for the first time, honoured me with openness, trust, and curiosity. I feel an enormous sense of awe at the strength, determination and vulnerability these women shared with me. I also thank the maternity care providers who gave me their time in their busy schedules, and offered a great deal of insight into my research questions.

I am indebted to two women whom I consider mentors in the field of natural birth: Louise Smith and Kathie Lindstrom. They exposed me to a deeper understanding about the female body and childbirth. They ignited my passion to study and work in this field, and awakened a deep desire to give birth naturally to my two children.

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I thank my mom for being so casual and confident about childbirth – I never felt it was something to fear. Thanks to my mom and dad for their encouragement during my studies.

Lastly, I thank Quinn and Nova - the lights of my life. They have brought indescribable joy and sparkle into my days and they have been (mostly) generous in sharing their mama with a computer during their precious early years. Memories of their beautiful, natural births inspire me every day, and reaffirm my passion for this field of study.
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## GLOSSARY

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<td>Maternity care providers</td>
<td>Midwives, doctors, labour/delivery nurses, doulas, and childbirth educators.</td>
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<td>Nulliparous</td>
<td>Never before given birth.</td>
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<tr>
<td>Metro Vancouver region</td>
<td>Metro Vancouver region consists of 21 municipalities in close proximity to the city of Vancouver.</td>
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<tr>
<td>Fraser Valley region</td>
<td>Fraser Valley region consists of 6 municipalities to the east of Vancouver.</td>
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<td>Natural birth</td>
<td>For the purpose of this study, natural birth is defined as normal vaginal birth at home or in hospital where labour begins spontaneously and the baby is born without the use of pharmacological, instrumental, or surgical interventions.</td>
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1: INTRODUCTION

Childbirth is arguably one of the most natural experiences of life. Yet negative attitudes and fear surrounding childbirth are common in our society and these fears are reinforced by a medicalized approach to birth. Only a very small percentage of nulliparous women give birth without any obstetric intervention (3.2%) which means that nearly all first time mothers experience some form of surgical, instrumental or pharmaceutical intervention during childbirth (British Columbia Perinatal Health Program [BCPHP], 2009). These trends are meaningful, particularly if our medicalized approach to childbirth has negative population health consequences.

Among the many factors that affect a woman’s plans for childbirth, her attitudes and beliefs about birth are important. This study looks at why some women plan for natural birth despite the normative medicalized culture of childbirth. In the context of this study, natural birth refers to normal vaginal birth at home or in hospital where labour begins naturally and the baby is born without the use of pharmacological, instrumental, or surgical interventions.

It is important to identify individual factors that contribute to positive attitudes about childbirth among pregnant women. However, it is equally if not more important that we pay close attention to the modifiable factors in our health care system that either support women to give birth naturally or get in the way of this natural process. The World Health Organization states that “[i]n normal birth, there should be a valid reason to interfere with the natural process (World Health Organization [WHO], 1996, p.4), and many maternity care providers, researchers and consumers argue that there is far too much medical interference in normal childbirth. This medical approach to childbirth makes it difficult for women to be able to achieve a natural childbirth even if they are highly motivated to give birth naturally (Davis, 2003).

Natural birth, without unnecessary medication or surgical interference, is the safest for mother and baby. Many medical interventions that are commonly used in normal childbirth interfere with the natural process of labour and some of the interventions, when used unnecessarily, may pose additional risk to women and their babies (Kitzinger, 2005; Simkin, 1989; Dick-Read, 1985). There are a number of routinely used interventions such as continuous
electronic fetal monitoring and induction of labour, that have been associated with increased rates of surgical and instrumental deliveries without a clear benefit to mother or baby (WHO, 1996).

Women who seek natural birth do so for a variety of reasons. Some wish to avoid the risks of medical intervention, and others have a broader view of childbirth as a natural process that is a rite of passage for the mother (Carlton, Callister & Stoneman, 2005; Heinze & Sleigh, 2003). However, not all women view childbirth in this way, having been influenced heavily by the medical paradigm that depicts childbirth as a dangerous event that needs to be medically managed (Davis, 2003). Negative stories and messages about childbirth are prevalent in our society and can instil a fear about childbirth among pregnant women (Fisher, Hauck & Fenwick, 2006; Wildner, 2008). In fact, fear of childbirth is a very common phenomenon among pregnant women who are concerned about pain, complications and interventions (Melender, 2002; Hallgren, Kihlgren, Norberg & Forslin, 1995).

While it is important to understand the various factors that increase a woman’s motivation to have a natural childbirth experience, many factors influence the outcome. A woman’s motivation to have a natural childbirth increases her chances of a non-medicated birth, but it is not a guarantee. In fact, only about a quarter of first time mothers who want a natural birth will actually go on to give birth without interventions (Kringeland, Daltveit & Moller, 2010; Kannan, Jamison & Datta, 2001). The literature explains some individual and systemic factors that increase the chances of a woman having a natural childbirth. Individual factors include: being motivated to have an unmedicated birth (Heinze & Sleigh, 2003); having little or no fear about childbirth (Kringland et al., 2010); and having confidence in the ability to give birth naturally (Lowe, 2000). Systemic factors that affect childbirth outcome include the location of the birth (home or hospital) and the maternity care provider she has chosen. Women giving birth at home have the lowest rates of intervention compared to women giving birth in the hospital, and women who have midwives as their maternity care providers experience fewer interventions than those who have doctors (Janssen et al., 2009).

From a population health perspective, given the high cost of medicalized birth from risks to mother and baby to the actual financial cost, it is in the best interest of our population to increase the number of women with low-risk pregnancies who are encouraged and supported to give birth naturally. Public health has a historical connection in improving childbirth outcomes through changes that improve population health such as sanitation, refrigeration, immunization and improved work conditions (Simkin, 1989). One may still be able to link public health’s
contribution to childbirth in much the same way today, by improving the health of the overall population.

Fairly recently, options in prenatal care and childbirth have expanded in British Columbia. Women in British Columbia now have more freedom to choose their maternity care provider and location of birth. Women can give birth at home or in the hospital under midwifery care, or opt for a hospital birth with a physician (Midwives Association of British Columbia [MABC], 2009). As a result of the recognition of midwifery as a profession, and the official training and registration for midwives, more women are opting to have midwives as their primary maternity care providers. In British Columbia, the percentage of midwife deliveries is 10%, much higher than the Canadian average of 2% (MABC, 2009). Given that midwifery clients tend to experience fewer interventions than clients of doctors, this is one systemic factor that can help increase the natural birth statistics in British Columbia.

However, midwives can not be the only answer. Public health could play a role in improving childbirth experiences and outcomes, and in shaping attitudes and beliefs about childbirth. Currently, in British Columbia, there is a dearth of public health programs offered to pregnant women. The only core services within Health Authorities that serve the perinatal population are prenatal classes. This seems to send the message that pregnancy and childbirth is not a public health issue, it is a medical issue handled almost exclusively by the medical system.

It is important that research continues to discover ways to increase rates of natural birth in British Columbia and across Western countries. Modifiable individual factors must be explored fully. As well, changes need to be made at the systems level in public health and health care in order to increase the numbers of women seeking, being supported in, and having natural, non-medicated childbirth experiences. Prevention is an important component of public health, which should include preventing unnecessary medical interventions to improve childbirth for women.

The purpose of this study is to explore the factors that influence attitudes and beliefs about childbirth among pregnant women, to learn more about the motivations behind women seeking a natural childbirth experience, and to develop a conceptual framework of the contributing factors that positively influence women towards natural birth.

While there has been some research done on motivations for natural childbirth, much of the research has looked at factors that create fear, affect perceptions of pain, and influence choice of birth place and caregiver. There appears to be a gap in understanding why some women reject the medicalized view of childbirth and plan for a natural birth experience. What experiences have
they had in their lives that may contribute to their motivation for a natural birth? Who or what have been their primary influencers in forming their perception of birth? What factors during their pregnancy influenced their attitudes about birth and motivation for a natural birth?

It is hoped that the results of this exploratory study can provide important information about factors that support the choice for natural birth and which of these may be amenable to intervention at a systems level. The study may illuminate ways in which our society could improve our communications, imagery, and assumptions about pregnancy to put this experience in a more positive light. This research may also serve to inform further research into natural birth choices.

The primary research questions for this study are:

1. What are the attitudes and beliefs about birth among pregnant nulliparous women seeking natural childbirth?

2. What factors influence attitudes and beliefs about labour and childbirth among pregnant nulliparous women seeking natural childbirth?

3. What motivates pregnant nulliparous women to seek a natural childbirth experience?

This exploratory study used grounded theory principles and feminist methodologies within a constructivist paradigm. There were two sequential phases of data collection in the form of semi-structured interviews. The first phase was with maternity care providers who provided insight into the research questions and informed the interview guide for the second phase. The second phase of data collection was with pregnant nulliparous women in their third trimester who wanted to give birth naturally in hospital or at home. Nineteen interviews were conducted in Metro Vancouver and the Fraser Valley between November 2007 and May 2009 with maternity care providers (n=7) and with pregnant women (n=12).

An exploratory design was appropriate for this study due to minimal literature on why some women seek natural birth experiences, whether at home or in the hospital. I identified an opportunity to explore the motivation for natural birth and identify factors for further study. Feminist methodologies and grounded theory principles informed the methods of data collection and analysis, described in detail in Chapter 3.

Reflexivity is a core element of feminist research and grounded theory. These methodologies accept that researchers can not be unbiased because they come to the research with a certain perspective and level of understanding of the topic. Being reflexive throughout the
duration of the research study allows researchers to reflect on their perceptions, noting when their own ideas may be interfering with the data collection or analysis. Reflexivity also demands a level of transparency about oneself to the reader. In the spirit of reflexivity, I share some of my relevant personal history. I am a mother of two children, both born naturally at home with midwives. I chose this topic after the birth of my first child when I was asked why I was drawn to experience a natural childbirth despite the pressures in our society towards a more medical approach. Strangely, I had no answer, but I thought it was an important question and decided to pursue a version of that question in my research study.
2: BACKGROUND LITERATURE

2.1 Natural Childbirth

Natural childbirth tends to be understood as childbirth without the use of obstetric interventions, where mother and baby are not separated and breastfeeding is early and exclusive (Young, 2009). Within a wholistic paradigm, childbirth is not something that needs to be medically managed and is seen a healthy, safe and natural biological process (Davis-Floyd, 2003). It follows that natural childbirth, viewed within a wholistic paradigm, means more than just using no interventions in labour, but includes a faith in women’s bodies and physiology, and a belief that pregnancy and birth are safe and trustworthy.

The term “normal childbirth” is used frequently in the literature, sometimes in place of natural birth, to describe vaginal birth with limited interventions (as opposed to a broader wholistic definition). In the literature, the descriptions of normal may include a range of medical interventions. The Society of Obstetricians and Gynaecologists of Canada recently issued a Joint Policy Statement on Normal Childbirth, which defines normal labour as “[s]pontaneous onset and progress of labour to a spontaneous (normal) delivery at 37-42+0 gestation with a normal third stage. It can include pharmacological (opioids/inhalation) and non-pharmacological analgesia and routine oxytocic for the third stage” (Society of Obstetricians and Gynaecologists of Canada [SOGC], 2008, p. 1163). This statement goes on to define natural childbirth as having “..little or no human intervention” (p. 1163). Interestingly, the statement included the phrase ‘normal versus natural’ in the definitions, presumably to differentiate between what they are proposing is ‘normal’ in childbirth and what is abnormal (i.e. “existing in nature”), yet there was reference that care providers should be encouraged to support natural birth. This discrepancy in the document is perhaps a reflection of something Diony Young pointed out in her editorial on definitions of normal, that natural childbirth “…is an unusual event in a hospital, and most likely to occur with a midwife at home or in a free-standing birth center” (2009, p. 1). To some practitioners, “normal” may very well include the use of various obstetrical tools.
2.1.1 History of natural childbirth

I want women to want to give birth normally. But wanting normal birth is only the first step. Having a normal, not a medical, birth requires more than knowledge and confidence; it also requires strategy in the political world of birth. (Lothian, 2003, p. 38)

Natural childbirth is a term first brought to light in the 1930s and offered an alternative to “…women wanting to experience non-interventionist, women-centred approaches to birth” (Noble, 2000, pp. 12). This idea of natural childbirth was first discussed in Britain by Dr. Grantly Dick-Read around the time when anaesthesia was becoming widely accepted in childbirth (Canton, 2002). He questioned the medical management of birth and proposed an alternative view of birthing that avoided unnecessary interventions and sought to reduce the pain of childbirth by reducing fear and anxiety (Dick-Read, 1985; Cassidy, 2006). He described natural childbirth as one in which there is no disruption of the normal flow of labour and birth by any chemical or physical means (Cook, 1982).

Dick-Read’s focus was on ‘pain free’ childbirth, and this focus was continued by Dr. Fernand Lamaze in the late 1950s in France (Cook, 1982). The teachings of Lamaze were adopted widely by childbirth educators and women seeking natural childbirth, although the concept of the original Lamaze teachings have been adapted to mean supported and prepared childbirth, moving away from notion of a ‘painless childbirth’ (1982). The increasing popularity of these two physicians indicated increasing concern about the obstetrical techniques that were dominant in childbirth, as well as a fear of the safety of anesthesia for women, labour and babies (Canton, 2002).

By the 1970s, the feminist movement was gaining momentum, and women began to resist the perceived medical control over women’s bodies (Kornelson, 2000; Bourgeault, Benoit, & Davis-Floyd, 2004). The strength of the feminist movement exposed the inherent sexism of medicine, which contributed to a resurgence in the natural birth movement in Canada and the United States (DeVries, Salvesen, Wiegers, & Williams, 2001; Cassidy, 2006; Bourgeault et al., 2004). There was a growing desire to demedicalize childbirth, addressing the power structure of the medical system and seeking to make obstetrics more woman-centred (DeVries et al., 2001).

Women began to demand more choices in childbirth including location of birth and caregiver. This alternative birth movement paved the way to changing or eliminating many routine obstetric practices, and sought to re-establish midwifery as a legal and legitimate
profession (DeVries et al., 2001). In Canada, lay midwifery began to develop as a response to the woman’s movement. British Columbia is considered the origin of the new midwifery movement in Canada due to the women’s health movement and the counter-culture activity that was common in this region (Bourkeault et al, 2004).

Midwifery has a long and diverse history in Canada, but from the early part of the 20th century there was a dramatic decline in midwife-assisted births (Mitchinson, 2002). As the natural birth movement gained momentum and became more organized, there was a growing move to make midwifery a recognized, legitimate profession in Canada (Kornelson, 2000; Mason, 1990). In British Columbia, midwives gained official status in 1998 as they became regulated by the government of British Columbia and publicly funded (MABC, 2007), opening the door for women to choose midwifery care for pregnancy and birth. This has not been without tension and struggles as midwives sought to gain credibility among members of the medical community (Kornelson, 2000). Physicians and nurses expressed concern about the shift towards midwifery being an autonomous profession. Key areas of concern focussed on financial concerns, home birth, the role of the physician in prenatal care, and other issues related to the midwives’ scope of practice (Kornelson, 2000). There were also tensions among midwives, some of whom believed that legalizing midwifery would shift the profession too far into the medical realm (Mason, 1990).

Interestingly, as Carolyn Noble points out, “…more than sixty years after the agreed beginnings of the natural childbirth movement, women are less likely to experience non-interventionist births than their mothers or grandmothers” (2000, p. 13). While this viewpoint may not be held by all, and may reflect a difference in the changing trends of medical interventions in childbirth, it is interesting to look at the choices women now have that impact childbirth.

2.1.2 Social construction of natural childbirth

There are many different ways of defining “natural childbirth”. Some researchers critique that natural birth is a social construct that has been conceptualized as an idealistic notion of a return to nature or “…passively letting nature take its course,” (Mansfield, 2008, p. 1093). Mansfield suggests that natural childbirth, without the use of medical interventions, actually requires significant planning and preparation by the woman, engaging both a social element combined with the natural element of birthing (2008). She questions the acceptance of natural birth as being purely natural and instinctive, when at the same time, proponents of natural birth promote ways to facilitate the process. She asks, “[i]f childbirth is so natural, how can there be
strategies to facilitate it? If it is instinctive, why does it need to be learned?” (Mansfield, 2008, p. 1086).

Shannon Carter also discusses this social construct of natural childbirth by describing how gender and gender expectations are linked with choices around childbirth. Specifically, she links social meaning of natural birth to gendered definitions of motherhood – if medical procedures are perceived as harmful, women will choose natural birth as a way to protect their babies from harm, something she describes as an “...important aspect of femininity: the good mother.” (2009, p.221). MacDonald also illuminates gender expectations around natural childbirth which support the belief that “…women’s bodies are naturally competent; that with proper support women can handle the pain of labour and even find it empowering; and that women can trust their gut feelings...” (2006, p. 251). She asserts that while this social construct of natural birth is compelling and strategically useful, it is problematic because it does not take into account feminist theory of gender expectations in childbirth (2006).

Margaret MacDonald also discusses the meaning of natural childbirth and puts it into context of the ‘new midwifery’ movement in Canada (2006). She describes how the natural birth movement constructed the definition of natural childbirth in order to present a dichotomy between ‘natural’ birth and ‘medical’ birth, accentuating the potential dangers of technocratic birth procedures. The promotion of natural childbirth “...posits women as naturally capable and strong, their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and interventions of physicians in a hospital setting” (MacDonald, 2006, p. 236). In her work, she describes how the new midwifery in Canada is reshaping this notion of natural birth, redefining it in ways that are more individual and contextual rather than a focus on an outcome that is entirely without technological interventions. She suggests that this redefining of natural birth is a reflection of a growing acceptance of technology in childbirth among midwives and among their clients (2006).

2.1.3 Women who desire natural childbirth

There is not a large body of literature about women who plan for natural birth. Some of the literature looks at beliefs about vaginal birth versus caesarean, others look at women who wanted to avoid epidural, and still others explore the lives of women who plan to give birth at home. Much of the literature on attitudes and beliefs about childbirth looks at the impact of cultural influences on perceptions of childbirth, namely the promotion of a medicalized approach
to childbirth. In this background chapter, I focus on the literature that did specifically look at attitudes about natural birth.

There is some evidence that many of the women wanting to give birth naturally see childbirth as a normal, natural process. They consider childbirth to be a rite of passage, they want to be fully present during the process of labour, and they believe that giving birth connects them to previous generations of women. The evidence also reflects that these women are concerned about the effects of medication on the baby or on labour and birth (Carlton et al., 2005; Heinze & Sleigh, 2003).

Some of the research looked at vaginal birth (not necessarily natural birth), as opposed to caesarean. In one such study, women wanting a vaginal birth had positive attitudes about vaginal birth and negative perspectives on caesarean, they had support from family and friends, and a greater confidence in their ability to give birth naturally (Smartt, 2004). In another study looking at attitudes of vaginal and caesarean birth among university students, the vast majority (91%) would prefer vaginal birth to caesarean section when they do become pregnant, citing the transformative nature of birth, the naturalness of the process, and that it is safer and healthier than caesarean birth (Stoll et al., 2009).

In a study looking at nulliparous university students’ perceptions of natural birth, it was interesting that natural birth was described as a conscious choice or goal set by women (Woodruff & Vezeau, 2005) as opposed to what happens if you don’t intervene in childbirth. It seems from these results that medical birth is definitely seen as the norm. In the same study, the respondents used positive descriptors when speaking of women wanting natural birth, using words such as “strong”, “determined”, and “informed”. However, these same women also felt that natural birth was countercultural (2005).

A British study about how decisions about caesarean sections are informed was unexpectedly relevant to understanding attitudes about vaginal birth (not necessarily natural birth). The women in the study highlighted a tension between desiring a vaginal birth while also believing that birth was hazardous. This tension was justified by expressing concern for the baby’s health, referring to media images of childbirth as dangerous, the potential problems arising from prenatal testing, and the normalizing effect of high caesarean section rates (Weaver, 2000).

Individual factors among women who prefer to labour naturally include less fear and anxiety about birth, an internal locus of control, and a focus on the process of birth rather than the end result (Heinze & Sleigh, 2003). There was a desire to be an active participant in childbirth
and these women were motivated to avoid medication because of concerns about harmful effects (2003; Carlton et al., 2005; Kannan, 2001). A natural birth carried with it a sense of belonging to generations of women (Carlton et al., 2005), and was seen as a normal process and a challenge (Hallgren et al., 1995).

The choices women make about location of childbirth also related to attitudes and beliefs. Women who chose to have their babies at home were more confident in their ability to give birth naturally and were more likely to view childbirth as a natural event without the need for technology (van Der Hulst, van Teijlingen, Bonsel, Eskes & Bleker, 2004). Women planning home births liked they would be in a comfortable environment, they would avoid conflict with medical professionals, they would not be exposed to unnecessary interventions, and they believed that home birth increased safety and resulted in better outcomes. A negative previous hospital experience, the positive influence of family, and an overall trust in birth were also factors that contributed to their choice of home birth (Boucher, Bennett, McFarlin, & Freeze, 2009).

In another study looking at home birthers, it was described that these women needed to reject the dominant medical paradigm and ‘redefine authoritative knowledge’ The women were described as having to unlearn the dominant messages about birth and relearn a new way of seeing childbirth. They developed what the researcher called ‘counter narratives’ which stimulated a transition from a faith in doctors to a faith in bodies and birth. This transformation of understanding was a major factor in women choosing home birth, helping the women “...create new realities and explanatory models around childbirth” (Cheyney, 2008, p. 259). This study also reflected on the sense of personal power and individual agency that these women claimed through their decision to give birth at home (2008).

Motivation for a natural birth is an important factor in having a natural birth. In fact, studies show that over 90% women who plan to have an epidural will receive one (Heinze & Sleigh, 2003), and they will actually receive it earlier in labour than women who did not plan to have an epidural (Carlton et al., 2005). It is important to note, however, that while women may be highly motivated to give birth naturally, there are factors outside of her control which influence her ability to achieve that outcome.

In one study looking at women who planned for a natural birth, only 23.7% of first time mothers succeeded in having the birth experience they had planned (Kannan et al., 2001). The women that succeeded were found to have supportive partners, confidence in ability to handle pain, and they anticipated more pain than they experienced (2001). In a study of women in Norway who wanted a natural birth with no medical interventions, only 29% of the nulliparous
women gave birth without interventions (Kringeland, et al., 2010). The factors that decreased the chances of these women having a natural birth were older maternal age, less education, and fear/anxiety about birth. In fact, even though the population of this study were women who were motivated to give birth without medical interventions, nearly half of them (43%) expressed a fear of birth (2010). One study found that 52% of those who planned to labour without medication actually ended up getting an epidural (Carlton et al., 2005). Length of labour, the inability to relax, exhaustion, and anxiety were listed among the reasons for the change in birth plan (2005).

A challenge in encouraging women to strive for a natural birth is that their satisfaction with the birth experience might be low if the birth did not go as planned. Among those who had planned a natural birth but ended up receiving epidural, 88% were unsatisfied with their birth (Kannan et al., 2001). Women who were found to be most satisfied with their birth experience included those with high levels of personal control, those who were well-prepared for birth, and those who experienced lower levels of perceived labor pain (Goodman, Mackey & Tavakoli, 2004). Interestingly, counter to the medicalized model of childbirth, a healthy baby is not necessarily a significant predictor of satisfaction with the birth experience (Hodnett, 2002).

Self-confidence is related to the desire to have a natural birth (Lowe, 2000). If a woman has a strong belief that she will be able to handle the pain of labour, her fear of birth is lower and her desire to have a natural birth is higher (2000). Several researchers have explored the relationship between confidence and ability to cope with labour and childbirth, demonstrating that women with higher levels of confidence have also been seen to have a lower perception of pain during labour, reducing their need for pain-relief medication (Lowe, 1989, 1991, 1993, 2000; Sieber, Germann, Barbir & Ehlert, 2006; Crowe & von Baeyer, 1989; Wuitchik, Hesson & Bakal, 1990). It was found that self-efficacy expectancy (described in this context as belief in ability to cope during labour) was the most important predictor of pain-control in labour, even more significant than the desire for an unmedicated birth (Lowe, 1991). In other words, wanting a natural birth is not enough – you have to believe that you can cope with labour.

Confidence not only decreased perception of pain during labour, but also decreased fear of childbirth (Lowe, 2000). Some researchers have attempted to describe how women develop confidence in ability to give birth. These factors included effective preparation, having a good previous birth experience, knowledge about childbirth, the use of internal coping strategies in labour, and the presence of a support person during labour and birth (Gibbins & Thomson, 2001; Drummond & Rickwood, 1997).
2.1.4 Rates of natural childbirth

Estimates on the number of women who should be able to give birth naturally and safely without interventions range from 70-80% (Buckley, 2009), to 85-90% (Gaskin, 2003; Mitchinson, 2002). The World Health Organization (1996) says that between 70-80% of all pregnant women can be considered low risk at the beginning of their labour. In 2008-09 in British Columbia, only 2486 women gave birth without any obstetric interventions. With a total of 44,007 births in BC, this means that 5.6% of women gave birth naturally. Nulliparous women have even lower rates of natural childbirth with only 3.2% giving birth without obstetrical interventions (BCPHP, 2009). Please see Appendix 1 for data on natural birth in British Columbia.

2.1.5 Home birth

The College of Physicians and Surgeons of British Columbia (2009) recently updated its policy on planned home birth which supports a woman’s right to choose home birth, and allows physicians the right to provide prenatal and maternity care for women planning home births. In BC in 2008-09, only 1.8% of total deliveries were home births (BCPHP, 2009).

The evidence is growing that planned home birth with midwives is as safe, if not safer, than hospital births. The components of safe home birth include systems that allow for effective consultation between home birth midwives and physicians during pregnancy and postpartum, the ability to transfer to a hospital if required, and the provision of care of a labouring woman upon transfer (Davis-Floyd, Barclay, Daviss, and Tritten, 2009).

There have been several recent studies looking at neonatal mortality rates and rates of obstetric interventions between home and hospital births. Two of these studies were in Canada (Ontario and British Columbia), one in the United States, and one in the Netherlands.

The British Columbia study compared planned home birth with registered midwives with planned hospital births with both midwives and doctors. This study showed that the planned home birth group had comparable rates of perinatal death and lower rates of all obstetric interventions including electronic fetal monitoring, instrumental delivery, severe perineal tears, and post partum haemorrhage (Janssen et.al., 2009). These results are similar to the two other studies that included maternal factors (Hutton, 2009; Johnson & Daviss, 2005) with a caesarean section rate of 8.3% for nulliparas in the United States study. The Ontario study showed that nulliparas planning home birth were more likely to be transferred to hospital than multiparas,
however they still had similar or better outcomes than nulliparas planning hospital birth (Hutton, Reitsma & Kaufman, 2009).

In all four of these studies, newborns of women who planned home birth had fared better or no differently than women who chose hospital birth, experiencing similar or less risk of morbidity (Janssen et al., 2009; de Jonge et al., 2009; Johnson & Daviss, 2005; Hutton et al., 2009).

In both Canadian studies, 78% of the women planning home births delivered at home, and 97% of women planning hospital birth delivered in hospital (Janssen et al., 2009; Hutton, 2009). The United States study also evaluated maternal satisfaction after successful planned home birth and found that 97% were satisfied with their childbirth experience (Johnson & Daviss, 2005). These statistics show that women who plan home birth have a very good chance of achieving their goal and feeling a sense of satisfaction about their childbirth experience.

The British Columbian study was unique because they matched the same midwives with the home and hospital births. The study clearly showed that being in the hospital, even with midwives, resulted in higher rates of interventions and adverse outcomes than at home births such as instrumental delivery, perineal tears and postpartum haemorrhage (Janssen et al., 2009).

From a purely economic standpoint, natural birth makes sense for our health care system. The costs of natural childbirth are substantially lower than caesarean section. A vaginal delivery with no complications costs approximately $2,700; a complicated delivery was approximately $3,200; caesarean deliveries about $4,600 per patient (Canadian Institute for Health Information [CIHI], 2006a).

### 2.2 Medicalization of Childbirth

Medical technologies can be credited for decreasing maternal and infant mortality rates during childbirth by managing dangerous situations (Lowe, 2000). However, the use of technology and medical interventions has become the norm because of a “...temptation to treat all births routinely with the same high level of intervention required by those who experience complications” (WHO, 1996, p. 2). Dr. Dick-Read (1985) summed up his belief of the dangers of a medicalized birth in 1933 by writing, “…it is generally agreed that one of the most important factors in the production of complicated labour, and therefore of maternal and infant mortality, is the inability of obstetricians to stand by and allow the natural and uninterrupted course of labour.” (p. xx).
2.2.1 History of medicalization in childbirth

Dramatic shifts towards highly medicalized childbirth practices occurred in Canada and the United States in a relatively short period of time. The medical management of childbirth began to increase in the early 1900s, with more power resting with medical doctors and hospitals (Davis, 2003; Mitchinson, 2002). Birth was being treated more and more as a pathological risk than a natural process, requiring hospitals to reduce the risks (Mitchinson, 2002; Declercq, DeVries, Viisainen, Salvesen & Wrede, 2001; Zwelling, 2008). Although there were physicians at that time who felt their role in birth was to be a watchful observer, there was a shift to a focus on the risks of childbirth. Canadian hospitals began to document models of how unproblematic births should proceed, which meant that any woman who did not fit the model would be considered a problematic labour (Mitchinson, 2002).

At that time, maternal and infant mortality was higher (Simkin, 1989; Mitchinson, 2002), and wealthy consumers were seeking safer births, so the medical sector began to apply medical solutions to the problems (Simkin, 1989). Canadian medical experts began to differentiate the modern woman from the less civilized women (believing that civilization makes childbirth too painful and dangerous), making the case for increased medicalization of childbirth among civilized woman (Mitchinson, 2002). At the same time, governments began to improve the health of the overall population through education, immunizations, and improved sanitation. Maternal and infant mortality rates began to steadily decline in the 1940s, although it is uncertain whether it was the medical interventions or the overall improvement of the population’s health that was the most significant factor in this shift (Simkin, 1989).

There was a corresponding shift in location of birth during the early 20th century. In Canada, at the turn of the century, giving birth at home was the norm. However, between 1926 to 1950, the rates of hospital births increased dramatically from 18% to 76% (Mitchinson, 2002). Giving birth is hospital continued to gain momentum, with nearly all births happening in hospitals today (BCPHP, 2009). This move into hospitals was in line with a general trend in the health care system that saw a shift of focus from the home to the hospital for many services (Declercq et al., 2001).

There was a growing awareness of the challenge of trying to distinguish between problematic births and normal births, which lead to a greater reliance on medical interventions in cases where there was any possibility of problems (Mitchinson, 2002). Generally, the trend continued towards more and more control of childbirth by the medical system. During this time, there was an increase in surgical and pharmaceutical interventions. As an example, episiotomy
was widely practiced and pain medications for labour were welcomed, despite the risks of such surgical and pharmaceutical practices (Simkin, 1989). The fear of maternal mortality led to an excessive use of interventions in normal childbirth to the point that the very interventions can actually cause morbidity and mortality of mother and baby (Davis-Floyd et al., 2009). It is interesting to note that obstetric interventions have often been defended on the basis that they save lives, however while there has been a rapid increase in obstetric interventions over the last couple of decades, “...there has been no corresponding fall in maternal or neonatal deaths” (Beech, 2008).

Penny Simkin (1989) chronicles the social climate in the 1980s and 1990s that contributes to a greater reliance on technological interventions in birth. She argues that a growing respect for technology in all aspects of life makes it easier to accept the benefits of using technology and professional expertise with the belief that it will increase chances of a healthy baby. It is argued that fear-based medical discourses leave little room for women to reject medical technology, resulting in increased acceptance of medical intervention in birth (Davis, 2003).

2.2.2 Risks and rates of medicalized childbirth

“Labour (including its onset) involves an extremely complex interplay of hormones that cannot be altered without upsetting the normal physiological pattern. Changing the normal pattern often causes other problems, necessitating more obstetrical interventions” (Gaskin, 2003, p.208).

There are psychological and physical risks to unnecessary medical interventions in childbirth. The mind-body connection is not considered an important element of birthing, and labour pain is considered unacceptable (Gaskin, 2003). In fact, within the medical paradigm “…some medical intervention is considered necessary for every birth, and birth is safe only in retrospect” (2003, p. 185). Within this paradigm, there is little space for trusting birth as a natural event because there is a strong belief that obstetrical science can reduce the risk of childbirth and is responsible for saving lives.

Medical discourse about birth separates the innate knowing that a woman has of her body and her baby, by privileging technology over women. Sarah Buckley talks about the way medical technologies, namely ultrasound, “…represents yet another way in which the deep internal knowledge that a mother has of her body and her baby is made secondary to technological information that comes from an expert using a machine; thus the cult of the expert is imprinted from the earliest weeks of life” (Buckley, 2009, p93).
Viewing childbirth as a potential emergency and the routine use of medical technologies throughout pregnancy and birth changes women’s relationship with the birth process, and undermines “…their beliefs in the ability of their bodies to give birth successfully and their beliefs in their personal ability to exercise control over their birth experience” (Lowe, 2000, p. 223). This dominant paradigm, and eroding of confidence to give birth can affect a woman’s perception of risk and influence her acceptance of medical intervention in birth (Woodruff & Vezeau, 2005). A study of college students found the medicalization model is deeply entrenched in young people’s views on childbirth, describing an “…unquestioning acceptance…of pain medication to reduce suffering during childbirth.” (Cleeton, 2001, pp.194-5).

There is a plethora of interventions during childbirth that have been used over the years, many of which are still used today. Some of these interventions include prenatal ultrasounds, artificial induction of labour, shaving of pubic hair and enemas given during labour, electronic fetal monitoring, prone birthing position with feet in stirrups, the use of anaesthetic and analgesic pain-relief medications in labour, episiotomy, and surgical or instrumental delivery of the baby (Kitzinger, 2005). This medicalization negatively affects women’s ability to labour effectively and birth naturally (Gaskin, 2003), leading to increased use of pain-relief medication and other interventions during labour, which often leads to an increase in surgical childbirth procedures including caesarean section (Janssen et al., 2001; WHO, 1996; Bak, 2003; Lothian, 2001). In 2004, 30% of babies in British Columbia were born by caesarean section (CIHI, 2006b).

Caesarean section has been on the increase in Canada, and internationally for many years. In British Columbia, the rates of caesarean section rose from 23.6% - 29.5% between the years 2000 and 2005 (BCPHP, 2008), and the caesarean rate for nulliparous women is higher than multiparous women (Public Health Agency of Canada [PHAC], 2009). A higher caesarean section rate does not mean improved safety for mother and baby. The World Health Organization (1985) has recommended that there were no health benefits associated with a caesarean section rate above 10-15%. Additional research indicates that neonatal and maternal mortality does not improve when the caesarean section rate rises above 10% (Plante, 2009). In fact, it is shown that developed countries with lowest caesarean rates (close to 10%) also have the lowest maternal and infant mortality rates (Wagner, 2000).

Caesarean section is a necessary procedure that can save lives in true emergencies, however, it is not without risk. This surgery poses additional risks to mother and baby (BCPHP, 2008). Maternal morbidity may increase (Liu et al., 2007), and there are increased risks for subsequent pregnancies and births after a caesarean section (BCPHP, 2008). There may be
psychological consequences of caesarean section as well. The Maternity Experiences Survey of the Canadian Perinatal Surveillance System found that women who had caesareans less likely to report their birth as a positive experience than women who gave birth vaginally (Chalmers et al. 2010). This survey also found a link between medical interventions in childbirth and caesarean section. The women who had caesarean sections were significantly more likely to have experienced obstetric interventions during labour such as electronic fetal monitoring, induction/augmentation of labour than the women who gave birth vaginally (2010).

Medical forms of pain relief are the norm in Canada (PHAC, 2009). Epidural anaesthesia is widely used in normal labour (WHO, 1996) and has been shown to increase the rate of instrumental deliveries (BCPHP, 2008; Chalmers et al., 2009; WHO, 1996; Romano & Lothian, 2008). Instrumental deliveries increase the risk of perineal morbidity including urinary incontinence (Williams, Herron-Marx, & Knibb, 2007). Epidural can also slow the progress of first and second stage of labour and can increase the use of oxytocin (BCPHP, 2008; Chalmers et al., 2009). There may be risks to baby and mother due to maternal fever, possible interference with breastfeeding, and may decrease a woman’s satisfaction with the birth experience (Buckley, 2009). Epidural may increase the risk of caesarean section, although this finding is controversial (BCPHP, 2008; Romano & Lothian, 2008).

The rates of epidural vary across regions, however in the Canadian Maternity Experiences Survey, 72% of nulliparous women reported having an epidural (Chalmers et al., 2009). British Columbian data shows that the rates of epidural among nulliparous women in 2008-09 was 44.6% compared to a rate of 16.3% among multiparas (BCPHP, 2009). The World Health Organization (1996) states that “...epidural analgesia is one of the most striking examples of the medicalization of normal birth, transforming a physiological event into a medical procedure” (p. 16).

Other types of drugs used to treat pain in labour can have deleterious effects on the newborn including respiratory problems and reluctance to breastfeed (WHO, 1996).

Electronic fetal monitoring in labour has been found to increase interventions such as caesarean section, instrumental deliveries (WHO, 1996; Romano & Lothain, 2008), and the use of pain medications (Chalmers et al., 2009). For normal labours, electronic fetal monitoring has not been shown to have a clear benefit for the fetus, but results in increased interventions in birth and discomfort for the woman whose mobility is restricted with this technology (WHO, 1996). In the Canadian Maternity Experiences Survey, 94% of nulliparous women reported experiencing electronic fetal monitoring during their labour (PHAC, 2009).
The use of oxytocin to induce or augment labour is also related to adverse outcomes. Augmentation or induction has been associated with an increase in instrumental deliveries, uterine rupture and caesarean section (Chalmers et al., 2009). The induction of labour by oxytocin in nulliparous women has been associated with a two-fold increase in the rate of caesarean section (BCPHP, 2008), yet there is no evidence that attempting to accelerate normal labour is beneficial (WHO, 1996). There is growing evidence that the induction of labour is a practice that “...sets the stage for medically managed labor and birth characterized by intravenous lines, electronic fetal monitoring, and very often epidural analgesia. This makes the overuse of induction of labor perhaps the greatest risk to normal physiological birth: (Romano & Lothian, 2008). In the Canadian Maternity Experiences Survey, 50.7% of nulliparous women surveyed reported induction or augmentation of labour (Chalmers, et al., 2009).

Prenatal testing may also be a source of additional stress for pregnant women. Sarah Buckley (2009) talks about the “nocebo” effect which is the “... unintended negative effect of a medical diagnosis or treatment” (p. 44). She highlights the importance of women to safeguard their emotional well-being while they are pregnant in preparation for childbirth. She also encourages women to “...choose caregivers who will increase joy, rather than reinforce fear and worry...” (2009, p 45). Ultrasound is one commonly used prenatal medical technology. The use is controversial and Sarah Buckley points out that is can cause added stress and anxiety among pregnant women who are seeking reassurance from the ultrasound that the pregnancy is progressing normally. The Public Health Agency of Canada (2009) refers to studies that show routine ultrasound may increase prenatal hospitalization and induction of labour without improving perinatal outcome. The Canadian guidelines for ultrasound recommend that one ultrasound be offered at 18-19 weeks for a normal pregnancy, however, the rates of ultrasound use in British Columbia demonstrate a different practice. Nearly 80% of women reported having two or more ultrasounds in their pregnancy.

2.2.3 Medical paradigm

It is often said that childbirth can only be deemed normal in retrospect, therefore it is the norm of obstetric practice to treat all birthing women as if they were high risk. This is problematic because it means that a normal process becomes a medical procedure and often leads to unnecessary obstetric interventions (WHO, 1996). In Canada and the United States, “...the birthing system is more likely to be managed as a medical and technological event by physicians rather than guided as a physiological and social experience by midwives” (Young, 2009, pp. 1-2).
Within a medical paradigm, childbirth is portrayed as a risky medical event. Discourses within this paradigm accentuate the importance of medical interventions during pregnancy and birth in order to reduce risk for mother and baby (Davis, 2003). Some researchers have argued that this paradigm presumes that the woman’s body is like a machine and is fundamentally flawed (Davis-Floyd, 2003; Downe & McCourt, 2008). If the body is a machine, then when it operates outside of a set of strict parameters, it is considered pathological (Downe & McCourt, 2008). In other words, a set of structured guidelines are established in the medical system in order to control risks in childbirth. When the process of childbirth does not follow the preconceived guidelines, it is deemed problematic or risky, and the medical system’s role is to intervene to decrease the risk by controlling the process.

Fear-based medical discourses leave little room for women to reject medical technology, resulting in increased acceptance of medical intervention in birth (Davis, 2003). It is argued in the literature that medical discourses, or the social context of birth, depict childbirth as dangerous and are very influential on women’s perceptions and choices concerning childbirth (Davis, 2003; Fisher et al., 2006; Simkin, 1989).

## 2.3 What Shapes Attitudes about Childbirth

When women tell stories of birth, it is often a competition about who has had the worst experience, whose labour was the longest, whose baby was biggest, and who had the most stitches. I look around and see a generation of women frightened of birth. Alongside them is a generation of doctors so terrified of the unpredictability of birth that they test, probe, monitor, augment and operate to hasten or avoid labour. Society sees the escalating intervention and operative rates as proof that birth is dangerous and thus needs to be managed by obstetricians (Morris, 2005, p.508).

The literature is quite clear on the various influences on women that shape their ideas about childbirth, however the focus has been more on factors that contribute to negative attitudes about childbirth.

Among the research that did not specifically focus on negative messages, it is suggested that the primary influencers about childbirth are mothers and other family members. Messages from society/community, television, the medical system, and drug companies are also influential (Woodruff & Vezeau, 2005; El Halta, 2001).
Among factors that contribute to negative attitudes about pregnancy and childbirth, cultural norms, media/pop culture, and normative obstetric practices are the prominent influencers (Woodruff & Vezeau, 2005; Smartt, 2004; DeVries, 2001). Stories shared by mothers, acquaintances and by medical professionals can cause fear in women (Fisher et al., 2006; El Halta, 2004; Melender, 2002; Morris, 2005).

Depictions of childbirth on television and in books show birth as a risky and dangerous event, and rarely is childbirth portrayed as a positive experience (Wildner, 2008; Zwelling, 2008; El Halta, 2004). Wildner (2008) reflects on how society normalized medical childbirth in the most innocent ways – simply asking a pregnant woman if she has received her first ultrasound makes medical birth normal.

2.3.1 Fear

In writing about the influence of fear in childbirth, it is hard to determine what comes first. While fear is shown to influence attitudes and beliefs about birth, it is attitudes about birth that create fear. Fear of childbirth has been extensively researched in the literature demonstrates a chicken and egg situation – fear can result in more medicalized births, and yet it is the normative medicalized culture around birth that creates the fear of birth.

Fear about childbirth is a common phenomenon among pregnant women, and is associated with fear of pain, fear of medical intervention, fear of complications that could harm baby and mother, and fear of losing control during labour (Melender, 2002; Eriksson, Jansson & Hamberg, 2006; Fisher et al., 2006; Hallgren et al., 1995; Lowe, 2000; Gibbins & Thomson, 2001). Women who experience numerous daily stressors combined with a history of psychological problems can experience the greatest fear of childbirth if she has little social support (Saisto & Halmesmaki, 2003). Evidence is building that associates fear of childbirth with longer labours and emergency caesarean sections (Laursen, Johansen & Hedegaard, 2009; Johnson & Slade, 2003; Ryding, Wijma, Wijma & Rydhström, 1989).

Fear and anxiety in childbirth is related to maternal request for caesarean section in the absence of medical reason (Kringeland et al., 2009; Weaver, Statham & Richards, 2007; Waldenström, Hildingsson & Ryding, 2006; Saisto et al., 2003; Dodwell, 2002). The phenomenon of maternal request of caesarean section has been greatly reported in the media, indicating some sort of growing trend, however the media representation has been dubbed ‘too posh to push’, focussing on the celebrities who choose caesarean section as opposed to keeping the focus on fear of childbirth and the causes of this fear. The evidence on this trend is
controversial and challenging to measure, however it seems to indicate that the percentage of
nulliparous women seeking this procedure without medical reason is less than 5%, as opposed to
the growing trend reported in the media (Dodwell, 2002, Weaver et al., 2007).

Fear of childbirth can influence women to be more willing to accept medical
interventions in birth. Elaine Zwelling (2008) observes that fears may be misplaced, with
pregnant women fearing pain of labour, but not the pain of recovering from a surgical birth.

In one recent study, among primiparous women who were seeking a natural birth, almost
half (42%) reported a fear of childbirth (Kringland, et al., 2010). They found that fear of birth was
a predictor of not having a natural birth, even if it was a planned natural birth. This was an
interesting finding, as the subjects were motivated to have a natural birth, yet they still expressed
a fear of the childbirth process.

2.3.2 Systemic factors

The literature reveals two main systemic factors that create fear: care providers and the
power of the medical paradigm that shapes cultural expectations and choice around childbirth.
Systemic factors of maternity care such as the perspectives of her care providers (van Der Hulst et
al., 2004), the availability/utilization of technology (Simkin, 1989), and the discourses that imply
a medically oriented birth is safer and the “right” choice in prenatal care or childbirth (Davis,
2003) can have a profound effect on a woman’s ability to have a natural birth. It is noteworthy
that the attitudes of the maternity care providers are a significant influence not only on shaping
attitudes and beliefs, but can influence the type of birth a woman actually experiences (Davis-
Floyd, 2003; Hodnett, 2002).

Wendy Mitchinson (2002), in her exploration of the history of childbirth in Canada, noted
that with the medicalization of childbirth comes a power imbalance between birthing mother and
physician. The expansion of prenatal care meant women were visiting their physician more and
more, and the influence of the doctor over the woman was strengthened. The more childbirth
became entrenched in the medical system, the greater the power imbalance. Many women, in fact,
embraced the medicalization of birth because of their “...faith in the objectivity of medical science
and the physicians who possessed its knowledge” (p. 302).

Maternity care policy is also influential because it defines what is possible under the
health system and therefore defines childbirth norms (DeVries et al., 2001). Choices in childbirth
will be influenced by the opinions about childbirth that are “culturally determined or expressed by experts” (Kringeland et al., 2010, p.22).

Deborah Davis (2003) argues that personal choice in pregnancy and birth is affected by the medical discourses prevalent in our society that have constructed a reality that birth is dangerous and medical intervention is necessary. She questions, “[w]hen women and society at large are held within the powerful sway of medical and scientific discourses, can we say that their choices are free from coercion?” (p. 575). Another issue around choice, particularly as it relates to the “choice” to use medical interventions, is the amount of technologies now available to pregnant women. Women are told they have a choice on whether or not to use these technologies, but as Davies (2003) points out, in if women reject these technologies and medical care during pregnancy and birth, they may be accused of taking undue risks and putting their desires over the health of their baby. Further, medical practices that have become routine in childbirth are often “…not presented to women as choices at all” (p. 576), but simply accepted as part of normal prenatal care.

The midwifery model of care is situated within the wholistic paradigm of birth and focuses on the normality of pregnancy and birth rather than potential pathology (Wagner, 2000; Morris, 2005). It is encompasses a model of care honours women, believes in women’s ability to give birth, and embraces the mind-body connection of birth (Gaskin, 2003). As a result of this alternative model of care, midwifery clients are shown to have lower rates of obstetric interventions in home births and hospital births than obstetricians (Janssen et al., 2009).

In a recent study looking at attitudes of maternity care providers, it was found that obstetricians were more likely than midwives to oppose home birth, were more likely to be in favour of a woman’s right to choose elective caesarean section without clinical indications, and were less likely to be comfortable with vaginal birth (Klein et al., 2009). Many obstetricians did not believe that women have the ability to influence their own childbirth experience, whereas midwives strongly believe this to be true. Overall, obstetricians favoured a more technological approach to childbirth, whereas most midwives tended to favour a more natural approach (2009). This research is perhaps not surprising to people who are familiar with the literature around the medicalization of childbirth, however, this evidence is important to demonstrate the different paradigms from with many obstetricians operate as compared to many midwives.

The perspectives of a woman’s care provider are influential on shaping a woman’s desires and attitudes around birth (van Der Hulst et al., 2004; DeVries et al., 2001). If frightening information is shared by caregivers, women may feel compelled to accept interventions if they
believe their baby will be at risk (Zwelling, 2008). Jane Weaver, in her research on how women’s decisions on caesarean are informed, found that care providers can plant the “...seed of fear of vaginal birth” (2000, p. 489) by the use of technology during pregnancy when something was found to be a potential deviation from normal.

Some evidence shows that women select care providers that reflect their own beliefs about childbirth. A British study demonstrates that women who chose nurse-midwives for their maternity care providers wanted to be more active and in control of their own birth experience, as compared to women who chose obstetricians because they perceived childbirth to be risky and they felt safer with medical professionals (Callister, 1995). Those who chose nurse-midwives were more actively involved in their own birth process and over 87% had natural, unmedicated births. Those who chose obstetricians had a significantly higher rate of analgesia and anaesthesia during labour and only 23% having unmedicated births (1995).

Women in Canada report that their most important source of prenatal information came from their maternity care provider (PHAC, 2009), so the care provider has a strong influence over the attitudes and beliefs of pregnant women about pregnancy and birth. Who are the maternity care providers supporting Canadian women in birth? In 2006-2007 in British Columbia, the vast majority of women, approximately 84%, had either family physicians or obstetricians as their maternity care provider, and nearly 10% of women received their maternity care from midwives (PHAC, 2009). If doctors are more likely to favour a more technological approach to childbirth, and they provide care to the vast majority of women in Canada, the next logical extension is that they have a great deal of influence in shaping women’s attitudes and beliefs about childbirth.
3: METHODOLOGY AND METHODS

3.1 Methodology

This is a qualitative, exploratory research study using grounded theory and feminist methodologies within a constructivist paradigm. Childbirth is a social experience. Women learn about childbirth from other women, from books, media and from their care providers, and they are influenced by the way childbirth is portrayed through these various means (El Halta, 2001; Fisher et al., 2006). For this reason, this study applied a constructivist paradigm, assuming that the social aspect of childbirth has the capacity to shape the attitudes and beliefs of women who have not yet had the experience. Feminist and grounded theory methodologies are both useful in social constructivist approach to research, supporting the belief that people create meaning in their world as a result of interactions with the world around them – with people, amidst cultural norms, and through historical contexts (Creswell, 2003; Denzin & Lincoln, 2005).

3.1.1 Feminist research

Childbirth is a woman’s issue. What makes it a feminist issue is the way in which we frame the cultural and historical context of childbirth in our society. The research questions in this study fit well within feminist methodologies because of the cultural influences on women’s attitudes and beliefs about birth and the effect of the medical paradigm on women’s health and on women’s choices.

While there is no singular feminist methodology or research method, some common elements distinguish feminist inquiry from other forms of research. Some of these elements include: studying and making sense out of women’s lived experiences; carefully choosing the methods used to gather data; considering the sensitivity of the researcher/respondent relationship; and using reflexivity in data collection and analysis.

Feminist research is generally grounded in women’s lived experience, and it is the researchers role to make sense out of women’s interpretations of their experiences (Maynard & Purvis, 1994). There is a consideration of how much we ‘believe’ women and their own interpretation of their story, and how much do we use our academically developed skills of interpretation to analyze and make sense out of their stories. It is the dance between moving
forward and respecting their lived experiences while pulling away to analyze within the cultural and historical context of the issue. Individuals do not necessarily have the insight nor the knowledge to be able to fully understand and explain their actions or attitudes (Maynard & Purvis, 1994), so a role of the feminist researcher is to make connections from the data that may not have been explicitly reported by the participant, but which reside in a larger context of social norms and personal/societal history (Maynard, 1994; Letherby, 2003).

In feminist research, the power dynamic between researcher and respondent is acknowledged and attempts are made to mitigate this differential. An argument of feminist researchers has been to acknowledge power issues between researcher and respondents and to address ethical issues in order to reduce the opportunity for exploitation (Letherby, 2003; Maynard, 1994). Feminist methodologies accentuate the importance of reflexivity and the location of the researcher within the study which, among other things, speaks to this issue of power.

For the very reasons discussed above, qualitative methods fit well within the feminist methodology. In feminist research, the researcher needs to be aware of power issues between the researched and the researcher. In-depth interviewing is an appropriate method of data collection in feminist research because it is there is a level of human connectedness between respondent and the researcher that may help to minimize issues of power and control (Reinharz, 1992; Oakley, 2000). Reinharz (1993) describes feminist interview research as a way to uncover “…previously neglected or misunderstood worlds of experience…” by “…listening to women, understanding women’s membership in particular social systems, and establishing the distribution of phenomena accessible only through sensitive interviewing…” (p. 44). Oakley (2000) goes on to propose that one of the great benefits of in-depth interviewing as a qualitative feminist method is that it provides an “…opportunity to ground knowledge in concrete social contexts and experiences” (p. 47).

Feminist methodologies heavily stress the need to locate the researcher within their research. This takes the understanding of constructed knowledge one step further because it acknowledges the researchers’ own understandings (hence construction) of the topic based on their personal experiences, perspectives, and biases. Feminist researchers also need to be transparent about the “…subjective nature of qualitative research and strive to explicitly recognize the researcher’s personal values, life experience and relationship to the research topic” (Letherby, 2003, p. 9).
In this study of factors that shape attitudes and beliefs about childbirth, the underlying assumption is that the respondents have developed a set of beliefs as a result of various influencers in their lives. Within a constructivist paradigm, people “…seek understanding of the world in which they live and work and they develop subjective meanings of their experiences…” (Creswell, 2003, p. 8). A constructivist paradigm does more than explain how participants in this study have made sense out of their world, it also shapes how I, the researcher, analyzes the data. The researcher has an important role to “…rely as much as possible on the participants’ views of the situation being studied…” (Creswell, 2003, p. 8) while constructing theory and concepts by locating participant’s stories within the complexity of their life experiences (Creswell, 2003; Corbin & Strauss, 2008; Denzin & Lincoln, 2003). In other words, “…theories are constructed by researchers out of stories constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves. Out of these multiple constructions, analysts construct something that they call knowledge” (Corbin & Strauss, 2008).

The term “natural childbirth” has been critiqued as an idealistic and strategic social construction that has not been sufficiently problematized in childbirth literature (MadDonald, 2006; Carter, 2009). Historically, the natural childbirth movement used the term “natural childbirth” to provide an opposing definition to the medicalized approach to childbirth, underscoring a notion that childbirth can be completely instinctive and purely natural in all cases. This definition does not take into account the social learning aspect of childbirth, nor does it address gender performance expectations that shape women’s notions of birthing or their plans for childbirth. This study, while acknowledging the role of social construction, used the term ‘natural childbirth’ strategically in order to understand experiential factors contributing to women’s desires to give birth without medical interventions. That is, I was less interested in how women came to their definition of ‘natural birth’ or how the natural birth movement shaped women’s perceptions of childbirth, although these would be interesting avenues for further study.

3.1.2 Grounded theory

The literature reflects a diversity of uses of grounded theory, from the methodological considerations that guide data collection and analysis, to the ultimate production of a substantive theory. Researchers acknowledge the divergence among researchers in the application of grounded theory in qualitative studies (Charmaz, 2006; Corbin & Holt, 2005). As a result, there are tensions among researchers about what constitutes grounded theory research, with some
critiques that many grounded theory researchers do not actually generate theory or generate hypotheses/predictions (Charmaz, 2003). Others have suggested that grounded theory is used in a range of disciplines because the defined methods outlined in grounded theory are useful to gain credibility for qualitative inquiry (Henwood & Pidgeon, 2003).

Because of this divergence in interpretations and usages of grounded theory in the literature, it is important to be explicit about my use of grounded theory in this study. In this research, I used the principles of grounded theory more as a methodological framework than as a theory-generating approach. What this means is that I applied a selection of methods informed by grounded theory methodology to collect and interpret the qualitative data. The analysis resulted in a conceptual analytical framework, grounded in the data, that exposed a dominant theme and proposed two high level influencers that could account for that theme. The analysis did not result in a formal or explanatory theory that can make formal predictions about the subject. The Methods section of this chapter reviews the research methods used in this study and, where appropriate, illustrates where grounded theory methods were used in collecting and analyzing data.

Grounded theory uses a systematic and iterative approach to qualitative data collection and analysis that derive theories about a phenomenon that are grounded in the data (Corbin & Strauss, 2008; Charmaz, 2006; Creswell, 2003). The origins of the grounded theory methodology reach back to the 1960s with Barney Glaser and Anselm Strauss (Henwood & Pidgeon, 2003; Charmaz, 2003). These sociological researchers challenged commonly held assumptions that qualitative research was not rigorous, that it could be systematic and credible (Charmaz, 2003). They developed a methodology to “realize the alternative goal of generating innovative theory that is well-grounded in qualitative data” (Henwood & Pidgeon, 2003, p. 133).

They combined positivist, quantitative approach to research from Glaser’s training at Columbia University with the symbolic interactionism and ethnographic research legacy from Strauss’ Chicago school heritage (Charmaz, 2006). What this means is that the original methodology developed by Glaser and Strauss had a rigorous, systematic approach to data collection and analysis, combined with the notions of human agency and social meanings of human behaviour (Charmaz, 2006). It provided researchers more accustomed to quantitative methods, a qualitative approach that was systematic with clear, formalized procedures for data collection and analysis (Henwood & Pidgeon, 2003).

The original methodology has been criticized for its positivistic assumptions and a number of researchers use grounded theory procedures while rooting it more firmly within a
A constructivist paradigm (Charmaz, 2006; Corbin and Strauss, 2008; Henwood & Pidgeon, 2003). Glaser and Strauss’ original approach involved the emergence of theory from the data as opposed to the construction of that data through an interpretive process. It is argued by constructivists that theory can not be ‘discovered’ but rather, theory is constructed through an interpretive process of the data by the researcher (Henwood & Pidgeon, 2003; Charmaz, 2006). Kathy Charmaz’s approach to grounded theory is guided by a constructivist approach because of her belief that “we construct our grounded theories through past and present involvements and interactions with people, perspectives and research practices” (Charmaz, 2006, p. 10).

Grounded theory is a methodology that guides qualitative research towards theory development. However, it also suggests rigorous methods for qualitative data collection and analysis in order to develop theory grounded in the data, not derived from a preconceived notion of the research problem (Charmaz, 2003). Some of these methods include: using open and focussed coding; constantly comparing data as categories and themes are developing; writing memos to explore themes; and using theoretical sampling during data (Henwood & Pidgeon, 2003).

It is important to note that grounded theory and feminist methodologies have a number of areas of convergence in the generation of knowledge (Wuest, 1995). Wuest (1995) discusses some areas of epistemological convergence. She notes that in grounded theory, participants’ interpretations of their experiences are relevant data, and theory emerges from analyzing their own words. In feminist research, it is accepted that women’s experiences, their perceptions, and their subjective interpretation of these experiences is valid data. She also points out that both grounded theory and feminist research acknowledge the inherent bias in researchers, underscoring the importance of being transparent and reflexive in how the bias may affect their interpretation of the data (1995).

### 3.2 Methods

Women’s experiences, and their own interpretations of these experiences, are at the forefront of this project. The first phase of research collected data from key informants, mainly to inform the interview guide for interviews with pregnant women. In choosing to hear the ‘voices’ of professionals first, and to have their responses shape my interview questions with women, I was constantly mindful of maintaining openness to the women’s experiences as they were told to me, and of making a clear separation of the analysis of the two phases of interviews.
In depth semi-structured interviews were used to collect data from key informants and pregnant women. This method of data collection allowed me to get closer to the respondents and establish a more personal relationship with them, which I believed contributed to a sense of openness they exhibited during the interview. Particular to the interviews with pregnant women, this method of data collection allowed me to delve more deeply into their lived experiences than would have been possible using quantitative methods. Being in their homes for the interviews added a level of richness to my data through observing an unspoken part of their lived experience.

Semi-structured interviews gathered rich, descriptive details from the participants in this study. There were two sequential phases of data collection. Maternity care providers\(^1\) were the key informants for phase one of data collection. They offered a clearer cultural familiarity with the topic and helped to inform the interview questions for phase two. Pregnant nulliparous\(^2\) women who indicated a desire to give birth naturally were interviewed in the second phase of data collection. These interviews drew out attitudes and beliefs about birth, and focused on intentions for their upcoming birth experience.

Issues of quality in qualitative research is interpreted in many different ways among researchers. Evaluative concepts such as trustworthiness, credibility, authenticity, reliability, validity and rigour are used in qualitative research when describing the quality of the study – its design, data collection methods, and data analysis (Neuman, 2006). In this section, I state the methods I used to position myself transparently in the research (reflexivity), I speak to the concepts of rigor/reliability in the methods of data collection, and I refer to authenticity/validity of the study within the data analysis section. Lastly, I will discuss the ethical considerations inherent in this study.

### 3.2.1 Sampling and recruitment

This study used non-probability sampling procedures for both phases of data collection including snowball sampling and purposive sampling. Purposive sampling differs from random sampling in quantitative studies because individuals chosen do not reflect a particular population, rather they are selected based on what information they can contribute specific to the research questions (Neuman, 2006; Creswell, 2003). Snowball sampling uses networks of people to find new and relevant cases, so the sample starts small and becomes larger (Neuman, 2006).

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\(^1\) Maternity care providers – for the purposes of this study on natural childbirth, this term will refer to midwives, obstetricians, doulas, and childbirth educators, all of whom could be assumed to have insights into women seeking natural birth.

\(^2\) Nulliparous = never before given birth
Key Informants – Phase One

The key informants were selected through a combination of purposive and snowball sampling. I invited maternity care providers in my existing personal network whom I knew would be insightful about the research questions, and they suggested other people for me to interview based on their knowledge and understanding about pregnant women’s attitudes and beliefs about childbirth. These interviews took place between November 2007 – January 2009.

Inclusion criteria for key informants: Key informants selected for interviews were maternity care providers (midwives, doctors, nurses, doulas and childbirth educators) who have provided services to pregnant and birthing women in Metro Vancouver and the Fraser Valley. Maternity care providers were initially weighted more heavily if they had specific experience with women motivated to give birth naturally, therefore insight into the second and third research questions. As a result, most of the initial sample of five key informants included professionals with a particular interest in decreasing the medicalized approach to childbirth. My advisors suggested I round out this sample by interviewing two additional care providers who may not have a strong connection or commitment to natural birth. Through snowball sampling, I interviewed two additional key informants who were not as engaged in the natural childbirth paradigm.

Characteristics of key informants: The seven (7) key informants included in this study were all maternity care providers who have provided services to pregnant and birthing women in Metro Vancouver and the Fraser Valley. Six out of the seven were still actively working in their profession, and one was retired from practice. The sample included two midwives, two childbirth educators/doulas, one family physician, one obstetric specialist, and one maternity nurse.

Pregnant Women – Phase Two

Purposive sampling was used to recruit pregnant women for interviews. Key informants from phase one were invited to assist in recruiting their clients who fit the inclusion criteria. In addition, information about participation in the study was also sent out through electronic mailing

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3 Metro Vancouver consists of 21 municipalities in close proximity to Vancouver. http://www.metrovancouver.org/Pages/default.aspx
4 Fraser Valley consists of 6 municipalities to the east of Vancouver. http://www.fvrd.bc.ca/Pages/default.aspx
5 Research Question 2: What factors influence attitudes and beliefs about labour and childbirth among pregnant nulliparous women seeking natural childbirth?
6 Research Question 3: What motivates pregnant women to seek a natural childbirth experience?
lists that are commonly subscribed to by maternity care providers. These interviews took place between February – May, 2009.

**Inclusion criteria for pregnant women:** Pregnant women were included in this study if they planned to have a natural childbirth (in hospital or at home), were nulliparous, would be in the third trimester at the time of the interview, were considered to have a ‘low-risk pregnancy’, and were over the age of 19 years.

The term ‘natural childbirth’ was not defined in the recruitment material of this study intentionally. A theme that developed from the key informant analysis was a notion of ambivalence among pregnant women. Key informants described a differential understanding of the term ‘natural childbirth’ among pregnant women, meaning that they say they want a natural birth, but they really mean vaginal birth that may include pain medication. I was curious if I would see that theme play out with phase two, so I left it open for women to self-select into the study based on their desire for a “natural childbirth”.

Women were interviewed in the third trimester. It was my personal experience, confirmed by two of the key informants in casual conversation, that women in the later stages of pregnancy are more likely to begin thinking seriously and making plans about labour and childbirth, and therefore would provide me with the richest data. The study included nulliparous women because the history of past childbirth experiences may impact attitudes for subsequent pregnancy. Women considered to have high-risk pregnancies were excluded due to the higher probability of necessary medical interventions during birth (for example, with multiple births). Lastly, women under the age of 19 were excluded due to the ethical complexity of interviewing children.

Potential respondents for phase two were screened in advance of scheduling an interview by way of email or phone call. The screening was used to confirm that the respondents fit within the inclusion criteria.

**Characteristics of pregnant women:** An initial sample of 18 respondents was gathered, but it would not have been possible to interview all 18 participants given time constraints. They were all in their second or third trimesters and there was a small window in which to conduct the interviews. I used purposive sampling techniques to select women from this initial sample to include some diversity within the final sample. I selected 12 women from different geographical areas, women with midwives, women with doctors, women who were planning home births and women who were planning hospital births. Of course, being a small qualitative study, I was not
seeking a representative sample, nor is my sample large enough to do a comparison between groups (for instance, women with midwives compared to women with doctors). Instead, I intentionally sought respondents who would provide rich, descriptive data from slightly different perspectives.

3.2.2 Data collection

Nineteen interviews took place over the course of this study. Seven interviews were with maternity care providers (key informants), and 12 were with pregnant women. Semi-structured interviews provided rich, descriptive details for both phases of data collection.

Interviews: The key informants were asked about their perceptions of pregnant nulliparous women, specifically exploring the factors that influence women’s attitudes and beliefs about childbirth, as well as those factors common to women seeking a natural birth experience. These interviews were transcribed and analyzed. The interview schedule for phase two was developed using insights and understandings gained from phase one. The interviews with pregnant women explored in detail their attitudes and beliefs about birth, and the factors that may have contributed to their desire for a natural childbirth. The respondents were also asked about useful services that could have been provided during their pregnancy. Please see Appendices 2 and 3 for the basic interview guides.

Questionnaire: At the beginning of the interviews with pregnant women, I asked them to fill out a brief questionnaire. The intention of this was three-fold: 1. to collect basic demographic information; 2. to gauge how motivated they were to have a natural birth, and; 3. as a mechanism to put them at ease and prepare the respondents mentally for the interview. Please see Appendix 4 for this questionnaire.

Field Notes: I took field notes during and after each interview. Included in these notes were: poignant phrases from the respondents; linkages to comments from other respondents; basic description of the respondent and the location of the interview in order to record visual contextual reminders to use during analysis; any ideas that came to me about evolving concepts; and changes or additions to the interview guide. I would also take the time to reflect on my personal reactions to the interview. These personal reflection comments included my own responses to how the interview went, any reactions I had to issues that arouse in the interview, and if I felt like there was anything left unsaid in the interview (for example in one interview, it felt like the respondent was cautious about sharing too much information).
**Recording and Transcriptions:** Each interview was audio recorded using a hand held digital recorder. I transcribed all interviews myself. The average length of the interviews were 54 minutes for key informants, and 62 minutes for pregnant women for a total of 1577 minutes (26 hours) spent collecting data during interviews.

I was sensitive to issues of power when entering into this research study in phase two. I respected and honored the fact that the women were inviting me into their homes and sharing a very significant moment of their lives with me. Increasing the respondent’s trust of me was in line with feminist inquiry, and making them feel at ease was essential in order to collect rich and high quality data. There were several occasions when the pregnant women would cry because of a feeling of excitement or joy at what she was about to experience, or the depth of fear about the upcoming childbirth. The intensity of emotions that would arise during these discussions made me realize two things: 1) that the women felt a level of comfort and openness with me, and 2) that I had an important obligation to treat the experience with utmost respect from the basic protection of confidentiality to the way in which I interpret and write up their stories. The following points illustrate efforts I made to minimize power issues and develop trust with the respondents:

- Snowball sampling meant they were made aware of the research by a trusted source, often their maternity care provider.
- Initial email or phone communication provided information about the study, described the process of the interview including audio recording, assured confidentiality, and established a private location that was comfortable and convenient for them.
- I shared my reproductive history following most interviews when appropriate or when asked directly.
- I emailed respondents and update following all of my interviews and informing them of the timeline for producing my paper.

Reliability/rigor within the data collection phase was achieved thought a number of steps. The sampling and recruitment strategy outlined previously demonstrates my commitment to rigor in this phase. In addition, I conducted each interview myself, so there was no difference in the interview process for each interview. Each respondent, once recruited, was sent the same general information about the study. The flow of the interview was essentially the same for each interview. For the pregnant women, I would I would give an overview of the study, review the consent form and answer any questions, ask them to fill out the questionnaire, then turn on the
recorder and begin the interview. For the maternity care provider interviews, the only difference in this flow was that they did not fill out a questionnaire.

3.2.3 Data analysis

Tools and techniques from grounded theory and interpretive phenomenological analysis informed the methods of data analysis as described in Charmaz (2006), Denzin and Lincoln (2003), and Smith and Osborn (2003). In this study, there were two phases of data collection. Coding and preliminary analysis of the data from Phase 1 (key informants) was completed prior to interviewing pregnant women because the purpose of the main key informant interviews was to inform the interview guide for phase two. As a result, the two phases were analyzed separately.

I used several successive and simultaneous techniques in data analysis. Before sitting down to code the transcriptions, I had reviewed the audio tapes, read my notes, and created memos about interesting ideas emerging from the raw data. Once the interviews were transcribed, I immersed myself in the data to enhance my familiarity with the material, and I also reviewed notes I made during and after each interview to put the dialogue into context. I then began a more detailed review of the transcriptions, making broad initial codes per several lines of text. These initial codes were meant to capture the broad meaning of the data set. From this point, I moved into a categorization of my data, something Charmaz (2006) refers to as focused coding. Categories and themes began to take shape as I moved iteratively through the data, enriching the emerging themes from within each interview, and between interviews. As a theme would be more solidly developed, I would go back to the raw data to compare what was actually said by the participants to the emerging theme, analytically working through divergence, convergence and negative cases.

The uniqueness of grounded theory is that, when possible, data analysis begins at the same time as data collection, a technique called theoretical sampling. This “...allows a researcher to identify relevant concepts, follow through on subsequent questions and listen and observe in more sensitive ways” (Corbin and Strauss, 2008. p57). Theoretical sampling has less to do with identifying people to interview and more to do with the type of information the researcher is seeking from the respondents. It is an iterative method of sampling for ideas in order to build on the developing theory. While this study did not generate a substantive theory, a conceptual framework was designed that took shape following an iterative process of data analysis that was informed by grounded theory principles.
Due to time constraints, I was unable to do a full analysis after each interview before proceeding to the subsequent interview. However, I did review the audio recordings following each interview, write memos on ideas that seemed particularly interesting or insightful, and I transcribed the interviews throughout the data collection phase. Doing this level of analysis during data collection allowed me to make subtle revisions to the interview questions between interviews in order to follow up in these areas of interest. For example, I added a question about their ideal location for childbirth because that seemed to invite reflections that enriched the growing theme of ‘ambivalence’. This technique is in line with what Corbin and Strauss (2008) suggest, that the initial interview guide should adapt during data collection to reflect the emerging concepts.

Memos were used frequently throughout the research process to document evolving themes and to explore unique ideas and concepts that would arise through discussions with my advisors. The writing of memos in grounded theory research is used as an important analytical tool between data collection and a final theory. Memos capture ideas the researcher has while collecting and analyzing the data (Charmaz 2006).

During data analysis, I followed the tenants of theoretical sampling by analyzing each subsequent interview for concepts that were developing in the analysis of previous interviews. As each new concept evolved, I would write memos and then analyze subsequent interviews with an eye to the developing concepts. These concepts would evolve through each subsequent transcription. Some concepts would not expand further if little or no data supported it, and other concepts would shift depending on the new data and the evolving theorizing about that concept. One I finished coding each interview in this fashion, I went back through the interviews, starting with the last interview and ending with the first interview. This allowed me to refine and challenge the developing concepts, and ensure once again that I was grounding the evolving concepts in the data. Corbin and Strauss regard this as an appropriate method of theoretical sampling, although they caution that there may be gaps in a full understanding of a concept if the researcher is unable to go back into the field to collect additional data in order to explore a concept more fully (2008).

Although the original grounded theory researchers suggested entering the research with no preconceived notions about the questions, and having conducted no literature review, in this study I did enter the field with personal and theoretical knowledge of the issue. I also conducted a literature review prior to establishing my research questions, mainly to get a sense of what the literature said about attitudes and beliefs about childbirth, and to determine what new direction
might be interesting to explore. The available literature was not extensive in the focus on factors that motivated women to want a natural childbirth, so I did not go into the field with well-established ideas about the research questions.

Following that, there were no in vivo codes used, only open codes that emerged from each phase of data. That being said, as I got further into the coding and development of themes for the phase 2 interviews (pregnant women), I looked back at the key informant interview codes to compare for similarities and differences. This was a particularly insightful step in my analysis, as it allowed me to develop more fully one of the dominant themes, ‘ambivalence’, that emerged, albeit differently, from both the key informants and pregnant women.

3.2.4 Quality considerations

Qualitative analysis is many things, but it is not a process that can be rigidly codified. What it requires, above all, is an intuitive sense of what is going on in the data; trust in the self and the research process; and the ability to remain creative, flexible and true to the data at the same time (Corbin & Strauss, 2008, p.16).

This research study analyzed women’s perceptions of childbirth with an eye to prevailing medical discourses and the widespread fear-based messages about childbirth in our culture. Women did not talk about the tension or ambivalence they felt between believing in natural birth and lacking in trust of natural birth, however it was one of the core findings of this study; a finding that emerged from an iterative and contextual analysis of the data. There were a number of steps taken to enhance quality of data collection/analysis in order to increase trustworthiness of the resulting themes and conceptual framework.

In addition to the iterative analytical process described in the previous section, I will highlight a few steps I took to enhance the quality of this project.

Immersion in the data: Throughout the data collection phase and through analysis, I was immersed in my data. First, following each interview, I listened to audio recording, made additional field notes and wrote memos. Then, I transcribed the interviews personally which I found to create an intimate relationship with the data. After the transcriptions were complete, I read through all the transcriptions once without making notes, then proceeded with the coding process outlined previously in section 3.2.3. Each interview was reviewed thoroughly five times during this process. Being immersed in my data allowed me to feel close to the respondents and I
am still able to quickly draw upon the context of their experience and specific components of their story.

**Peer debriefing:** When I starting the extensive coding of my interviews, I shared one transcription with my advisor and we both independently coded the interview. We met to compare our coding and analysis in order to increase confidence in my analytical skills. I periodically met with my advisors to discuss developing categories and my evolving analysis.

**Negative cases:** During analysis, I would identify cases that did not fit an evolving category to question the category or develop deeper insights into the emerging concept. For example, in one case, it was the personal experience of friends who were critical of their highly medical childbirths that motivated the respondent to want a natural birth - this was different from the emerging theme that suggested positive stories encouraged natural birth and negative stories discouraged natural birth. In this case, the negative stories encouraged her to seek a natural birth. This negative case provided a new way to look at the theme of ‘personal experience’, and also was the initial seed for the new theme of critical thinking and scepticism about birth norms.

**Triangulation:** In this study, initially thought I would use the key informant interviews to triangulate with the data on pregnant women. However, I decided this would not be an appropriate use of that data, because the key informant interviews were sharing their experience and *perceptions* of pregnant women, which may or may not accurately reflect pregnant women appropriately. Instead, I referred back to the literature to compare what other researchers have said about this issue. While there was not much existing evidence informing my exact research questions, literature on the reasons women choose home birth and literature on why women are fearful of childbirth were useful to compare to and challenge my data.

### 3.3 Role of the Researcher: Reflexivity

I reflected on my own personal attributes in chapter one. I will use this section to describe how I addressed issues of quality (reduction of bias) by being self-reflective. I do not believe my personal beliefs in natural birth and my critical eye towards the medicalized approach to birth is a significant source of bias in this study. The research questions do not pertain directly to the medicalization of birth, nor was I trying to set up a situation where I could point to the problems within our medical system. I was interested in women’s own ideas about what influenced their motivation towards a natural birth. I had no preconceived notions as to what the participants would share with me, other than what I drew from my own experience.
During data collection, I made notes during and following each interview and noted my personal reactions following the interviews. I would debrief with my advisors on the developing concepts and highlight areas where my own personal reactions were arising. For instance, there were a few interviews which arouse concerns about the midwifery care some of these women were receiving. I felt a sense of frustration and disappointed for these women. I did not want that personal reaction to cloud my analysis, so I discussed it with my primary advisor. The process of sharing my concerns was useful in order to refocus my analytical attention to the task at hand, and to be self-reflective of how I interpreted comments about midwifery care to ensure I was being true to the data. While I was coding interviews, I would make notes as a way of bracketing my personal values/perceptions about the subject.

3.4 Ethical considerations

This study has been approved by the Behavioural Research Ethics Board at Simon Fraser University. I describe in this section what ethical issues were taken into consideration for each phase of data collection.

**Key informant interviews:** The identity of key informants are kept confidential, and all notes and digital audio recordings were coded with a pseudonym. In some cases, additional effort was necessary to protect the identities of some respondents, such as their professional credentials. There are no foreseeable risks to participating in key informant interviews as the participants are not disclosing information specific to themselves, but about their interaction with pregnant women and their understanding of factors that influence attitudes and beliefs about birth.

**Interviews with pregnant women:** In the selection process, potential participants were invited to contact the researcher if they were interested in participating, ensuring that participation was voluntary. Participants’ names were kept confidential and any notes and digital audio recordings will be coded with a pseudonym. Participants were given the option of where they preferred to conduct the interview in order to ensure their comfort and convenience (choices included their home, or a local library or community centre where I could rent a meeting room). All respondents chose to conduct the interview in their homes.

There were minimal risks associated with the interviews of pregnant women. Respondents may have been sensitive about discussing their plans for birth. To address this potential risk, I stressed that participation is voluntary and confidential, and there is no right or wrong answer. I also assured them that this research is independent and has nothing to do with
their maternity care. In case the participant had any follow up questions or concerns, I left contact information for the Behavioural Research Ethics, my supervisor Dr. Marina Morrow, and me. Lastly, if there were aspects of the interview that were upsetting to the respondent for any reason, I was prepared to follow up with community resources of relevant information.

Respondents were asked to choose their own pseudonyms, however because many of the respondents chose to use their own name, I later changed the pseudonyms of all respondents to further protect their identity.

For both phases of this research, the respondents received some basic information about the study by email when the interview was scheduled. Immediately before the interview began, respondents reviewed a consent form outlining the purpose of the study. I explained the form to them, and they were invited to ask questions. Then they were asked to sign the form if they agreed to participate. Please see Appendices 5 and 6 for these consent forms. The interviews were audio recorded using a digital recorder. The digital recorder, transcriptions and notes are kept in the researcher's home office, in a separate location from the identifier code sheet.
4: IN PURSUIT OF THE LOVE COCKTAIL:
CHILDBIRTH AS AN INSTINCTIVE AND LIFE-CHANGING EXPERIENCE

...I watched a movie, The Business of Being Born...one of the doctors talked about the 'love cocktail'. Like just the endorphins you release, and that sort of thing, and how the baby experiences them as well... I look forward to that feeling of natural euphoria. When would you ever get to experience that otherwise? Like, a once in a lifetime opportunity. (Kelly)

This first broad category, In Pursuit of the Love Cocktail (a term taken directly from Kelly's quote, above), highlights the belief among the respondents that childbirth is a natural, instinctive and life-changing event. Many expressed excitement at their impending birth experience, and saw it as a personal challenge of their own individual strength. Many of the women expressed a belief that women’s bodies are designed to give birth, and so they should be able to give birth to their babies naturally. Respondents were influenced to have a natural birth by family and friends who had personally given birth naturally and by support they received in their community of influence. Some of the respondents were also positively oriented to seek a natural birth due to the range of maternity care choices available to them.

The first section of this chapter, section 4.1, reviews the theme that childbirth is natural and should progress without medical interventions. The second section, 4.2, explores the factors that influenced the respondents to desire a natural childbirth experience.

4.1 Belief in Birth and Belief in Bodies

This section reviews the respondent’s beliefs that childbirth is beautiful, empowering and a life changing experience. Respondents believed that childbirth was natural and instinctive, and there was a strong mind/body connection to birth. There was a strong feeling that women’s bodies were designed to give birth, as many generations of women before were able to do. Respondents also felt childbirth was more than just ending up with a healthy baby – the process of childbirth was an important part.
4.1.1 Childbirth is beautiful and empowering

The vast majority of the pregnant women interviewed talked about the desire to embrace childbirth as a beautiful and joyful experience. When some of the respondents spoke of birth, their eyes lit up with excitement. There was urgency in their voices and mannerisms as they spoke of their upcoming birth experience. They expressed a belief in natural birth, and a desire to welcome it fully. While some respondents were not as ebullient as others, no one was indifferent about birth, and there were no descriptions about it being something to simply endure in order to have a baby. The belief in the process and the naturalness of it came through in each interview.

When asked the first word that comes to their mind when they think of childbirth, their responses ranged from exalted descriptions of birth to very ordinary depictions of the normalcy and naturalness of childbirth. “Beautiful”, “bliss”, “joy”, “magic”, and “normal” were among the words used, and some of respondents used the words “pain” and “scary”. Some of the respondents described that natural birth was something more than unmedicated birth – it is also having more freedom, being in a comfortable environment, having a community of supporters, and letting a woman do what she instinctively feels is the right thing to do.

Many of the respondents described childbirth as intense and joyous, and they wanted to experience it fully without interventions. There was a spiritual element to some of the respondent’s beliefs about birth, that it is a unique gift to be experienced fully. A couple of the respondents talked about the importance of experiencing the hormonal surge during natural birth - one woman called it the ‘love cocktail’.

I believe that the intensity that I am going to experience delivering my baby will be one that is amazing because I do believe that there is no light without darkness. There is no darkness without light. So, for me to fully experience the unbelievable joy of giving birth to a human baby sometimes requires moving through a bit of that darkness, and moving through a bit of that intensity, to really truly appreciate the light at the end of the tunnel. To really truly appreciate the gift you have been given. (Jennifer)

I also don’t want to affect my after-high. Like the inner pharmacy again, like you could be high for days on that, but if you have been on drugs, then you don’t get that, you know. (Heather)

A few of the respondents also spoke of childbirth being a life-changing experience, a demonstration of their power as a childbearing woman. These women spoke about a feeling of accomplishment or an enhancement of their self-esteem that they were seeking through natural
childbirth – a feeling of pride and empowerment that would result. The following quotes highlight a desire to embrace their power and give birth to their babies the way nature intended.

I think something that I have heard about natural birth is the feeling of empowerment. I think I will look forward to the reward at the end, that I did it myself. (Kelly)

…it is also very much about self-esteem building for me. Because I know that if I can do that, it is just going to feel amazingly good to me, and I will be like “ooo powerful woman!” (Heather)

I look forward to feeling my uterus and my cervix and my muscles in my body and to feel the baby descending, and to have the opportunity to reach down and touch my baby as she is coming out, and to have her on my chest, and to really be able to experience everything about that. …I gotta have that experience! I gave birth to my baby, to a human, like WOW, how amazing is that? I really want to experience it all. I don’t want to be numb to it, I want to be there. (Jennifer)

Some of the key informants echoed these sentiments, as evidenced in the quotes below. They reflected that women seeking natural birth saw birth as something much more meaningful than simply a baby at the end, but a natural process will affect who they are as women and mothers.

…it’s a maturational experience, they know that it’s an empowering experience, they know it’s a life affirming experience, they know that it will affect, or believe it that it will affect, their relationships with their child and with their partner having gone through it, they know all of that. (William, Family Physician)

[Women who want natural birth] …grew up knowing that birth is safe and beautiful and something that they can do and powerful and it was life-changing and what a gift you are giving to your child. (Elizabeth, Midwife)

…I gotta have that experience! I gave birth to my baby, to a human, like WOW, how amazing is that? I really want to experience it all. I don’t want to be numb to it, I want to be there. (Jennifer)

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[Women who want natural birth] …grew up knowing that birth is safe and beautiful and something that they can do and powerful and it was life-changing and what a gift you are giving to your child. (Elizabeth, Midwife)

…[a] person who is focusing on a natural birth will see it as more of a life transitional experience, something with depth and emotion and a spiritual component to it. (Jessica, Childbirth Educator/Doula)

4.1.2 Childbirth is natural and instinctive

The majority of respondents spoke about childbirth as being a natural and instinctive process that is best when left alone without interference. They express a faith in their bodies and their instincts as women to be able to give birth. Some respondents expressed a belief that natural birth allows for a more natural progression of labour, and enhances the bonding between the baby
and the mother immediately after birth (as compared to using interventions such as pain medications). This instinctive belief in birth is emphasized in the following quotes.

So I trust that my body will know what it is doing and that it was made to do that, and that I can just do it. And if my body tells me that I need to walk around or squat or go on all fours or breathe or take a bath or get massaged or whatever, then that is what I will do. Natural just means my body’s instincts taking over. (Christina)

I just kind of feel that probably I will know what to do at the time or what I will want to do. Then I think I will just do that… [B]odies work in general how they are supposed to, so you might as well let them go for it. (Lisa)

I have heard a lot of people who have had babies without any sort of drugs and they just think it is great because they are so alert and I think it helps with the bonding right away, and it’s just an amazing feeling to have the baby look at you in the eyes... (Amy)

This theme was reinforced by a few of the key informants who reflected that women seeking natural birth often thought of it as instinctive and the way a baby was meant to come into the world.

…a lot of them have a sense that, have some belief in their body, some faith in their body knowing they can do it. (Elizabeth, Midwife)

…they just believe birth is a completely natural process, like breathing or eating whatever. (Amanda, Maternity Nurse)

Four of the respondents referred to the wisdom of the generations of women that came before. They claimed to have gotten strength from the knowledge that they are continuing a tradition of birth and that their ancestors were able to give birth safely and naturally. For these women, acknowledging this history instils a belief that their bodies are made for this purpose and makes the case for why babies should be born naturally – it is the normal way. A few of the respondents gave a nod to the fact that more women and babies used to die in childbirth, however, this did not sway them from believing natural birth is normal and possible. A few of the respondents also talked about their bodies, that women are designed to give birth, so it follows that they should be able to do it naturally.

…women for thousands of years have been doing it, it is the way our bodies are made and we were meant to give birth without the help from drugs or surgical tools and we should be allowed to experience that. (Christina)

I have a really feminine form, so I think it is just kind of, function fits form, so to me I think it’s going to happen the way that it should. (Amy)
A few of the respondents touched on a mind-body connection to birth. They expressed the belief that birth was much more than just a physiological process, that the psychological connections to a positive birth outcome were real and vital. They reflected that being relaxed, not being anxious and afraid, was an important part of letting their bodies do the work of labour and birth. One woman spoke of the need to clear any emotional wounds before birth because of the concern that these emotional issues may stall labour. Several of the respondents had practiced hypnosis in order to learn to enter a deep state of relaxation during labour and birth.

…there is an element of surrender to your body and to your baby. And there is an element of trust into the process that is occurring. And the things that I will be able to control will be my breath. And I will be able to control how I am responding to the intensity or to the sensations in my body….That really my intention is to surrender and to trust the process and in baby and my body... (Jennifer)

I really believe that if I am relaxed all of the labour will go well, if I think my body will open up as it should do, and it will move the baby down as it is supposed to. (Christina)

I think when you go in there really relaxed, that helps a bit. And when you have everything well prepared and you know a bit about what to expect, you are not fearful of any pain. I think that could really help you. (Stephanie)

Several of the respondents expressed the importance of the process of childbirth, not just the end result of a baby. They believed in the entire process of birth and that it was an important part of the whole experience of bringing a baby into the world. For these women, it is not just about a healthy baby at the end, it is also about the journey that the child and mother take together.

I want to give the baby – I believe this child is a sentient being and I believe that she deserves, um, the best chance at starting life… you know, a baby has to do a lot of work to get through the birth canal, and I think that is important work! So, if that sentient being doesn’t have to go through that work, and is just kind of yanked out of the stomach without any effort whatsoever, how does that relate to the way that they are going to make effort strategies for the rest of their lives. (Heather)

There are a lot of mothers out there who, regardless of how your birth process goes, you have your baby and that is the important thing. But I think for me, it is just also, it is really emotional to think about doing it [voice quavering] in a way that I can say ‘hey, you know what, this is in keeping with my whole entire philosophy during my pregnancy’. (Kimberly)

I do believe that there is no light without darkness. There is no darkness without light. So for me to fully experience the unbelievable joy of giving birth to a human
baby sometimes requires moving through a bit of that darkness, and moving through a bit of that intensity, to really truly appreciate the light at the end of the tunnel. (Jennifer)

4.2 Factors that Influence Women to Want a Natural Birth

This section discusses the factors that influenced respondents to desire a natural birth. The three main factors included having a personal connection with someone who has had a natural birth (or in one case, having personal connection to people who have had highly medicalized births), being supported by people in their communities of influence, and having choices within the maternity care system that support natural birth.

It will be demonstrated in later chapters that the flip side of these positive influences are negative stories about childbirth and a lack of support for natural birth which also factor into shaping attitudes and beliefs and result in tension, or ambivalence, between a belief in natural birth and a lack of trust in natural birth.

4.2.1 Positive stories and experiences

The women in this study did not hear many stories of natural birth, but those positive stories they did hear were influential in their plans for giving birth naturally. This study demonstrated that knowing someone who had a natural birth at home or in hospital and spoke highly of the experience was a significant influence on the respondent’s motivation to give birth naturally. The positive stories and experiences helped to normalize that experience in women’s minds and give them the desire to do the same, as well as the confidence that it was even possible to have a natural birth.

…three of them have had children, and two of them did it completely natural. It did [influence me], because it is nice to know that it is possible, I guess. Obviously you know it’s possible, but my friends did it…I can see myself doing it because they have been able to do it. (Nicole)

Like even my grandma had six kids at the time when people were all doing the, you know those drugs that turned out badly, and not breastfeeding and all that stuff. And my grandma breastfed, and I think maybe it makes sense for my family. (Lisa)

Well, my sister had a baby a year ago... and it was painful and manageable, and they went through it just the two of them. So that is probably what I thought was, OK if they can do it, I can do it. (Stephanie)
Like, if she can go through seven births naturally at home, there is no reason I should try to do it naturally at home, there is no reason I can’t try to do it natural too, right? (Rebecca)

A few of the respondents spoke of their desire to be a positive influence about natural birth, or a role model, in their own communities. This was a motivating factor for them to want a natural birth – so that they could share positive stories about childbirth and counter the negative stories that most women hear about natural childbirth. They spoke of the desire to demonstrate to other women that birth can be different from the normative fear-based imagery.

…when I get with my other girlfriend that are trying to get pregnant or are pregnant, and when we talk about pregnancy and stuff like that, I’d like to be able to give them the flip side of the coin of the options, because I know the doctors are not doing it. (Rebecca)

I have seen [a friend’s] intensity and how she is such an advocate for natural birth, and how she empowers women to be women who can really, truly give birth…I want to be an advocate, too. I feel like I want to be the one telling women “yeah you can do this!” you know? That is why I want my mom and my sister in the room. That is why I want to, after I give birth, then go around and tell everyone my birth story because I want to change what women believe…that it can be different. [H]opefully I can then inspire other people to want to do that to. To find that path and be that person. So then you can slowly start to move forward and beyond those fears. (Jennifer)

It is interesting to note a negative case to this theme. One of the respondents planning a home birth did not have any particular influence towards a natural birth in her family. For her, the negative experiences her friends had with interventions in birth were more influential towards her desire for a natural, home birth. These friends had a negative perspective on their medicalized birth experiences, which in their opinion, could have been avoided. Even though the fear of interventions will be discussed in a later chapter, it felt appropriate to include a different perspective on ‘personal experience’ that motivated one of the respondents to seek a natural birth.

But a couple people that I do know, friends, my age, interestingly enough they both had caesareans and both sort of feel like their experiences were traumatic. And one of them swears that the caesarean could have been prevented, wasn’t necessary…. then anybody recently that’s had birth has had horror stories about the interventions basically, and the drugs, how scary the drugs are and even though they took away the pain, things like the side effects and stuff like that. (Kelly)
The key informant interviews reflected the same theme, that personal experience and positive stories can expose them to a possibility they may not have otherwise considered, and increase confidence and determination for natural birth.

If they [pregnant women] have been at a home birth, or they have been exposed to a home birth before, then that would feel like the norm to them. (Jessica, Childbirth Educator/Doula)

…they [women wanting natural birth] have somehow had an influence, that someone important in their life has said to them, ‘you know birth is a great thing and you don’t have to be medicated and put unconscious and there are great things that can happen for you and your baby if you don’t do that’. (Elizabeth, Midwife)

### 4.2.2 Pro-natural community of influence

The data suggested that the community of influence (the immediate circle of family and friends) is a factor in shaping respondent’s attitudes/beliefs and their plans for childbirth. While some of the respondents had pressure against seeking a natural birth, something that will be discussed in subsequent chapters, several demonstrated that having people encourage them to avoid interventions helped support their decision to aim for a natural birth.

But he [husband] has also said, “if I can influence you one way or the other, it would be to encourage you to try not to use too much medication, or anything that has any risk associated with it whatsoever. (Melissa)

… she [her mother] was actually the one who said to the midwife, “so if she has no complications throughout the rest of her pregnancy, is there any reason she can’t do it at home?” And that is when everything kind of snowballed from there. (Rebecca)

For some of the respondents, their motivation for natural birth was supported by being in a ‘natural’ community where natural birth fit into the ideology beside environmentalism and alternative health therapies. Even though there may not have been a direct reference to natural childbirth within these communities, there was an inclination towards more natural choices, such as cloth diapers or organic food. These respondents linked this to a global worldview that made them more inclined to seek alternative birthing strategies away from the normative medical birth culture. Several respondents talked about avoiding medications in general and they linked this lifestyle choice with their desire to avoid medication during labour.

I think the group of people that I choose to hang out with, I am sure they influence me hugely…. I am a bit of an environmentalist, a bit left-leaning, and I think that probably goes along with the more natural childbirth experience I would think. (Melissa)
Overall medication is something that you would use when you really need it...my family and my partner’s family are both like that. They won’t take medication for headache or anything if it has not been for two days already. …Yeah, if I am sick I eat oranges. But I am not taking any medication. (Stephanie)

Yeah, I think my family and my friends...my friends before that worked at a health food store, a vegetarian restaurant, I think maybe I just ended up surrounded…by people for whom that wouldn’t be different at all from what they would do [natural birth]. And the same with cloth diapers, none of my closest friends would be like, “oh, I just went and bought you Huggies for your baby treat. (Lisa)

So depending if I talk to, like if you are out in the conventional world, people are like “oh which hospital are you going to?” But in my world, people are like, “so have you rented your tub yet? (Angela)

Kimberly points out the incongruence in our society and in our maternity care system, where women are advised to avoid a large number of potential hazards during pregnancy, yet providing medication to labouring women is the norm.

…it if I go through this entire birth without taking cold medication, aspirin, Tylenol, like any other thing that I would normally take, alcohol, caffeine, like everything that I have decided that I want to proactively get rid of for my life right now, to then step in and say ‘oh, by the way, I haven’t taken any Tylenol, but let’s put a whole other bunch of other drugs in my system. (Kimberly)

Some of the key informants also reflected on this theme, highlighting the influence that family, friends, and the woman’s upbringing, has on her beliefs and plans for childbirth.

It’s really…how you grow up, how your beliefs and values are formed...whether you are in an environment where things are questioned readily, and you are open to look at other ways of doing things. I guess what is considered normal in your group, I think that is probably one of the biggest factors. (Jessica, Childbirth Educator/Doula)

…people who might choose a home birth and uh, with a midwife will be a large proportion of people who will not immunize their children and who will use alternative health practices of all sorts. (William, Family Physician)

4.2.3 Choices in maternity care

Respondents talk about how the ‘system’ is shifting, and enabling a more natural approach to childbirth. In British Columbia, women can choose to have a midwife or a doctor for their maternity care. Many of the respondents chose to have a midwife as their care provider and have the baby in the hospital. The ability to choose midwifery is seen by respondents as a
reflection that natural childbirth is normal, and the fact that midwives have hospital privileges supports their feeling that the norms around childbirth are changing for the better.

Several of the respondents expressed a sentiment that the birthing system has improved a lot over the years, compared to what their own mothers had to endure. They felt the system is more supportive of natural birth because midwives are in hospitals, birthing rooms are available, family and friends can accompany the birthing woman, and there is a greater range of natural pain management techniques encouraged in hospitals. While it was not stated outright, it seemed as if these changes in the mainstream childbirth system made natural birth seem more attainable and played a role in influencing their decision to aim for a natural birth.

Oh my gosh. You get a choice! Most people don’t actually understand that you can choose. The British Columbia government allows you the opportunity to choose a midwife or a doctor! And if they are going to pay for that? (Jennifer)

Like I feel like, I don’t know when it really started but at one point along the way it seems like natural childbirth was the only option, and then it kind of slowly shifted towards being more medical childbirth, and my parent’s generation was like that. ...[N]ow I feel like, maybe because I live in Vancouver, I felt like I knew lots of different options and lots of my friends were doing different things, and so I feel like we’re…its great. It’s like it is swinging back a little bit, at least for me. Which is I think awesome, I am really happy about that. (Melissa)

But, um, it’s just in the sense that in those days and age, it was like, not even 30 years ago that my father was not allowed in the birthing room. So... he had to stand outside and he could watch through a window, but he couldn’t be by my mom’s side to be there for that. And I can’t believe it happened like that! (Rebecca)

So...we get to choose our care provider and um this business about labouring at home for a fair amount, and walking around and having a birth ball and being in the shower…it seems as though those choices are much more available now than, say, a generation ago. (Lisa)

Within the same theme of choices in maternity care, I expected to find that midwives would have a large influence on the plans and attitudes of the pregnant women I interviewed. With very few exceptions, I did not find this to be the case. When asked about the most significant influence on their motivation for a natural birth, the care provider was not mentioned once. It may very well be that they purposefully chose care providers that would support them in achieving a natural birth, and it may be that their caregiver provided the support to maintain confidence in their plans for natural birth. But this did not come out in the interviews.
4.3 Summary of Themes: In Pursuit of the Love Cocktail

The respondents were all very motivated to have a natural, unmedicated birth. They believed in birth, and felt that a natural process was the best for mother and baby as well as something that would hold lasting personal significance in their lives. They embraced positive, empowering stories about birth, and were positively influenced by their community of influence who either set an example for them through their own history of natural birth, or supported and encouraged them in their plan to give birth naturally. There was also a feeling among some of the respondents that there was an expanding array of choice in maternity care, including care provider and place of birth, which opened the doors to a larger cultural acceptance of natural birth.
5: THINGS CAN GO SIDEWAYS:
A FEAR-BASED CULTURE OF BIRTH

I personally think I am not going to have any complications, but I am sure lots of people think that. Things can go sideways. (Angela)

This chapter will report the main themes that emerged that reflect a fear of natural birth in society. These themes were raised by respondents and key informants, highlighting the negative messages about childbirth that are prevalent in our society, and identifying how these messages can be influential in shaping attitudes and beliefs about childbirth. Respondents reported that they were considered ‘crazy’ for wanting to have midwives, irresponsible for wanting home births, and naïve to want natural, unmedicated births. As discussed in the previous chapter, these women were determined to give birth naturally, and they believed that natural birth was an important part of how they wanted to bring their child into the world. However, they described that regular exposure to fear-based messages about birth played a role in shaping their beliefs about childbirth and, in some circumstances, planting seeds of doubt.

Building on the previous chapter, there is an interesting tension or contradiction that is exposed in this chapter – respondents expressed a strong desire for natural birth, yet they did not fully trust natural birth. Most of the respondents did not talk about a fear of birth. In fact, quite the opposite, a few of these women said quite plainly that they were not afraid of childbirth, and they implied that they were more concerned about medical interventions than a natural, uninterrupted childbirth. This sentiment was underscored by Kimberly below.

But I don’t consider childbirth risky or scary. .... I think risk is one of those things that people have to decide for themselves, what it means to you. I am not scared of this childbirth experience. (Kimberly)

That being said, a closer look at the data reflected that fear of natural birth, to some degree, was indeed present in most of the respondents. Most telling was the belief expressed by most of them that childbirth can very suddenly, and unexpectedly, ‘go sideways’. Heather’s quote below reflected a belief that there are quite a few dangers associated with childbirth.

I mean, it used to be the main killer of women, childbirth. It is potentially dangerous. For sure, there are lots of problems that can happen to mom and baby.
The baby was sacrificed or the mom was sacrificed if there were problems. There’s a lot of potential danger for sure, but if it is a natural, normal one, you should be able to do it at home and it should be fine. (Heather)

The first section in this chapter, *Fear of Natural Childbirth*, reflects the fears that respondents shared about their upcoming childbirth. The second section, *Factors that Influence Fear*, looks at the various factors that contributed to a feeling of uncertainty or fear in the respondents about childbirth. The final section, *Self-Preservation*, discusses the ways the respondents would actively protect themselves from negative influences that promote a fear of birth.

### 5.1 Fear of Natural Childbirth

While it may be misleading to say that the respondents were afraid of natural childbirth, there were some elements of truth to this statement. Clearly, the respondents were enthusiastic about their upcoming childbirth experience and expressed determination to give birth naturally. However, because of the ways in which they spoke of childbirth - the uncertainty of it, the randomness of potential complications, and the need to plan for emergencies - an element of fear of the entire childbirth process came through clearly in the interviews.

When asked what about having a natural birth were they most afraid of, the respondents were ready with a few concerns including tearing of the perineum, a long labour, the baby’s health, postpartum haemorrhage, baby’s size, and caesarean section. Key informants highlighted women’s fear of pain as being significant, yet this was not strongly reflected in the interviews with pregnant women. What seemed to be the most significant fear among these women was a general concern that something could suddenly go wrong during childbirth, putting themselves or the baby at risk. This fear was enough to make them cautious about planning only for a natural birth without considering other possible medical scenarios.

#### 5.1.1 Fear of pain

Most of the key informants talked about this theme, the fear of pain. They reflected that the most common fear of birthing women is a fear of pain, so the use of medication is common and desirable. (Mary, Midwife) reflected this theme in the following quote.

> You know, it used to be about dying in childbirth, then it was getting into the baby dying, and now it’s a fear of pain. (Mary, Midwife)
Interestingly, there was inconsistency between what the key informants have observed and what came out in the interviews with pregnant women. The majority of respondents expressed confidence that they would be able to manage without pain medications. There were a small handful of comments made about the pain, wondering aloud if they would be able to deal with it, but I did not get the feeling that they were keeping the door open for an epidural. Melissa and Heather were exceptions, expressing some concern about their ability to handle the pain of labour. Amy’s comment below was reflective of most of the respondents, indicating a belief in the ability to deal with the pain of labour and childbirth. Jennifer reflects the connection she understands between fear and pain.

I guess [pain is] the thing I am probably most afraid of oddly, really. Which is good I guess cuz if I am not, it is nice to not be scared of dying through the experience...I guess it’s because I could just decide well, I will have an epidural and that will relieve that fear. But I really don’t want to do that, I really want to do this [naturally] ...of course it’s a bit worrying. At the same time. Like I really want to go without the pain medications, but because I want to do that, I know it is going to be not not painful. (Melissa)

Who knows, maybe I will only last a few hours...I’ll be like, ‘screw it, just give me the stuff!’ I don’t feel as confident about my body as I would like to. (Heather)

I am not completely unrealistic about it, I realize that there will be pain, but I also think that I most likely will be able to handle it. (Amy)

…fear always creates pain. You manifest it. If it’s going to be this horrible, painful experience and you are fearing it before it comes, then law of attraction, it is going to happen. (Jennifer)

It was clear that these women wanted to avoid epidurals and pain medications and were confident in their abilities to manage using natural mechanisms of coping with labour. However, some qualified their perspective on their potential need for pain medication, by raising unexpected situations that may lead them to use pain medications.

Yeah, if the baby is in the right position, and, you know, things are progressing, I am pretty confident that I can handle that [meaning labour pain]. (Angela)

So I guess I feel like as long as I have kind of a normal birth like nothing goes crazily wrong, then I think I should be able to go without the pain medication. (Melissa)
5.1.2 Fear of sudden and random complications

The concern most widely expressed about childbirth among respondents was the fear that things could go wrong at the last minute. The key point here is that they felt complications could arise in a very sudden and random way. Angela’s quote at the beginning of this chapter, that labour and birth can suddenly “go sideways”, reflects this common concern. Despite the extent to which they embraced the normalcy of childbirth, this theme came up repeatedly. For some, it was not necessarily expressed as a fear of birth, but rather an indisputable truth of the reality and randomness of childbirth. This theme arose among respondents most often when discussing their views of home birth. The small selection of quotes below demonstrates this theme that was pervasive among the respondents. This theme will be explored further in chapter six which discusses the perceived ambivalence between believing in natural birth, yet not fully trusting natural birth.

…I think that things do not always go as planned. So I like the idea of going in with a plan, but who knows what is going to happen. (Melissa)

… if you are informed, you know that this can go in many different directions. (Kimberly)

Um but I guess I just feel that there are so many things that could happen, like I go about the labour business and it is fine, and then for some reason I don’t know, it just seems like so many people have stories of things not going as they expected. (Lisa)

I think, it really depends on your body at that moment. And it really depends on how everything is going. (Stephanie)

This theme was raised with a couple of the key informants, as well. Sara mentioned several times that birth is predetermined, and it will go the way it was meant to go, regardless of what the woman does to prepare herself.

Labour is such a fluid thing, constantly changing…I just really let people know that birth is a really fluid thing like, things can happen… [labouring women] are just not sure what will be dished out to them. (Amanda, Maternity Nurse)

This fear seems to be isolated to stage two and three of labour – the pushing stage and the immediate postpartum. The majority of the respondents (planning a hospital birth) indicated their desire to stay home and labour as long as possible before going into the hospital. Apparently, the fear is not about first stage of labour, as they felt comfortable being home for the early and active stages of labour. (Stephanie)’s sentiment below is reflective of this theme.
What I am hoping is that we can be at home for a long as possible, and really go to the hospital at the last moment. (Stephanie)

Some of the respondents also brought up fears that were based on how their mothers’ experienced childbirth. For instance, Lisa herself was a breech baby, so up until her final weeks of pregnancy, she was concerned that her baby might be breech as well. Nicole’s mother had a caesarean section with Nicole because her cervix did not dilate. Nicole expressed concern that she may not dilate, either. Both of these women intellectually rationalized that what happened to their mothers is not indicative of their own experience, but that seed of doubt was planted.

5.1.3 Childbirth is unknowable

Over half of the respondents expressed another related belief, that childbirth is something unknowable until it is experienced. They felt that they needed to experience their first birth in order to have more confidence in subsequent births. Regardless of the preparation, the confidence, and the positive influences, this feeling was pervasive - if she has not done it, she does not know what her body is capable of or how much control she actually has in shaping her birth experience. The selection of quotations below illustrates this theme.

But somewhere in me I just wanted to make sure that my body would react OK the first time. (Nicole)

I guess, I mean its pretty unknown...having never been through that experience, how are you going to know. (Melissa)

This theme seems to conflict with some general themes brought up in chapter four. That chapter reported that many of the respondents believed childbirth is natural and instinctive, and women’s bodies are designed to give birth. It was expressed by some of the respondents that they gained confidence in having a natural birth through the generations of women that came before, as well as through friends or family members that had natural births. So there appears to be a disconnect between a belief in natural childbirth and a faith in their own ability to have a safe and natural birth. This observation will be discussed in detail in chapter seven.

A few of the key informants also reflected this belief, that pregnant women are afraid of the unknown, that they do not know what labour will be like until they experience it. Confidence in their ability to give birth can be shaken because of this feeling of childbirth being such an unknowable experience.

Particularly in the primigravida, they have never experienced it before, so they don’t know what it is. (Thomas, Obstetric Specialist)
… they are just a little bit nervous about how their bodies are going to react.
(Amanda, Maternity Nurse)

…there is a tendency in our population to think that, women don’t know that they know how to give birth to their babies … a lot of women lose confidence because they don’t know that they know what to do. (Elizabeth, Midwife)

Alternatively, another key informant spoke of the inner wisdom of women, and their knowledge in their ability to give birth, even if their confidence is shaken.

I really believe that every woman that has a baby has that knowledge in their gut and in their heart about what this is all about. There’s things that have maybe happened in her life, things around her, things she’s heard, things she’s seen, that cause her to doubt, cause her to question her ability to do this. But there are many, many very confident, strong, brilliant women that recognize what is good and what is bad because it doesn’t sit right with their gut because they know, that place of knowing.
(Laura, Childbirth Educator/Doula)

5.1.4 Reluctance to plan for success

Another theme, and a tension, that was expressed through most of the interviews was a reluctance to plan only for a natural birth. A majority of the respondents felt the need to mentally and physically prepare themselves for potential medical intervention. They wanted a natural birth, were determined to have a natural birth, but felt the need to plan for worst-case scenarios. The main reason relates to the previously discussed concern that unexpected events can happen at the last minute. If it is likely that something unexpected could happen, they wanted to be prepared for that eventuality.

This is particularly interesting, given that many of the respondents talked about the mind body connection to birth, and the importance of the mental state to achieving a good birth outcome. They also talk about having to buffer themselves against negative influences in order to stay focussed on their plans for a natural birth. Yet, many of the respondents felt the need to plan for potential problems. It was hard to determine from the interviews whether they felt this preparation - knowing what to expect should an unexpected situation arise - would enhance their ability to relax during birth, thus improving their ability to give birth naturally, or if this need to prepare for the worst-case scenario was a reflection of the belief/fear that birth was unpredictable.

Everyone I’ve talked to about birth plans says ‘don’t plan’. [My doctor] said ‘don’t have a birth plan], because if it doesn’t go exactly how your birth plan is, you are just going to feel disappointed. And most of the time it doesn’t go exactly how you planned, so just don’t set yourself up for disappointment'. (Amy)
I think that reading too much, I might just get too many expectations. Like I do have a vision, like some intentions about what I like my birth to be like, but I also know that anything can happen and I need to stay open. And I think if you read too much, you could have like really rigid expectations about the way you want things to go, and I think that could be a recipe for feeling disappointed afterwards, or feeling like you failed in some way. (Angela)

All these things [potential problems] could happen, so I want to allow room for them to happen. (Lisa)

Several of the respondents indicated that they had prepared a birth plan (a written document about the birthing mothers’ plans for her childbirth experience that can be provided to maternity care providers). Amy was sceptical about birth plans because things rarely go as planned. She also reported that her family advised against a birth plan for the same reason. One of the key informants reflected this theme as well, how women with birth plans are not taken very seriously in the hospital.

…don’t know, it just seems like….like we sort of have a joke, the longer the birth plan, the faster you go to the O.R [operating room] type thing. I don’t know what it is, I think people that really want this ultimate natural birth experience they are so focussed on that, that they can’t, it is hard for them to take new information and incorporate it in… (Amanda), nurse

Confidence in birth is related to this theme. It was shown previously that most of the respondents were quite confident in their ability to handle the pain of labour. This is categorically different from the confidence that birth will go well, that they can plan for a successful natural birth because most births are normal and safe. These women may want a natural birth but perhaps their confidence, and that of their support people, in the safety of birth has been shaken. A loss of confidence may lead them to feel they should plan for unexpected medical events rather than having faith that their baby will be born safely and normally. This quote from Amy may illustrate this point.

What am I sure will go well? Uh…I don’t know. Nothing, I don’t know. I am not 100% sure about anything. (Amy)

Confidence was also raised by a few key informants, illustrated by Mary’s quote below. They reflected that women who want natural birth have the self-confidence and the knowledge to believe they can give birth without undue risk and without pain medications.

Self-esteem is part of it, yeah. It’s like they [women who want natural birth] have it in them to know they can do it…Versus other people that are like, ‘I don’t know, I don’t know if I can do it, I don’t know I don’t know I don’t know’. (Mary, Midwife)
5.2 Factors That Influence Fear

Stories. I found that there’s a lot of stories. But I find there’s a lot more women talking about bad experiences than there are women talking about good experiences. Um, which has been hard. Really hard. Hard to let go of those stories and allow yourself to create your own. (Jennifer)

Respondents spoke easily and freely about the societal messages about birth, whether in pop culture (TV, movies, magazines, news, etc.), or in their immediate community (friends, family, acquaintances, etc.). They reported that most of what they heard from other people about childbirth was negative and they talked about the role of pop culture in instilling fear of childbirth in our society. But these women made a division between pop culture influences and immediate, personal influences. Pop culture was not deemed a significant influence on their ideas about birth, whereas the influence of negative stories within their immediate environment was palpable.

The results show that the maternity care system and care providers have played a role in shaping attitudes and beliefs about childbirth among the respondents. The women talked about how birth is a medical event in our society. Respondents also talked about the narratives about birth that are prevalent in society. These narratives tend to focus on the risks of birth rather than the beauty and normalcy of birth. In fact, some of the respondents reflected that there seems to be very little space to talk about natural birth in our society.

5.2.1 Pop culture

The respondents spoke quickly and easily about the negative images in pop culture about birth. They described that pop culture is full of fear-based messages about birth, from movies, to celebrity culture, to trendy books for pregnant moms-to-be. They criticised the negative messages about birth in pop culture as being untrue and unrealistic. They spoke of the depictions of the drama of birth, that something usually goes wrong. Birth is shown to be unbearably painful, frantic, and risky. The respondents would typically dismiss the negative pop cultural images that are found on TV or in movies, seeing it as something that is far from the reality.

I would say you get a lot of messages from TV and movies about what labour looks like, and it is usually um, usually very medicalized and very comedic, like the women started freaking out, and screaming for medication and stuff. (Angela)

It is true that you see this kind of immediate, like rush to the hospital, screaming, painful, “I hate you” to my partner... (Lisa)
And you see it from the movies and the media, screaming and stirrups, and pulling your knees in, and “push push push” until blue in the face! You know, Baby Story, I used to watch that but I refuse to watch it anymore. This is NOT a good picture of birth. But that is what women are told is birth. (Jennifer)

So they are relegated to seeing a media representation, a movie, a television show. Obviously that kind of hype is always best when...the birthing mother, is going through some sort of extraordinary circumstance. (Kimberly)

What was interesting is that the respondents seemed to suggest that this negative imagery affects other people, but not them. Pop cultural imagery of birth was not something they identified as being a major source of influence on their beliefs about birth. However, it turns out that some of the respondents reported purposefully avoiding pop cultural messages about childbirth in order to keep their focus on natural birth (described in more detail in section 5.3 Self-preservation). This theme reflects another tension between their dismissal of the pop cultural images of childbirth coupled with a belief that they needed to avoid these images during pregnancy because, perhaps, they knew on some level that these messages had the potential of stimulating fear.

These themes were reflected in the key informant interviews as well, with a clear belief among most of the key informants that the majority of images and messages about birth are negative. They put a large amount of the blame for the negative images of birth on pop culture.

… of course in the media they are exposed to an unending barrage of nonsense of caesarean section whether from Madonna or Catherine Zeta Jones or the star of Sex and the City or...Posh Spice ..or worse, Britney Spears. And they see this stuff all around them, they see this on market check-out lines, and they see the glorification of that process of being modern, as being the way to do it…in the United States, it’s becoming normalized. In the United States, caesarean is now referred to as a “c”, not even a c-section, a “c” quote unquote ‘c’. Wouldn’t you, like, want to have one? (William, Family Physician)

If this is what they are watching [baby story], you can see they are terrified. I mean, we have convinced a whole generation of women that they can’t give birth. (Laura, Childbirth Educator/Doula)

5.2.2 Childbirth discourse

This theme, about childbirth discourse, was raised by most of the key informants and a lot of the pregnant women interviewed. What these interviews seemed to describe was a situation where there is little or no cultural space, no common discourse, to talk about natural birth in our society. Horror stories and the traumatic births which require emergency heroics are shared
widely by women themselves and through media and pop culture. There is a normalization of the medicalized birth experience. Some of the respondents reflected that natural birth is marginalized, midwifery is on the fringes, and home birth is seen as an extreme and dangerous act. This section explores what birth narratives are and explores how they are developed. Kimberly astutely illustrates this issue in a broad way in the two quotes below.

Because the sad thing, again, talk to the young women I know and it is almost like pregnancy is a disease that has to be managed at every step, and micromanaged at the labour process. And if we set ourselves up for that, it just seems to me that we are tipping, it’s a tipping point. We are tipping ourselves towards that philosophy.

(Kimberly)

I think it would be really nice if there was more social discussion about non medical interventions in birthing. I just don’t feel that we talk about it. Like, a lot of my friends didn’t even know what a doula was, didn’t know what a midwife can do versus a doctor, why did you go with a midwife?

(Kimberly)

**Horror stories:** Respondents often used the term “horror stories” to discuss the fear-based messages that women hear directly from other people. Nearly all of the respondents reported being bombarded with negative stories about births that went wrong, emergency situations where mother and/or baby almost died. In fact, the respondents observed that most birth stories they heard were negative. Other women would tell them that it is horribly painful and pain medication is necessary. Several of the women reported that these negative stories affected them and made them fearful about birth. They reported that hearing all of the possible things that could go wrong made them concerned about their plans for a natural birth, and certainly made them second-guess any ideas they may have had about having a home birth.

Yeah, just after hearing my friend's experience, too, and I mean she really only made it and all she had to do was get wheeled from the birthing room to the emergency room and she still only just made it…that definitely scared me after hearing her story. (Melissa)

And actually, when my godson was born, he got stuck in the birth canal, and they had to rush her to emergency to do an emergency c-section and then had to push him back in, and he was actually born with a lack of oxygen and there was a learning disability from that…you always hear the bad things... (Rebecca)

…a lot of women at work are telling me their horror stories, yeah, like how painful it is, and ...a lot of the women tell me their story. I don’t know if they only remember the bad parts about it, and tell me those, or… (Amy)
I have one friend who was two complete days in labour and everything, and at the end she had a c-section and after that a second operation because there went something wrong with the c-section. So that was a horror story. (Stephanie)

The key informant interviews also brought up this theme. In their experience, pregnant women are very influenced by the messages in society, and most of the messages are negative, fear-based and dramatic. Even the most confident clients who want a natural birth or home birth can have their confidence eroded by these stories.

I just think that people talking about it would really be influential and the nature, whether the stories are positive or negative, you know? Like how often do you hear, “oh it was fabulous, it was great! Don’t worry it was a little bit painful but…” You always hear about, ‘Oh my gosh!’ The story about this happening, all this drama. (Amanda, Maternity Nurse)

I think even women that come in knowing they want a home birth…their confidence is definitely challenged frequently. So they tell me…how they were at the grocery store, and strangers will walk up and tell them their horror stories about birth. And…sometimes they come back into the office and they are in tears!” (Elizabeth, Midwife)

…I think even women that come in knowing they want a home birth…their confidence is definitely challenged frequently. So they tell me…how they were at the grocery store, and strangers will walk up and tell them their horror stories about birth. And…sometimes they come back into the office and they are in tears!” (Elizabeth, Midwife)

…the power of other people talking to them, their friends, their relative’s stories, and like if your best friend had a really bad tear, like I know people really focus on that. Like, ‘oh a friend had a bad tear, I am really scared about that’. (Amanda, Maternity Nurse)

A couple of the respondents also reported that the negative stories had an impact on family members. Kelly talked about how the horror stories about birth had generally made her mother and grandmother firmly believe that birth belongs in a hospital, disregarding their own personal experiences of easy and safe births of their own children. Jennifer talked about the effect of the personal attacks on her husband’s confidence in birth. She was determined to have a home birth, but after hearing so many negative stories, he was unable to support her in a home birth. As her main support person for labour, and as her life partner, his comfort was central to her birth experience, so they decided on a hospital birth.

And then you draw on their personal experiences, ‘oh why? What hospital procedures or interventions did you need?’ ‘Oh none, my birth was fine.’ ‘OK, then why do I have to go to the hospital?’ ‘Oh, you just do.’ So just in general, an inherent fear of childbirth is what I see in them. (Kelly)

I feel part of that [horror stories] has influenced my husband… he has taken on part of their worries and part of their fears and heard so many stories about it that he is having a hard time letting the positive things and letting the information that the
midwives have given him influence his decision, or even trusting in me a little bit...Yeah. I wouldn’t have cared about anyone else as long as I had him on my side, but he was feeling uncomfortable with it so we changed. (Jennifer)

Several of the respondents talked about being personally attacked or insulted for planning a natural birth or a home birth. This went beyond the general horror stories about frightening birth experiences into a much more personal realm. These messages were delivered presumably to pressure the woman to change their plans to a more medically controlled birth. Their beliefs and plans were mocked or blatantly condemned.

But I am pretty sure, um, when I started talking about home birth I got a lot of attacks. It was like personal attacks. Like “you are harming your child, you are a bad mother, that is just stupid. (Jennifer)

But at first, especially older women I found, um, looked at me kind of like, “oh, you’ll see”, “there is no way to describe it, just wait until you are on that table”…They looked at me like I was just naïve or I expected it to be easy… (Christina)

…really good friends of mine, or even family members, the first words that come out of their mouth is “you’re crazy”. And it is just because, they’re so…it’s the stereotypical thing in birth you have to have the epidural and all that stuff. (Rebecca)

One of the key informants reflected this idea, that mothers can sometimes be influenced by their support people towards a more medically managed birth, even if it is not what they want.

But the woman is probably the last one to give in. Usually. Those that are around her, mothers-in-law, wanting to see this baby, and everybody’s saying, ‘well, do something.’. (Thomas, Obstetric Specialist)

It would seem from the data that negative stories played a role in instilling fear or concern among the respondents. Some of the respondents reflected on this phenomenon, about why women felt the need to share their traumatic birth stories. Angela and Christina both compared this need to tell extreme stories to a general trend where people like to tell ‘fish tales’. Jennifer and Amy both questioned why women, even if they have had normal births, focus only on the negative aspects of their birth experiences. Jennifer reflected that her mother had two normal births and one traumatic birth, but never talked about the good births, only the traumatic one. Kimberly speaks of the healing aspect of women wanting to share their stories, but displays her frustration that women do not think of how their story may negatively impact the ideas young or pregnant women have about birth.

I think other mothers who for psychological reasons feel that they have to share these extraordinary interventions….I know there is a healing nature to sharing
stories, but to punish a woman who has not even had her birth experience before she has even gone through it by putting that in her psyche that is going to be the norm. (Kimberly)

I think there is a lot of fear about it. Just stories people tell. There is kind of a martyrdom around it, like it is almost fun to talk about how, or not fun, but it is kind of glorifying to talk about how bad your labour was and all the things that had to happen to you and it seems like those are the stories that are the most prominent. (Christina)

Little cultural space to talk about natural birth: The data seems to suggest that the dearth of positive stories makes the negative ones so much more compelling. Some of the respondents brought up this issue, that there are so few positive stories. Even women who have had positive birth experiences, or good pregnancies, tend to censor themselves from talking about their experience.

Most of them said they rarely heard stories of wonderful birth experiences. Of course, almost all of the respondents were influenced by at least one positive story about birth, as reported in chapter four, but it is clear that these stories make up the vast minority of what women hear about childbirth on a regular basis. Some of the respondents reflected on this phenomenon, and felt that there really is not much opportunity to talk about natural birth, or home birth, in our society, or that women who have positive stories do not seem to share them. Stephanie shared that she felt there was no room to mention her healthy, happy pregnancy amidst a group of pregnant woman in the doctor’s office who were complaining about their problems. Jennifer reflects on the dearth of positive stories and Christina highlights the lack of ‘fan fare’ among women who have had natural childbirth.

Well, I went to the doctor’s office at a certain point, there were five people in the waiting room and they were all talking about their problems, and I was just like, “Oh I will just shut up.” Because they all had something, one had diabetes, the other one had low iron or whatever, or high blood pressure or whatever. Ok I’ll just be quiet. (Stephanie)

They say it takes 10 positive stories to erase the one negative story that you hear. And I can tell you in one day you will hear 10 bad ones to one good one. (Jennifer)

And then I have other friends who have had natural births and home births and they don’t glorify it on the other end, they don’t say ‘oh I had my baby naturally and I am so great for it’. They don’t do that at all, it was really just a natural, normal thing. Like, “yeah, I had the baby at home and it was a beautiful experience and that is it. They don’t go into the gory details the same way that people who have had really hard experiences. (Christina)
Christina mentioned that one of her friends had a natural home birth and only mentioned it in passing. She did not go into details about her natural birth or seem to seek any acknowledgement for her accomplishment. Heather suggested that women who have had their babies naturally do not feel comfortable widely discussing their births because of a need to censor themselves amidst a society where accomplishment is muted. I have included quotes from Christina and Heather to illustrate this discussion.

And then I have other friends…who have had like natural births and home births and who, they don’t glorify it on the other end, they don’t say ‘oh I had my baby naturally and I am so great for it”. They don’t do that at all, it was really just a natural, normal thing. Like, “yeah, I had the baby at home and it was a beautiful experience” and that is it. (Christina)

I think it is because women who get through it naturally, it is like so triumphant. And in this society, people don’t like to hear these success stories. It is almost like when you succeed really well at something, when you do a really good job, you don’t brag about it, you don’t talk about it, you don’t pat yourself on the back….and it is unfortunate because I think we need to celebrate these things more with each other, and be really excited for people that succeed at something. That is hard to do, too. Whether it is business or natural childbirth…I think people feel like, ‘oh, I shouldn’t say anything.’ But if you have suffered, then oh yeah! Everybody knows and you have this huge story, and it’s like, ‘and I suffered, and I suffered’. (Heather)

Most of the key informants also mentioned this theme. They reflected that natural birth and alternative maternity care (e.g. midwives) are on the fringes and that our society is not open to hearing about natural birth. A few of the respondents reflected that their clients who have had natural births do not feel comfortable sharing their experience. Laura suggests these women feel guilty talking about their great experience in the midst of other women who may not have had such a great experience. Elizabeth comments on this issue as well, that even if they feel shut down, she encourages all of her clients who have given birth naturally to spread their story widely. Jessica points out that many people may not be open to hearing about natural birth narratives because they are so rare. It is easy to dismiss these positive stories when the medicalized birth stories, the epic birth dramas, are so dominant.

[our society tells women], ‘I don’t want to hear about your home births’. You know, ‘if you want to go be a primitive and squat in a field, go tell it to someone else, I am not interested’. It is not interesting anymore. All of this earth mother shit, you know, we don’t want to know about that, we want to hear about Posh Spice, we want to hear about Angelina Jolie. We don’t want to hear about you. (William, Family Physician)
Well, what I do is, after every fabulous birth I attend, I encourage my clients to tell everyone they can, and not to get shut down by someone saying, “that's you, not me”, to really share that it is possible, and the benefits that they felt. (Elizabeth, Midwife)

And I think some people are never truly open to the idea of these [natural birth] narratives. Unless maybe there is some sort of loading point, after you have heard 10 of them, then all of a sudden it sounds normal to you or something.” (Jessica, Childbirth Educator/Doula)

**Shaping birth narratives:** The respondents and key informants highlight the theme about birth narratives and how these narratives are created. Kimberly and Jennifer succinctly illustrate this theme of how birth stories are created and sustained.

...by putting them into routine medical situations, we are in a snowball effect where one intervention leads to second, leads to a third, leads to a major intervention. Then of course we all watch the healthy baby and say ‘whew’ sigh of relief, ‘I am glad you are in the hospital, look at all the things that had to be done with you?’

(Kimberly)

And somewhere along the line, we were told what our experience was going to be like, and we all assume that that is exactly how it will be, and that generalization carries on. (Jennifer)

Kelly brought up an interesting point about this issue. She reflected that in her prenatal class, as well as in the pregnancy books she was reading, that natural birth was an afterthought. It was what you had if you did not get interventions. She expressed surprise that her prenatal class did not talk about natural birth more, and she had the feeling that the instructor was trying not to offend anyone who was planning a more medical birth. As a result, natural birth was not addressed as a normal and attainable option. Later in the interview, she also reflected that nobody talks about natural birth, and it is not a central message in most of the pregnancy books.

It is really more if you plan to take medication, here are the options. Implying that you may not. It is more of an implied natural birth….I wouldn’t say they are pushing the drugs, but they are definitely not glorifying natural birth. It is really neutral like that…I think they try to be really careful not to offend anyone who is planning on taking medication. So it is sort of hard to speak highly about how great, or how good of an idea it is to have a natural birth. Well, I know you are speaking to two different groups of people like I think there is some of that. It is literally kept neutral, very neutral. (Kelly)

There were a few mentions of protecting women from feeling like failures if they did not get the natural birth that they had planned. Thomas stated that most women will have some
intervention in birth, and it is an important job for the caregivers to normalize the experience for that person so she does not feel like a failure. Amanda gives an example about easing a woman’s guilt by normalizing her need for an epidural use after eight hours of contractions.

I would say that maybe 50% are saying “I don’t want to have all these things [pain medications]”. But most of them end up having it, and part of our job is to make them feel that they are not failures because they actually ended up having some morphine or an epidural or whatever. (Thomas, Obstetric Specialist)

Those who want no intervention whatsoever, are usually very confident right up to the time they go into labour. You know, if they are very strongly opposed to any kind of intervention, they often, you know, take more convincing during the progress of the labour to…because often you know, you can see that they are suffering, and you offer this and they say “no way”. I generally, personally would counsel them and say, “Listen. That is OK, if you don’t want anything, no one is going to give you anything. But just remember that if the going gets really rough, you are not a failure if you relent and take something. (Thomas, Obstetric Specialist)

I really think that women get a lot of guilt from things. I really try and just, I guess my whole thing is to try and help women decrease any possible guilt, or try to help them to support them, you know, if they get the epidural. “You know what? You did a great job, you know. You did eight hours of contractions and its ok, and you needed this epidural and its ok. (Amanda, Maternity Nurse)

By all accounts, these maternity care providers appear to come from a place of genuine desire to help women feel satisfied with their experience. However, the take home message to these women is that the interventions used are normal and were necessary in her case. So regardless of the genuine efforts to preserve the woman’s dignity and self-esteem, it is easy to see how that story is not the woman’s story at all, it is the story of the care provider. If a woman internalizes that story as her truth, then that is the story she will be sharing with friends and relatives.

With the high rates of caesarean section and other interventions, the reality of outcomes in maternity care tells a story, as well. Jennifer and Mary illustrate this point, that the rates of caesarean section normalize the procedure.

…you assume most women can’t deliver because everyone is having a c-section. (Jennifer)

… with caesarean rates being what they are, what I used to see is people were like, ‘Oh my god, I had a caesarean, this is awful.’ And now I hear, ‘I had a caesarean and this is fine. I’m fine with it.’ I mean, that has really shifted in 15 years. And I think
Wow,…to have a c-section is not a horror story. When 25-30% of the population is having a c-section, it’s not that odd. (Mary, Midwife)

Fear-based discourses about childbirth may be particularly impactful because of the lack of firsthand experience most women have about childbirth. Most of the respondents have never seen a birth, natural or otherwise. In fact, only Heather had ever seen a baby being born. So they get their visuals about birth from secondary sources - stories, books, and pop culture. Kimberly expressed this sentiment in a different way, commenting on the misplaced priorities of pregnancy that seem to be more about the commercial aspect of pregnancy and birth, and less about the actual experience that they will soon be going through.

Like, on average, you see a pregnant women and you think “Oh, it is all about getting the stuff and all the pretty things you do,” and prepping the baby’s room, and nobody really talks about, or sees, the reality of what the birth is like. (Kimberly)

William and Jessica, key informants, both brought up this same theme, that women do not have any experience in birth and this affects their attitudes and beliefs about labour and childbirth.

Well I think the most important thing is that women are no longer experienced in birth. They don’t see it in their families, and they are often away from their family of origin. They are having fewer babies…particularly professional women are delaying childbearing and having smaller families. (William, Family Physician)

Um, cuz I really think the average person has never seen a normal birth. They are completely blown away when they see it, it is just outside their realm of possibility, unless perhaps they have come from another cultural community where it is the norm.” (Jessica, Childbirth Educator/Doula)

5.2.3 Prenatal experience

Some of the respondents gave examples that showed how their care providers and routine prenatal care played a role in creating uncertainty, or planting seeds of doubt about their upcoming birth experience. Respondents had doctors who did not see pregnancy/birth as natural or normal and instilled fear in the women by the way they reacted to issues during or before pregnancy.

Several respondents spoke of some of their experiences with maternity care providers during their pregnancy that worked against building their confidence towards a natural birth. Jennifer talked about sarcastic comments made by doctors that seemed to presume pregnancy and birth, was going to be difficult and uncomfortable. Christina mentioned that the doctor she saw to
confirm her pregnancy suggested that there was good chance she could miscarry. Most of the respondents spoke of the first appointment they had with their doctor to confirm their pregnancy, which sent them to seek a different approach to prenatal care (specifically midwifery). Rebecca also mentioned this phenomenon, but she specifically pointed out that her family doctor created the image of a medicalized birth process with how the options were presented to her. She suggested that if she had not known there were alternatives, she would have assumed that a more medical process was the only way to have prenatal care and give birth.

...even just the medical doctors, I was really sick at the beginning, and they would make little comments like ‘this is just the beginning’. (Jennifer)

...my first visit to my doctor...everything was all very medically associated, right from the beginning. And I think we are blindsided we don’t really know, nobody has really told us anything else. (Rebecca)

[During an appointment at a medical clinic to confirm pregnancy, doctor said], ‘well, there is a 50% chance that you are going to miscarry. So just, it happens and there is nothing you can do about it’. (Christina)

Rebecca made another comment about her early pregnancy when she experienced some light vaginal bleeding, or spotting. Her words seemed to indicate that the spotting caused her quite a bit of concern. She reported that her care providers were “really concerned” about this, but she “pulled through”, meaning the pregnancy continued without incident. There is no way of knowing what the communication was between the care provider and Rebecca, however, this language seems to demonstrate that an early prenatal experience may have set the stage for some of her concerns about the pregnancy and the birth that were present later in her pregnancy.

And I had spotting from six to seven weeks, and they were really concerned that I was just going to, like, miscarry. But I pulled through… (Rebecca)

Some aspects of prenatal care and prenatal testing were also identified as a source of stress and a shift away from the natural for several of the respondents. The testing and ambiguous results planted seeds of doubt. They were hanging onto the feeling that everything was alright with the pregnancy, but were challenged by the technology and the care providers serving them. Christina talks about the stress of having a questionable gestational diabetes result that not only made her concerned and doubt her own health, but increased her anxiety about having to defend her desire for a natural birth in the face of this possible medical concern.

I had my gestational diabetes test done by the doctor. And the first one, they said my blood sugars were high and I had to go do the three-hour one, but it came back normal….It was a bit scary and disappointing. I thought, like I had taken really good
care of myself, and then I wasn’t sure what it would mean. I know for doctors, if you have GD [gestational diabetes] there is a tendency to be like, ‘Oh, that baby is going to get too big, we are going to have to induce you early’ or whatever, and that would just mean another fight where I would have to be ‘no, I could handle it, my mom had 10-pound babies, I can do it too.’ And, so just anticipating the confrontation that having gestational diabetes would bring was really stressful.

(Christina)

Lisa was measuring small for dates later in her third trimester, and her care providers continued to order tests even though neither the extra tests, nor her own intuition, indicated a problem. She was the one respondent that expressed a cautiousness and scepticism about ultrasounds, and she ended up having several ultrasounds throughout her pregnancy. Kelly hurt her ankle in a car accident and was told by her midwife that she would not be a good candidate for a home birth because of the possible risk from the car accident. Both of these respondents were very committed to, and very confident in, their ability to have a natural birth, but these events made them feel sceptical about their care and felt that their choices were being taken away.

[Kelly was told by her midwife that she would not be a good home birth candidate because of a minor car accident.] So I just had a lot of questions suddenly. It sort of scared me, I said, ‘what does the baby need to be monitored for? Like what are the risks? Fair enough, but what exactly would you be looking for?’ And she said, ‘well, because of the accident, there could be a problem with the placenta…’ and I was again confused…(Kelly)

But I didn’t feel in that instance that I had any choice [regarding extra testing due to measuring small for dates]. I don’t think there was really a way to say no to that. I mean, I could have, but I think… [my midwife] wouldn’t have felt comfortable with it.

(Lisa)

Later in her pregnancy, Nicole had taken herself to the hospital with some concerning symptoms. She was diagnosed with borderline high blood pressure and had to stay for monitoring for three days. She was discharged without incident, but was well informed about the most catastrophic risks of high blood pressure in pregnancy. She said that this experience did not influence her desire to have a natural birth, but it did make her more sceptical about how hospitals deal with pregnancy. It is important to note that her maternity care provider was not overly concerned and her blood pressure was only considered ‘borderline high’ when she was in the hospital. She told me her understanding of the risk of high blood pressure in pregnancy, quoted here.
...just the risk to the baby. And eventually to my organs. Um, I guess it can start to affect my kidneys, and then once my kidneys are affected, I can start to seize and things like that. My body would start to reject the baby. (Nicole)

Several key informants brought up the influence that maternity care providers have over the women they are serving. They described the challenge of different paradigms about birth among different care providers, and how this can impact the woman’s beliefs about childbirth, and plans for her birth experience. In the quotations below, Amanda and William note that a maternity care provider play a very influential role in normalizing medications in birth and demoralizing natural birth. Elizabeth observes that there are passive ways of medicalizing birth, for example, by having prenatal clinics in hospitals, and she also points out that there could be more information about alternative birth practices provided at family doctor’s offices.

…there is one doctor in particular who really does talk [highly] about pain management and a lot of his patients…they want epidural the moment they walk into the hospital. (Amanda, Maternity Nurse)

So the pressure for technicalization from the providers is greater and greater as more and more obstetricians are doing the things that family physicians used to do and not enough midwives are coming on stream, and they won’t come for a long period of time, so the attitudes of the providers are also impacting on the attitudes of the women. They are being told what is safe, they are being told what is ideal, and of course, what’s available coincides with what they are told. (William, Family Physician)

And a lot of women go to the hospital for their prenatal care. I mean right there, there’s a medicalized birth. I mean its …where you see all the sick people. I don’t know what influences they had, but I see all these pregnant women walking, when I go to the hospital just for other things or deliveries with my own clients, and I think ‘that’s so sad, what are they doing going to the hospital for their prenatal check-up – they are not sick’?! (Elizabeth, Midwife)

...a lot of women go to a doctor to confirm they are pregnant, and I think if at that point there was education about what their maternity options are, I think that would make a big difference. (Elizabeth, Midwife)

There was also a common theme about a lack of communication with their care providers about their birth fears. I asked each respondent what they most feared about the birth, and if they had talked to their care provider about it. Most had not discussed their fears with their care providers. Some expressed surprise, realizing that they had not had that discussion with their care providers. Others seemed to think it would not be useful, as their fear can not be ‘fixed’.
Because there is really nothing, [complications] are things you can’t really predict. So there is really no point [in talking to her midwife about them]. (Amy)

I haven’t brought it up with them. I guess I always thought, there is not much I could do about it anyway, so, yeah. (Melissa)

I found this particularly interesting with the women who chose midwifery – they welcomed the close personal relationship that developed between them and their midwives, yet it seemed that the line of communication with respect to deep concerns about childbirth was not open for many of these women.

5.3 Self-preservation

In the previous discussion about how little cultural space there is to discuss natural birth, the interviews with pregnant women demonstrated a few techniques they needed to develop for self-preservation. In other words, in their desire for a natural birth, they very purposefully had to block out negative influences and seek out positive influences. One technique was described previously, which was censoring themselves – being very careful about with whom they would share their plans for a natural birth, choosing to remain silent if they did not feel there would be support.

This section describes three other mechanisms that the women used to keep them focussed on their goal of a natural birth, despite negative influences. Many of the respondents grew teflon skin, in other words they would block out negative stories about birth, and make efforts not to internalize the stories. They also used purposeful preparation where they sought out positive stories and supportive information that would keep them focussed and positive about their natural birth. Lastly, they embraced the supporters in their immediate community, typically their partners, to gain strength and maintain their confidence.

5.3.1 Teflon skin

The majority of women in this study showed astuteness when it comes to the cultural messages about birth. They were undoubtedly aware of how the negative stories that they heard, read, or watched on television impacted their confidence in having a natural birth. These stories planted seeds of doubt about their upcoming birth among most of the respondents, shaking their confidence in their ability to have natural birth or their confidence that everything would go well. Rather than being the passive recipients of these negative messages, these women found ways to
protect themselves from the negative stories. They realized that, in order to be successful at having a natural birth, they needed to buffer the negative stories and focus on the positive.

Growing a teflon skin was one technique described, not in those words, by respondents. The women used this technique in various ways. Some women described blocking out stories by actually shutting down people that were sharing negative stories.

So if I was more nervous, I think, about having the baby, I would be less inclined to listen to stories depending on how the birth went? I mean if someone had a little bit easier birth, it was kind of easier to hear, but if it was a tougher birth, wasn’t always something I wanted to hear about...More just cut them off, I think. Let them know that I wouldn’t be able to handle it today. (Nicole)

…I mean if they are already half way into the story, it is hard to stop them, I don’t want to be rude. But generally when they start off, I will say, or have been in the last couple of weeks just saying “you know what, is this a really good story because I would love to hear a really good story.” And if they say “no, not really” just like “you know what, do you mind if we talk about something else, then? (Jennifer)

Other women describe the way they would process the stories after the fact. For instance, three respondents reported that they would disassociate their own experience with that of the person sharing the story. Christina would avoid internalizing another woman’s story about an emergency birth by attributing the emergency to the cascade of medical interventions that happened leading up to the perceived emergency. This ability to let the stories slip off them, like teflon, seemed to be a helpful technique to maintain their confidence because they have placed the story firmly into the reality of the other person’s experience. The following quotes illustrate this theme.

I just feel that I need to just block that information almost, like I…just like, that is good for you, I am sorry that it happened, but you know, it’s not going to happen to me. (Heather)

[when someone tells a horror story] I kind of think, ‘oh that is you.’ I actually kind of evaluate the person...I think, well, I don’t get sick a lot, and I don’t really complain a lot about a lot of things, but you do anyways, so I am not surprised that childbirth was bad for you. (Amy)

Umm, at first, when we first started hearing them, it made me fearful, and now I am kind of, I think of it more as, “well, perhaps the reason why you had those emergencies was because of interventions you had done in the first place.” So I don’t see their experience as even applying to me anymore. It makes it a lot easier to tune it out, because every story I have like that has started with something like an induction or giving an oxytocin to speed up contractions, or delivering the placenta
before it is ready. So, um, for me now, I just tune it out. I just kind of smile and say, ‘wow that sounds like a really crazy experience that you had’ and just let it kind of go over me. I don’t want to internalize it. That is their birth, and my birth will be different. It will be what it is. (Christina)

Every negative story that I would get, I would change into a positive affirmation which I would post in my bathroom, or just repeat to myself so that I could change…so like for tearing, for instance, my mantra has been “sometimes people tear and you will heal if you do. (Jennifer)

Kimberly and Stephanie processed negative stories by being thoughtful about the stories and incorporating them into their knowledge base without personalizing the story as something that could happen to them. They would take more of an intellectual approach to the stories, considering it information and then basically ‘file it away’. They did not feel that they were impacted by these stories in a negative way because they kept the information an arm’s length away rather than something to be afraid of for themselves.

If anything, every little bit of information is helpful. Because you can decide for yourself OK, well, I am the kind of person who, I love to hear people’s opinions, but I don’t tend to take things as fact until I really look into them. I like to hear what people think, and there are great benefits to having a circle of friends who want to share their experience with you. But it didn’t deter me at all from my path. (Kimberly)

I just….take the stories and put them away somewhere in my head. I am not going to worry about it. (Stephanie)

Elizabeth, a midwife, reflected on this theme. She also observed that most of what women hear is negative and fear-based, but she brought in the notion of confidence. She feels that a woman who is confident in her decision around birth may need to be reminded of why she was choosing a natural birth, but she will be able to let the negative stories pass by her without internalizing them.

Because there is, there seems to be like a constant stream of [negative stories]. And the more confident women say, ‘no you’re brave to go to a hospital and have a doctor who you might not know. That is a very different model of care, and I am choosing to have a midwife who specialized in normal birth who is going to be with me. I don’t feel that that is brave.’ (Elizabeth, Midwife)

5.3.2 Purposeful preparation

Many of the respondents were using purposeful preparation by actively seeking out positive stories and experiences about birth that would support their views, and avoiding negative
ones. This applied to books they chose to read (and those they did not read), and movies or natural birth videos they sought out. Several of the respondents watched Business of Being Born, which is a countercultural documentary highlighting the problems in the normative birth culture and showing natural birth.

The things I have liked the most have been reading the positive. Because I am good enough at the negative. (Kimberly)

…when I found out I was pregnant, there was a lot of fear, being so sick, I just stopped reading the books that were creating more fear in my mind, and started reading the books that were really positive. (Jennifer)

Most of the respondents knew that they wanted a natural birth before they were even pregnant, so they actively sought out that supportive information early in their pregnancy. Christina described that the more she read in support of natural birth, the more focused and confident she became in her goal to have an unmedicated birth. Jennifer was an anomaly amongst the respondents because she was initially preparing for a normative medical hospital birth, but after a few interactions with natural birth supporters, and a weekend class about natural birth, she changed her plans totally. She changed her care provider, began planning for a home birth, and actively sought out information that would support her plans.

…the more I educated myself and the more research I have done I have found that that is just not true [that birth is risky]. (Jennifer)

Two of the respondents participated in a unique community based maternity care program that supports natural birth. This program offers the support of midwives, doctors, nurses and doulas, and provides integrated prenatal care/education and childbirth support in the hospital. These women knew about the program before they were pregnant, and believed it was a program that would be extremely helpful towards their goal of a natural birth, so they got involved early in their pregnancy.

…joining the [maternity care program]…is absolutely one of the best things that we could have done. Not just for me, but for my husband as well, so that we both felt that this was something that we could go through together and not be falling prey to someone else’s philosophy because we weren’t educated about what all of our options were… (Kimberly)

A few of the respondents reported a hesitancy to attend mainstream prenatal classes because of concern that the messages would not be supportive of a natural birth. They expressed a feeling that some prenatal classes would focus on interventions in birth and would not support natural birth. Jennifer had a bad experience at a hospital tour, at which point she decided she
wanted a home birth in order to avoid what she perceived as a range of unnecessary interventions that are the norm in hospital births. She also shared a different concern, that ‘natural’ prenatal classes could also be biased against hospital births, questioning the trustworthiness of the information from those classes as well as the hospital classes. Some of the women sought out alternative childbirth education experiences that were more naturally inclined such as hypnobirthing or a program called “Birthing from Within” in order to build on their confidence and find supportive ways to prepare for their birth experience.

No, we decided that, in a prenatal class, we would kind of get information we wouldn’t need. Like about interventions and stuff. We know about the drugs, we know about the different interventions and I don’t want to be in an environment where they talk about the pain and about how hard it will be and how painful it will be and here is what happens when you get your epidural. Because for us those are not options, like we do not want to do that, we need to do it our way. (Christina)

I did a tour of the hospital … the person that was doing the tour was very negative and a ton of ‘what ifs’ and a ton of talk about basic things that occur when you come into the hospital and you walk in and ‘we’ll give you some gravol and morphine and then you know we will get you in a gown, we’ll set you with an IV, we’ll have a 30 minute, you know, put a fetal monitor on and do a vaginal test, and….’. It was like that entire paragraph for me was unnecessary and terrifying. And I’m going, if that is what I am getting, that is not what I want. (Jennifer)

Among the key informants, several of them talked about the importance of self-confidence among women wanting a natural birth. However, Elizabeth and Jessica both brought up the theme of purposeful preparation. They described how women wanting natural birth or home birth have to educate themselves in order to maintain their confidence. They both reflected that pregnant women who are seeking a natural experience are usually challenged to change their plans towards more medically controlled birth, and by educating themselves, they have confidence and ready replies for those who challenge their choices.

Most women have to continually like, be strong. …anyone choosing especially home birth, they have to do their homework and they have to do their research. It can’t be just an idea, they have to look at the facts and figures that we have. So I think that helps them build their confidence, so when they do have those questions from people, they do have more information to help, um, support their decision. (Elizabeth, Midwife)

Being able to be insightful enough to understand why you are doing this in the first place? Because you will probably be challenged at certain points of your decision making and to be able to stand your ground essentially. (Jessica, Childbirth Educator/Doula)
Following this issue of maintaining confidence by preparing and educating themselves, one of the respondents expressed a need to censor their plans for a natural birth. Christina quickly realized that her plans were not accepted in the broader society, and often not even within her immediate environment, so she stopped telling people about her plans to avoid defending her beliefs about childbirth. She was afraid of being judged, of making a choice that is uncommon in society, and having to live with consequences if the birth did not go as planned. In fact, even though she wanted a home birth, she leaned towards a hospital birth because she was worried about what people would say about her experience if she had to be transferred to the hospital for any reason. I have included a quote that describes this issue clearly. While this need to censor their plans for natural birth was not brought up widely among the respondents, Christina’s experience was profound and, in light of this overall theme of birth narratives, was important to include.

…we have stopped talking about it with the family because the reaction we get is kind of an eye-roll or we don’t know what we are getting into I guess… it makes me feel kind of ‘why am I having this conversation if I am not going to be supported?’ Like, so, it just makes it feel kind of pointless. (Christina)

Her experience was also reflected in a comment made by Elizabeth, a midwife, who encourages her clients to be cautious about whom they share their birth plans with in order to protect themselves from naysayers who could erode confidence.

But also I encourage people not to share that with people who they don’t feel will support them, or if they feel they do not have the strength to defend their choice….Like, people won’t tell their mother or mother-in-law that they have a midwife even, if that’s going to just cause too much problem in their pregnancy, and then they won’t be able to be strong in their decision. (Elizabeth, Midwife)

Another example of purposeful preparation was the decision by some of the respondents to avoid certain prenatal tests. Half of the respondents reported turning down some prenatal tests because they did not see them as useful, but potentially harmful to their pregnancy and birth experience. The tests most commonly turned down among these women were the triple screen, glucose screening for gestational diabetes, and amniocentesis. Amy’s comment reflects a rationale shared by the other respondents.

So what if it says your probability is high and you stress yourself out for your entire pregnancy, and end up with a normal baby. Or if you don’t end up with a normal baby just because you were stressing yourself out the whole time! I just think it is unnecessary. Maybe for people who, I don’t know, who would consider the abortion, I guess. (Amy)
5.3.3 Support network

A supportive community of influence was mentioned in the previous chapter as a motivating factor for respondents to desire a natural birth. In this section, ‘support’ refers to the people closest to the respondent who support her choice to have a natural birth and help them maintain their confidence in the face of negative, fear-based stories. They are not necessarily the catalysts to make her decide to have a natural birth, but they are the people she has gathered around her who help her maintain her confidence. Almost all of the respondents mentioned that their husbands, partners or other chosen support people were very important to increasing their feelings of confidence at being able to have a natural birth. Several mentioned that their maternity care providers were sources of support for maintaining their confidence to have a natural birth. The following selected quotes reflect the sentiments shared by most of the respondents.

So for me, I am talking daily about what I am feeling, what people are telling me, what my experience was. Even if I just have a moment when I am nervous, I'll just turn to him and say “I'm feeling really nervous right now” and he'll just kind of give me a hug and he'll say “we can do this, you can do this, we can do this together.” It is almost like having your little pep squad there. (Jennifer)

I am grateful to him [husband] that he trusts me that much. And that he reminds me to trust myself. Because I think especially in moments of vulnerability or weakness, I am going to rely on that trust, him saying, “don’t forget, we need to do this.” (Kimberly)

Yeah, and I just, I think my partner can help me through a lot of the pain and really make me feel relaxed. (Stephanie)

In addition to the buffering effect of immediate friends/family, there was a common sentiment among many of the woman that their midwives and doulas would be positive supporters in their choice of having a natural birth, and would also provide a buffer between them and ‘the system’ in the hospital. This will be discussed in greater detail in chapter six.

5.4 Summary of Themes: Things Can Go Sideways

Despite believing in natural birth, many respondents indicated a certain level of fear of natural birth. They expressed that it is not possible to know how childbirth will go until it happens, and that unexpected complications can happen suddenly, eliminating the possibility for a natural birth. They were influenced by negative messages in society that depict childbirth as a dangerous and painful experience, and are particularly impacted by the ‘horror stories’ that are
told by family and friends. Other experiences with the health care system, before or during their
maternity care, also contributed to reducing their trust in natural birth. Respondents spoke of
using techniques to maintain their confidence and desire to have a natural birth, including
shielding away the negative stories, embracing the positive, and gathering supporters.
6: A MIDWIFE AND A HOSPITAL, THE BEST OF BOTH WORLDS: A LOVE/HATE RELATIONSHIP WITH MEDICALIZED BIRTH

Most people’s reaction was, ‘ok, great, you got the midwife part, so why not do the hospital. Best of both worlds’. (Kelly)

The theme of ambivalence emerged very strongly in the interviews with pregnant women and also with the key informants. Respondents clearly illustrated this theme by the way they held two overriding beliefs in tension – a desire for natural birth held in tension with an uncertainty about natural birth. These appear to be two contradictory beliefs. In chapter four, we learned how the respondents embraced the naturalness of childbirth, and believed that the best birth should be without medical interventions. In chapter five, we learned that a great number of these women still expressed fear of natural birth, concerned about the risks of sudden and random complications. In this chapter, we explore the ‘love/hate relationship’ with medicalized childbirth and build on the tensions/contradictions raised in the previous two chapters.

The pregnant women in this study were very determined to have a natural birth without medical interventions, yet almost all of them stopped short of being convinced they could have that experience. They feared interventions and were sceptical of medicalized birth practices, yet they wanted to be in the hospital in case of complications, and they embraced some elements of prenatal technology without question. They saw the benefits of natural birth and expressed a belief in the mind-body connection in childbirth, yet they did not feel they really had much control over the process. They believed in childbirth because generations of women before them managed to do just fine, but they are afraid that it may not be possible for them.

In this chapter, these apparent tensions will be illuminated in greater detail, first by acknowledging how respondents are critical of birthing norms including the risks of interventions, and then through the respondents’ beliefs that the safest way to give birth is to have the medical system readily available. The third section discusses the ambivalence seen in relationships with their maternity care providers, and highlights key informants’ perspectives that the ambivalence they see in their clients is due to fear of pain.
6.1 Critical of Birthing Norms

The respondents in this study were all knowledgeable about natural childbirth - they had thought about it, read about it, were very informed. They questioned birthing norms, tending to be critical thinkers about how childbirth is handled in the mainstream. They are uncomfortable and, in some cases, enraged about how childbirth has been moved so firmly into the disease model of medicine. A few were sharply critical of what they perceived to be a system that unfairly takes control away from birthing women. The first theme in this section, Sceptical about the Medical System in General, demonstrates that the respondents’ scepticism of the medical model in childbirth may stem from a broader philosophical view that modern medicine, while important in emergencies, is not the answer to preserving health. The second theme, Sceptical about the Medical System’s Role in Birth, reflects the respondents’ critique of the medicalized approach to childbirth.

6.1.1 Sceptical about the medical system

Some of the respondents described bad experiences they had with the medical system, or authority in general. These experiences opened their eyes to alternative types of health care available, and focussed their critical eye on their perceived failings of the medical system. A few of the women felt very confident in the ability of the medical system to deal with acute or emergency situations, but did not see the medical model playing a role in prevention of illness. Several of the respondents also stressed that the medical model tends to intervene with surgery or other interventions too quickly before exploring other non-invasive approaches to healing. Heather was told by a gynaecologist, when she was younger, that she may not be able to deliver vaginally because her vagina was short, causing her to have creeping doubts nearly 20 years later about her ability to safely give birth vaginally.

Well that was when I was about 21, and my gynaecologist telling me that I have a short birth canal and I may not be able to deliver vaginally because of that. And he didn’t give me information and I was very young, and I didn’t even question like what that meant. (Heather)

… I was 12 years old at the time, and every hour having nine vials of blood taken out of you because they didn’t know what was wrong. And they couldn’t figure it out, and all that. It just…I think that kind of hampers your trust in doctors and in the medical field. (Rebecca)
And then being a nurse, I think I see just medical interventions that aren’t necessary and there is that aspect of it. I think our bodies can do a lot, and you just don’t need to fuss around with it. (Amy)

But I definitely feel that a lot of the times that aren’t emergencies, either you are left neglected, not listened to, or are given unnecessary interventions. OK, that is literally my experience for the last 10 years. Really good under emergency situations, but then when it comes to overall proactive health or personal care, that there is a complete missing gap. (Jennifer)

Most of the key informant interviews also reflected this theme, observing that women who want natural birth sometimes have had negative experiences with the medical system, or authority in general, and they want control of their birth. Elizabeth’s quote summarizes this theme among the key informants.

And often, my clients have a lack of belief in the medical system, to some degree. Some more extreme than others, feeling let down, and not only in childbirth, but just feeling like this is a natural experience and they haven’t been satisfied with the medical care they have had before, so why would they have a medical, medicalized birth? (Elizabeth, Midwife)

### 6.1.2 Sceptical about the medicalization of birth

Many of the respondents expressed their scepticism over the way they perceive the medical system handles childbirth. Several of the respondents became quite impassioned when discussing their perceptions of the normative birth culture, and expressed anger and frustration over the medically controlled birth culture. It was felt that medical personnel are trained to deal with illness, not health, so they intervene inappropriately in the natural process of birth. A few of the respondents spoke about their perceptions of the various non-health reasons that interventions are used in normal birth including time, convenience, money, and legal protection.

… but let’s put a whole other bunch of other drugs in my system, and lets cut me open in a place that is naturally designed to stretch by itself, and lets try all these things that might be good for safeguarding the doctor’s legal means, but might not be great for me, strapping me down to a bed, or having me be reclined when moving around may be better for me. I guess I don’t believe so much in the tenets of the medical birth. So I am starting to think in the absence of that, my other option is the natural childbirth. (Kimberly)

It makes me angry, to be honest. Um, it means that the medical system or the doctors are intervening in a natural process. To get the baby out quicker or wanting to get the labour moving faster. And in my own personal opinion, it feels completely
unnecessary and more driven at money, or just efficiencies in the medical system. (Jennifer)

Yeah, so the conventional approach has a more disease care model rather than a health care model, so for pregnancies that are healthy and progressing well, I think they don’t really... like, the medical system is trained to intervene in some ways, and it’s not like they have a lot of experience with letting things happen at their own pace. (Angela)

And then being a nurse, I think I see just medical interventions that aren’t necessary and there is that aspect of it. I think our bodies can do a lot, and you just don’t need to fuss around with it. Like the fetal monitoring, and you know, IV for no reason. I just think a lot of it is maybe that, my profession has kind of shaped that a little bit. (Amy)

Lisa touched on this theme of being critical of the health care system in a larger more philosophical way. She had referred to the challenges she had in her pregnancy to keep it normal, and how various different tests indicated possible problems that further tests would then discount. She was frustrated by the medical approach taken by her midwives and felt like she was powerless to refuse the extra testing she was being sent for, even though she felt intuitively that she was fine. The following quotes were illuminating; the first one about her lack of power to make a decision to keep things natural in the face of medical testing that indicates possible problems, and the second quote talks about a broader philosophy that influences her thinking about this whole issue.

I guess it is the hard thing between choosing and not choosing. Like how much control you have over that situation, because on the one hand, I thought that everything was fine so then I felt like probably it should be left alone. But on the other hand, if these tests showed that, you know, everything was not alright, then probably I would want to have the baby outside sooner rather than later for its health. (Lisa)

I have a lot of confidence that I will survive. And this baby seems to be strong and healthy and I hope that it is. And at the same time I hope that if it weren’t, I would recognize that that’s also something that was meant to be, and I think that our medical system makes that a really hard thing to do. (Lisa)

Not every respondent expressed a dislike for the medicalization of birth and most respondents expressed relief that the medical system is available in case of complications. Most of the respondents were choosing to give birth in a hospital because they felt safer or more comfortable knowing that emergency medical help was close.
**Risks of Interventions:** Medical interventions in birth are a source of anxiety for many of the respondents. Their desire for a natural birth links with their belief that how the baby is born affects the health of mother and newborn. The majority of respondents spoke of the concern that medication and operative deliveries could be harmful for the mom and the baby, and may reduce their ability to be instinctive and responsive to their babies during labour and post partum.

The effect of drugs on the baby, entering its system, and what it will do to my body that will put pressure on the baby. Um, and then afterwards like breastfeeding, I am really keen into breastfeeding, so one thing I worry about is with a medicated birth or interventions, like especially something extreme like a caesarean, it interrupts that instant bonding that the mother and child can have, so that to me sort of threatens my chance of being successful at breastfeeding. So I see natural childbirth as a means to getting to that goal as well. (Christina)

...for whatever reason those medical interventions actually scare me more than the pain of childbirth or the fear of natural childbirth….I feel like it's safer somehow [natural home birth]. Even though that is contrary to other people’s belief. (Kelly)

I don’t think I need those [interventions], and those aren’t going to make it any easier. I mean some of those interventions seem really nice, but there’s also a lot of complications that can make things a lot worse. So I would rather stay away from anything that can further complicate things. (Nicole)

The majority of women also expressed their beliefs that interventions could negatively affect the labour process. There was a sense that interventions are sometimes unnecessary, and they force the labour process into a direction that is unnatural. Some respondents raised concerns that interventions such as epidural would slow down the labour process and make it impossible to react instinctively to the urge to push. As we saw previously, many of the respondents believe in birth being natural and instinctive, so anything that moves childbirth into a more medically controlled experience is approached with caution.

… if everything is still OK, why would you want to induce [to start labour], why would you start doing that? I mean the body is not ready, the baby is not ready. And it means it doesn’t want to come out naturally, so why don’t you give it that extra time….why would you start something that your body is not saying it is ready for? (Stephanie)

I have a bit of a belief that, I think that interventions sometimes make the birth riskier than it has to be. So with a natural childbirth I would say “no” [birth is not risky]. But with a highly intervened birth, I would be more concerned about worse outcomes. (Kelly)
I have heard a lot of people saying when they have the epidural that the nurse tells them when they have to push, and I just think that it is really counter-intuitive, like isn’t that kind of the reason that we have that feeling, that you are blocking it? I just think it would be better that I know when to push rather than somebody else telling me because we have blocked that off. (Amy)

I think for me that was kind of what was more unappealing about it was that it feels that, if you can’t feel stuff, then it’s harder to be in control of what is happening. Or to be able to let your baby do its thing, if you are not quite sure how your body is or should be responding. (Lisa)

Many of the women referred to a snowball effect, or cascade of interventions, when medical professionals apply an intervention to a normal birth which causes the need for more interventions.

…if we look at some of the statistics of what happens to women in hospital situations, and we really look at them, it may be actually very valid to claim…that by putting them into routine medical situations, we are actually in a snowball effect…where one intervention leads to a second, leads to a third, leads to a major intervention. (Kimberly)

…it seems that when one intervention comes in, it is a trickle effect. And it affects everything else. And generally at the end of that list leads to a caesarean section…you even start with fetal monitoring, and it makes them think the baby is in duress, and then it follows from there…. Pitocin scares me a lot … because you are forcing this upon the baby and your body, and the hormones don’t have the opportunity to kick in, and you just don’t have the opportunity to birth naturally… how your body is ready to do it.” (Jennifer)

I just heard a lot of quote unquote horror stories of the “domino effect” of interventions... I have been told by people who have had children that once you sort of have one intervention, their feeling was that it would lead to another. It is nearly impossible to have one without the other, from their experiences. (Kelly)

In my mind, there are more risks to having a birth with interventions than one that is natural. … but it just seems to me that having all the drugs and interventions would be riskier….it just seems like a slippery slope. (Christina)

This theme was echoed in a few of the key informant interviews. They observed that women wanting natural birth were informed consumers about birth, they are aware of their choices, and they use resources, support and information to increase their confidence and ability to birth naturally. They also described that these women understood iatrogenic disease and understood the risks of intervening in a natural process.
And I think those that are looking for more [a different approach to medically controlled birth] have either been scared by the stories, have been angered by what has been done to women.... (Laura, Childbirth Educator/Doula)

They do understand about side effects, they do understand that one thing leads to another, they do appreciate what I call the obstetrical cascade, that as soon as you let one cascade item into the door then you are you know, you are well on your way to a whole group of others that follow one after another...They understand iatrogenic disease, they understand how inadvertently every time you do something it has a consequence. They understand that very well. (William, Family Physician)

…they are maybe worried about risks for the baby, too, like vacuum, forceps, and epidural. Epidural which could lead towards vacuum and forceps and all that kind of stuff, whether or not it does is like, not necessarily the case, but I think there is that belief that things could affect the baby, and they want to have the least amount of interventions. (Amanda, Maternity Nurse)

It is important to note that a couple of the respondents were more concerned about interventions from the perspective of side effects of allergic reactions. They also referenced errors that occur with medications in the hospital setting. So their concern of interventions was expressed, but it was less to do with the labour process and immediate post partum bonding, and more to do with traditional concerns of adverse reactions or mistakes by care providers. Angela reflects this sentiment in the below quotation.

I know that all of them can have some risk. I also know it’s debatable, like it depends who you ask how much risk there is associated with each one of them. I think there is probably a time and a place for all of them. But…any time any action can, anyone can react anyway to anything. So you can always have some kind of adverse reaction to something, any intervention. (Angela)

It is interesting to compare the beliefs about the risks of interventions to the beliefs expressed about the risks of natural birth. When asked about the risks to having a natural birth, most respondents said that they would not want a natural birth at all costs meaning that, if there were complications, it would be risky to refuse interventions and insist on a natural birth. It was interesting that they responded to that question by referring to true emergency situations that may occur in childbirth, as opposed to reflecting on any risks to a healthy and normal natural birth.

I think there is always small risk with natural childbirth. But, um, I don’t think you want to push it too far, I mean I would never give up the health of me or my baby by choosing for a natural birth. I would say, ‘just do something about it’. Get that c-section or get an epidural, whatever you need’ at the moment. I would never replace that and say, ‘Oh I am really going for a natural birth and whatever happens, happens’. I mean we don’t live in Africa. (Stephanie)
…as much as I want a natural childbirth, if there is a doctor standing over me saying, ‘your baby is going to die unless we give you a c-section right now.’ I will say ‘ok’ like do it...I am not going to argue and say ‘no no no, I have read the books about this!’ (Christina)

An interesting tension within this theme is mistrust, yet acceptance, of medical interventions. Even though most of the respondents expressed concern about interventions in childbirth, and were quite worried about that eventuality, most embraced the use of interventions if something went wrong during the birth. In other words, they are not so afraid of interventions that they would turn them down if there were complications. It was clear that a number of the respondents would be disappointed if they needed interventions during birth. However, a few respondents reported that if they had interventions in birth, they would be content if they had a healthy baby at the end. They expressed a belief in the system that interventions would only be used if absolutely needed.

**Losing Control:** The theme of control was found more among the small group of respondents who had considered home births (even if they were planning hospital births). This theme represented a concern of having their birth experience taken away by medical professionals. This fear of losing control of the experience stemmed from their plans to be in a hospital and a concern that medical professionals in the hospital setting do not share their desire for a natural birth. There was a strong belief that the midwives offered women more control over their own labour and birth, and there was a belief that doctors took away control and choice.

Fear that there will be interventions because I am at the hospital. (Jennifer)

And I think, when I think about being in a hospital, I think of the medical staff wanting you to stay in the hospital bed. They don’t want you to walk around if you are not progressing, and…I just feel like you are so controlled and you have to follow the certain rules or guidelines of whatever they have set up. (Rebecca)

But if we are challenged [in hospital to accept interventions]...I don’t have a problem being kind of bossy about it, I guess, and saying ‘this is what we want’. (Christina)

Laura, a key informant, took it a step further to state that women would indeed have a hard time having a natural birth in an environment where the medical professionals did not deal regularly, or trust, natural birth.

If you have a care provider that does not know normal birth or trust in birth, it’s really hard for a woman to get that. (Laura, Childbirth Educator/Doula)
This fear of having control taken away was most pronounced in Christina’s interview. She was unable to get a midwife and felt very vulnerable in the hospital with a doctor as her main care provider. She feared that her desire for a natural birth would not be honoured in the hospital and she was expecting, and preparing for, confrontations with medical personnel. Christina mentioned this a few times - she actually wanted a home birth with midwives, but she was unable to get a midwife in her new community, so she was concerned about how she would maintain control in the hospital with doctors as the primary care providers.

I am about 90% confident [that I will have a natural birth]. Like I said that earlier, I am a little worried about being challenged by the doctors cuz I haven’t even met them all, and that makes me a little bit anxious. I was 100% confident when I had the midwives. Now I am a little worried about being forced into doing something that I don’t want to do. (Christina)

Heather and Rebecca emphasized this point from a more political perspective, referencing women’s right to make decisions about their own bodies, and the loss of control that women experience in the maternity care system. There was a message within their interviews that women were having an important aspect of their personal power taken away.

I am quite a feminist so I just feel that women are getting really ripped off, so are babies, of the natural experience. And um, it gets my back up pretty strong. (Heather)

It’s your body, it’s your life, it’s your child that you are bringing into the world and yes a doctor or midwife or somebody else obviously has more knowledge in that area, but in the end, to, o it is your body and you should have the say over what you want done to you. Cuz I personally wouldn’t want somebody telling me that I need to have an epidural, or I need to do this or that to have my child, if I don’t feel comfortable with it I won’t do it. (Rebecca)

Several key informants raised this theme as well, but their comments were in reference to women choosing home birth. They observed that one of the reasons some women choose home birth is to maintain that sense of control over their experience. They do not want to risk being put into a setting where medications and interventions are readily available, widely culturally accepted, and used in the majority of births.

And some people were afraid of being in the hospital, and afraid of medical interventions, um, so they are looking for, what can I do instead, and where they would have more power. (Mary, Midwife)

..the ultimate example of wanting a natural childbirth is a home birth, the control that she wants is total control of her own environment. Not somebody else’s
environment, not somebody else’s rules, not somebody else’s regulations and structures. …When you enter a hospital, you are entering foreign territory and you are by definition out of control. You go with the rules and structures that have been established for women, not you, but women and providers, and that’s ultimately loss of control. (William, Family Physician)

6.2 Acceptance of the Medical System’s Role in Childbirth

Despite their reservations and condemnations of normative medicalized birth procedures, the respondents also showed that they not only accepted the role of modern medicine in birth, but they embraced it. Most of the respondents saw the need for a medical safety net for birth, and embraced some aspects of medicalized maternity care without question, including giving birth in a hospital and certain aspects of prenatal technology (i.e. ultrasound). Kimberly sums up this theme with a particularly poignant comment into this issue of ambivalence between a natural and a medical birth.

Well, I am really grateful to be a Canadian. To live in a society who has decided that socially we will support people at their weakest moments as well as their strongest moments. … I am really grateful I can have these experiences, but it is not like I am having them with the lack of any other options. I am making these decisions, but I still have a back up of wonderful doctors, nurses, surgeons, medical personnel, equipment, medications, we couldn’t be more lucky. So it is perhaps, I am cognizant about how cavalier it is to be talking about ‘oh, of course I will be doing this, of course I would be doing that.’ Would I feel so lucky to have a natural childbirth if it was my only option? I have always wondered about that. (Kimberly)

6.2.1 Hospital birth trumps home birth

While this study did not focus on hospital births versus home births, it was inevitable that this discussion would arise in the interview process. The belief that childbirth can go ‘sideways’ influenced most of the respondents to choose to be in a hospital as a precaution. So, while they were fearful about medical interventions in birth, they felt having easy access to these interventions was the safest choice. Being within easy access of medical help, in case it was needed, was a high priority for most of these women.

Most of the respondents, while giving the nod to positive aspects of home birth, were planning a hospital birth because they felt it would give them the greatest sense of security. Three of the 12 respondents indicated that they would like to have a home birth, however, only one of these women was planning to have her baby at home. Two of the respondents who wanted to
have a home birth chose to be in a hospital because of a lack of support from their family or husband. A fourth respondent was undecided at the time of the interview, but was leaning towards a hospital birth.

“…I know home birth is perfectly safe and they can transfer you, but my fear was, if we did have to transfer for some reason, I would never hear the end of it. Like …‘good thing the medical care system prevailed and you didn’t have this hokey home birth. I bet next time you will just go to the hospital right away.’ Because in my heart I would have known that it was fine, but I guess I just didn’t want to hear ‘I told you so’s’. (Christina)

According to a handful of respondents, including those who wanted to have a home birth, the risk of hospital birth was greater than the risk of home birth. They expressed their belief that being in the hospital could increase their chances of having medical interventions, and (as was mentioned previously) they worried about losing control over their birth process by giving control to medical professionals.

I think you would talk about the risks that aren’t in a home birth! Because you don’t have the risk of unnecessary intervention or, again, being taken down someone else’s philosophical road about what a birth should be like. (Kimberly)

I feel like it’s safer somehow...being in my own surroundings and doing it on my own terms makes me feel more comfortable about it. (Kelly)

[I have] fear that there will be interventions because I am at the hospital. (Jennifer)

The remaining eight respondents were planning hospital births. While many of these woman acknowledged some of the benefits of home birth, including being in their own surroundings, the perceived risks of being too far from the hospital should something go wrong outweighed the benefits. A few of the respondents had friends who experienced serious complications in childbirth and required emergency interventions, and these stories influenced their decision to plan a hospital birth. Interestingly, over half of the respondents also mentioned the “mess” associated with home birth, although that was only a minor factor in their decision to have a hospital birth.

By far, the dominant reason respondents chose hospital birth was the reassurance they felt of knowing medical care was close if there were sudden complications. They expressed discomfort at the idea of having to drive to the hospital if something went wrong, and would rather just be there. (Melissa) likened the birthing rooms in the hospital to being at home, except with the option of medical help if needed. (Nicole) felt that being in the hospital was more of a
safety precaution than an intervention. The following quotes reflect what several of the respondents shared.

…I feel like I can get everything that I could get at home in one of these great birthing rooms that they happen to have close by, and I still have the option of help if I need it, which seemed kind of good to me. (Melissa)

And so the convenience of having medical technology there, if it is needed, is a really big thing for me. Just knowing that, if anything does go wrong, God forbid, that I have the backup there if needed. [If] I go through labouring and then all of a sudden the baby is in distress and we have to call for the ambulance, and the ambulance takes 10 minutes to get there, or whatever it may be before I get to the hospital. ..[T]hat part of it really scares me...I get really worried about it. (Rebecca)

…you are farther from the hospital [at home birth] if things go wrong with the baby, or if you start bleeding out, or whatever, you know. Placenta issues and stuff, whatever. You know there’s a whole host of issues that can happen, but you are farther from the hospital, so it’s obviously more dangerous. (Heather)

When asked about risks of hospital births, most of the respondents were quick to point to the risks of infectious disease. This was really the most prevalent concern that was raised by respondents planning hospital births. As mentioned previously, only a few respondents expressed the concern that being in the hospital would lead to unnecessary interventions and a loss of control. In fact, most of the respondents were quick to minimize any major concern about hospital birth, despite their critical eye to the medicalization of childbirth. Four main factors seemed to contribute to their confidence in being in the hospital: 1. they felt that their care providers would protect them from unnecessary interventions, 2. they planned to labour at home as long as possible before going into hospital, 3. they had support, and 4. they were well prepared for childbirth.

It was interesting to note that over half of the respondents planning for a hospital birth suggested they would consider a home birth for subsequent pregnancies providing the first birth went well in the hospital. This dovetails with a theme discussed in chapter five, that birth is generally unknowable. Heather and Nicole reflected this sentiment in their statements.

But once I have this labour, if it goes well, then I am definitely doing the next one at home. Because then I have the frame of reference, I’m OK, everything went well, it’s good, so I would definitely do the next one at home, or I will plan to do it at home anyway. (Heather)
And it would still be something I would consider in my second birth. With it being my first, I just wanted to be sure that I knew what I was doing, and I knew the process I think. (Nicole)

Key informants also reflected this theme, that pregnant women view hospital as the place to give birth and they observed that this is a very strong trend that is difficult for most women to challenge.

Well, I still think the medical system, the health care system, sees hospital as being the norm. Ah, and that they don’t make it easy to question, or to … it's just the hegemony that is present in that whole system, it’s just quite huge. (Jessica, Childbirth Educator/Doula)

I mean, we are taught to go the hospital. And I think, you know, I think over the years it’s been skewed against, midwives are dirty, and home birth is bad, and you know to get the care you need if there is an emergency, the hospital's the best place to be. (Mary, Midwife)

6.2.2 Reassurance of prenatal testing

As a group of women who were committed to having natural birth, and who were sceptical about the medical approach to childbirth, it was somewhat surprising to learn of their almost total acceptance of ultrasound use in prenatal care. It was interesting that only one respondent expressed concern about the routine use of ultrasound in prenatal care. As mentioned in a previous chapter, some of the respondents purposefully turned down some of the prenatal diagnostic testing after doing a risk benefit analysis and determining that the test would cause more stress than the perceived benefit of knowing about a remote possibility of a problem. However, none of them refused ultrasounds.

Eleven of the 12 respondents talked very positively about their ultrasounds. One respondent expressed some hesitancy that perhaps they were not necessary, but the procedure reassured her of the health of her pregnancy. Another respondent felt that her baby did not like one of her ultrasounds, but she did feel it was necessary and enjoyable to have that experience. Most were delighted with the opportunity to see their baby, and this technology reassured them that the baby was healthy and the pregnancy was going well. This observation is again indicative of the larger theme of ambivalence – the ideological dance between accepting the norms that are perceived as harmless, and rejecting the norms that are perceived as potentially harmful.

One respondent, (Lisa), was cautious about ultrasounds and expressed surprise at how her midwives did not even raise the controversy about this technology. She ended up getting more
ultrasounds than she wanted because she was measuring small for dates. The ultrasounds showed normal growth each time, which provided reassurance to her midwives that everything was progressing normally. This was a source of frustration for (Lisa), who felt intuitively that she would rather just let things progress naturally, but expressed the impossibility of having to make an intuitive decision for one’s health and that of one’s babies when care providers are raising the alarm.

All these ultrasounds for one thing….it seems like so many things have become really normal, medical things have become normal. (Lisa)

It seems to me that people are very calm about ultrasounds in general. And I think I feel more concerned about them than anyone else including and especially even our midwives, I would say. And so, I know there have been some studies where they say ‘are repeated ultrasounds dangerous’ and the level of repeated seems too extreme, it seems everyday ultrasounds…and they always seem to think that it is not such a problem. (Lisa)

Some of the respondents also mentioned the reassurance provided by diagnostic testing, putting a great deal of faith in the ability of the testing to confirm that the baby was healthy and the pregnancy was going well. A mentioned in the previous chapter, a few of the respondents turned down some diagnostic tests because they felt the stress the test would cause would outweigh the benefits. Other than being a source of stress, most of the respondents did not mention any downsides to prenatal diagnostic testing. Alternatively, a couple of the respondents reflected that the testing itself created a more medicalized pregnancy than what they wanted, and expressed concerns that the results of the testing could lead to more medicalized birth process. (Lisa)’s quote reflects her exasperation at having more medical tests than she expected during pregnancy, and (Christina)’s quote refers to the concern that testing leads to more medicalization.

There is the triple screen, and there is the ultrasound, the 18-week one. And then more recently I have had [tests] about, do you have this certain bacteria…and then a urine test, do I have a hidden UTI? And then a blood test, since I am going anyway, just check on the haemoglobin. And these two extra ultrasounds, and the non-stress test which is also an ultrasound. …And then every time we go to the midwife there is that little Doppler thing which is an ultrasound that does the heart rate. And yeah, so that is just the pregnancy! (Lisa)

Like I know...if you have GD (gestational diabetes) there is a tendency to be like, ‘Oh, that baby is going to get too big, we are going to have to induce you early’ or whatever, and that would just mean another fight…(Christina)
6.3 Relationships with Maternity Care Providers

In the choice of care providers, this theme of ambivalence was demonstrated again. Most of the respondents said that they were inclined towards a natural birth before they were even pregnant, and were sceptical of the normative medicalized birth culture, yet most went first to a doctor when they discovered they were pregnant, rather than seeking out midwifery care. It was interesting that most of the respondents chose midwifery after an initial unsatisfactory appointment with a doctor – they sought midwifery initially as a rejection of the medical model (perceiving midwives to be less inclined to medicalization in childbirth) as opposed to a planned course of action upon learning of the pregnancy. About half of the respondents were not previously aware of midwives, did not know that they were covered under British Columbia’s provincial health care plan, and were unaware that they had hospital privileges.

Nine out of the 12 respondents had midwives. Among the three with doctors, one did not know midwives were available at the beginning of her pregnancy, but would have been interested in midwifery care, one started with a midwife, but could not get a new midwife in her new community after she moved, and one had a trusted family doctor who delivered babies.

The respondents (including those who had doctors) indicated that the benefits of midwifery care included emotional support, the relationship, better informed consent, and the continuity of care. Midwives were mentioned in chapter five as a source of support for maintaining confidence during pregnancy in planning for a natural birth in the face of negative influences. In this section, the theme speaks to the role that midwives are seen to play during childbirth to enable the woman to give birth naturally.

Several of the respondents suggested that they would have had more concerns about being in a hospital if they had a doctor, but a midwife gave them a feeling of comfort due to the perception that the midwives would support them in having a natural birth. Some thought that having a midwife in the hospital would be like being at home except with medical back up should it be needed. Many of the respondents put a great deal of faith in their midwives making the right decisions for them during labour, and along with doulas and other support people, buffering against unnecessary interventions.

Originally we started the pregnancy with midwives and I felt we had total control then. Because they made it very clear from the beginning that they were there to advocate for us and do what we wanted. (Christina)

But I know that, I trust that at that point, where a decision needs to be made, that the midwives are going to look at me and tell me why, what is going on. And my
husband and I can make that decision because we have a choice...I know that with the doctors that I was seeing before, I don't know that they would have given me the choice, they would just do it. (Jennifer)

This is my first birth [laughter] so I don’t know….you use experienced people for every type of job you have. I mean, you bring your car to a garage, you hire experienced people! And why not for this? I mean, why would you go through without having ever seen it or done it and think you can do it? (Stephanie)

Among the respondents with midwives, three expressed some concern that their midwives were more medically oriented than they had expected, a response illuminated in the following quotes.

...[there is a] kind of switch between midwifery being quite outside medical establishments to being quite inside them. Maybe the practice itself has changed a lot….we don't [want to] say ‘we don't like the midwives, we like doctors better, they seem more relaxed’, you know? (Lisa)

Maybe it’s because the midwives are feeling closely watched by the medical community right now because they have just sort of just begun to get on board... maybe the midwives are just trying to prove that they are also reliable health care providers as opposed to bush doctors. So I don’t know, but I just feel that they are way more medical than I would have expected. Lots more tests and...I just kinda thought midwives would be a little bit more earthy? Like a little bit more natural, so I am a bit surprised. (Heather)

This belief was echoed in one of the key informant interviews as well, offering that the midwifery profession was changing as a result of regulation and integration into the hospital setting. There was speculation about the role of midwives shifting due to the registration of midwifery in British Columbia and the hospital privileges.

…midwives now are not as adverse [to] intervention as it applies to pain medication and that sort of thing as they once were. You know, midwives are now, there is structure and control and standards…I think their profession has changed a bit, it is homogenized and we still have radicals on both sides… (Thomas, Obstetric Specialist)

…there is a medical model and there is a midwifery model. One is that labour and delivery is normal, and one is that labour and delivery is an accident waiting to happen….And somewhere in the middle is the right thing. And midwives have to move a bit to the right, and physicians to the left, or vice versa. And I think there is an influence, at least a potential anyway, for a positive influence. (Thomas, Obstetric Specialist)
It is interesting to note that a number of the key informants felt that it was their clients who were actually more oriented to medicalized birth. This suggested an interesting tension between what the care providers perceived (women are more medically oriented), and what a couple of respondents were saying (care providers are more medically oriented). It should be noted that these two perspectives may not be mutually exclusive - given the medicalized culture of childbirth that was discussed in chapter five, one would expect that the dominant narrative of childbirth could impact everyone associated with birthing - women and their care providers.

The theme of ambivalence that emerged from the key informant interviews stemmed from their views that many pregnant women who say they want a natural birth are actually open to accepting pain medications. They say that these women talk about having a natural birth, they set themselves up with midwives and doulas, yet they keep the door open for an epidural. One of the key informants even went so far as to suggest that many women do not see the epidural as a medical intervention, just a way to manage the pain. This is a notable difference between how the theme of ambivalence was reflected in the interviews with pregnant women, which was not actually about pain, but a mistrust of natural birth.

The normative woman will say that she’d like to have an unmedicated birth with the possible exception of epidural. She will say, ‘I want as few interventions as necessary, I want as natural a birth as possible.’ If you dig down, there are a large number [of those women] who would say, ‘I don’t want epidurals either’, but there are an even a larger number who say, ‘I want it as soon as possible’. (William, Family Physician)

Midwives joke about this; they say a woman who wants a midwife for a hospital birth wants a midwife and an epidural. (William, Family Physician)

I would say most of the clients I have worked with in the last while have tried to leave it very open-ended. I’d say most of them….they are aiming towards a natural birth…I mean just the fact that you are hiring a doula, means you are paying money, that just kinds of makes more of a commitment, right? But a lot of my clients have said that lately, ‘but if I am under too much pain, I will have something for the pain’. I have noticed a lot of that lately, actually. (Jessica, Childbirth Educator/Doula)

So I think that they…go into it knowing, when people are planning a hospital birth, they have that backdoor, you know? They want midwifery care, but they want that backdoor if they need it. ‘I’m going to try to do it without, but if I need something…’ (Mary, Midwife)

A few of the key informants explained this tension with reference to the universal access of midwifery care in British Columbia, suggesting that it is responsible for a growing
diversification among women who seek alternative care providers (midwives, doulas). They reflected that midwifery clients historically would be adamant about having a natural birth and home birth, but now are more mainstream, looking for a supportive caregiver, but inclined to the perceived safety of a hospital birth and receptive to using pain medications in labour. They observed that this diversification means many midwifery clients are not necessarily seeking a natural birth.

And now, it’s more across the board [women seeking midwifery care] … health care is available to everyone in Canada, you know, it’s more like a general population here, versus people that are more health conscious, health minded that are wanting to avoid interventions. So, that is what I see more than in the U.S. It's more broad.

(Mary, Midwife)

And women are going to that because they want that model of care, they want that person. They see midwives, they are keepers of the norm and so they're seeking that, and they may, it’s not necessarily that they want a home birth or a water birth and they are going to be in the black sea or you know Hawaii and all the rest, but they just want that care and that nurturing that the midwifery model of care [provides].

(Laura, Childbirth Educator/Doula)

6.4 Summary of Themes: A Midwife and a Hospital: the Best of Both Worlds

This chapter focussed on the attitudes and beliefs about the medical system’s role in childbirth and highlighted the apparent contradictions that have arisen in the data. Being open to think critically about normative childbirth practices contributed to the respondent’s scepticism about the role the medical system plays in childbirth. However, it was clear that the respondents saw an important role of the medical system in childbirth and most viewed the hospital as the safest place to give birth. Respondents were, on the whole, reassured by prenatal testing. Most respondents felt confident that choosing a midwife meant a less medical approach to childbirth, even in a hospital setting however, a small number of respondents were surprised that their midwives were more medical than expected. Overall, the respondents reflected a desire for natural birth while holding in tension an uncertainty or lack of trust in natural birth.
7: DISCUSSION:
DESIRE AND UNCERTAINTY

The respondents were nearly unanimous in their belief in childbirth being a natural, normal event. The data did not cast any doubt that intellectually and emotionally, these women really did believe that natural birth was the gold standard and they were very motivated to experience birth without unnecessary interference.

However, this is where it got confusing. Even though the respondents drew on the instinctive nature of childbirth and the wisdom of the generations of women before them in their desire for a natural birth, they felt that birth was unknowable - they could not know how their bodies would respond to labour until they experienced it. Even though they expressed a belief in the mind/body connection of birth (that fear hinders labour and relaxation enhances labour), they felt birth was unpredictable and uncontrollable - labour would happen the way it was going to happen and there was little to be done about it except manage the pain, preferably without medication. Even though they were very motivated to have a natural birth with no medications or interventions, almost every respondent felt the need to plan for the potential of unexpected complications that would result in the need for obstetrical intervention.

Ambivalence is a central theme that runs through the data. The dominant tension that emerges from the data, as reflected in the above tensions, is between their desire for a natural birth and their uncertainty of natural birth.

Figure 1 depicts this dominant tension. This conceptual framework identifies factors and beliefs that are involved in creating ambivalence. The left side of the framework illustrates the beliefs and factors that help to create and/or sustain a desire for natural birth. The right side displays the beliefs and factors that erode trust and create an uncertainty about natural birth. These tensions exist together, and vacillate over the course of the pregnancy. Sometimes, the women are pulled more strongly by the factors that contribute to a trust and belief in natural birth, and other times, the factors that create fear and uncertainty are more compelling. Some factors are actually on both sides of this figure, indicating that they play a role in both promoting a desire for natural birth and instilling fear or uncertainty. The vacillation between this multitude of factors and the resulting shifts in perspective create ambivalence about their plans for birth.
Figure 1: Ambivalence: A Conceptual Framework

Factors and beliefs that create/sustain a desire for natural birth

BELIEFS
Natural birth is beautiful
Natural birth is instinctive
Natural birth is safer if in hospital
Interventions are risky
Normative maternity culture is untrustworthy

FACTORS
Positive stories of natural birth
Support from family and friends
Self-preservation techniques
Availability of midwives
Critical thinking and scepticism about birthing norms
Prenatal testing that reinforces normalcy

Factors and beliefs that create uncertainty about natural birth

BELIEFS
Natural childbirth is risky
Childbirth is unknowable until it is experienced
Complications are sudden and random
Hospitals are safest place for childbirth
Midwives can buffer against unnecessary interventions in hospital

FACTORS
Dominant fear-based discourse about childbirth
Negative stories about the risks of childbirth
Lack of societal support and/or deliberate discouragement for natural childbirth
Prenatal testing that raises concerns about pregnancy or baby

Tension between coexisting factors/beliefs during pregnancy
I would like to refer to Jane Weaver’s study (2000) about how women’s decisions about caesarean sections are informed because she highlighted a broad theme similar to this theme of ambivalence. She reported a tension between two beliefs - that vaginal birth is both desirable and hazardous. Even though she was talking about caesarean sections rather than natural birth, it is interesting that a similar overall theme emerged. She discussed some of the same factors that contribute to fear and uncertainty about childbirth such as prenatal testing and frightening stories from other women. However, a notable difference between our studies is that she did not delve into factors that create a desire for natural birth. Her analysis focussed more on the creation of fear and uncertainty about childbirth as compared to my study that also explored factors that create trust in natural birth. Kringeland (2010) also highlighted this phenomenon, that even among women very committed to natural birth, there exists a significant fear of childbirth.

Ambivalence was an unanticipated finding because I anticipated having more data that illuminated why women were able to trust birth in the face of the dominant fear-based discourses. It would not be fair or accurate to say the respondents were overly fearful about natural childbirth - they had strong intentions to deliver their babies without medical interventions, and they were informed and educated on the politics of childbirth. Intellectually they knew what they wanted, but most had concerns about natural birth and felt safer in the hospital. It is probably fair to say that fear can be a normal part of pregnancy and childbirth because there are many unknowns. The central issues seems to be how fear impacts a woman’s plans and desires for her birth – if the fear is great enough that it pulls women away from the natural birth that she instinctively desires.

Robbie Davis-Floyd (2003) describes that the women in her study who actively sought out natural childbirth “...based their expectations for achieving a natural birth not so much on trust in the natural process of birth as on the intellectual knowledge they have gathered” (p. 207). In many ways, the respondents in my study also fit with this description. Knowing people who had a natural birth opened their eyes to the possibility of a way of giving birth that was alternative to the normative medicalized birth. They sought out the information and the facts supporting natural birth, and developed a strong scepticism of the medicalized birth system. Nevertheless, in many ways, these intellectual pursuits were not necessarily strong enough to override the omnipresent fear-based discourses.

Mitchinson (2002), in her research of the history of childbirth in Canada, refers to this phenomenon across the decades by observing that “...people are often able to live with contradictions in their lives; women could focus on the ideal of birthing that medicine promised and could overlook the specific reality of their own birth experience” (p. 303). Sarah Buckley
(2009) also noted this tension, claiming that, “[m]any [women] will feel the conflict between their own desires, needs, and ways of knowing, and the technology-does-it-better approach that the medicalization of birth has produced” (p. 8).

It was interesting to compare the difference in the literature between women wanting home birth (Boucher, 2009) and the women in my study who wanted natural birth, but not necessarily at home. As I did not specify place of birth in my participant selection criteria, most of my respondents were planning hospital births, which may in fact be an important aspect of the theme of ambivalence. In one recent study on why women choose to give birth at home, it was found that these women had a ‘trust in birth’, and they felt that “…birth would proceed more normally in a home environment than in a hospital environment” (Boucher et al., 2009, p. 123).

In other words, women who chose home birth seemed to see natural childbirth as a process that could facilitate an unmedicated childbirth experience. This is quite different from what women in my study were inferring – that natural childbirth is something that can happen only if labour progresses perfectly, and medical interventions are the solution when things do not go as hoped. Most of the respondents in my study did not seem to make a connection that a natural birth, in the broadest definition, could prevent or overcome complications. Further, they believed in natural birth when things were going well, but stopped short of fully trusting the process of natural birth as a way to keep normal birth healthy and safe.

This research exposed a dominant theme of ambivalence, and I am proposing two higher-level influencers that play a role in shaping this theme. This theme is examined through a discussion of two main influencers that shape women’s perceptions and plans for birth: the dominant medical paradigm of childbirth and risk-based discourses that promote fear of childbirth; and a reflection on the power of personal stories to shape women’s perceptions and plans for childbirth. This chapter will conclude with implications including individual and systemic considerations that may support women who are committed to natural birth.
7.1 Medical Paradigm and Discourses

“...I realized an entire system of medical procedures and interferences had been established to treat normal birth as a risky, dangerous, painful, and abnormal process in which pregnant women have no choice other than to submit gracefully” Suzanne Arms (1975 pp. xii)

The dominant theme of ambivalence may reflect the tension that the women experience between two paradigms – a medicalized paradigm and a wholistic paradigm. My results are comparable to a finding in Robbie Davis-Floyd’s research. The ‘women-in-between’ is a defined group within her study of women who wanted control over their birth experience (as opposed to a reliance on technology or medical professionals), but also believed that childbirth is safest in a hospital (Davis-Floyd, 2003).

Cultural messages about birth play a role in instilling fear among women about childbirth. Existing literature and this study demonstrate that fear of childbirth is prevalent in our society. From stories overheard on the bus, to birth stories shared at baby showers, to depictions of birth in pop culture, women are exposed to the construct of birth as a dangerous, painful process that needs to be medically managed. These messages are internalized - the decisions women make about how they want to give birth, how supported they are in their choices, and how confident they feel in being able to give birth are shaped by these messages.

Dominant discourses or paradigms are the prevailing messages in society about a particular topic. These dominant discourses are the stories we tell ourselves, and what the general population tends to believe and reinforce. In childbirth, this means that childbearing women, their support system, and their care providers are all influenced by and play a role in shaping the discourses around childbirth. The respondents and the key informants in this study concluded that the prevailing messages about childbirth painted a picture of risk, fear, danger and the need for obstetric intervention.

There are two broad paradigms about birth introduced in the literature review that are discussed in this section: a wholistic paradigm that sees birth as a normal, natural event, and a dominant medical paradigm that views birth as risky. The women in my study were influenced by these two conflicting paradigms about birth. They viewed birth through a wholistic paradigm but were influenced by the dominant fear-based discourses making it difficult for most of them to fully trust the natural process without medical back-up. This analysis is not unique. In fact, it is in line with what many other researchers have concluded over the years, that the discourses within
the dominant medical paradigm promotes a fear of childbirth through risk-based discourses that overstate the risks while negating the normal (Davis, 2003; Fisher et al., 2006; Simkin, 1989). As described in the literature review, these risk-based discourses are influential towards women’s perceptions and choices concerning childbirth.

It is suggested that women may be so deeply influenced by the dominant technocratic discourse that they do not even realize it themselves. Robbie Davis-Floyd proposes that “[w]hat makes this whole issue so delicate and complex is the tension inherent in the natural ideal, and thus, within the belief systems of the women who hold that ideal, between the wholistic and the technocratic paradigms of birth: many pregnant women consciously espouse one while at the same time unconsciously believing in the other” (Davis-Floyd, 2003, pp. 187-188).

Edwards and Murphy-Lawless assert that the “…[o]bstetric medicine has been very successful in persuading the public to accept that it alone can improve birth outcomes by identifying, managing, and safeguarding against risk in birth” (Edwards & Murphy-Lawless, 2006, p38). In fact, so dominant is the risk management ‘logic’ in childbirth that many women, including those in my study, may override their own views and core beliefs in order to avoid being seen as immoral for putting their babies at risk by having something other than a normative medical birth (Edwards & Murphy-Lawless, 2006).

Fear-based discourses are particularly pervasive, mainly because women want to keep their babies and themselves healthy and safe, so avoiding risk is paramount. I argue that while the respondents did have a solid and healthy belief in natural childbirth, the fear-based discourses had the power to override, to varying extents, this belief. In fact, in a couple of cases, it was the perception of risk they were trying to avoid, by planning a hospital birth because of familial pressure as opposed to the home birth they actually wanted.

Fear-based medical discourses influence maternity care and leave little room for women to reject medical technology, resulting in increased acceptance of medical intervention in birth (Davis, 2003, Davis-Floyd, 2003). In my study, the only way most of the respondents felt comfortable to trust birth was to have that medical system at the ready in case of sudden complications.

It is relevant to refer back to Deborah Davis’ work that was highlighted in the literature review on choice in pregnancy and childbirth. Through a feminist research lens, it is important to look at women’s choices in childbirth and how that plays out in choosing natural or medical birth. Choice and control in health care is a key tenet of feminist theory and the feminist health
movement, so with childbirth, the issue really is about true choice as opposed to coerced choice. Many women in British Columbia now have choice of having a midwife or doctor, and giving birth at home or in a hospital. But they don’t have the choice to be immersed in a society where the dominant paradigm about childbirth is positive, wholistic and natural. That choice does not currently exist because the dominant paradigm is one of medical control and fear of pregnancy and birth. As a result, true choice to have natural birth is limited and highly influenced by the stories, depictions and messages about birth that permeate a woman’s daily life.

There are certain expectations from society about what pregnancy and childbirth should look like, and what is expected of childbearing women. These expectations are so strong that they can affect even those women who are determined to have a childbirth experience that may be outside of the normative medical birth. Family and friends can very innocently perpetuate the medical discourses around birth by simply asking pregnant women about their ultrasounds or doctor’s appointments (Wildner, 2008).

The images and messages of birth that they receive from other women are typically referred to as ‘horror stories’. All respondents referred to these horror stories when responding to a question about what people have been telling them about childbirth. In reaction to these stories, respondents spoke of the need to protect themselves from fear-based stories, and found they constantly needed to defend their choice to give birth naturally.

An earlier quote from Davis-Floyd made reference to the unconscious influence of risk-based paradigms. I propose that my study demonstrates the influence of the medical paradigm is not entirely unconscious. In fact, I think on some level the respondents were well aware of the fear based stories and their own reaction to these stories – they spoke of the influence of so-called ‘horror stories’ on their psyche, and they developed techniques to buffer negative influences during pregnancy (i.e. teflon skin) and during their birth (i.e. choosing midwives and doulas).

The medicalized approach to birth is so prevalent that women wanting natural birth feel the need to actively protect themselves from negative messages in order to maintain their confidence in having a natural birth. Women feel they need to defend themselves against wanting to have natural birth and/or a home birth. Yet they do not feel a similar need to defend themselves against wanting a hospital birth because that is the norm – it is what is expected of birthing mothers.
7.2 Power of the Personal

The findings in this study demonstrate that it is the ‘power of the personal’ that had the most profound impact on women’s attitudes and beliefs about natural childbirth. It was the personal stories that the respondents heard from their community of influence (their relatives, friends and acquaintances) about their own birth experiences that carried the most weight. The theme of ambivalence is illuminated through an understanding of the influence of personal stories. The stories from women they knew about beautiful natural births persuaded them to believe in the possibility of a natural birth. However the ‘horror stories’ reinforced the dominant discourses around birth, planting seeds of doubt and challenging the respondents in their plans for a natural birth. It is the tension between these two very personal, and very influential, messages that contributed to ambivalence.

Over the years, there have been tremendous shifts in the ways in which women experience childbirth. Being present at birth was once common for girls and women but with the shift towards medicalized birth, as well as a move away from the support of extended families, most women do not experience birth until they are giving birth to their own babies. Women are having fewer babies later in life so, presumably, they have had more years to be influenced by dominant paradigms of childbirth, and horrible birth stories that are “...shared at baby showers and workplace lunchrooms across the country [reinforcing] the ideas of pathology and danger” (Wildner, 2008, p. 18). These personal stories are heard and considered without real, actual personal experience of childbirth. In this study, most of the respondents had not seen a real birth. If that is true for most women, unless they actively seek out alternative, wholistic perspectives, they would be resigned to the messages presented in the media or in depictions of birth from other women.

It is interesting that the Canadian Maternity Experiences Survey showed that the vast majority of women surveyed said their care provider and books were the most important sources of prenatal information during their pregnancy (PHAC, 2009). Only a small percentage said their friends or relatives were the most useful sources of information about pregnancy and childbirth.

At first glance, this may seem a contradiction of my findings. However, the survey was asking about sources of prenatal information, whereas my study highlighted sources that shaped ideas about birth. I did not ask respondents about their most useful sources of information, however, most volunteered that they read books, attended prenatal classes, and learned information from their care provider. It is interesting to consider the possibility that personal stories influence women’s attitudes and beliefs about childbirth, but they go elsewhere for
prenatal information. It makes me wonder if perhaps most women take the horror stories with a grain of salt. The stories may be enough to plant seeds of fear, but pregnant women are not seeking prenatal information from these same women, they are going to sources which they presumably deem more trustworthy – books and professionals.

The prenatal information they receive from books and care providers has the capability of then either reinforcing or counteracting the fear-based messages they are hearing from other women. This opens up a whole other level of influence, depending on the books they are reading and the care provider they have chosen. A recent discourse analysis of readily available and popular childbirth books concludes that many of these popular childbirth books “...do not consistently support birth as a normal, physiologic process and, in fact, may act as causative factors in the growing trend of technological birth” (Kennedy, Nardini, McLeod-Waldo & Ennis, 2009). In addition to books, the existing literature and the findings in this study showed that care providers who see childbirth through a medical paradigm can reinforce fear-based messages about childbirth.

But the power of the personal does not stop with horror stories and negative depictions. In fact, an important finding in this study showed that respondents were positively influenced by someone in their lives who had given birth naturally. Somehow, on some level, it made the unknowable experience of childbirth slightly more knowable. They felt strength in believing that if their mom/sister/friend/grandmother could give birth naturally without incident, they should be able to as well. However, there is not a normative natural birth culture to bolster this belief. If women primarily hear negative stories, and very few stories of natural, safe births, even if they want this experience for themselves, it may plant enough doubt and fear to ‘seek the protection of hospital’ and to lose confidence in their own abilities.

In fact, with so few friends/relatives who had given birth naturally, and with such a cultural dominant force against natural birth, respondents illustrated the difficulty in sustaining a belief in the possibilities of an alternative way of birthing. The women end up putting more energy into fighting off the negative influences than shoring up the positive. Simultaneously, the respondents consciously reflect on the horror stories that are shared by other women, and dissect these stories for meaning and significance. They intentionally develop ways to block out the negative stories that they hear to reduce their influence.

The women in this study were most negatively influenced by the fear-based stories told to them by other women. Interestingly, the respondents claimed to be less influenced by the negative discourses in pop culture about childbirth, presumably because they had educated themselves on
natural birth and the politics and risk of medicalized births that they could intellectually explain away these discourses. However, hearing stories about women’s birth experiences – friends, relatives and acquaintances – those are harder to explain away. These stories were impactful. In fact, they were probably the most influential part in challenging their much-desired trust in the birth process. If their friend had to have an emergency caesarean section, it would open the door to the possibility it could also happen to her.

7.3 Supporting Women Who Want Natural Childbirth

While the results of this small study of women in the Lower Mainland of British Columbia cannot be generalized to a larger population, some themes that arose from the data and which are reflected in the literature, may be relevant to increase the numbers of women who want a natural birth, and assist them in staying motivated during their pregnancy. Of course, it should be clearly stated that wanting a natural birth is only one small piece of the puzzle. As the literature suggests, there are much larger societal and systemic issues that shape childbirth culture and normative obstetric practices. In other words, wanting a natural birth does not guarantee a natural birth in normal healthy pregnancies for reasons far more complicated than basic physiology or truly random complications.

The following factors (individual and systemic) may be considered to support women wanting natural birth, and are discussed in the subsequent sections:

1. Amplify positive stories and messages that show natural birth as possible and desirable.
2. Encourage self-preservation techniques and critical thinking in pregnant women (teflon, purposeful preparation, etc.).
3. Clarify misconceptions about safety/risks of obstetric interventions and birth location
4. Increase awareness of maternity care options.
5. Question the use of prenatal technology.
7.3.1 Amplify positive stories and messages

“We must find creative ways to disseminate the message that [women’s] bodies are to be trusted – that birth is a healthy and achievable event within their personal power” (Kennedy, 2009, p.434).

It is demonstrated in the literature that fear of childbirth can lead to higher rates of intervention, and my study showed that hearing mostly negative stories and messages about childbirth can erode confidence and trust in natural birth. Positive stories about natural birth were instrumental in planting the seed of possibility among the respondents in this study, yet there is a dearth of positive stories about natural birth in our society. Several researchers encourage the need to promote positive images of birth in order to start changing attitudes and beliefs about birth (Weaver, 2000; Wildner, 2004, 2008; Zwelling, 2007). In fact, there are documented practices that promoting the positive can have enormously beneficial impact on pregnant women. The Albany Midwifery Practice is one such practice that actively promotes home birth and midwives strive to keep natural birth at the forefront in all of their client interactions by “…instill[ing] in women and their families a confidence in the birth process and the idea that birth can and should be a joyful event” (Reed & Walton, 2009, p150).

7.3.2 Encourage self-preservation techniques and critical thinking

“... natural childbirth requires hard and very conscious work, rather than passively letting nature take its course. In this view, then, respecting birth as a natural process does not mean being passive; rather, respect of nature requires active and very social involvement” (Mansfield, 2008, p.1093).

The data seems to suggest that women preparing for natural childbirth are not just passively expecting ‘nature to happen’. They are actively preparing themselves for the experience by educating themselves about natural birth, choosing care providers who support their more natural approach to pregnancy and birth, questioning dominant obstetric practices, and developing ways to buffer against negative influences. The theme of ‘self-preservation’ was a particularly interesting emergent theme, because it demonstrated a very conscious decision to guard against negative stories that may erode their confidence in a natural birth. Of course, these techniques did not prove to be infallible. Many respondents still had their confidence shaken by the stories, but using these techniques seemed to help them make sense out of the stories they were hearing, striving not to incorporate the stories into their own reality.
Becky Mansfield (2008) offers a very interesting perspective on this very issue, suggesting that “… natural childbirth is not just a worldview or set of cultural ideas, but is instead a set of practices: things women, their caregivers, and their wider social networks do to make birth a normal, physiological not risky, pathological experience.” (p. 1093). This is reflected as well in a comment by one of the midwives in my study who required her home birth clients to learn all about the safety of home birth so that they could defend themselves against critics. Self-preservation techniques and learning/practicing critical thinking skills appear to be an important part of preparing for a natural birth.

7.3.3 Clarify misconceptions about safety/risks of obstetric interventions and birth location

This study underscored the prevalence of misperceptions about the comparable risks of home birth and hospital birth. The women in this study were informed and critical about obstetric practices and determined to have natural birth, yet they were not aware of all the risks of hospitals births, were concerned about the safety of home birth, and believed that their midwives would protect them against unnecessary interventions. The evidence is clear, and is growing, that planned home birth with a trained midwife for normal pregnancies is as safe as or safer than hospital birth, and has a lower change of unnecessary obstetric interventions (Janssen et.al., 2009).

Even though my study did not focus on home birth, if women want to give birth naturally they should be aware that the location of birth has an important influence over birth outcome, regardless of the care provider or determination of the birthing women.

7.3.4 Increase awareness of maternity care options

Most of the respondents visited their family doctors after finding out they were pregnant, and only a few received information about midwifery and birth options. Many of the respondents were not even aware that midwifery services were available and covered under the Medical Services Plan of British Columbia. If this small group of women highly motivated towards natural birth were unaware of midwives, it suggests that this information is still not in the mainstream, and that family doctors could provide a valuable service to share information about maternity care options with prospective parents.
7.3.5 Question the use of prenatal technology

It is important for our maternity care system to question the use of prenatal technology. My study demonstrated that a number of the prenatal tests contributed to anxiety during pregnancy, even if the tests showed that things were progressing fine. A number of the respondents even chose to refuse certain tests, predicting the anxiety would outweigh the benefits of the test.

The routine use of many obstetrical technologies is controversial and seems to come from the medical paradigm that assumes technology provides a level of safety in normal pregnancy and birth. The routine use of a number of these technologies presumes that all pregnancies are prone to complications that could be remedied through careful and frequent monitoring and the application of obstetric technology, something that is debated in the literature. Further, given that the use of prenatal technologies may contribute to anxiety about pregnancy or childbirth, these practices in normative obstetric care should continue to be questioned at the policy level rather than the individual level. While informed choice about obstetric practices is an important component of women-centred maternity care, it was suggested in the literature review that “choice” in maternity care is not free from fear or coercion. If a woman is lead to believe that a certain test is important, her choice is essentially made for her.

7.4 Implications for Future Studies

The analysis of the data brought to light some of the beliefs and factors that contributed to women’s motivation for a natural childbirth. The data also illuminated beliefs and factors that I was not intentionally looking for - those that created fear or uncertainty in the minds of the pregnant women about natural birth. These factors exposed the overall theme of ambivalence, which was reflected in a conceptual framework showing the tensions between seemingly divergent ways of viewing childbirth. The analysis did not result in a broader explanatory theory that could explain interrelationships between the factors or weighting that may privilege one factor over another in explaining motivation for natural childbirth. Further research could explore some of the tensions and themes more thoroughly in order to build formal, substantive theories. The theories could potentially explain relationships between the influencing factors and create a richer understanding of how they play out with different women under different circumstances.

While this study did answer the primary research questions, highlighting some factors that shape attitudes and beliefs as well as some of the reasons women want a natural childbirth
experience, what is lacking is an understanding of *why some women reject the dominant medical discourses around childbirth and trust natural birth*. This was not one of my research questions, but it is an important one. The respondents in this study did question the dominant fear-based discourses and viewed them with some scepticism, however they were clearly influenced by the negative societal messages about childbirth, limiting their ability to fully trust natural childbirth. If I had limited the sample to women seeking home birth, I may have been able to explore what allows women to reject the dominant discourse and trust natural birth. This would be interesting for future research, perhaps with a view to theories of power and human agency.

7.5 Conclusion: Natural Childbirth as a Public Health Issue

Public health focuses on broader societal issues that affect the health of a population. Highly medicalized childbirth practices are risky to large number of birthing women. With the increasing rates of caesarean and other obstetric interventions, promoting natural childbirth is a public health issue.

Natural childbirth minimizes the negative effects of unnecessary obstetric interventions, but because of the complexity of this issue and the dominance of the medical paradigm that views normal childbirth as a potential risk, changes need to be supported at a level beyond just the individual woman. In other words, we cannot convince a generation of woman that they can give birth safely without the protection of medical interventions if most messages they receive from medical professionals, media, mothers and friends says something very different. Since women are, at present, effectively disconnected from first-hand childbirth experience before the birth of their own babies, they are influenced by the images and messages in their immediate environment and in the broader society.

Of course, sometimes things do go legitimately wrong in birth, but it is suggested in the literature and among the professionals interviewed in this project that much of what ‘goes wrong’ in birth is the result of medicalizing a normal process. This study, while illuminating some of the factors that motivate pregnant women to seek natural childbirth, also revealed societal factors that can erode trust in natural birth. It takes more than individual efforts to change the trajectory of medicalized birthing norms in our society. It takes enormous cultural change and a willingness to look at the larger systemic issues that prevent childbirth from being a natural, life-altering and beautiful experience for women.
APPENDICES
Appendix 1: Natural Childbirth in British Columbia

The following information was provided in a report from the BC Perinatal Health Program for the entire year of April 1, 2008 – March 31, 2009.

**Includes:**
- Vaginal deliveries
- Spontaneous labour
- Local anesthetic may be included

**Excludes:**
- Surgical deliveries – caesarean sections
- Instrumental deliveries - vacuums, forceps
- Anesthetics / analgesics during labour & delivery – Generals
- Spinals, Epidurals, Narcotics, Entonox, nerve blocks, IV sedation
- Induction of labour
- Augmentation of labour
- Episiotomies
- Electronic Fetal Monitoring

### Natural Birth in BC

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### Total Births in BC

<table>
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<tr>
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<tr>
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<tr>
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Report Prepared For: Brenda Kent, Student, SFU
Date Report Prepared: April 6, 2010
Request #: 2009113
Data Source: BC Perinatal Database

BC Perinatal Health Program
Appendix 2: Interview Guide - Key Informants

1. Please tell me about your profession and how long have you providing maternity care (or care for pregnant women, in case of CB ed/doula)?

2. In this study, we are interested in what shapes women’s attitudes/beliefs about childbirth. Broadly speaking, what do you think influences women’s attitudes/beliefs about birth?
   - What would you say has the most influence?

   PROBES: personal/societal/family/cultural

3. I want to focus in on natural birth for a moment.

   [Inform them: For the purposes of this study, we are defining ‘natural birth’ as normal vaginal birth where the labour begins naturally and the baby is born without the use of pharmacological (e.g. pain relief medications), instrumental (e.g. forceps), or surgical (e.g. caesarean section or episiotomy) interventions.]

   i.) Approximately what percentage of your clients plan to have a natural childbirth (before labour starts)?
   - Generally, what proportion of these clients successfully give birth naturally?

   ii.) Have you observed any common characteristics among women who wish to have a natural birth?

   iii.) Among those who wish to have a natural birth, what do you believe has influenced their decision?
   - Are there some that are most influential?

4. I would like to focus now on women who plan to use pain medications and medical technology during their birth experience.

   [Inform them: For the purpose of this study, medical intervention is defined as a birth which uses any pharmacological (e.g. pain relief medications), instrumental (e.g. forceps), or surgical (e.g. caesarean section or episiotomy) interventions.]

   i) In your estimation, what percentage of your clients plan to have some form of medical intervention in birth?
   - Approximately, what proportion of these women receive medical intervention in their birth?

   ii) Have you observed any common characteristics among women these women?

   iii) Among those who plan for some form of medical intervention, what do you believe has influenced their decision?
• Are there some that are most influential?

5. Would you say that some of your clients are more confident about childbirth than others?
   
   i.) Do you see a relationship between confidence and the type of birth desired during pregnancy?
   
   ii.) Do you see a relationship between confidence and the type of birth attained?
   
   iii.) What do you think influences confidence?

6. From your experience, what are some common factors that can prevent a woman from achieving her goal of a natural childbirth?

7. I am interested in your experience with the maternity care system in our province.
   
   i. Do you feel that there are aspects of our health care system that influence women’s attitudes towards birth?
   • If yes, in what way?
   
   ii. Does public health play a role in shaping attitudes around birth?
   • Should it have a role?
   
   iii. Do maternity care providers have a voice in the larger system?
   
   iv. Do women have a voice in the larger system?
   
   v. What changes could be made at a systemic level, to increase the number of women seeking a natural birth?

8. Is there anything else you would like to share? (Anything you thought I might ask?)

9. As I mentioned at the beginning, following analysis of interviews with care providers, I will be interviewing pregnant women. I would benefit from feedback on the interview questions. [Give a brief overview of the types of questions I am planning to ask]. From your perspective, is there anything else you would ask?

10. What would you suggest would be an effective way of recruiting women to take part in this interview? Would you be willing to help me recruit participants? (This would mean I would contact you again following this interview.)

11. Can you suggest anyone else I should contact regarding this study?
Appendix 3: Interview Guide - Pregnant Women

Part A – Attitudes/Beliefs about Birth (general)

A.1. What is the first thing that comes to mind when you hear the word “childbirth”?

A.2. What kinds of messages do you think women hear a lot about childbirth in our society?
   • Where do these messages come from?

A.3. If a pregnant woman told you she wanted a natural birth, what would that mean to you?

A.4. What about if she told you she was planning an unmedicated birth, would that mean something different to you?

A.5. Let’s say for this question, we are defining natural birth as unmedicated birth without the use of any medical technology. Are you aware of any risks to having a natural childbirth?
   • Are pregnancy and birth risky?

A.6. If I talk about medical interventions in pregnancy and birth, what does that mean to you?
   • Are you aware of any risks to having medical interventions in pregnancy and birth?

A.7. How much control do you think a woman has over her labour and birth?

Part B – Plans for Birth/Factors Influencing Plans

B.1. How do you feel about being pregnant?
   • Have you had any concerns/problems with your pregnancy?
   • What types of tests/procedures have you had for your pregnancy?
   • Did you use any reproductive technology in order to conceive?

B.2. What have people been telling you about labour and birth?
   • How does that affect you?
   • If you think across your life, what are the things that have influenced your impressions about birth?

B.3. (Refer to intake sheet). I see you have a midwife/doctor/obstetrician. Tell me about how you chose your maternity care provider.
   • Have you changed care providers at any time during pregnancy? If yes, why?
   • Are you getting the kind of care your expected?
   • Do you feel satisfied with the options available to you in your choice of maternity care provider?
   • Ever consider a doctor/midwife?

B.5. Now, I would like to talk about your plans for birth. Why do you want a natural birth?
- What do you want from your childbirth experience?
- Tell me about what you are planning/hoping for your birth.
- How important is it to you to have that experience?
- People who know you well, are they surprised by your plans?
- Does anyone have any expectations on how your birth should go?
- Have your plans for birth changed at all during your pregnancy? If yes, tell me about it. What has changed? What has influenced that change?
- How flexible are you about your plans?

B.6. Did you ever consider having a home/hospital birth?
- What risks are associated with having a home birth?
- What risks are associated with having a hospital birth?
- What would be your ideal location for birth?

B.7. How confident are you that you will be able to have the birth experience you want?

B.8. What are you sure will go well during your labour and birth?

B.9. How much control do you think you have over your birth experience?

B.10. Do you have any fears about your upcoming birth?
- Have you discussed these fears with your care provider?

B.11. How do you feel about your body’s ability to give birth? (Do you feel that you can trust how your body handles different challenges?)
- Do you have any concerns about what might happen to your body during childbirth?

B.12. What do you think has had the greatest influence on your plans for birth? (Probe: Experiences, people, care providers, outlook on life?)

B.13. I want to ask a bit your experience with the medical system. How would you describe your confidence in the medical system?

B.14. If you think over your pregnancy, is there any type of service or support that would have been helpful to you during your pregnancy as you prepare for childbirth?

B. 14. Is there anything else you would like to share with me?
Appendix 4: Intake Form for Pregnant Women Interviews

1. Name you would like to use for this study: _______________
2. Age: ______ 
3. Relationship status: __________
4. Household Income range:
   - $0 - $19,999
   - $20,000 - $39,999
   - $40,000 - $59,999
   - $60,000 - $79,999
   - $80,000 – $99,999
   - $100,000+
5. Ethnicity:_______________
6. Highest Level of Education:
   - □ Less than high school
   - □ High school diploma
   - □ Some post secondary
   - □ Undergraduate degree
   - □ Graduate degree
7. # weeks pregnant: __________________ Due date: ____________
8. Where do you plan do give birth? _____________
9. Who is your maternity care provider?
   - □ Doctor
   - □ Midwife
   - □ Obstetrician
   - □ Other:______________
10. Are you currently taking a prenatal education class? Yes No
    i. If no, do you plan to take one? Yes No
11. Are you planning to have a doula/labour support person at your birth?
12. On a scale of 1-10 (strongly agree - strongly disagree) please answer the following questions:
   a. I believe childbirth is a natural process that should be allowed to proceed without any medical intervention.
      1 2 3 4 5 6 7 8 9 10
      Strongly agree Strongly disagree
   b. Having access to the medical system during labour and delivery is very important to me.
      1 2 3 4 5 6 7 8 9 10
      Strongly agree Strongly disagree
   c. I am fully committed to having a natural childbirth experience.
      1 2 3 4 5 6 7 8 9 10
      Strongly agree Strongly disagree
   d. I am open to accepting pain medications if I need them.
      1 2 3 4 5 6 7 8 9 10
      Strongly agree Strongly disagree
Appendix 5: Informed Consent Form - Key Informants

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 778-782-6593.

Your signature on this form will signify that you have received a document which describes the procedures, whether there are possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

Title: Prefer to Push: A study of factors that shape women's motivation for a natural childbirth experience

Investigator Name: Brenda Kent

Investigator Department: Faculty of Health Sciences

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in the Study Information Document describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below:

Purpose and goals of this study: This study will explore the factors that influence women’s attitudes and beliefs about childbirth, as well as those factors common to women seeking a natural, unmedicated birth experience. The results of these interviews will provide insights into the research question, and inform the interviews that we will have with women who prefer a natural childbirth experience.

What the participants will be required to do: You will be interviewed for approximately 60 minutes. This interview will focus on your experience with pregnant nulliparous women, and your understanding of women's motivation behind choices around childbirth.

Risks to the participant, third parties or society: There are no foreseeable risks to participating in this interview. Participation in this study is strictly voluntary. You may withdraw from this study at any time, or decline to answer any question.

Benefits of study to the development of new knowledge: Benefits to participation include the contribution towards a better understanding of the factors that influence women’s attitudes, beliefs and choices about childbirth.
Statement of confidentiality: The data of this study will maintain confidentiality of your name and the contributions you have made to the extent allowed by the law.

Inclusion of names of participants in reports of the study: All notes and audio recordings will be coded with an alias, chosen by you.

Contact of participants at a future time or use of the data in other studies: You will be asked at the end of the interview if you are receptive to being contacted again to assist with participant selection for interviews with pregnant women. Data will not be used for other studies, and will be safeguarded for 5 years following the study, then destroyed.

I understand that I may withdraw my participation at any time. I also understand that I may register any complaint with the Director of the Office of Research Ethics.

Dr. Hal Weinberg, Director, Office of Research Ethics
Office of Research Ethics
Simon Fraser University
8888 University Drive
Multi-Tenant Facility
Burnaby, B.C. V5A 1S6
hal_weinberg@sfu.ca

I may obtain copies of the results of this study, upon its completion by contacting:
Brenda Kent
bckent@sfu.ca
604-538-0391

I understand the risks and contributions of my participation in this study and agree to participate:

The participant and witness shall fill in this area. Please print legibly

Participant Last Name: ___________________________ Participant First Name: ___________________________

Participant Contact Information:

Participant Signature (for adults): ___________________________ Witness (if required by the Office of Research Ethics):

Date (use format MM/DD/YYYY) ___________________________ Contact at a future time / use of data in other studies
Appendix 6: Informed Consent Form - Pregnant Women

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What the participants will be required to do: You will be interviewed for approximately 60 minutes. This interview will focus on your perceptions about childbirth, and discuss your plans for the birth of your baby.

Risks to the participant, third parties or society: There are no foreseeable risks to participating in this interview. However if some of these questions raise an emotional response you are free to pause the interview, reschedule, or end it. In addition, if the interview is upsetting in anyway, the researcher can provide information about resources that may be beneficial. Participation in this study is strictly voluntary. You may withdraw from this study at any time, or decline to answer any question.

Benefits of study to the development of new knowledge: Benefits to participation include the contribution towards a better understanding of the factors that influence women’s attitudes, beliefs and choices about childbirth.
Statement of confidentiality: The data of this study will maintain confidentiality of your name and the contributions you have made to the extent allowed by the law.

Inclusion of names of participants in reports of the study: All notes and audio recordings will be coded with an alias, chosen by you.

Contact of participants at a future time or use of the data in other studies: Data will not be used in other studies, and will be safeguarded for 5 years, then destroyed.

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Participant First Name:  

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REFERENCES


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