Giving Birth at Home: Journeys of Trauma, Resistance, and Peace

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Abstract

Giving birth is common, life altering and life threatening all at once. Research suggests that the medicalization of childbirth has proved advantageous in reducing maternal mortality rates however this has been at the expense of women's embodied experiences of birth. Moreover, women are more likely than not to receive medical inventions in order to treat and prevent complications during pregnancy and childbirth. However, the negative sequelae of these hospital practices involve women losing control of their birth experiences and enduring negative psychological affect. Due to this women in Canada have been turning to home birth to circumvent medicalised birth. Midwifery services are available in the majority of Canada, however in some provinces, such as New Brunswick, midwives are unavailable. The purpose of the present study is to examine the experiences of women who give birth at home in New Brunswick in order to shed light on how women decide to give birth at home and where women draw support during their birthing processes. Grounded Theory methodology was used in this study in order to explore women's experiences. Findings revealed that women endure a journey before they give birth at home that involves previous hospital birth experiences, discovering home birth communities, becoming educated on home birth, and resisting medicalised pregnancy and birth. Participants also employed women who are home birth attendants in order to assist them during their first home births. Women then decided to give birth unassisted in their subsequent home births. Participants also discussed their beliefs regarding birth as a fundamental humans right issue. The findings illustrate the importance of women's authority during their birthing process and the fact that their care preferences mimic traditional midwifery practices rather than current midwifery practices.

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Introduction

Giving birth is one of the most natural and common occurrences of humanity; yet, it remains a life-threatening and life-altering experience for women. Research has indicated that women consider childbirth a major turning point in their lives (Rúdólfsdóttir, 2000), and researchers argue that childbirth is an event affected by social, historical, and cultural influences (Wertz & Wertz, 1979; Chalmers, 2012; Behruzi, Hatem, Goulet, Fraser & Misago, 2013). Childbirth in Canada today predominately takes place in hospitals (Statistics Canada, 2009) at the hands of healthcare professionals who monitor, assess, and treat any complications or medical conditions that arise during pregnancy, childbirth or the postpartum period (Public Health Agency of Canada, 2012).

Women who give birth in Canadian hospitals are more likely than not to undergo an array of medial interventions during their labour and delivery such as labour induction, caesarean section, and episiotomy (Chalmers et al., 2009; Chalmers et al., 2010; Chalmers, Kaczorowski, O'Brien, & Royle, 2012). For example, nearly 90% of women reported receiving at least one medical intervention during their birth process (Chalmers et al., 2009) and nearly 50% of women reported having their healthcare professional trying to induce their labour (Chalmers et al., 2012). Research also suggests that women who undergo caesarean sections are more likely to receive additional inventions (i.e., induction, continuous electronic foetal monitoring) and are more likely to have adverse birth outcomes (i.e., new-born admissions to Neonatal intensive care unit, longer hospital stays) than those who had vaginal births (Chalmers et al., 2010). Additionally, there are an array of policies and procedures that take place in hospitals that structure the way pregnancy and childbirth complications and treated medically (Public Health Agency of Canada, 2012) that

convenience the needs of the medical institution rather than the needs of birthing women (Webb, Burdett, Poulin & Gouliquer, 2013; Webb, Burdett, Poulin, & Gouliquer, 2014). Although this is the current state of affairs in Canada regarding childbirth, this has not always been the case. Moreover, our nation has a rich history with changes to the leading standards of care for pregnant and birthing women.

History of Childbirth Practices in Canada

Childbirth practices in Canada have changed drastically over the last few centuries and these changes have made a profound impact on women's childbirth experiences. Childbirth traditionally took place in women's homes with family members and a woman from the community who attended the birth in order to help the woman during her labour and delivery (Cross, 2014). These women were called midwives (Cross, 2014). However, the maternal mortality rates were high and after the invention of forceps in the 1700's North American birth practices started to shift (Zwelling, 2008). Forceps meant that infants could be pulled from women manually, and this marked the establishment of the medical science of childbirth (Historica Canda, n.d.). Although technological advances were helpful in reducing maternal mortality rates the roles of midwives dwindled rapidly (Cross, 2014). During the nineteenth century the belief that birth was safest attended by a respectable physician became widespread and by the beginning of the twentieth century midwives only attended births in poor and remote areas (Historica Canda, n.d.).

During this societal shift in the twentieth century childbirth was moved from women's homes to the hospital setting and physicians began to put women under harsh anesthetic to relieve labour pain (historica Canada, n.d.). Chloroform, ether, and twilight sleep, a combination of anesthetics that made women amnesic during labour, were used to

relive labour pain and women would wake up to find out they had given birth (Caton, Frölich, & Euliano, 2002). The next shift in birthing practices involved an emphasis on analgesia (i.e., epidural) to relieve pain during childbirth without putting women to sleep (Caton, Frölich, & Euliano, 2002). However, with the advent of technology to make birth safer, women became passive receivers of care and control over women's birthing process was passed from women to masculine authority figures (Wertz & Wertz, 1979; Massey, 2005) at the expense of women having an embodied experience of birth (Mennill, 2014).

After increased medicalization of childbirth a resurgence of the idea of natural home births began around the 1960's (Historica Canada, n.d). Midwifery legislations started in the 1990's allowing women in some provinces to birth with the assistance of a midwife (CAM, 2013). For example, British Columbia and Ontario offer regulated midwifery services to women in the hospital or at home (CAM, 2013). Although 98% of births still take place in Canadian hospitals (Statistics Canada, 2009), the notion of natural pregnancies (Westfall & Benoit, 2004) and natural childbirth appear to be a topic of interest for many women in Canada today (Parry, 2008). Why is there a resurgence of interest in home birth? To answer this question we must turn to the research that documents women's experiences of birth in the hospitals context.

Hospital Births in Canada

Hospitals are presumed to provide the ideal care for women during pregnancy and childbirth, however research suggests that the hospital context deprives women of control over their birthing process (e.g., Parry, 2008). Due to this lose of control women endure a plethora of negative experiences in the hospital setting (e.g., Fox & Worts, 1999; Jimenez, Klein, Hivon, & Mason, 2010). Some of the negative consequences include anxiety resulting

from medical interventions (Fox & Worts, 1999), feelings of exclusion from decision making during labour (Jimenez et al., 2010), and suffering from post traumatic stress symptoms following childbirth (Verreault et al., 2012). Moreover, some women have reported being emotionally scarred due to the psychosocial trauma they endured after giving birth in the hospital (Rosenthal, 2006). Although the negative outcomes associated with hospital births have been well documented, a plethora of research also indicates that women in Canada are opting to give birth at home with the assistance of midwives in order to circumvent having a medicalised birth experience in the hospital (Hutton, Reitsma, & Kaufman, 2009; Janssen, Henderson, & Vedam, 2009; Murray-Davis et al., 2012; DiFilippo, 2015).

Home Birth in Canada

Research suggests that women who give birth at home in Canada have very positive experiences (Janssen, Henderson, & Vedam, 2009) and undergo fewer interventions (Hutton, Reitsma, & Kaufman, 2009) than women who give birth in hospitals. Notably, women who gave birth at home with midwives in British Columbia revealed that they trusted their midwives skills and knowledge, they felt empowered and emotionally supported by their midwives, they felt relaxed giving birth at home, and they felt informed and included in the planning of their care (Janseen et al., 2009). Further, the women in this study revealed that their confidence in their midwives stemmed from the preparation and partnership with their midwives that allowed them to plan their birth experience to a degree that would not be possible in a formal setting (Janseen et al., 2009). Another study in Ontario also revealed women having positive outcomes with midwives at home (Hutton et al., 2009).

Hutton and colleagues (2009) revealed that low-risk women giving birth at home in

Ontario with midwives had lower rates of medical interventions compared to women who gave birth in hospitals with midwives. Namely, women who birthed at home had reduced rates of induction, augmentation, pharmaceutical pain medication, episiotomy, assisted delivery, and caesarean section (Hutton et al., 2009). Women who gave birth in hospitals also had higher rates of perineal trauma, greater blood loss, and transfers of care from midwives to another practitioner (i.e., obstetrician) compared to women giving birth at home (Hutton et al., 2009). Another study by Murray-Davis and colleagues (2012) revealed that women in Ontario and British Columbia also wanted to avoid receiving medications, caesarean sections, and the cascade of medical interventions that are associated with hospitalised birth (Murray-Davis et al., 2012).

The persistent theme common theme across the literature is that women opt for home birth because they want to exercise choice, comfort, and control over their birthing experiences (Parry, 2008; Murray-Davis et al., 2012; Murray-Davis, McDonald, Reitsma, Coubrough, & Hutton, 2014; DiFilippo, 2015). Women chose home birth because they feel safe and relaxed at home, they want to avoid medical interventions, it allows them more options to deal with pain and cope with labour, and they have continuity of care with midwives (Parry, 2008; Murray-Davis et al., 2012; Murray-Davis et al., 2014; DiFilippo, 2015). What appears to be of utmost importance is women's desire to have a personalized birth experience, which women do not consider available in institutionalized contexts (Parry, 2008; Murray-Davis et al., 2012; DiFilippo, 2015).

Current Midwifery Practices in Canada

Midwifery is regulated and practiced in the majority of Canadian provinces (i.e., Ontario, British Columbia, Alberta) offering publicly funded midwifery services whether

women chose to give birth at home, in the hospital, or at a birth center if available (CAM, 2013). On the other hand, in provinces such as Prince Edward Island and New Brunswick, there are no publicly funded midwifery services and therefore there are no practicing midwives in these provinces (CAM, 2013). Although this is the case, New Brunswick did receive legislation for midwifery to be implemented into its provincial health care system in 2010, however the provincial government cut all funds allocated to implementing midwifery services into its health care system in 2013 (CAM, 2013). With this, the government also cut all funds for the Midwifery Council of New Brunswick, making it impossible for midwives to register in the province (CAM, 2013).

Purpose of the Present Study

No previous research has examined women's home birth experiences in New Brunswick, Canada. Given that there are no support systems or services available to women in New Brunswick for home birth it is essential to research how women give birth at home in order to shed light onto how women negotiate finding care for this childbirth practice. The present study aims to this this gap in knowledge by exploring women's experiences of home birth in New Brunswick, Canada. The Grounded Theory methodology was utilized in this study. The research questions that guided this study included: What are women's experiences of giving birth at home in New Brunswick? Given that there are no practicing midwives in NB, where do women draw their support when they give birth at home? What can be done to enhance the experiences of women giving birth at home in New Brunswick?

Methods

Grounded theory Methodology

The Grounded Theory methodology structures the design of the present study (Glaser & Strauss, 1967). Grounded Theory is an exploratory methodology used in the social sciences (Stebbins, 2001) that allows researchers to derive theory based on research data (Glaser & Strauss, 1967). Grounded theory is inductive in nature and it allows theory to originate directly from research participants' personal accounts and lived experiences (Glaser & Strauss, 1967). Grounded theory allows researchers to identify concepts, or common themes, among participant's experiences, which are coded into categories and their properties (Stebbins, 2001; Glaser & Strauss, 1967). Moreover, categories are utilized to illustrate concepts, which are theoretical abstractions about what is going on in the data (Glaser & Strauss, 1967). Therefore, categories and their properties serve as the foundation of a grounded theory and are directly derived from the research data (Glaser & Strauss, 1967).

Grounded theory is inclusive to both quantitative and qualitative studies, however the nature of the present study is qualitative. Grounded theory methodology is a stark divergence from the positivist tradition of research that involves solely the verification of previous theories (Glaser & Strauss, 1967). One of the main benefits of grounded theory is the richness of the data obtained and the applicability and usefulness of the theory generated (Glaser & Strauss, 1979; Stebbins, 2001). The richness is of data is attainted because of the fact that categories emerge in the data naturally and they are not influenced by concepts in previous theories (Glaser & Strauss, 1967).

One of the pillars of the Grounded Theory methodology is that researchers engage in

theoretical sampling throughout the research process (Glaser & Strauss, 1967). Theoretical sampling is the process of data collection in which the researcher jointly collects, codes, and analyses data and in order to decide what data to collect subsequently and where to find that data in order to develop the theory as it emerges (Glaser & Strauss, 1967). Theoretical sampling can involve collecting data on many different groups in order to theorize one phenomenon (Glaser & Strauss, 1967). Glaser and Strauss argue that comparing differences and similarities among groups urges researchers to generate categories and their properties and understand the interrelations among the data. This is a lengthy process that often involves concatenating many studies on the same topic (Stebbins, 2001). Concatenation of studies can take years, or even decades, of work on the part of the researcher (Stebbins, 2001). The present study reflects the initial stage of research in a grounded theory study that involves exploring a sample of women that has not been researched yet to date.

Data Collection

Eight women took part in this qualitative research project. All of the participants had given birth in their home in New Brunswick, Canada. Although some participants also had prior hospital births and multiple home births, the selection criterion was that they had given birth at home in New Brunswick within the previous two years at the time of being interviewed. Some participants also had previous hospital births in other Canadian provinces, and some women had previous home births in other Canadian provinces as well. Participants were primarily recruited by disseminating posters on Facebook groups that were directly aimed towards childbirth or home birth in New Brunswick. The snowball, or word-of-mouth, method was also used to recruit participants. This usually occurred when a

participant took part in the study and shared her experience with other women in her home birth community. Women who took part in this study ranged in age from 25 to 43 years, with a mean age of 32 years.

Table 1: Women's Birth Locations (Home vs. Hospital)

Pseudonym	# Home Births	# Hospital births	# Births outside of New Brunswick (home or hospital)
Monica	4	1	1
Zoe	6		2
Sophie	1	1	
Emily	1		
Jayme	1	2	1
Serena	4	1	
Mindy	3	2	
Bonnie	2		1
Total	22	7	5

In-depth semi-structured interviews were conducted with participants. By conducting qualitative interviews, I was be able to capture their birthing journeys, starting with their first pregnancy and birth to their most recent birth. This allowed me to understand their overall birthing experiences whether or not the birth took place at the hospital or at home which was beneficial for me to understand how participants decided to birth at home. The interviews were comprised of three sections. The first was a demographic section in which participants were asked to provide their demographic information, which facilitated the building of a rapport between myself as the researcher, and the women as participants. Furthermore, it allowed me to determine the presence of any prevalent patterns across participant's background information. The second section consisted of the interviewee providing the researcher with their birthing story beginning with their first birth and walking me through all of their birthing experiences. The third section consisted of me

exploring any perceived gap in the coverage of the women's birthing stories and asking additional questions from the interview guide about their stories.

The interviews were face-to-face and took place at a time that was convenient for both the participants' and myself. Ethical approval for this project was obtained at Athabasca University (REB # 21735). The interviews began with participants being asked to sign an informed consent form in which they also consented to the interview being audio-recoded. The consent form covered the fact that they could terminate the interview at any time, refuse to answer any question, and that their personal information would remain confidential and their anonymity would be protected in any presentation of the data. At the end of the interviews, participants were given a debriefing letter in which they were given some follow-up information on the study and asked if they had any questions or concerns regarding the interview or research. Women were also asked if they were interested in receiving the results from the study when they become available.

Data Analysis

After the interviews were audio-recorded they were later transcribed and sanitised. This meant that any identifying information relating to the participant, such as names and locations, were changed to pseudonyms. This is when I conducted theoretical sampling (Glaser & Strauss, 1967) in which I interviewed participants, read transcripts, and analysed data simultaneously data in order to determine what questions I should be asking future participants, and which concepts were most salient in women's home birth stories. Field notes were also taken during interviews and memos were recorded sporadically throughout the analysis in order to record my thoughts, feelings, and reactions to the data

and research process. After coding and re-reading all of the interviews categories and properties emerged out of the data.

Results

Table 2: Overview of Results

Categories	Properties
Previous hospital experience	-Negative/traumatic first childbirth/miscarriage experience in the hospital
Becoming Educated	Attending workshops on homebirth, going to home birth support groups
Resisting Medicalization	Opting out of routine tests during pregnancy, not receiving check-ups after birth
Home birth Support	Hiring home birth attendants or giving birth unassisted
Birth Philosophy	Natural, physiological process, birth as a woman's rights issue

Previous Hospital Experience

The first category that emerged out of women's home birth stories was that many participants had previous hospital birth experiences prior to giving birth at home. Many of the participants in this study knew that they wanted natural and non-medicalised childbirths however they went to the hospital to give birth to their first child. These women revealed that they did not realize that home birth was an option in New Brunswick and therefore they went to the hospital for care during their first childbirth. The women who had previous childbirths that took place in the hospital reported their births being either negative, traumatic, or subpar experiences. Some participants also had traumatic miscarriages in the hospital context. These previous hospital experiences took place not only in New Brunswick, but in other Canadian provinces as well.

The participants in this study wanted natural and non-medicalised birth processes however, when they went into the hospital their expectations and plans were not met. Women reported that they continually had to comprise their needs with the hospital staff, and ended up enduring medical interventions and medications that they originally wanted

to avoid. Due to the fact that women's expectations for their birthing process were hastened in the hospital many women reported feeling disempowered and demoralized after giving birth in this context. Some participants also described their hospital birth or miscarriage experiences as traumatic because of the negative treatment they received from hospital staff. Some women revealed that their hospital birth experience caused them to have post-traumatic stress disorder after birth that lasted months after their baby was born. Zoe's quote below illustrates her traumatic experience of miscarriage in a hospital outside of New Brunswick.

> *I just sort of thought that there was something wrong and I figured I should go to the hospital because that's sort of what is done in that situation and my experience of miscarrying in the hospital was absolutely horrific. I was treated like dirt, I was sneered at by the hospital staff, and then when I asked the staff if I could have the foetus I remember the doctors and nurses starring down on me in bed and the doctor looked at me and said, "why would you want that? It's dead tissue, its been disposed of." That experience was so horrific and very traumatic.* (Zoe)

When women discussed their previous hospital birth experiences they also revealed a disdain for hospitals procedures and policies that they felt were not beneficial to them or their infants. These policies included: scheduled breastfeeding, having their abdomens pushed on after delivery, and taking their infant away to the Neo-natal Intensive Care Unit (NICU) for health check-ups after birth. Many of the participants thought these policies were detrimental at a time when they wanted to develop a bond with their newborn infants and they believed the hospital procedures were actually not favourable for their infant's

health. Serena depicts below how the policies in the hospital reflect an institutional machine.

> *They were professionals just going about their day and I was part of the puzzle and I kind of sensed a little bit of fear like always trying to stay one step ahead in case something went wrong. I just felt like I was part of this big well-oiled institutional machine or something we do all our tests on you, we are going to get the baby, clean up, we do these things and then send you on your way* (Serena).

Becoming Educated

The second category that emerged in women's home birth stories was that they became active participants in their care during their subsequent pregnancies by becoming educated on home birth. Given the negative childbirth experiences women had previously they decided to do research when they got pregnant a second time in order to ensure that they would have a natural childbirth. Many women did research on home birth and became aware of home birth communities in New Brunswick and joined groups that were organized by home birth advocates. Once women became aware of the support groups for home birth in New Brunswick they decided they wanted to give birth at home and became educated on the process. This involved women taking part in home birth workshops and attending home birth meetings. Sophie illustrates her experience of becoming educated in the quote below.

> *It was just eye opening [going to home birth meetings], it blew my mind, it's all the things that I didn't really think of before and hearing these women talk about it, it was like "oh my god." Just simple things like you don't have to cut the chord, you know what*

it's even better if you don't cut the chord right away, it was just things that I hadn't really thought of before, and I found it empowering and very helpful (Sophie).

Many of the women were introduced to home birth attendants in these home birth communities and hired them to assist them during their home birth. Further, once they hired their birth attendants they met with her prenatally and she further educated the participants on home birth and supplied women with resources to aid them during their labour and birth.

Resisting Medicalization

The next category that emerged out of women's home birth stories was women resisting medicalization. After women became educated on home birth from their home birth communities and their home birth attendants they decided to start opting out of routine medicalised care during pregnancy, childbirth, and the post-partum period. This involved women opting out of prenatal screening tests that are deemed necessary by health care professionals such as: gestational diabetes tests, blood tests, tests for vaginal bacteria, and ultrasounds. Women also refused to being weighed and having their fundal height measured at doctor appointments. After becoming informed on the risks of tests (i.e., ultrasounds), and becoming educated on the low risk of having complications (i.e., gestational diabetes) women were confident in their decisions to opt of routine medical checks. However, women revealed that nurses and doctors treated them negatively and made them feel like delinquents for resisting medicalization. Women also reported that when they dismissed these medical tests doctors (i.e., obstetricians) and nurses tried to scare them into doing the tests by highlighting the risks of not having tests done. Participants highlighted how the medical professionals attempted to coerce them into these

tests when they refused them. Zoe's quote illustrates her experience resisting medicalization.

> *It was very hard for me to attend those prenatal sessions, because I would arrive and they would say, "okay dear, we would like to weigh you now," and I would say "no, I am fine, I don't need to be weighed," and they would say "oh well its part of our policy," and I would say "yeah that's fine, I am declining." Then they would say, "well its time for an ultrasound," and I would say, "no thanks I am not having an ultrasound." Each appointment would involve them bringing in the obstetrician, who would sit down and have a nice talk with me to explain to me why I am wrong. It was just this incessant coercion; I cannot use another term, just pure coercion. So they found me infuriating, and I found the whole process infuriating* (Zoe).

Many women also opted out of meeting with obstetricians and other doctors during their pregnancies and post-partum periods because they believed that they were healthy and did not have symptoms that warranted medical attention. Many women also resisted medicalization by monitoring their own prenatal care that was characterised by eating healthy, getting adequate exercise, and resting well. Women also resisted medicalised post-partum care. For example, women reported having vaginal tears after childbirth and leaving them to heal on their own rather than receiving stitches. Women used techniques such as keeping their legs closed and bathing in herbal remedies to heal their vaginal tears. Women also felt confident in knowing their bodies and knowing if something was wrong, and therefore decided not to get their own health status monitored after giving birth at home. Moreover, if women did want a second opinion on a complication, such as vaginal tearing, they would ask their birth attendants to observe their tears and give them their opinion.

Although participants actively resisted medicalization during their pregnancies, home births, and post-partum periods they often discussed their natural, home birth experiences in comparison to their own medicalised births or medicalised births they had witnessed. For example, women revealed that they did not go into labour until they were at least forty-two weeks pregnant and they waited to go into labour spontaneously or used natural labour induction techniques (i.e., herbal remedies). The participants discussed how their ability to make an informed choice to wait until their bodies went into labour naturally (or wait until their babies were ready to come out) would have been dashed if they had been in the hospital to give birth. A quote by Monica illustrates how she compared waiting for her baby to come naturally to what she believed would have happened if she was in the medicalised context:

> *I had a lot of people caring and they were not threatening or pressuring me, there was no threatening about the baby dying there was no, "you are overdue, we need to induce," there was none of that, it was just the baby is going to come when the baby comes* (Monica).

The notion that women who birth at home compare their experiences to medicalised birth has been echoed in previous literature (e.g., Miller, 2009; Chadwick & Foster, 2013; Chadwick, 2014). For example, Miller (2009) argues that because of the dominance of the medical discourse surrounding childbirth women who give birth unassisted by anyone describe and compare their experiences to the medical model even though their aim is to resist it entirely. Moreover, women draw on medical discourse by the language they use to describe their home birth experiences (Miller, 2009), and women make sense of their birth experiences and tell their stories by negotiating the medical discourse with alternative and

relegated discourses of natural childbirth (Chadwick & Foster, 2013). Chadwick (2014) also found that women who give birth at home in South Africa experience home birth as fun, pleasurable, and normal, disrupting the socially pervasive notion of childbirth as a horror story or a medical event prone to dysfunction and complication. However, Chadwick discusses how these positive home birth stories can be paradoxical. She argues that on the one hand positive home birth stories are important for providing counter stories to pervasive medicalised birth stories, however they can also be silencing to traumatic birth stories. Moreover, she argues that home birth stories can be linked to disempowering natural childbirth discourses that require women to have good birth experiences in order to succeed as good mothers (Chadwick, 2014). Although it could be the case that women give birth at home in order to meet ideological expectations of being a good mother (Chadwick, 2014), the participants in the present study emphasized their ability to make informed choices for themselves and their babies my becoming educated and resisting medicalization. For participants in this study, having authority over their home birth experiences was the bottom line and the pathway for this to happen was to make informed choices regarding their care.

Home Birth Support

Another category that emerged out of women's home birth stories was the importance of their home birth support. Many of the women in this study hired home birth attendants to assist them during their birth and paid them out of pocket for their services. Women depicted the support they received from their birth attendants positively. Women appreciated how their birth attendants took the time to develop a relationship with them and their partners prenatally. Further, women were happy with the treatment and

assistance they received during their birth process by their birth attendants. Women revealed their birth attendant were "hands off" in the sense that they did not provide any medical assistance (i.e., vaginal checks) to them. But rather, birth attendants were there solely for the purpose of supportive encouragement and to take care of the environment during the birth process. Some of the tasks they covered were making sure women were drinking water during labour, preparing birth pools, helping women find a comfortable position while birthing, helping women to breath through contractions, cleaning up sheets and/or pools after birth, and doing women's laundry. Women were extremely happy with the home birth support they received as illustrated in Emily's quote below.

> *Oh my gosh my birth attendant was my little guiding light, she was so good and because I was starting to breath too heavy or maybe making more sound which I didn't need to be, she was just bringing me back down and it was really relaxing* (Emily).

Women felt that the support they received from their birth attendant was well worth what they paid for, however many women only hired a birth attendant for their first home birth experience because of the cost. Moreover, women felt comfortable giving birth all on their own, also known as unassisted childbirth (Dannaway, & Dietz, 2014), after having a home birth assisted by a birth attendant. Women decided to give birth unassisted because they realized they could do it on their own and felt they didn't need assistance from anyone and they underscored the importance of trusting their bodies to give birth. Although some women had unassisted childbirth experiences they still wished to have family and friends in their house be part of the birth experience. When women were talking about their home birth support it was clear that they had positive and peaceful home birth experiences, whether they were assisted by birth attendant or unassisted. All of the women also

reported feeling empowered after giving birth at home and felt that there infant had a positive and gentle start to life. Some women reported feeling ecstatic and euphoric after giving birth at home, and many women reported feeling on top of the world. Zoe discusses her emotions when she gave birth at home.

> *It was just transient; I was flooded with the most intense feelings of joy, and ecstasy and relief and adoration for this tiny baby . . . I felt really in love with the process and everyone who was there, it was completely life changing and I think the experience of feeling so powerful and so happy really, that first birth completely changed my life* (Zoe).

Interestingly, many of the women in this study were stumped when I asked them if there was anything that would have made their home births better, or what they would have changed about their home birth experiences. Women revealed that they would change nothing about their births and that nothing could enhance their experiences. Moreover, they believed they were the best birth experiences they could have possibly had. Women discussed receiving individualised, personalized, and woman's centred care from their home birth attendants, which they believed, was imperative for their childbirth experiences.

Birth Philosophy

The last category that emerged out of women's home birth stories was a shared philosophy regarding birth. Women's birth philosophy regarded how they believed birth occurs and how it should be managed after experiencing their home birth. Women developing the philosophy that birth is a natural, physiological process and that it is best to be left alone to occur spontaneously. Many women also considered birth as a sacred event

that should take place in a similar setting as when they conceived their child. For example, many women reported giving birth at home with their lights dime, candles lit, and in a quiet environment, similar to the level of intimacy they had during conception. While some women wanted to have the support of their birth attendants or partners, some women also described labouring and giving birth in a room all by themselves while their families were in another room. Participants highlighted the necessity for birth to occur on its own without any disruptions as illustrated in Monica's quote below.

> *I don't want anyone there while I am labouring which is why I go to bathrooms . . . I learned very early that I am not someone that you help have a baby* (Monica).

Women also shared a common viewpoint after their home birth experiences regarding how birth represents a fundamental woman's right issue. Women believed that birth is a fundamental woman's right issue because they believed women should be treated as smart enough to have the responsibility and authority to choose where she gives birth (home versus hospital) and with whom (i.e., family, friends, birth attendant) she gives birth. Similar to previous research (Rúdólfsdóttir, 2000) women in this study also highlighted the importance of birth as a life altering experience in a woman's life affecting her physically, emotionally, and spiritually. Below Serena illustrates how she views birth as spiritually moving.

> *I think that there is something extra sensitive and special and deep for women that really touches down to her soul when she gives birth* (Serena).

Lastly, a sensitizing concept that participants discussed was their belief that midwifery services were not the answer to medicalised birth in New Brunswick. Participants discussed the fact that midwives are still medical professionals that have

policies they have to follow whether they attend hospital or home births. Moreover, participants believed that a woman could not have full authority over her birth when a midwife had guidelines to follow, such as not being able to attend a home birth if the woman was overdue (over 41 weeks pregnant).

Discussion

The purpose of the present study was to explore women's home birth experiences in New Brunswick, Canada. Previous research has revealed that women endure negative experiences when giving birth in Canadian hospitals (Fox & Worts, 1999; Rosenthal, 2006; Jimenez, Klein, Hivon, & Mason, 2010; Verreault et al., 2012), yet women who give birth at home in Canada tend to have positive experiences (Janssen, Henderson, & Vedam, 2009; Hutton, Reitsma, & Kaufman, 2009; Murray-Davis et al., 2012). However, this research has focused on how midwives played a crucial role in women's home birth experiences. Furthermore, this previous research was conducted in provinces that have publicly funded midwifery services available to women if they wish to give birth at home. However, none of this research focused on exploring the experiences of women who give birth at home in New Brunswick where midwifery services are not available. As well, no research has examined where women draw social support to make the decision to give birth at home and who they receive support from during their home birth experiences in New Brunswick. Thus, the present study provides insights into 1) women's decision making processes to give birth at home, 2) women's strategies to find support and knowledge to give birth at home, 3) women's overall childbirth stories (i.e., home and hospital experiences), and 4) how they think about their overall childbirth experiences.

Overview of Findings

Women's childbirth stories represented journeys in which they navigated their paths to home birth similarly. Women's journeys began with undergoing childbirth or miscarriage experiences in the hospital that were traumatic, negative, or subpar. Women wanted natural, non-medicated births and their expectations were not met in the hospital.

Then, when women became pregnant again they were active in finding ways to become educated on alternatives to hospital birth in New Brunswick by attending home birth support groups and workshops. By doing this women met and hired home birth attendants who educated them during their pregnancies. After becoming educated on the risks of medical interventions, the unnecessity of routine medical tests, and the normality of childbirth women resisted the medicalization of pregnancy and childbirth. Women also resisted medicalization by opting out of routine medical examinations and decided it was unnecessary to seek medical attention any time during pregnancy, birth, and the post-partum period unless they had a symptom that warranted medical attention.

The next stage of women's journeys involved women having their first home birth experience with the support of a home birth attendant. Women admired the care they received from their birth attendants and revealed having empowering and positive home birth experiences. The next part of the birth journey for many women involved giving birth at home unassisted. This journey from hospital birth, to home birth with a birth attendant, to unassisted birth at home, evolved from the feeling that women could give birth on her own. Further, after women in this study experienced home birth they revealed sharing a common philosophy on birth that emphasized the normality of birth as a natural, physiological process. Women also viewed birth as a fundamental woman's right issue in which women believed that women should be able to give birth with whom and where they desire. Lastly, for many women giving birth at home was a life-changing event that affecting them physically, emotionally, and spiritually.

Theoretical and Practical Implications

Women go through childbirth journeys that often began in the hospital context and end in the comfort of their homes. But what does this mean? As aforementioned, prior to the introduction of hospitals women gave birth in the comfort of their homes attended by women midwives who learned through experience how to assist birthing women (Cross, 2014). However, after the invention of technologies that could be used to assist birth, women lost authority over their birth processes and it was passed to male physicians and surgeons (Wertz & Wertz, 1979; Massey, 2005). While medical inventions had the positive outcome of treating complications and decreasing maternal mortality rates, medicalization has also had detrimental outcomes to women's embodied experiences of childbirth (Mennill, 2014). The findings from this study illuminate how women are usurping authority over their childbirth experience at home that was taken away from them in their initial birth experiences in the medicalised context. Furthermore, the finding that women are hiring home birth attendants, who are women from home birth communities rather than trained health care professionals, mimics the pattern of traditional midwifery that took place centuries ago (Cross, 2014).

Research also suggests that women's birth experiences can play an influential role in how they transition into motherhood and shape their identity as a mother (Dahlen, Barclay, Homer, 2010). Moreover, having positive birth experiences rather than experiencing trauma is a step towards women having a positive transition into motherhood (Dahlen, Barclay, Homer, 2010). The women in this study represent a sample of women who had positive experiences without adverse outcomes for themselves or their infants. Given the plethora of research that reveals women's negative experiences of giving birth in Canadian hospitals (e.g., Fox & Worts, 1999; Rosenthal, 2006) the current research should be used to

promote change to New Brunswick's health care system specifically surrounding childbirth practices. Given that women had positive experiences both physically and psychologically giving birth at home alternatives to hospital birth should be made publicly funded and available in New Brunswick.

Research also suggests that negative and traumatic birth experiences can lead to post-partum depression (PPD) and in some cases Post Traumatic Stress Disorder (PTSD) after childbirth (Rosenthal, 2006; Verreault et al., 2012). These are considered psychiatric illnesses that negatively affect women and their infants in an array of ways (Hunker, 2007). For example, women with PTSD can have difficulty breastfeeding, difficulty bonding with their infants, and problems parenting to name a few (Bailham & Joseph, 2003). Notably, one Canadian study revealed 8% of women experiencing depressive symptoms in the post-partum period therefore it is considered a major public health concern in Canada (Dennis, Heaman, Vigod, 2012). Given that birthing complications play a role in the development of these psychological sequelae it is important to maximize women's ability to have a positive birth experience in order for women to have a positive transition into motherhood (Dahlen, Barclay, Homer, 2010), and to avoid enduring psychiatric suffering at a vulnerable and life-changing time in women's lives. The women's stories in this study illustrate how this positive transition is possible.

Women in this study had positive and empowering birth experiences without medicalization. The experiences revealed by women in this study represent an opportunity to how educate health care professionals about the benefits of non-medicalised birth and educate governmental bodies on the benefits of funding home birthing practices with home birth attendants. Moreover, the way birth is viewed, as a medicalised event, should be

problematized among health care professionals in this province. If health care professionals had knowledge on natural childbirth women could readily make informed choices about their care during pregnancy, childbirth, and during the post-partum period without feeling reprimanded by health care professionals. This study sheds light on the fact that women actively circumvent medicalised childbirth meanwhile having a positive birth experience and therefore a positive transition into motherhood.

Strengths & Limitations

Like any other research project this study has both strengths and limitations. One of the major strengths of this study is that the Grounded Theory methodology allowed for an exploratory analysis derived directly from women's lived experiences (Glaser & Strauss, 1967; Stebbins, 2001). However, because this study represents a preliminary analysis, the present findings cannot be considered as exhaustive of the information contained in the data. Because this study is exploratory and the first of its like, future research is needed in order to be able to generalize these findings. Concatenation of studies on home birth in New Brunswick and Canada-wide is required in order to ensure the reliability and validity of these findings (Stebbins, 2001). Although this is the case, given that the data conducted in this project included 14.5 hours of recorded interviews there is a lot of information and, because it is first-hand accounts, the data is very rich. Also, I was an outsider conducting these interviews and I shared the fact that I had only hospital births with participants during the interviews. It is possible that having been an insider would have allowed participants to feel more comfortable talking freely about their experiences however being an outsider also allowed me to delve into unclear issues deeply.

Conclusion

Although midwifery services are unavailable in New Brunswick women nevertheless give birth at home happily and healthily. Women in this study reported feeling empowered by their ability to birth at home, and many women had euphoric and life changing birth experiences giving birth at home in New Brunswick. The main finding from this study is that women's childbirth experiences represent a life journey that involves: women enduring negative childbirth or miscarriage experiences in the hospital, women becoming educated on home birth options in New Brunswick, women actively resisting medicalised childbirth, women hiring home birth attendants, and lastly, women giving birth at home unassisted by anyone. This is a novel area of research that must be further researched however it sheds light onto the imperative of women's ability to make informed choices and underscores the importance of women receiving individualised care during their childbirth experiences. This study exemplifies an alternative to medicalization chosen by women that allowed them to have a positive transition to motherhood at the life changing time of childbirth.

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