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Therapeutic Landscapes of Home: Exploring Women's Perceptions and Experiences of Home as a Place of Birth in London, Ontario

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Geography

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Abstract

Home birth is a very controversial issue in today's research literature. Using a therapeutic landscapes approach, this thesis focuses on the perception and experiences of home as a place of birth in London, Ontario, Canada. Thirty interviews were conducted during the summer of 2014 with women who lived in the London area and either planned a home birth in the previous two years or were currently pregnant and planning a home birth. Results demonstrated that women chose home birth, and did not choose hospital birth, due to the need for comfort, control, and support. Key themes around barriers included overwhelming criticism, a lack of information, not enough midwives, and the absence of an alternate choice in birth location. Findings from this study contribute to the literature by providing a unique geographical perspective to women's health. Policy applications range from the local to federal level and involve such elements as providing a more relaxing and welcoming hospital environment for women; knowledge mobilization within the health care community; and, further acceptance of alternative locations of birth within the Ontario and Canada contexts. Future research should seek to grow the breadth of understanding of the perceptions of home as a place of birth. Similar studies at municipal levels or longitudinal studies of women's experience pre- and post-birth could fill certain gaps in the literature and give further credence to women's voices as key elements in shaping the health care system.

Keywords

Geography, therapeutic landscapes, birth, home birth, health care, sense of place, ontological security, London, Ontario

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The completion of this thesis is the finale of a long journey through graduate school. It was a journey of two advisors, three projects, and various roadblocks, but it is a journey I can look back upon and smile because it has been completed successfully. I wouldn't be here, however, without a number of important influences.

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Chapter 1

1 Introduction

This thesis focuses on the perception and experiences of home as a place of birth in London, Ontario, Canada. Thirty interviews were conducted during the summer of 2014 with women who lived in the London area and either planned a home birth in the previous 2 years or were currently pregnant and planning a home birth. The intent of the study is to examine what it is about the home that encourages women to birth there, as well as to discover what barriers the women have experienced along the way.

This chapter begins by providing a brief contextual background and introducing the reader to geographic perspectives. It touches on approaches to health geography – most particularly, therapeutic landscapes – in terms of defining home and establishing it as a geographic space of study. The research questions and objectives will be discussed, along with the current research gaps and the contributions that this thesis can provide. A description of how this thesis integrates into the broader disciplines of health geography, therapeutic landscapes, and the overall study of women's health and policy are included. The chapter concludes with a complete overview of the thesis organization.

1.1 Contextual Background and Geographical Perspective

Home birth, and whether it should be supported or discouraged in the health care system and in society as a whole, is a very controversial issue in today's research literature. Obstetricians and public metanarratives (Cheyney, 2008) speak of home birth as an unsafe, risky decision by mothers who care more about the experience of giving birth than about their health and the safety of their baby. Midwives and a small group of home birth advocates display individual, ontological narratives (Cheyney, 2008) regarding home birth as a method for enhancing autonomy, safety, and a natural birth process. Since the dominant social narrative has become overpowering, it is important to give a voice to the women who value home birth and emphasize reasons for why they choose the home for this life-changing event. This is especially important today due to the gradual increase in home birth rates (Edwards, 2005; Sjoblom, Nordstrom, & Edberg,

2006; Murray-Davis et al., 2012) and the revolutionary calls for a more humane and woman-friendly birthing system (Cheyney, 2008).

Health geography provides an ideal approach from which this topic can be studied. Health geography embodies a more holistic approach than that of its predecessor, medical geography, concerning itself with the promotion of well-being and larger social health issues rather than intervention and prevention (Dyck, 1999; Meade & Earickson, 2000; Kearns & Moon, 2002). Health geography builds a conceptualization of elements such as place and location, and geographies of health and well-being (Dummer, 2008). It considers health care structures in terms of planning processes and how people use and access these systems (Dummer, 2008).

This study focuses on the notion that health and geographies are intimately linked (Gatrell & Elliott, 2015). It has been suggested that it is not just the geography, but the place, that influences our health and well-being. The idea of place does not just include a spatial location, but encompasses the individual and collective experiences of environments and the perceptions which they develop (Eyles, 1985; Kearns, 1993). It is evident that relationships between people and their environments are an important influencer of health (Cummins, Curtis, Diez-Roux, & Macintyre, 2007).

A theoretical framework often used in health geography studies is therapeutic landscapes. Therapeutic landscapes can be defined as “places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing, and the maintenance of health and well-being” (Williams, 1998, p. 1193). This thesis employs this framework in order to look at the aspects of home that give women a positive psychological attachment to this place and encourages them to birth there. My goal is to understand why the home is a place of health and healing and how it evolved to represent safety and comfort for those who choose such a setting. This will further allow us to gain knowledge around the inextricable connections between health and place.

Home birth rates are on the rise (Edwards, 2005; Sjoblom et al., 2006; Murray-Davis et al., 2012). More and more women are choosing home birth, however there is very little

research looking at what it is about the *home* that encourages women to birth there. A lot of the studies look at what it is about the hospital that encourages women to not birth there, but only one (Abel & Kearns, 1991) looks at what aspects of the home – also by employing therapeutic landscapes – encourage women to birth there. This takes a more positive look at a woman's preferred birth space and can give key insight to policy makers and hospital designers about how we can better serve birthing women and what it is about a specific environment that appeals to them. I also hope to gain insight into how to properly care for and integrate home birth women into our health care system so that all women are fully supported in their choice of place of birth.

1.2 Research Question and Objectives

Despite the integrated health care system in Ontario, where midwives have hospital privileges and are financially covered under our health care program, women are still experiencing barriers when it comes to choosing home birth. By asking home birth women *why* they choose home as their place of birth, I hope to bring to light the perceived advantages of home and disadvantages of hospital that these women experience. By analyzing the needs and barriers that they have encountered, we have the opportunity to create a health care system that is inclusive for home birth women, and therefore more inclusive for *all* women.

Given the above-noted context, my thesis seeks to answer the following questions:

1. Why do women choose home as a place to give birth?
2. What barriers do women experience in London, Ontario, Canada, when they choose home as a place to give birth?

The research questions are supported by the following six objectives:

- i. To establish an understanding of the existing studies on why women choose home birth, along with the methodologies used.
- ii. To examine the literature and establish a brief timeline/understanding for the progression of therapeutic landscapes.

- iii. To determine which aspects of the home environment encourage women to choose home birth.
- iv. To determine what common barriers exist for women who have chosen home birth.
- v. To recommend measures to mitigate potential barriers
- vi. To establish policy implications at the municipal, provincial, and federal levels to improve the home birth experience for women who choose it.

1.3 Potential Contributions of this Research

Findings from this study will contribute to discussions within health geography and can be used in order to further improve the knowledge of why women choose the place of birth that they choose.

Research has been completed asking a similar question to that of this paper, '*Why do women choose the home as a place to give birth?*', however each work approaches this issue from a different background, with varying questions, and diverse research methods. A comprehensive list, with attributes and research methods, of these studies can be found in Appendix A. This thesis will analyze these previous studies to show where this research will fit within current literature as well as indicate how this study will fill current gaps in research regarding why women choose the home as their place to give birth. Given the recent rise in home birth rates, this research will strengthen the understanding of therapeutic landscapes and its use in home birth and choice of birth place studies. Further, when considering the lack of research in Canada and Ontario that uses therapeutic landscapes as a means to analyze why women choose home as their place of birth, it is hoped that this thesis will provide a guide for future research.

This thesis has the potential to contribute towards the development of policy in multiple areas. First, hospital design could be improved upon based on what aspect of the home gives the perception of safety and comfort. Bringing those aspects into the design of a hospital could aid in bringing the feeling of home, and the healing properties that it may have, into the hospital. This type of policy development can aim to remove many limitations of hospital birth for women who want a home birth, but medically are unable

to choose this place of birth, or to improve the healing feelings of home for home birth women who end up transferring to hospital during labour. It also has the added benefit of bringing home-like and calming feelings to all birthing women, even those who did not choose home birth. Second, by understanding why women choose home as their place of birth, we can start to acknowledge that their choice is grounded in safety and comfort; that it is not a frivolous decision made from a lack of knowledge; and, that their choice is the best location for them. We need to acknowledge that health care cannot be a one-size-fits-all mentality and that some women require a different environment during labour and birth compared to others. As such, policy needs to support the fact that home birth and hospital birth are the right choices for different women, and therefore should be equally supported in the health care system. Lastly, understanding the barriers women face when choosing their preferred birth place is essential in creating a health care system that encourages equal and fair access for all women. This thesis aims to highlight the barriers that home birth women encounter, so that policy can be developed to try to remove these barriers for women who feel the home is the best therapeutic environment, and therefore the best location, to give birth.

1.4 Organization of Thesis

This thesis is organized into five chapters, inclusive of this introduction. This chapter establishes a brief background of health geography and therapeutic landscapes as a philosophical approach to the study of *home* as a geographical space. The research questions and study objectives are also highlighted.

Chapter 2 gives a more in-depth review of the literature relevant to this study. It establishes key historical timelines for the study of therapeutic landscapes, common methodologies including a deeper understanding of therapeutic landscapes, and important findings and trends with respect to the study of home birth and home as a place in the fields of health and health geography, while noting gaps in the literature for current and future study consideration.

Chapter 3 focuses on the methodological approach to the study. It introduces and acknowledges my possible biases by looking at my unique background and experiences.

This chapter also discusses the requirements for participant selection and the usefulness of in-depth interviews. The chapter concludes with a brief overview of the data analysis techniques and outlines the benefits of using qualitative data analysis software.

Results from the in-depth interviews are compiled and evaluated in **Chapter 4**, with a focus on capturing the perceptions of research participants and their experiences of choosing home as a place of birth. Themes about why women choose home birth that emerged through thematic analysis were perceptions and experiences around comfort, control, and support.

Finally, **Chapter 5** discusses the results more fully within the broader constructs of home and therapeutic landscapes. Key findings are synthesized and further considered with respect to prevailing literature, which lead to important methodological and policy considerations for home birth practices in general. The chapter also summarizes limitations as well as potential areas for future research. The aim is to begin the establishment of a framework to better inform and serve those individuals who choose home birth, while understanding their motivations for doing so.

Chapter 2

2 Literature Review

This chapter will discuss three essential areas of understanding for this research. First, I will analyze the existing literature on ‘why women choose home birth’ and attempt to categorize these research studies, and the countries in which they were performed, into three broad groups of health care systems and home birth acceptance. I will explain where the study area of London, Ontario, Canada fits into these categories to give an overarching context to the research. Second, I will explain some major themes around home birth by addressing the questions: i) why do women choose home birth; ii) why do women not want to choose the hospital; and, iii) what are the barriers that may prevent home birth from being chosen. These questions will be explored based on what is currently available in the literature. Third, I will draw attention to the theoretical frameworks employed by others and then explore the structure of the therapeutic landscapes framework employed herein.

2.1 Overview of Maternal Health Care

An expansive literature search was completed looking for studies that addressed the primary research question as this paper. Fifteen papers (highlighted and summarized in Appendix A) were located that addressed the question, ‘why do women choose home birth?’

2.1.1 Three categories of health care systems

Rules and regulations about home birth differ across the globe, resulting in what appears to be three distinct categories of maternal health care systems and home birth acceptance. The three categories identified in this thesis are summarized in Table 1. Specific information for different countries where similar studies to this research were completed is included in Appendix A. Details include whether home birth midwives are accredited and have insurance and whether home births are publicly funded and supported by hospitals and the health care system.

Table 1: Categories of Maternal Health Care Systems

Category	Home Birth Rate	Example Locations	Description
First	0.1%	Finland Sweden	<ul style="list-style-type: none"> - Home birth is not part of the health care system and is not publicly funded - Relationships among medical professionals and home birth women can be dangerous due to lies and withholding of information - The metanarrative is against home birth
Second	1-2%	New Zealand United Kingdom USA Turkey	<ul style="list-style-type: none"> - Home birth is available, but sometimes hard to find - Home birth is not (typically) supported by the health care system - The metanarrative is that home birth is not safe
Third	30%	Netherlands	<ul style="list-style-type: none"> - Home birth is encouraged and supported by the health care system - The metanarrative is supportive of all birth places

The first category includes countries in which home birth is completely unsupported and accounts for only 0.1% of all births (Viisainen, 2000; Sjoblom et al., 2006; Lindgren, Radestad, Christensson, Wally-Bystron, & Hildingsson, 2010). Finland and Sweden are prime examples of this group. Home birth is not part of the health care system and is not publicly funded. In these countries, it is very difficult to find a midwife who can legally attend a woman's home birth (Viisainen, 2000; Sjoblom et al., 2006; Lindgren et al., 2010). Obstetricians and other hospital care providers have become so adamantly against home birth that many will not give home birth parents accurate information about the condition of their baby, thus scaring them into having a hospital birth (Lindgren et al., 2010). This has created a considerable distrust of the health care system by home birth women, so much so that the women will lie to their health care provider about planning a home birth (Viisainen, 2000).

The countries populating the second category of home birth acceptance include New Zealand, the United Kingdom, the United States, and Turkey. In this particular category, home birth can be regulated and available in varying degrees, but is not typically supported by the hospital system. These countries have higher home birth rates (1-2%)

(Longworth, Ratcliffe, & Boulton, 2001; Boucher, Bennett, McFarlin, & Freeze, 2009); however, they are still dominated by the metanarrative that home births are unsafe. Midwives are easier to find than in the first group, however, they typically cannot care for the patient if a transfer to hospital is required because they are not seen as part of the health care system. In instances where midwives are readily available, they choose to only work in the hospital system and provide very few home birth services. The United States is unique because it has two types of midwives and therefore meets both of these descriptors. A Certified Nurse Midwife (CNM), which technically can attend both home and hospital births, is more fully integrated into the health care system. Many, however, choose to not provide home births. The more common Certified Professional Midwife (CPM) has very little training, typically does not have insurance, and does not have any privileges to attend hospital births. Although their regulation and integration into the health care system is varied, the overall climate in the United States does not embrace home birth as an acceptable option and the metanarrative of 'hospital is best for all women' is dominant in society. Turkey is considered to belong in this category, but due to its fledging health care infrastructure and its higher maternal mortality rates, home birth may not be safe, especially in poorer, rural areas where women cannot afford to hire trained midwives and instead have very unsafe, unassisted home births (Kukulu & Oncel, 2009). In this case, a lower acceptance of home birth may have a positive influence as it can discourage women from choosing a possibly unsafe home birth. In general, these countries do not have the integrated home and hospital system in order to safely support home birth.

The third category of home birth acceptance is currently rare, and only exists to a certain extent in the Netherlands. In the Netherlands, home birth is typically encouraged and completely supported in the health care system, resulting in a home birth rate of 29% (Pavlova, Hendrix, Nouwens, Nijhuis, & van Merode, 2009). The main contributing factor is that the home birth narrative is not overpowered by the medical and/or hospital metanarrative. This is due to cultural influences that speak to the safety and naturalness of home births (Pavlova et al., 2009).

2.1.2 Maternal Health Care in Canada, Ontario, & London

Ontario, Canada is a unique case. We technically fit into the third category of maternal health care systems, where home birth is regulated, publicly funded, and integrated into the health care system. Since all midwives are properly trained and licensed, they all have privileges to practice in at least one hospital. This means that all midwives have the ability to offer all women a choice in their place of birth (Murray-Davis, McDonald, Rietsma, Coubrough, & Hutton, 2014). However, Ontario home birth rates match those of the second group where about 2.5% of women have a home birth (Murray-Davis & Reitsma, 2015). Although our health care system is created in order to support complete choice of birth place, our metanarrative has not adapted to align with the system. This misalignment between the integrated system and societal beliefs may be most visible when we find that almost 90% of Canadian obstetricians do not support home birth (Vedam et al., 2012).

A brief history of the evolution of birth in Ontario and Canada may help to explain the process of how our metanarrative came to be what it is today and how that fits in with the misalignment of our integrated health care system. Home birth with female birth attendants used to be the normal mode of delivery, however, when hospitals and medical professionals started becoming more prominent, birth began to migrate into the new and medically advanced locations. As recently as 1938, Ontario hospital births outnumbered home births for the first time in our history (Stanger-Ross, 2006). With this change in birth location came a change in the birth attendant. The medicalization of the birthing process demanded that predominately male medical professionals oversaw birth. This new role came with a high paying salary, and as soon as large amounts of money became involved, it became lucrative to encourage women to choose a hospital delivery (Cassidy, 2006). During this transition of birth location and birth mentality, home birth drastically decreased, creating multiple generations of women (and men) who viewed the hospital as the only safe place to give birth. This model of birth cemented itself as the norm in our health care system and our narrative, until midwifery was regulated in Ontario in 1991. Since then, the rate of home births have slowly been increasing, however, the view that hospital is the only safe place to give birth is still the dominant narrative in Canada and

Ontario. Our health care system and society experienced a large shift from home to hospital for place of birth, and although our health care system is beginning to take steps to shift birth place choices to include both home and hospital, our metanarrative has proved to be slower to adjust to the latest shift in birth location choices.

Although obstetricians and the Canadian public metanarrative are of the belief that it is safest for all women to deliver in a hospital, studies such as Hutton, Reitsma, & Kaufman (2009) and Janssen et al. (2009) have shown that planned home births in Ontario, and Canada, are associated with positive outcomes for both the mother and baby when:

- i. Midwives are integrated into the health care system;
- ii. Midwives and women have good access to emergency services;
- iii. Good communication exists between all maternity care providers;
- iv. Supportive relationships among all maternity care providers are viewed as an essential part of care, especially when serious complications occur; and,
- v. All maternity care providers ensure that both mothers and babies receive the best possible care (Ontario Better Outcomes Registry & Network [BORN], 2011).

This level of integration and support among maternal health care providers also has an added benefit of using each individual care provider in an optimal manner to utilize their various skill sets. Midwives excel in normal and uncomplicated births, while obstetricians excel in high-risk and emergency births (Murray-Davis et al., 2012).

Appropriately leveraging the various skill sets will create a better health care system. It should be noted that although Ontario and some other provinces have an integrated system, the communication and supportive relationship pieces appear to be areas in need of improvement, especially considering the previously mentioned statistic that almost 90% of Canadian obstetricians do not support home birth (Vedam et al., 2012).

To the best of the author's knowledge, Murray-Davis et al. (2012 & 2014) are the only Canadian studies focusing on how woman come to choose home birth that have been completed since the regulation of midwifery and home birth in Canada. Due to the unique circumstances of our misalignment of the health care system and societal beliefs, Canada is in need of more research to indicate why women choose the home as a place of birth

and how we can improve the system to increase our support of home birth. This could be accomplished through the education of society as a whole, focusing on female populations and health care providers, and strengthening the home birth narrative. Ontario is the ideal location to complete this study as it has the longest history of regulated midwifery in Canada (Kaufman, 1998), and has the largest number of home births compared to all other provinces (Hutton et al., 2009). We have an opportunity to transform our metanarrative both provincially and federally by allowing women to freely choose their place of birth. This could be an opportunity for Canada and Ontario to show other countries that, by enhancing education and choice of place of birth, we can have a healthier and happier birthing culture, while at the same time potentially reducing the burden of increasing health care costs.

Today, hospitalization due to childbirth is the number one reason for Canadians to be hospitalized (Canadian Institute for Health Information [CIHI], 2014). As a result, hospital birth accounts for 10% of all costs related to inpatient care in hospitals (Canadian Institute for Health Information [CIHI], 2006). This means that maternity care and birth accounts for a large proportion of our provincial and federal health care spending. Table 2 shows the average cost for varying types of hospital births.

Table 2: Canadian Cost of Birth by Place of Birth and Type of Delivery

Place of Birth	Method of Delivery	Examples	Cost	Data Years	Source
Hospital	Vaginal delivery (uncomplicated)		\$2,700	2002-2003	CIHI, 2006
Hospital	Vaginal delivery (complicated)		\$3,200	2002-2003	CIHI, 2006
Hospital	Vaginal delivery (average)		\$2,800	2002-2003	CIHI, 2006
Hospital	Caesarean Section (uncomplicated)		\$4,600	2002-2003	CIHI, 2006
Hospital	Caesarean Section (with complicating diagnosis)	Fetal distress, obstructed labour, & fetus malposition	\$5,200	2002-2003	CIHI, 2006
Hospital	Deliveries with major procedures	Hysterectomy & surgical postpartum repair.	\$7,700	2002-2003	CIHI, 2006
Hospital	Obstetrical care delivery (average for all births)		\$3,000	2002-2003	CIHI, 2006

The cost of a vaginal delivery in a hospital ranges on average from \$2,700 to \$3,200, while a caesarean section ranges on average from \$4,600 to \$5,200, depending on whether there are complications or not. The average cost for obstetrical care for a hospital delivery in Canada is \$3,000. Even though vaginal deliveries are the least expensive mode of delivery, they account for more inpatient spending than the combined spending for all other methods of delivery (CIHI, 2006). This is because they account for the large majority of all hospital births. Some vaginal deliveries, such as a complicated vaginal delivery; a VBAC (or vaginal birth after caesarean) delivery; or, a vaginal delivery from a woman who has other health complications, are high-risk. Therefore, these need to be performed in a hospital under the care of an obstetrician. However, 70% to 80% of all women start their labour as a low-risk pregnancy (World Health Organization [WHO], 1996) and 43% of all Canadian births actually result in an uncomplicated, vaginal delivery (CIHI, 2004). This is the group of women that have the option to birth at home, if that environment is deemed ideal for her needs and well-being.

An uncomplicated home delivery with a midwife requires fewer resources and results in fewer interventions. Cost savings have therefore been noted in Canada (Blais, 2002), the United States (Anderson & Anderson, 1999), and the United Kingdom (Henderson & Mugford, 1997). Some studies found that the cost of an uncomplicated home birth ranged from 49% to 76% less than that of an uncomplicated vaginal hospital birth (Anderson & Anderson, 1999; Beech, 2012). A study in British Columbia, Canada (Janssen, Mitton, & Aghajanian, 2015) found that a planned home birth costs 50.7% less than a hospital birth with a midwife and 52.8% less than a hospital birth with a physician. Even in the hospital, midwife-attended births result in earlier discharges due to fewer interventions, thereby reducing costs compared to physician lead births (Johnson & Daviss, 2005; Janssen et al., 2015). This means that midwives reduce the costs of birth in hospitals, and then greatly reduce the costs of birth when it takes place in the woman's home. Since 43% of all Canadian births are uncomplicated vaginal deliveries, this means that a midwife could attend 43% of all Canadian births. If these took place in a hospital, it would result in a small cost savings. However, if more of these births took place at home, this cost savings could have a substantial beneficial impact on regional, provincial, and federal health care costs.

In a 1994 survey by Statistics Canada, 31% of Canadian women indicated that they would go to a birth centre instead of a hospital to give birth to their baby (Wen et al., 1999). Unfortunately, since that survey, we only have 2 pilot birthing centres in Ontario right now, located in Toronto and Ottawa. Their current capacities are quite small due to their nature of being a pilot study. For most women in Ontario, and for all women in this study, the only two options for place of birth are hospital or home. During 2013-2014 in Ontario, 2.49% of women gave birth at home, while 0.03% chose a birth centre and 97.35% chose hospital (Murray-Davis & Reitsma, 2015). In the South West Local Health Integration Network (LHIN), which includes the London area in its boundaries, home birth rates have increased from 2.85% in 2009-2010 (Ontario Better Outcomes Registry & Network [BORN], 2011) to 3.11% in 2011-2012 (Ontario Better Outcomes Registry & Network [BORN], 2013). This represents a rise in home birth rates of 0.26% in only a two year span. If all women were given an educated choice in terms of place of birth, we do not currently know how many of these women would choose home instead of the birthing centre or hospital. However, since 31% of Canadian women would be willing to give birth in a birthing centre instead of a hospital, it shows that there is a large population of women who seek a viable alternative to a hospital. By looking at creating a health care system that supports these other locations of birth place, this will allow women to not only choose the birth place location that best suits her and her needs, but it will also have the added benefit of reducing our maternity health care costs.

2.2 Home Birth Explained

According to literature, home birth is chosen by well-informed women who know the options that are available to them, whereas the women who choose hospital birth may be less informed of the alternatives and most assume that a hospital birth is their only option (Madi & Crow, 2003). The literature illuminates many reasons why more informed women may choose home birth. One of the main concepts is the need for control, autonomy, and empowerment (Hodnett, 1989; Kearns, 1993; Lothian, 2006; Boucher et al., 2009), which is consistent in today's culture through global growth in women's rights and their ability to control their own bodies, or personal space, especially during birth (Lothian, 2006). Pavlova et al. (2009) explained that higher educated women tended to

want more say in the decision-making process. Choosing home birth gives them more control over the entire process. Some researchers have also described the hospital as a gendered institution (Kearns, 1993) where ‘male’ doctors know best and therefore make the decisions, regardless of whether the birthing woman agrees with them (Lothian, 2006). This may lead to a negative hospital birth experience, which, according to Boucher et al. (2009), is one of the most common reasons for choosing a home birth. Furthermore, safety and the need to avoid medical interventions that women may feel are unnecessary, form other reasons for why women may choose home birth (Boucher et al., 2009). Olsen and Jewell (1998) confirmed these fears by discovering that low-risk women who plan a hospital birth may increase their risk of unnecessary interventions, and resulting complications, without any known benefits.

Literature also points out that women choose home birth due to the ability for family to become involved (Hodnett, 1989; Kearns, 1993) and for the opportunity to give birth to a new addition of their family in the comfort of their own home. There are no limits to the number of support people allowed in the room, as opposed to most hospitals which have a policy stating that only two support people are allowed in the birthing room with the woman, and there is little risk of intrusion by strangers or hospital staff during this private event (Kearns, 1993). Beyond privacy, it is important to understand what feelings the home creates. When women are at home they have a sense of belonging, of having their own space, of being in the place where they raise their families, and all of the good emotions that come with this important place (Borquez & Wieggers, 2006; Kearns, 1993). When women feel comfortable and relaxed they are able to trust their body’s ability to give birth and this reduction of fear results in the need for less intervention (Borquez & Wieggers, 2006). Feeling safe and comfortable during birth is therefore a key contributor to actually having a safe birth. This is a paramount motivation for why this research has chosen to look at birth within the theoretical framework of therapeutic landscapes. Therapeutic landscapes accounts for the feelings that the home contributes to a woman during her birthing process. This knowledge is essential in informing the development of programs aimed at supporting home births as a safe, empowering, and cost effective birthing environment.

2.3 Health Geography

Health geography is a great field in which to look at this problem. Emerging from medical geography, which focuses on the prevention and treatment of illness, health geography embodies a more holistic approach concerning itself with the promotion of well-being and larger social health issues (Dyck, 1999; Meade & Earickson, 2000; Kearns & Moon, 2002). It “conceptualizes the role of place, location and geography in health, well-being and disease” (Dummer, 2008, p. 1177). Health geography also looks at health services in terms of planning processes and how people use and access the health care system (Dummer, 2008).

This thesis is based in one of the core health geography tenets, that our health and our geographies are intimately linked (Gatrell & Elliott, 2015). Further, it is not just the geography, but the place that influences our health and well-being. The idea of place does not just include the spatial location, it encompasses the experiences of people in their environments and the perceptions that they have about their surroundings (Eyles, 1985; Kearns, 1993). It is now clear that the relationship between people and their settings is an important influencer of health (Cummins et al., 2007).

2.4 Theoretical Frameworks

Only three of the studies included in Appendix A specifically indicated the theoretical framework from which they worked during data collection and analysis. This research will add to current literature as it will collect and analyze data using therapeutic landscapes as its theoretical framework.

Boucher et al. (2009) posed a written question to women asking, “Why did you choose home birth?” (p. 119). The question was very simple and left much to the interpretation of the woman. As such, the authors indicated that the answers were specifically analyzed using the cultural care diversity theory created by Leininger (Boucher et al., 2009). This theory is aimed at nurses to better prepare them to serve the diverse needs of varying cultures (Boucher et al., 2009). Boucher et al. (2009) view home birth women as a minority, or differing, culture from which nurses need to provide “culturally congruent

nursing care” (p. 120). Their goal was to educate nurses on how to treat this minority group differently from the way they have been treating women from the dominant metanarrative portrayed by hospital birthing women, the media, and obstetricians (Boucher et al., 2009).

While Boucher et al. (2009) takes an approach where the responsibility for change is placed on the nurses and caregivers, Cheyney (2008) places the responsibility for change with the home birth women themselves. Cheyney (2008) asks many questions over the course of her interviews focusing on ‘What made women choose to deliver outside the hospital system?’ and analyzes the narratives from a critical medical anthropology perspective. With this framework, the goal is emancipatory because it views the women as explicitly able to permanently change the system to align with their needs (Cheyney, 2008). It “converts medical problems into social and political issues” (Cheyney, 2008, p. 255) to create an environment for change.

This paper will use the theoretical framework of therapeutic landscapes while questioning and analyzing the women’s responses. This differs from Leininger’s theory and medical anthropology inasmuch as it does not have the purposeful aim to create change. Instead, this research aims to discover and understand specifically how a place comes to represent safety and comfort.

2.4.1 Therapeutic Landscapes

2.4.1.1 *Definition and history*

Therapeutic landscapes can be defined as “places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing, and the maintenance of health and well-being” (Williams, 1998, p. 1193). Its definition encompasses a vast number of environments, be them physical, psychological, social, or emotional places (Williams, 2002; Rose, 2012) that are created by people because they are perceived to have health and healing properties (Williams, 2002). Studying therapeutic landscapes allows us to gain knowledge and understanding around the “complex interconnections between health and place” (Wilson, 2001, p. 347).

Gesler first introduced this concept in 1992 when he saw a link between health geography and the newer cultural geography. He surmised, “by incorporating theory from cultural geography such as sense of place and symbolic landscapes, health geographers could begin to examine ‘locations of healing’ as symbolic systems” (Wilson, 2003, p. 84). Gesler (2005) described therapeutic landscapes as being a “quintessentially geographical concept”.

Although this concept is not new, it has grown and shifted over the course of its study and application. Originally, it was applied only to those places that had gained a reputation for ‘healing places’ and sites with special significance (Gesler, 2003); however, further research acknowledged the restrictiveness of this definition. Williams (1999) was one of the first to apply the concept to places that merely promote well-being and have reputations as ‘healthy places’ (Smyth, 2005). This shift from the act of healing to the simple maintenance of well-being was crucial for the application of this research. The evolution of its applicability has allowed it to apply to more varied places and thus, more types of analysis. The concept of therapeutic landscapes can now be applied to the study of the tranquility of nature (Williams, 1999), the community of residential neighbourhoods (Williams, 1999), and the sanctuary of a person’s own home (Abel & Kearns, 1991), the latter of which will be discussed in this research paper. Only in the past 15 years has the concept of therapeutic landscapes been applied to these more abstract places of well-being.

Smyth (2005) attempted to categorize the evolving therapeutic landscape research into three groups. The first is the original concept of ‘therapeutic places’, where geography was key and healing was linked to the literal environment of springs and topography. This included the research of Hot Springs, South Dakota (Geores, 1998), Bath, England (Gesler, 1998), and the Denali National Park in Alaska (Palka, 1999). The second is ‘therapeutic spaces’, which originated around public health needs (Smyth, 2005). This research moved away from the healing properties of the natural environment, and has instead centered on the health benefits (and negative impacts) of the built environment. Many of these studies focus on health institutions, such as hospitals (Kearns, Barnett, & Newman, 2003; Gesler, Bell, Curtis, Hubbard, & Francis, 2004; Wood et al., 2015).

However, other aspects of the built environment are also included in these studies, such as the design and social landscape of prisons (Stoller, 2003) and schools (Holt, 2003). Smyth (2005) titled the third and final category for the expansion of research based on therapeutic landscapes as ‘therapeutic networks’. This group of research studies more informal networks of support and care that typically exist outside of the traditional spaces for healing, such as in First Nations communities (Wilson, 2003), the home (Williams, 2002), and other alternative health therapies and services (Williams, 1998; Wiles & Rosenberg, 2001; Andrews, 2004).

It is important to understand that therapeutic landscapes are dependent on context, individuals, and time (Gesler, 2005). People experience these places in different ways, and over varying times, so they are not necessarily intrinsically therapeutic (Conradson, 2005; Williams, 2007). Conradson (2005) developed the concept of ‘ecologies of place’, which discusses how the interactions between people and things grow to develop a sense of place. The emergence of place therefore, is a direct result of these interactions. This explains why some people see value in a place that others do not. These people have been a part of the creation of this therapeutic place, while the others were not. Also emerging from this literature is the notion of therapeutic selectivity, whereby people have to make choices regarding which landscapes they consider therapeutic and which can no longer be (Luginaah, Smith, & Lockridge, 2010; Smith, Luginaah, & Lockridge, 2010). Many times this selection process is brought about due to the changing contamination of the land, which is especially relevant in First Nations communities due to their sacred connection to the land (Luginaah et al., 2010; Smith et al., 2010).

The ‘ecologies of place’ aspect is typically applied to marginalized groups in society, such as the homeless or the mentally ill (Bridgman, 1999; Geores & Gesler, 1999). These studies “highlight the variable ways that those in different social positions respond to their environment, and also the processes by which dominant social groups often impose on others their own sense of what is therapeutic, thereby sometimes exacerbating social exclusion of less powerful groups” (Curtis, 2001, p. 149). Although different from the typical marginalized groups in these studies, it may be beneficial to view home birth women as a type of marginalized population, simply because they are a smaller

population and their views of the home as a place of birth are drastically opposing those of the larger population and prevailing metanarrative. This dichotomy of views is apparent when discussing home birth versus hospital birth. This topic can become a very heated debate, because the larger societal metanarrative is to view the home as dangerous and unsanitary for birth. Laws (2009) talks about how certain landscapes may be seen as “unhealthy” or “unsavoury” to some, but to others these settings are seen as ideal therapeutic environments. This does not validate one person’s opinion over the others, it just emphasizes that therapeutic landscapes are not intrinsic, and instead, they are created by each individual person. This is a key concept in therapeutic landscapes literature. It is the knowledge that these spaces are perceived differently by different people.

The concept of therapeutic landscapes has evolved over the years, however there are still some gaps in our knowledge, and it is hoped that this thesis can aid in contributing to these areas of the literature. First, Wilson (2001) notes that research around specific cultural and gendered therapeutic landscapes is lacking. Although this research does not take a specific feminist view, it is hoped that adding to the literature about a quintessentially feminine therapeutic landscape will advance our knowledge in this area. Second, it has been mentioned how areas of health and well-being are greatly studied, however, places that are associated with negative health are often not considered (Wilson, 2001; Gastaldo, Andrews, & Khanlou, 2004). Although the focus of the research questions in this thesis are related to why women choose the home, this thesis also addresses why women do not choose the hospital due to the negative health effects associated with this part of the health care system.

A larger gap in the literature exists around the concept of scales in therapeutic landscapes. Gesler first asked some key questions around ‘On what scale is place encountered?’ and ‘What are the bounds of a place that has significance to those within it?’ (1991, p. 166). Often, research within therapeutic landscapes can have multiple scales. Generally, researchers have failed to address the different scales and boundaries at which therapeutic landscapes are created and experienced. Parr (1999) begins to explore this concept. The study discusses how therapeutic landscapes can exist across multiple

scales, such as the individual and the collective, when studying mentally-ill people (Parr, 1999).

However, “recent critiques have acknowledged that the traditional ways in which the concept of therapeutic landscapes has been used may not adequately inform or explain the strong therapeutic qualities of all potential therapeutic places or the ways in which individuals construct and use them” (Gastaldo et al., 2004, p. 159). It is restrictive to assume that therapeutic landscapes are created based on a physical or symbolic location and that physically visiting these locations is the only way to experience a therapeutic place (Wilson, 2003; Gastaldo et al., 2004). It becomes restrictive if the physical space is an overwhelming element in therapeutic landscape research (Andrews, 2004).

Therapeutic landscapes are created through complex interactions that can incorporate mental, emotional, physical, environmental, and/or societal experiences (Williams, 1998; Milligan, Gatrell, & Bingley, 2004). Therefore, they can become more abstract concepts, where they “may consequently be individualized, everyday, dispersed, unbounded and complexly constructed. Moreover, precisely locating, measuring or mapping them may be very difficult or even, under some circumstances, inappropriate” (Gastaldo et al., 2004, p. 159). As a result, it is essential to broaden the research to include places that are not physical in nature.

The only study, to this author’s knowledge, that specifically studied therapeutic landscapes outside of a physical location was Gastaldo et al. (2004). They studied the therapeutic landscapes of the mind that are created by new immigrants and how these individuals used mental strategies, such as the recall of memories or pictures from home, to bring aspects of their home country into their new lives in order to enhance their mental health and well-being. Therefore, although a few researchers have started to look at different scales in which people experience therapeutic landscapes, the only areas of study include immigrants and those who are mentally ill. Looking at the different scales in which women experience the therapeutic landscapes of birth will be a unique contribution to the literature.

2.4.1.2 Using 'place' studies to change hospital settings

This study hopes to illustrate why the health care system should take into account the role that place has in its effectiveness, especially when dealing with birth. Gesler et al. (2004) used therapeutic landscapes to show how it could be used in hospital design. Hospitals are being encouraged to look at the way they set up their birthing environments in an effort to “humanize” their birthing units by adding home furnishings and allowing family to become more involved in the birth (Melia, Morgan, Wolfe, & Swan, 1991). This will give women who cannot have home births or women who choose not to have home births the chance to give birth in a home-like environment (Melia et al., 1991).

“Exploring the positive, healing or therapeutic characteristics of place – an increasingly important determinant of health – is consistent with the development of health promotion throughout the world” (Williams, 1999). “While the healing properties of places are important, so too are the negative health effects associated with particular places. To understand fully the role of place in shaping health we must broaden our understandings of therapeutic landscapes by exploring the negative impacts of place experiences on health” (Williams, 1999). This research will aim to address both aspects of place by asking the questions ‘why home’ and ‘why not hospital’. I want to know why women choose the home due to its therapeutic qualities, but also why these same women do not want to choose the hospital. By attaining knowledge about both aspects, I hope to achieve a broader and more complete understanding of their decision around place of birth. Through this, I hope to further increase the awareness that place has on health.

2.4.1.3 Therapeutic Landscapes and Home Birth

Abel & Kearns (1991) is currently the only study that used the framework of therapeutic landscapes when analyzing why women choose home birth, with his area of study being Auckland, New Zealand. Similar to Ontario, New Zealand midwives were regulated in 1990, despite opposition from other medical professionals (Abel & Kearns, 1991). New Zealand has many other similarities to the Canadian maternity system, such as publicly funded births (Davis et al., 2011) and a home birth rate around 2-3% (Gulbransen, Hilton, McKay, & Cox, 1997; Murray-Davis & Reitsma, 2015). However, there are also some

stark differences, such as that fact that 78% of women choose a midwife as their lead maternity caregiver in New Zealand (Davis & Walker, 2011), compared to just under 10% in Ontario, Canada (Murray-Davis & Reitsma, 2015). The study by Abel & Kearns (1991) was completed immediately after the new regulations around midwives was created, therefore the results may be very different now than they were in 1991. Even though there are some similarities between the maternity health care systems in both locations, the study itself was completed in a place and time completely different from that of today in London, Ontario, Canada. As a result, this research will greatly extend our understanding of why women are increasingly choosing to give birth at home.

An individual can develop a personal attachment to a place that they view as a therapeutic landscape, which creates a feeling of being calm and “at home” in a familiar environment (Williams, 2002). This concept is especially relevant when researching women due to traditional ‘public’ and ‘private’ work situations, where women tend to maintain the household and thus have a unique attachment to their home (Abel & Kearns, 1991). This may prove to be an essential aspect of why the home is perceived to be safe and comforting for some women during birth.

Another aspect that may influence women when choosing their home as their place of birth is the concept of home as a place of ontological security. Ontological security is the sense that things are reliable and that there is constancy in a person’s life (Giddens, 1984; Giddens, 1991). These feelings can be related to self-identity, social relations, or material environments like the home (Giddens, 1984; Giddens, 1991). In a general sense, this term is almost akin to the idea of ‘belonging’ (Saunders & Williams, 1988). Many researchers have found that the home is the ideal place to experience these feelings related to ontological security. This is because the home acts as a secure base around which a person’s identity can be constructed (Saunders, 1989; Saunders, 1990; Low and Altman, 1992; Hill, 1996; Dupuis & Thorns, 1998; Arku, Luginaah, Mkandawire, Baiden, & Asiedu, 2011). Regular daily routines are performed here, people feel the most in control when at home, and they are free from surveillance by society when they are in their own home (Saunders, 1990; Dupuis & Thorns, 1998; Hiscock, Kearns, Macintyre, & Ellaway, 2001; Curtis, 2010; Arku et al., 2011). People can truly be themselves and at ease, they

can relax, they are free from social restrictions, and they are safe from the unpredictability of the outside world (Saunders, 1989; Saunders, 1990). This is a very important concept when looking at how our housing impacts our health. Research has shown that having the home act as a secure base improves both mental and physical health outcomes (West, Livesley, Reiffer, & Sheldon, 1986; Fonagy, 1996; George and West, 1999; Sroufe, Carlson, Levy, & Egeland, 1999; Hiscock et al., 2001). This suggests that using the home to create a sense of ontological security has substantial implications for individuals' health and well-being (Hiscock et al., 2001). This means that choosing the home as the place to give birth, due to its therapeutic and ontological security qualities, allows the healing, wellness, and safety promoting abilities of the home to regularly take effect during the woman's labour and birth, thus possibly resulting in easier and healthier deliveries for these women (Williams, 1998).

Chapter 3

3 Methods

3.1 Researcher Bias and Background

This research aimed to answer the question, “Why do women choose the home as a place of birth?” by using London, Ontario, Canada as its case study. I come from the non-medical field of Health Geography with a focus on access and barriers to the health care system. Although I have not personally given birth, I have attended both home and hospital births in a non-medical support role. This unique combination of knowledge and experience puts me in an interesting position in terms of insider/outsider perspectives. I am an outsider because I have never given birth at home, and yet I have attended home births in a support role and have seen first hand the needs and experiences of the target population. This background is very different from that of the rest of the literature and puts this research in a unique position to fill a very prominent gap.

Although Health Geographers have asked questions related to the home and its effects on health and well-being (Kearns & Gesler, 1998; Dyck & Dossa, 2007; English, Wilson, & Keller-Olaman, 2008), they have not readily asked questions in the area of home birth. This means that the influence of the home and its varying therapeutic landscapes have not adequately been analyzed as part of the decision making process when women are choosing their ideal place to give birth. Abel and Kearns (1991) studied the topic from a Health Geography perspective; however, the lead author was a medically trained midwife. Midwives, nurses, and doctors have written much of the current literature, accounting for ten of the fourteen articles included in Appendix A. Other literature is written from backgrounds in Public Health, Health Economics, Social Science and Law, and Maternity Services. This greatly favours the current literature towards a medical approach with questions that tend to be created from a medical and ‘scientific’ background. This tends to result in many of the studies utilizing quantitative analyses, which can ignore the importance of giving a voice to the women (Abel & Kearns, 1991).

It should be made clear that in many countries, midwives work in hospitals and abide by a technocratic birth model (Davis-Floyd, 1993), so midwifery as a background does not necessarily imply a woman centered, holistic mindset. Lindgren et al. (2010), which included researchers with a midwifery background, clearly acknowledged their discontent with supporting home birth in Sweden by stating, “Knowing how women perceive risks when planning to give birth at home can assist health-care professionals in communicating possible short- and long-term adverse effects for the mother and the baby” (p. 164). The researchers wanted to know why women chose home birth so that they could better inform these women of the dangers of home birth. This biomedical view may favour knowledge production towards emphasizing the unsafe nature of home births, whereas this qualitative human geography research purposes instead to simply give a voice to these women. This study will aim to inform policy makers and programs of the women’s perception of the home as the safest and most comfortable place to give birth. The goal is not to use this information to dissuade them from choosing the home, but instead to educate the system on how they can better support this group of women.

3.2 Participant Selection

Current literature studying why women choose home birth use sample sizes ranging from six (Abel & Kearns, 1991) to 50 (Cheyney, 2008) women. This study interviewed 30 women; however, using the thematic saturation sampling (Baxter & Eyles, 1997), the best number of respondents may have only been about 12 to 15 women, as this seemed to be the point of saturation. Strauss and Corbin (1990) estimate the point of saturation for interview based research studies to be 20 interview participants. Interviewing well below this level of saturation may have resulted in the exclusion of important themes. However, because of the uniqueness of the topic and the potential similarities in women’s experiences on the topic, interviewing women well beyond this point can result in too much information and a loss in the deep and intimate case-oriented research for which qualitative studies strive (Sandelowski, 2000). Although this study did interview beyond the saturation point, I feel I adequately took the time to delve into each and every story to try to maintain the intimate feel that the research aimed for.

The reason for interviewing the full 30 participants, instead of stopping once saturation was reached, was because the response rate was overwhelming and I was unable to transcribe and code the data in between interviews in order to detect saturation. Over 100 women responded to the call for participants within the first week of advertising through printed posters displayed in libraries and midwifery agencies, as well as online postings on facebook and twitter. The high demand for women wanting their voices to be heard around the issue of home birth was a strong indication of the need for this research in this study location. The first 30 women who qualified were booked for an interview at a location of their choice. Some women were excluded due to their location (outside of the London area), the length of time since their last birth, and/or their inability to meet for an in-person interview during a 3-week period for scheduled interviews.

As summarized previously, this research study interviewed women in London, Ontario, Canada who were currently pregnant and planning a home birth, women who had a home birth in the past two years, and women who planned a home birth in the past two years, but ended up being transferred to the hospital. Murray-Davis et al. (2012) highlights the importance of interviewing currently pregnant women because this allows the collection of narratives and life-stories for why they chose home birth without the persuasion or hindrance of the outcome.

Pavlova et al. (2009) furthers this by excluding women who had previously given birth because the experience they had may bias the women's opinions about home birth. The disadvantage to this selective thinking is that all women have a bias, regardless of whether they have previously given birth. Women's opinions are based on stories and experiences from friends and family and on social and cultural perceptions, so it does not seem advantageous to exclude the women who have their own, personally lived, birth experiences. It is believed that this knowledge will add to the literature, not detract from it.

Fordham (1997) added to the literature by interviewing women aged 20 to 40, regardless of whether they had given birth. The perceived advantage of this would be to get a sense of what women would do if they became pregnant in the future from women of all walks

of life. This may not truly be a good indication of women's actual choices, because women who are not, or have not been, pregnant may not have researched their options like they may do once they are pregnant. Some people are not in a stage of life where they are thinking about having children and some women have decided not to have children. These women will typically not be as educated on the options because it does not represent a topic that the woman will have to encounter. For all of these reasons, this study will include all women who are planning, or have planned, a home birth.

Another area where this research differs from the main literature is the timeframe in which women were interviewed since their last home birth. Many studies interviewed women 3 to 15 years after their home birth (Abel & Kearns, 1991; Viisainen, 2000; Viisainen, 2001; Sjoblom et al., 2006; Boucher et al., 2009; Lindgren et al., 2010; Jouhki, 2012), which brings questions about the reliability and accuracy of the data as a result of recall bias. Sjoblom et al. (2006) argues that the memories of birth remain with a woman in detail for at least 10 years, but this argument may only be applicable to the memories of the actual event. The reasons for *why* the women choose home birth may not be as well remembered. Therefore, this research completed in-depth interviews with women who were currently pregnant so as to collect information about women currently going through this process, as well as women who planned a home birth in the past 2 years. This timeframe was chosen because the birth they discussed could be remembered with more detail, a reason indicated by Murray-Davis et al. (2012), and there was less chance of having had another child born between the home birth in question and the interview.

3.3 Data Collection

3.3.1 Surveys

Even though most of the studies asking women 'why they choose home birth' have been completed using surveys (Murray-Davis et al., 2012), this research study decided against this data collection method. First, creating reliable and conclusive statistical results requires a large participant base, but since home birth rates typically do not exceed 2-3% of the total births in an area, completing surveys on this population may not yield the needed volume of responses to create generalizations that quantitative research typically

strives for. An example of this issue can be seen in Fordham (1997) when he statistically analyzes 5 women who had a home birth and compares their answers to that of 241 other women who either gave birth in the hospital or had no kids. Due to the home birth group being a small, minority population, many researchers feel that qualitative, in-depth interviews are the best way to hear the women's voices and to create accurate and reliable results based on their narratives.

Seeing that birth is a very personal and emotional event that needs to be dealt with using care and compassion, a survey approach may lack the needed human element that allows for the women's voices to be cared for. An example of this issue can be seen in Pavlova et al. (2009) when the authors argued that their research study did not require ethical approval because the survey questions were not 'personal'. This shows how removed the researchers can become from their participants. Any researcher who believes that questions pertaining to a woman's birth of a child are not personal is most likely not invested in the life stories and narratives of these women.

Lastly, since most surveys in the literature were completed using close-ended questions that were answered using a scale or by using multiple-choice questions, it can result in an oversimplification or a misunderstanding of the issue. This is because the researcher may bias the results by assuming the questions and answers provided by the researcher are the only ones that a woman would respond with and view as important to her and sometimes fails to connect with the minority group. Abel & Kearns (1991) state, "It is felt that when women are researched merely as objects, their subjective and collective experiences as women are not validated, as the frames of reference are often male-biased" (p. 829).

3.3.2 In-depth Interviews

In-depth information on women's experiences or perceptions of home birth was required; therefore I used qualitative methods, specifically face-to-face interviews. Most studies, including this research, used semi-structured in-depth interviews. This type of interview is best used to allow the women to talk at their own pace and about what is important to them. Interviews are a great way to achieve life-stories and narratives from the women who are being studied because "social research is fundamentally grounded in *talk*" (Abel

& Kearns, 1991, p. 829). Surveys can mask the emotion and importance of these women's experiences and all too often the women's voices and stories are neglected (Murray-Davis et al., 2012). Kvale (1996) and Miller and Crabtree (2004) emphasize that the advantage of in-depth interviews is the lack of standardization, which increases the interviews' validity and quality due to the focus on the women's perceptions and life stories instead of the researcher's voice.

The semi-structure comes from a thematic guideline to help keep the interviews focused around the studies themes, which are posed as grand tour questions (Miller & Crabtree, 2004). A guide for the semi-structured interview used in this research is included in Appendix C. Critiques of in-depth interviews focus on the limited amount of participants due to its time laborious techniques (Miller & Crabtree, 2004); however the amount of knowledge gained by each interview can be immense. Although this type of study can result in the creation of theory, the goal of this research is to perform an individualized case-study and bring a voice to the women and the issue being studied.

In the literature, interviews lasted between 35 minutes (Sjoblom et al., 2006) and 4 hours (Edwards, 2005) with most studies interviewing the women once. Interviews in this study ranged in time from 45 minutes to 3 hours. Edwards (2005) and Cheyney (2008) both had multiple interviews with each woman to build a foundation of trust and to get a more in-depth look at the process and changes that occur while choosing home birth. The advantage of this is great due to the interviews taking place both during pregnancy and after birth with each woman. Due to time constraints, this study achieved knowledge using only one interview per woman; however the inclusion of women who are both currently pregnant and women who have previously planned a home birth should help alleviate this deficit. Cheyney (2008) also performed participant observation during midwife appointments, which is a unique addition to the literature as she was able to see what was important to talk about from both the midwives and woman's perspective.

In-depth interviews can become very emotional as a result of the topic being discussed and the intimate relationship that can develop between the woman and the interviewer. In cases where the researcher is also a midwife who regularly works for home birth women,

and can be seen as an insider or member to this group, it may be difficult for the researcher to not voice their own opinions, or it may influence the stories that the women divulge. In this case, Miller and Crabtree (2004), along with many other critics of in-depth interviewing, would bring forth the issue of the midwives not being able to maintain a personal distance from the data. Midwives have dealt with so many women and births over the course of their careers that they inevitably have their own ideas of what women want to say and what will change the birthing system in the best way. Murray-Davis et al. (2012) is a Canadian study where all of the authors are midwives. In Canada, this means they work in home and hospital environments. Their interview questions would have originated from a midwifery philosophy; therefore they may be leading the women to answer in specific ways based on wording. Unfortunately, the authors did not include an appendix of the interview questions for this paper to evaluate more closely. Cheyney (2008) is a US midwife who has also been trained in the field of home birth and the mindset and belief system that comes with it. I feel this is the greatest advantage that I can add to the literature because I am knowledgeable of the issue, but I have a distance from the data. As a human geographer, a woman who is not biased by having had her own birth, and someone who has acted in a support role for a handful of women, I understand home birth and the belief system that comes with this, but I feel I am removed enough from the data to be able to analyze it with a healthy distance.

3.4 Data Analysis

Many studies were vague in their description of methods by simply stating they used content analysis when completing their text analysis, which implies an objective, quantitative approach to the analysis (Hardy, Harley, & Phillips, 2004). This lack of detail leaves room for improvement in the literature. Sjoblom et al. (2006) used a ‘phenomenological-hermeneutic method’, but this required expertise in linguistics, is typically performed in psychology disciplines in Scandinavia, and focuses on the meanings and understandings of the whole, instead of on the individual. Although this technique may not be beneficial when looking at what the home has to offer the individual women, the technique used by Murray-Davis et al. (2012) may be. Their method of discourse analysis is the ‘constant comparative method’ whereby each line in

the narrative is coded individually and then compared with the previous lines. Chronic themes and codes are then combined to create larger categories. This research took a similar approach, and used a method called thematic analysis. Where discourse analysis typically uses latent themes to try to find underlying meanings and assumptions, this research focuses on semantic themes, which are explicit and come directly from the words of the participants (Boyatzis, 1998). An inductive, or bottom up, analysis was used to find themes in the data. This means that the identified themes came directly from the stories in the interviews (Patton, 1990), instead of being dictated and predetermined by the literature. By using this thematic analysis, the intention is that any preconceptions pertaining to potential themes or categories will be effectively eliminated (Braun & Clarke, 2006). This process of the data taking precedence and the themes emerging directly from the data is similar to a grounded theory approach (Braun & Clarke, 2006). This research followed along the lines of Braun and Clarke's (2006) six phases of thematic analysis:

Table 3: Phases of Thematic Analysis

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, and producing a scholarly report of the analysis.

NVivo, a tool that helps to analyze the data in a critical, organized, and rigorous manner, was used in this study. This is software that increases the reliability and dependability of

qualitative research by enhancing the transparency and presentation of the data (Welsh, 2002). For best results, a mixed methods approach was used combining both NVivo and manual discourse analyses (Welsh, 2002). Although Viisainen (2000 & 2001) used 'qualitative analysis support software' for their text analysis, no other details were given. As a result, using NVivo software may be a new addition to the home birth literature as no other study was found to have used this tool for text analysis.

Chapter 4

4 Results

The goal of this research was to explore why women choose home as a place to give birth, what women say their home provides that a hospital could not, and what barriers they encountered along the way.

A total of 30 women were interviewed between the dates of May 27th and June 12th 2014. Interviews ranged in length between 45 minutes and 3 hours. Although 30 interviews were completed for this study, saturation was reached after about 12 to 15 in-depth interviews. The fact that saturation was reached in such a small number of women implies that home birth women in London, Ontario are consistently facing the same barriers and are choosing home for the same reliable reasons.

Interview questions explored the character traits of the women, including age, marital status, home ownership, number of births, and chosen location for these births. Other discussion topics explored concepts under the umbrella of the therapeutic landscapes framework, which included perceptions around comfort, control, autonomy, empowerment, support networks, and societal norms.

This results chapter is written around the major themes that emerged from the interviews. These themes include: the feelings around home, factors that influenced women to choose home, reasons why women didn't choose hospital, safety concerns and the benefit of hospitals, and barriers that women encountered along the way. In the sections that follow, the results are presented with a focus on the main themes. Quotations, identified with a pseudonym, are provided to help contextualize the findings.

4.1 Character Traits

The characteristics of the women included in this study were very similar to that of other studies. Similar to other studies (Soderstrom, Stewart, Kaitell, & Chamberlain, 1990; Viisainen, 2001; Davis et al., 2011), all of the women interviewed had a partner and 27 of the 30 women were married. The other three were in a common-law relationship. For

age, the literature shows that older women are more likely to choose home over hospital (Soderstrom et al., 1990; Davis et al., 2011). Many women find out about home birth from friends who have had babies, therefore older women will have had a longer opportunity to be exposed to home birth. According to BORN (2011), the median age of a woman to give birth at home in the Erie St. Claire and South West LHIN Regions was 29 years of age. The women in this study were slightly older, with an average age of 32.8 years old. About half of the interviewed women had their first birth in a hospital and then subsequently decided to have future births at home. Of those who chose home birth without first having a hospital birth, most were over the age of 30 before they had their first child. 23% of the interviewed women gave birth to their first child in a one-year period around the date of the interview. This is only a fraction higher than the literature where, in 2009, 19.9% of the home birth women in the local LHIN regions gave birth to their first child at home, without first having a hospital birth (BORN, 2011). Additional characteristics about the individual women who participated in this research study, including their ages, type of employment, number of hospital births, and number of home births, can be found in Appendix B.

4.2 Home as a Therapeutic Landscape

This section addresses the foundation in which this research was completed. It is organized into two sections. The first addresses women's feelings about their home in general, not related to birth. The second starts to delve into the home as a therapeutic landscape for birth.

4.2.1 Feelings about the home

Many women instinctively felt an attachment to their home as a place of “peace, strength, familial bond... happiness.” (Holly)

As indicated in the comment below, home is where families thrive, raise children, build memories, and generally live their day-to-day lives.

“It’s a warm kind of environment. Our home is not just for sleeping and shelter, it’s more. [...] It’s the first house we’ve ever bought. At first it was kind of just a house and now it’s a home. There’s a little bit more love I guess in there. We got our first

dog in there and now we'll have our first baby there, so I feel like the home will have a lot of memories and just a comforted safe feeling.” (Catherine)

It should be noted that homeownership was not required for these perceptions of home to exist. Three of the four renters adamantly discussed their attachment to their homes. The fourth renter was in the process of packing up to leave to another city in a few weeks' time, so naturally her feeling of coziness and relaxation in her home at the time of the interview was decreased.

A few women did not have this innate connectedness with their home. A couple said they loved their home because of the community it was located in, not because of the actual house itself. “St. Thomas is my home, not necessarily this... [555 Smith Street].” (Kylie)

Overall, it was clear that the majority of the women identified themselves as homebodies and enjoyed spending quality time at home with their families.

“Our home is everything in our daily life because we all have to coexist in this home. [...] This is where we love to be. As long as we're together and happy, who cares about everything else? You know what I mean? So yeah, the home is very important to us. Like, come on! Without this, what do you got?” (Carmalina)

One woman felt such a passion for her home that she described it as follows:

“I have never loved a non-living thing the way I love my home. [...] It means everything to us. It is the absolute centre of our lives. [...] It's our sanctuary. We go there and we can hole up in there if we want to, the three of us. It's a small little place, so we feel very connected to each other.” (Alyssa)

4.2.2 Home as a birth space

The majority of the women planned to give birth in their bedroom and/or bathroom, which are quintessentially private areas of the home.

“I wanted to do it in my bedroom, 'cause it's the most private I guess, and comfortable... familiar... It's where I feel relaxed.” (Holly)

Some chose the bedroom because it is a quiet and intimate location, while others chose the bedroom simply because it is a room in which we typically have the lights off.

“The bedroom is a bit darker and when I was in labour I wanted a more intimate and dark room. [...] I'm pretty sure the midwives were working by candlelight. I was super sensitive to the lights being on and it really affected, like, how I was birthing, or how I was labouring. So I had my robe on with my hood and I was just

in my dark zone. [Laughs] I don't think I saw the midwives' faces until after he was born." (Julie)

Others chose equally private locations, but not in the bedroom:

"Jacuzzi tub. In the basement. Lights were dimmed, I had my playlist playing, and we just did our thing." (Carmalina)

Surprisingly, quite a few women chose very public spaces of the home to give birth, such as the living room, dining room, and playroom. Many of these locations were chosen due to their ability to fit a birthing pool and often times due to the feeling elicited from the location in the home.

"This room [the living room]. I love this room. This is my favourite room in the house. I like the colour of it. I like the light. She was born on Easter Sunday, in the morning. It was a beautiful sunny day. The sun was pouring through the window. It was amazing and invigorating. And so, I have all kinds of positive associations with that." (Wilma)

There was not always a special meaning attached to the planned room of labour and delivery, and instead, it was the home in general that brought about the feelings of safety and comfort. It was the home that brought about the therapeutic landscape of birth that the women needed.

4.3 Why Give Birth at Home?

There was one underlying commonality that should be discussed upfront. Even though it was not included as a specific question in the in depth interview guide, almost all of the women vocalized that they view birth as a natural and normal process. They did not view birth as a problem that needed to be fixed, but rather they saw birth as a regular part of life.

"Birth isn't a sickness. It's healthy and it's part of the natural course of things. This is how babies come into the world and they've been doing it since the dawn of time." (Cindy)

"It's not a pathological condition. It's a natural state for women. It's a normal physiological event that our bodies are prepared to do." (Alyssa)

They wanted their birth to be a normal and natural event in their lives and therefore home was the optimal choice for this mindset. If something is normal, it takes place in your home, not a hospital.

In the in depth interviews, the women were asked what it was about their home that encouraged them to birth there. The specific reasons vary, however three main themes emerged. These women chose home due to reasons that elicit comfort, control, and support. For brevity, and to make sure these were widely held views and not just the views of a few, only themes discussed by at least 75% of the women are included in this results section.

4.3.1 Comfort

It was unanimous that all women felt the comfort of the birthing environment was one of the key reasons to choose home. As previously shown, most of the participants had a natural attachment to their home, which elicits feelings of relaxation, familiarity, and comfort.

“I wanted to be comfortable and I wanted to be surrounded by comfortable things and people who made me feel comfortable. And this is where I feel the most comfortable.” (Annalise)

4.3.1.1 *My home is more relaxing*

Choosing home meant that the women could go about their day in a normal fashion. The woman below illustrates how being in her own space and participating in her regular routines allowed her to relax.

“I had some early labour at night, but I could actually sleep through the contractions. At 6 in the morning I got up and thought, ‘ok, things are getting stronger, I better get up and eat now before things get crazy’. We got the boys up, I was emptying the dishwasher, I was getting the boys ready for school and daycare, and then I would stop for a contraction. I didn’t realize how close I was to already having [the baby] be born. I was just doing my thing, living my life, doing my morning routine. [...] I was so relaxed, just by being in my own space. [...] Never felt an ounce of fear. Then my husband came home [from dropping off the boys] and he’d only been gone 20 minutes. When he came home I was full on in labour. He helped me get into the tub and all of a sudden I had the urge to push. Then in two or three pushes he was out. It was pretty empowering and it definitely confirms, yep, birth just happens. It’s a normal thing.” (Danielle)

When women had their home to ground them and keep them participating in their normal daily activities, labour was described as less powerful and more manageable.

“At home I was just kind of doing my thing. Labour was never as intense with this guy. I never realized how close I was to the end and I just think that’s because I

wasn't in the hospital and I was just, you know, at home. [...] I was more relaxed being at home. I don't think things would have gone as quickly if they'd been in the hospital, just because it's not my space." (Danielle)

The home and its natural calming properties brought an ease to their labour and births. This was highlighted when women would talk about previous labours and the hardships they endured due to leaving their homes.

"I remember being in active labour and having to take the 15 minute ride to the hospital and it was hell. [...] I felt like a caged animal. I needed to move and my coping strategy was gone being strapped in a car." (Rachelle)

The findings suggest that by simply staying in their home, the entire birthing experience and environment for these women is improved.

"My house makes me feel serene. It keeps me calm and relaxed. It grounds me." (Nadine)

4.3.1.2 My home is my own space

One of the reasons why home is calming is because the home is entirely the woman's own space. When comparing feelings of home to the hospital, one woman stated:

"It [the hospital] is not my place. So I just don't see why I'd go to a strange environment to have my baby. I just feel like it would be a more positive experience at home. More relaxed, calmer, peaceful..." (Danielle)

Other women mentioned the importance of acknowledging their home as their own space in allowing them to open up and be themselves during their labour and birth. Some women felt self-consciousness in a hospital and worried about making too much noise or not being a good patient. One woman mentioned that she was really quiet in the hospital, but then for her home birth she was really vocal. She had never really considered this dichotomy before, but when she said it, it is as if a piece of understanding clicked inside of her and she said:

"I think why that was, is because this was in my home. It was my domain. I felt way more comfortable here than I felt at all in the hospital. There I felt like you have to be this passive patient that's like, 'okay I'm just laying here and this is happening to me right now'. Whereas here, at home, I was like, 'No'. I can do whatever I want here because it's MY home." (Laney)

Acknowledging that their home was their own space gave the women the comfort to be themselves during one of the most intimate experiences in their lives.

4.3.1.3 *I have full use of the space in my house*

Participants also unanimously mentioned the benefit of being able to use the entire house space during labour and birth. Since epidurals and most pain medications are not used in home births, freedom of movement is an essential element of pain management.

However, it was more than just movement that women liked; it was the freedom to roam around their entire house.

“I mostly was in the tub that was across the hall. I was there when the midwives came. Then when we needed to see how close to delivering I was I got out of the tub and went to the bed and stayed there until I had the baby. Then I lounged on the couch [in the living room] after the baby was born. Yeah, like... who wants to go and just sit in a hospital bed?” (Courtney)

Some women mentioned how different rooms had different energies in them, or therapeutic qualities, and they were found to be advantageous during different parts of their labour and birth. For example, a tub was soothing, the kitchen was invigorating, and the living room was comforting. It also allowed women to roam around to change her support network around her. She could move into the privacy of her bedroom and labour alone or just with her husband for a while, then she could move back out into the living room when she felt she needed a bit more support.

It was important for women to have the freedom to move into the room that felt the most comfortable to them at that point in time.

4.3.2 Control

Many women felt that hospitals and doctors regularly take control away from women, so choosing home birth (and midwives) was a way for them to ensure that the control stayed in their hands.

”Home birth appealed to me because I would have more control over a lot of things. And really, it boils down to control. I would have control over what was done to my child after birth, but also how I laboured [...]. All those different things that are just not in your control at the hospital. That was important to me.”
(Tammy)

4.3.2.1 *I control the privacy in my home*

The only aspect of control that every woman mentioned as a contributing factor for choosing home birth was privacy. In a home birth, “I control who is there” (Brooke). Since the birth occurs in their home, the women naturally embody the power to dictate exactly who enters.

“It's my space. My husband and I are private people. We have a small group of friends and we're not much for small talk. We just want to have a quiet, personal event. I don't want to have to see staff or people that we don't know. I mean, my midwives aren't my best friends, but you do develop a relationship with them. And there is something about being in the context of someone's home that I do think they see you more clearly than someone who just sees you laying in a hospital bed.” (Kim)

This control was a huge advantage to choosing home birth with midwives. One woman described the intimate privacy of her birth as follows:

“I started cramping at night and then I got out of bed at about 3 am. I got into my tub and pretty much did not leave my bathtub until [the baby] was born at 3 pm the next day. I just remember being in the bath and my husband being there. We didn't have a doula or anyone. My midwife didn't come until I was about 8 centimeters dilated. So really, it was just the two of us, which was perfect. He was a great support and it just felt so perfect and intimate.” (Alyssa)

The ability to so easily experience the level of privacy that a woman wishes was especially important to those who may identify as introverts.

“It was to be just my husband and I... and my midwife. But really, like, when you picture it in your head I pictured it with my husband, and I pictured a lot of it by myself. I don't know, it may be rude I guess, but I like to spend time by myself. I'm okay that way. And I definitely am not somebody who likes to be around people when I'm in pain or anything like that. I just pictured a lot of it by myself. And my husband would be there, of course.” (Holly)

This privacy and control of who enters your birthing environment lends an element of safety that a hospital has challenges providing. During birth, women are physically and emotionally exposed and at their most vulnerable. They need to feel safe enough to completely let go. In order to do this, they need to know that they are protected and completely safe in their surroundings. If there are people moving in and out of their space, especially those who they do not know, it hinders this ability.

“I never had to open my eyes the whole time, but it's because I knew who was there. I feel like if I was in a hospital I'd always be checking out who was there and that would make me uncomfortable, especially if I didn't know people.” (Holly)

The ability to have full control of who entered their space was paramount in their birthing and postpartum experience. At home, “it was just myself, my husband, and the two midwives” (Carmalina). However, in the hospital there are many people who can enter the room without expressed permission from the birthing woman, and this can drastically alter the intimate feeling that these women wanted to have.

“Having the OB. Having the OB student. Having the nurses. Just having all of these people... It was a chaotic environment.” (Carmalina)

Many women expressed that they simply didn't know they could say 'no' to a doctor, and even if they knew they could say 'no', it was very difficult for them to do so. There is a power dynamic at play here and society tells us to listen to and obey those in a position of authority.

“You have to be strong enough to say no to all those extra people [...]. You can say no, but you don't know that you can say no. Nobody told me that I could say no. And I didn't feel comfortable and confident to say no to all these extra people and to say, 'Just leave me alone. I just want the doctor here'.” (Wilma)

The participants agreed that they should not be put in this position of opposition. They felt that it should be made clear that the birthing woman always has control.

4.3.2.2 I have control of the decisions making process in my home

Many women chose home birth due to the ability to be a part of the decision making process during labour and birth. The following are a few statements from the women:

“What I really, really liked about the midwifery / home birth approach versus the hospital approach is that I was involved in every decision and I could make every decision. It wasn't decided for me.” (Wilma)

“It just appealed to me in the sense that it was a much more collaborative process as opposed to going to a doctor and being told what to do or being told what not to do.” (Tammy)

The women expressed their feelings of being prevented from being part of the decision making process in the hospital and as a result, their instincts and bodily autonomy were being taken away from them.

“It feels very much like a controlling environment where you are having to submit to the will of others, as opposed to what you feel is best or what your body knows is best.” (Tammy)

As indicated in the comment above, they felt helpless in many ways because they were forced to ‘submit’, at which point they went from active participants in giving birth to ‘victims’ with no voice.

“I felt a lot was done *to* me when I was in the hospital as opposed to *with* me, if that makes sense. So yeah, the more I thought about it the more I thought that [choosing home] is one way to guarantee that I get to make as many decisions as I can.” (Kylie)

A participant described her feelings after a bad birth experience in the hospital, where she felt she had lost her ability to speak up at all:

“I was angry. I don't know if this is the right word, but I almost felt sort of violated. I feel like they took away my rights. I wasn't allowed to do anything on my own. [...] I was really scared and angry and in the end I was disappointed for a long time because it wasn't how I thought it was supposed to go. Thinking about it afterwards, it made me angrier because at the time you're so overwhelmed and it was my first baby. I thought, ‘Oh, maybe this is how it's supposed to be’, but then you hear other peoples birth experiences and their labor stories and you think, ‘Wait a minute. I had options? Why did no one give me options?’. I felt angry, hurt, disappointed. I mean, I was relieved when it was over and I got a beautiful son to show for it, but I never want to go through that again.” (Kylie)

The women who chose home birth did not want to lose this aspect of control and autonomy of their birth. Choosing home meant that their care was being guided by the midwifery model of achieving true informed consent and it also gave them the leverage of power because they were giving birth ‘on their own turf’.

“This was my home. It was my domain. [In the hospital] I felt like you have to be this passive patient [...]. Whereas here, at home, I was like, ‘No’. I can do whatever I want here because it's *my* home.” (Laney)

Simply being at home negated any power dynamic that may have existed if they had chosen the hospital. Since the women control their home, they also control everything that happens in it. This sense of security, the knowledge that they will have options, and the fact that they will be included in the decision making process, was a large part of what made the home the best choice for these women.

4.3.2.3 I control my ability to eat food at home

As part of the decision making process, women at home often enjoyed the freedom to eat what they wanted, when they wanted. On the other hand, due to rules and regulations in hospitals, this luxury is not available to most women who labour in the hospital.

However, at home, women have control over this aspect of including food into their birthing experience. Only a few cited this as a major deciding factor in choosing the home as their place of birth, however most acknowledged it as a very enticing benefit to choosing home.

The main idea around food was that food is involved in your everyday life. By including food into the labour and postpartum experience, it has a way of normalizing birth. When Alyssa was asked if she had a favourite memory about her birth, she said:

“This always stands out for me. I could eat and drink the whole time, because I was in my own house. So my mom and dad, they live just down the street from us, they dropped by with food. I’ll never forget that. [...] I can have people come to the door with things. It’s just such a more normalized experience.” (Alyssa)

Not only is food a normal part of our everyday lives, but it is also one of the main things that brings people together. Sitting down around a dining room table is one of the key past times for building family memories and connecting with everyone after a long day. As a result, it was important for some women to include this bonding event into their birth and postpartum experience.

“I think for all of them, what I really loved about the births was a couple of weeks beforehand, my mom would bake a casserole and we would put it in the freezer. Then, once I was in labour or once the baby had been born, she would come downstairs and put it the oven. Or in the case of, I think it was the third one, it was in the morning, so my dad was here and he was making eggs and bacon and pancakes downstairs. I’d have the baby and then I’d come downstairs and I’d sit in the recliner with the baby in one arm and my plate of food in the other arm and the kids watching cartoons around me and it was just... it was like you’re automatically bringing the baby into a home.” (Courtney)

4.3.2.4 I felt empowered and accomplished at home

Due to the women having control over every aspect of their labour and birth, they also experienced a heightened feeling of empowerment and accomplishment. When women finally gave birth to their babies, they felt as if they and they alone, had birthed their

baby. They made all of their own choices and they had the freedom to do whatever felt best for them and their baby. This tended to give the women an overwhelming sense of accomplishment.

“As soon as that baby came out. As soon as that baby was on my chest I thought, ‘Oh my gosh. I did this. I. DID. THIS. YES! I did this! I did it again’. Just... that moment. That moment of the baby skin to skin. Hearing the little cries. My midwife Karen, she said, ‘Carmalina, you did it.’ And when I watch my birth videos I hear that and I’m like, ‘yes, I did it’. [...] It was the most empowering thing I’ve ever done.” (Carmalina)

In contrast to this, many women expressed a lack of empowerment during hospital births.

“I don't think I would have been able to get empowerment at a hospital birth because I wouldn't have been in control. I wouldn't have felt like it was my accomplishment. I would have felt like it was somebody else's. It would have been the nurses that were cheering me on, “push push push push push push”, or the OB that caught the baby instead of me scooping my own baby out. I feel like it just would've been lost. I might have gotten a little empowerment, but I just don't think it would've been the same.” (Carmalina)

They felt the hospital system takes control of the labour and treats birth as a problem needing to be fixed and as a result, women were viewed as weak or in need of being saved. This innately took away any empowerment a women could feel about her own birth experience.

“A hospital feels to me very controlling, [...] and very much about taking women's power away. Whereas a home birth to me feels very empowering for women [...] that is what I most was appealed to, the ability to control. Not just control, but be empowered by my own body and by what's happening. [...] I feel like the hospital treats it as if the body is a problem that needs to be solved as opposed to the body knowing what to do.” (Tammy)

Some women did acknowledge that this was their unique view of birth and that different women need different environments. One woman stated:

“Maybe another woman would find that empowerment experience in the hospital. For myself, it would not have happened because I needed my home and my control.” (Jennifer)

Regardless of whether some women are empowered in the hospital and others are empowered from birthing at home, the core message remains the same. Empowerment is an important part of the birthing process, and for home birth women, they are able to find this element at home due to the power and control that their home provides them.

4.3.3 Support

The third main theme for why women chose home as their place of birth is support. This comes in the form of midwives who have unconditional support for the women they serve, families who are able to be involved in the birthing process, and the postpartum care and support that comes from being in your own home.

Without the hospital rules and regulations to define their birth and due to the holistic approach that midwives tend to bring to births, many women expressed how supportive midwives were.

“I never felt judged, and I never felt pressured, and I never felt as though there was a right way and a wrong way. That's what I really liked about it.” (Annalise)

In respect to having full support of all your decisions and having a support network behind you that will advocate for you and your wishes, “being at home lends itself to those things easier.” (Holly)

4.3.3.1 My home allowed me to have the birth support I needed

Many women described their support network during birth as the reason they were able to make it through. Many started stories as “I”. “I” gave up. “I” couldn't [sic] do it. However, it was interesting to see their vocabulary change into “we” in the end. “We” got through it. “We” did it.

“I remember just sitting in the tub, and the contractions were hitting one after the other, and I remember I finally broke. I was like, ‘I can't do this. Call the ambulance. Let's go to the hospital. I'm done. I'm not doing this anymore.’ And I remember my midwife came up and she rested her head against mine and she was like, ‘You can do this. You will do this. Your baby is coming. Breathe.’ And I just remember that moment. Her head touching mine. It felt like she transferred all of her strength to me and from then it was just... we did it. We just did it.”
(Carmalina)

In a way, their language around therapeutic landscapes started to shift and you could now start to see that their support network was also included in their therapeutic landscape. Below is the comparison from one woman of a hospital birth with nurses and doctors versus a home birth with midwives. The support she received completely changed her experience and comfort level for each birth.

“At first it was like I was bothering the nurses. They asked me, ‘Why do you think your water broke?’. My sweatpants were soaking wet. I was leaking all over the floor. They treated me like I was dumb [...] And then nobody was listening to me once they started augmenting my labour. I went into really hard fast labor and the nurses said a lot of things like, ‘Oh you're a first-time mom. You don't know what this is. You don't know what a real contraction feels like’. Meanwhile, I had dilated from 2 to 10 centimeters in less than three hours. [...] I was very angry after I got out of there because I really felt like nobody cared to listen to me.” (Kylie)

“If I just had one person come in and say, ‘You're doing a good job. This is great. Wow this is going really fast, but this is good. This is good and you can do it.’ That would have made the world of difference. And so that’s exactly what I made sure I had with my second birth and with a midwife and with a home birth. It's crazy how different that made me feel. After the first birth I was disappointed, crushed, and in shock [...]. It took me a long time to recover and it was a traumatic experience. It was the complete opposite with my wonderful and supportive home birth.” (Kylie)

Many women experienced this lack of support during their first births in hospital and as a result, they not only chose home birth for their next child, but also made it a point to surround themselves with a support network that would care about their feelings and believe in them, no matter what. This element of support is a large part of what made their home a therapeutic environment.

4.3.3.2 My home provided the family experience I needed

Another source of support was the fact that a home birth was able to be a true family experience. For most, that meant an intimate time filled with family bonding.

“I just remember being in the bath and my husband being there. We didn’t have a doula or anyone. My midwife didn’t come until I was about 8 centimeters dilated, so really, it was just the two of us, which was perfect. He was a great support and it just felt so perfect and intimate.” (Alyssa)

Being at home gave the birthing couple time to build a stronger relationship. It allowed them to feel connected as a family on a level that may not have been achievable in hospital.

“I felt very relaxed being at home and I think my husband felt more relaxed being at home and being together. I felt very much like my husband and I achieved the birth together [...]. It was just, we've done this together. On our own. I think in the hospital, more people just would have been in my business and interfering with what was going on. My midwife was sort of hands off. And I really felt that sense of completion and togetherness came from just us. My husband and I were able to be very close and very together.” (Holly)

For others, a family experience meant being able to include as many supportive friends and family as they wanted. In their home, they were not limited to the hospitals two-person rule.

“I don't feel like our children would have been allowed in the [hospital] room. We have a lot of people involved in our births. When we were at the hospital it was my husband, the two midwives and both of our mothers. Which was already stretching their two-person rule. Then with our first home birth it was my husband, the two midwives, our two mothers, my sister, and my son in the room. [...] It was the same for the third one. Then for the fourth one we had my friend in the room too. There were lots of people in our home and that's the way I like it. It's a show for the invited crowd, not so much for the uninvited crowd that comes along with the hospital.” (Courtney)

4.3.3.3 My home birth allowed for more personalized postpartum care and support

Many women chose midwifery and home birth for the postpartum care and support. As mentioned in the comfort sub-theme, women enjoyed the ability to use their own space. They were able to enjoy a bath in their own bathtub, lay down to sleep in their own bed, and they experienced very personalized care from their midwives.

“You don't have to leave your home. You're already here. You can just snuggle and go to bed. [...] My midwife helped me shower, [...] she put all my stuff in the dryer, so then when I got out of the shower she put me in nice warm clothes, tucked me into bed with my baby skin to skin, and wrapped me in warm blankets. You're just not going to get that in the hospital. It's just not there.” (Carmalina)

Another advantage was the ability to have their family come visit whenever they liked. Their postpartum support network was just as important to them as the support they surrounded themselves with during the labour and birth.

“People came over and brought food and it was much more of an inviting space. It was *my* space. It was more comforting to be here rather than to be somewhere that's very sterile and strange.” (Laney)

Women cited many of the same benefits in their postpartum care as they experienced in giving birth at home. They also mentioned the benefit of having their midwives come to their house for the first postpartum visit.

The entire birthing and postpartum experience was able to be accomplished in the therapeutic environment of the woman's home surrounded by an amazing support network of her closest family, friends, and care providers.

4.4 Why Not Give Birth in a Hospital?

Throughout the in-depth interviews, the women talked about their feelings associated with hospital births and why they ultimately chose their home as their place of birth, instead of the hospital. Just like the main themes for choosing home, their concerns around the hospital were grouped into the three categories of comfort, control, and support.

4.4.1 Lack of Comfort

During labour, a woman must be relaxed enough to allow the contractions to do their work. When a woman is tense it may inhibit the effectiveness of her contractions. This is one of the reasons why feeling comfortable in her birthing environment is so important to achieving a safe and happy delivery. All of the women viewed birth as something that should be a positive experience. The hospital environment did not mesh well with this ideology.

“The idea of entering the hospital through the same entrance that all the sick people go in and going past all the chaos and the reception desks and the ringing phones... That to me is part of the stress. I think it would even have to have a separate entrance, to me, for it to be an option... because birth is supposed to be something so positive, and hospitals to me are something so negative, that it would have to be so separate from the rest of the hospital, for it to remain a positive experience for me.” (Annalise)

Many women expressed that the hospital labour wards simply do not meet their needs in terms of comfort and relaxation, meaning that the hospital does not match their ideal therapeutic landscape.

4.4.1.1 *The hospital is an uncomfortable environment*

One of the main complaints about the hospital is the way it assaults your senses. Whether it is the smell, “I don't like the smell of hospitals. I don't know why, I just have this

reaction” (Alyssa); the fluorescent lighting, “This bright light shining over me. Just the environment. I didn’t want it. I didn’t want it.” (Kim); or simply the fact that it lacks a homey feel, “I think that’s what I dislike most about hospitals. The sterility and the coldness.” (Annalise), the overall result is a massive assault on your senses. When these home birth women are struck by this unusual and “very clinical” (Tammy) environment, it is difficult for them to find comfort in their surroundings.

“You always feel like an outsider. It’s such a sterile unwelcoming environment. And I know they have lovely new birth rooms now and I have had friends tell me how nice they are, but I’m sorry, they’re still all white and they still smell funny and they’ve still got really bright neon lights and they’ve still got a lot of people rushing around that you don’t know.” (Annalise)

Along with this unwelcoming environment, some women simply did not want to give birth in the sterile and impersonal environment that they viewed as the norm in hospitals.

“I imagine trying to give birth in this blue gown, with my legs in stirrups, and this doctor with this mask and a shield over his eyes and it’s just... no.” (Carmalina)

Although some just imagined what it would be like to deliver in a hospital, many women who had delivered a previous child in the hospital remembered being forced into very uncomfortable and revealing situations.

“My oldest was born with forceps in the OR. [...] I’m strapped into these big black boots with my legs spread as I’m rolled down the hallway to the OR.” (Wilma)

Although many had delivered a previous child in the hospital, some women had never seen the birthing units or even visited a friend in the postpartum ward. The entire environment was foreign to them and this resulted in a fear of the unknown.

“The hospital feels very unknown for me” (Tammy)

Some mentioned how they were even unable to tour the birthing unit in the hospital.

“No, they wouldn’t let me. And I asked specifically. [...] ‘Can I just take a peak? Walk around?’ [...]. They said that I wasn’t allowed to because of risk of infection or contamination or something like that.” (Wilma)

This lack of knowledge and familiarity with the hospital birthing unit was a contributing factor to why women could not picture themselves being comfortable in a hospital.

“I spent a lot of time focusing on how I want it to go, where we’re at, and how we’re moving forward and progressing, and how it’s going to end, right? Like, I envisioned it going well and how I would get there. I think if I had had to move to

the hospital... I couldn't envision it the same way because... at home I could envision it." (Holly)

4.4.1.2 *The hospital is for sick people*

The narratives showed that women viewed hospitals as a place for sick people, not as a place of comfort and well-being.

"I associate [hospitals] with illness and emergencies, so I wouldn't feel as comfortable, I wouldn't feel as relaxed, as I would at home." (Danielle)

Before pregnancy, they only went to the hospital when they were not feeling well. The hospital was there in case you were sick and needed help to get better. They simply continued this thinking throughout pregnancy, birth, and the postpartum experience.

"Just apply the same philosophy to birth. You only go to the hospital if something is not correct." (Holly)

A main complaint was that hospitals are seen as harbouring germs and disease, whereas pregnancy and birth are seen as a healthy and vibrant time in a woman's life. Their view was that illness and health should not be gathering in the same place.

"They're dirty. I don't care if they say that they're sterile or sanitized. They're gross. [...] That's where sick people congregate. Sick people go to hospitals. Birth is not sick! It's a miracle. It's different." (Carmalina)

This dichotomy of perspectives leads women to choose their home as their place of birth because they do not view themselves as being sick and in need of hospital care.

"I think hospitals, for people who are sick and who need to get better, are a fantastic facility. [...] so they're good for that. They're just... a baby is not a cancer. It's not a tumor that needs to be removed. I'm not sick. I don't need to be there." (Wilma)

4.4.2 Lack of Control

Many women cited a lack of control as a fundamental reason for why they did not choose the hospital as their place of birth. Under the theme of control, they chose home for privacy, decision-making, food, and empowerment, where as they chose to not deliver in the hospital due to a lack of decision-making abilities, an overbearing amount of rules and regulations, and too many interventions.

"I felt a lot was done *to* me when I was in the hospital, as opposed to *with* me." (Kylie)

For those that had previous births in a hospital, it was common for them to feel disappointed in their birth experience due to a lack of control.

4.4.2.1 I have a lack of decision-making abilities in the hospital

Many women felt that they were lost in the birthing process during a hospital birth because there was a lack of education, participation, and decision-making that was allowed on their part.

“I went in for my appointment and the OB stood at the door with her hand on the door knob for the entire thing. She brushed off every single question I had as a ‘you don't need to worry about that.’ [...] Nothing was presented as a choice for me, any question I had, I didn't need to worry about that because the OB knew better and you don't need to worry about that, that's not a question for you to ask.” (Courtney)

This habit of obstetricians keeping women uninformed, even if done unintentionally, resulted in the loss of control for many of the participants and a feeling of not being respected.

“I feel like OB's, they push. They push to have that baby born on their clock as opposed to when the baby is ready to be born. [...] I don't feel like the OB's are giving the information to women so that they can make those informed decisions. They say ‘ok, this is what we're doing next’ and women are like, ‘okay’, and they just do it. They just do it because we trust in these people, but I think there's been so much trust put in them that now they abuse that trust. They abuse that responsibility.” (Carmalina)

“I think that you're forced into doing things. I don't think you're given a lot of options. I don't think everything is explained to you in the detail that it should be because it's so routine for them, and it's not routine for you, and so if you question... if you even just ask for more information, it's like you're seen as a dissident and just... I don't feel like you're given the respect that you deserve.” (Tammy)

Although the majority felt an inability to be a part of the decision-making process in a hospital, a couple of women expressed a slightly different view.

“Hospitals get sort of a bad rap sometimes. But you are in charge. You may feel pressured one way or the other, and you will, let's face it, but if you really want to stand your ground, you will have the choices you want, [...] but it can be uncomfortable.” (Alyssa)

These women had strong personalities and were not afraid to go against the grain. Even though these women felt they could advocate for their wishes, the majority of the women did not have the strong personality required to fight for their decisions to be heard or they

simply felt as if they did not even have a choice in the first place.

“When you're in that medical model, you don't necessarily know you have another choice.” (Julie)

Regardless of where they stood on the issue, they generally agreed on one thing:

“I love that OB's are there should they be needed, but I don't think the power should ever switch hands.” (Carmalina)

4.4.2.2 The hospital has too many rules and regulations

Similar to a lack of decision-making abilities is the issue that hospitals have too many rules and regulations that are built for the textbook labour and delivery. Women felt that choosing a hospital birth meant that they had to choose to ‘submit’ and give in to all of the rules, regardless of whether they agreed with them or not.

“It feels very much like a controlling environment where you are having to submit to the will of others, as opposed to what you feel is best or what your body knows is best.” (Tammy)

One of the main regulations that women had issues with was the adherence to a specific ‘due date’ and the prolific use of inductions. Many had similar thoughts to the woman below:

“40 weeks is not a magic number where your potato is done, get it out of the oven. It's an estimate. [...] I'm sorry but babies are not convenient and they are going to pick their own due date and they should be allowed to.” (Kylie)

The other main rule that women talked about in their narratives was ‘the clock’. In a hospital, women are expected to dilate at a certain pace, otherwise they may be labeled ‘failure to progress’.

“I feel like... the medical model is like, ‘you have to dilate this much by this time and if you don't then something's wrong and we need to do something’. No, sometimes people take longer.” (Laney)

“Honest-to-goodness, I feel like women when they're in a hospital, I honestly feel like they're lied to. ‘Oh well you're not making progress’. Because they're only slowly progressing they're being told that they're not progressing, therefore its intervention after intervention. They just throw interventions at women for the sake of having a baby born on the OB's and hospitals timeline.” (Carmalina)

This ‘clock’ applies to more than just dilation rates. The women talked about ‘clocks’ for the overall amount of time that a woman is allowed to labour for, and also a ‘clock’ for

the amount of time that a woman is allowed to push for. These constraints on labour and delivery added an element of stress to an already stressful environment.

Choosing home removed a lot of the ‘clock’ and timeline pressures and gave the women the power to decide what rules and regulations were right for them.

“[In a home birth] they are there on your clock instead of you being there on their clock. It’s totally different. [...] I feel like OB’s, they push. They push to have that baby born on their clock as opposed to when the baby is ready to be born. [...] I feel that when you’re home you don’t have all that. You have you and your midwife. This midwife who followed you from the day you found out you were pregnant until now, who knows you, who takes the time to understand what you’re looking for in a birth and helps make those decisions *with* you, not *for* you. [...] It’s just so much better.” (Carmalina)

4.4.2.3 *The hospital has too many interventions*

In addition to not having their voice heard and having to submit to rules and regulations, the women also feared losing control in one other aspect of their labour: interventions.

For some, this loss of control was explained as simply having to allow the obstetrician to perform vaginal checks every two hours. The hospital rules dictated a need for a certain dilation every two hours, which meant that an intervention (vaginal checks) was needed in order to make sure the woman’s body was abiding by the regulations.

“I just didn’t like the doctors coming in and checking me every 2 hours and the parade of interns coming in like, ‘oh, can I check too?’, ‘can I check too?’ kind of thing. And I didn’t know I could say no.” (Wilma)

As soon as the woman’s body falls short of this timeline, the women talked about how a ‘cascade of interventions’ ensues.

“You see people go in with this amazing birth plan. And then it’s like, oh, well instantly, ‘You’re not progressing as you should, so let’s get you some Pitocin’. Pitocin leads to, ‘I can’t take this’. Epidural. Epidural leads to stalling of labour. And then they are being cut open. I mean, it’s just one thing after another.” (Carmalina)

This creates fear in the women and a worry that their bodies may not follow a perfect textbook labour, at which point this cascade of interventions would be inevitable.

Surprisingly, many of the women did not blame the obstetricians themselves for these issues. Instead, they blamed the hospital for setting such rigid regulations based off of a

textbook labour. Plus, the women talked about the inherent flaws in the education of obstetricians.

“I think a lot of times OB’s are taught about the risks associated with pregnancy and are taught about doing surgery and are taught about baby’s heart rate dropping and they are taught about all the bad things that can go wrong. I don’t think OB’s get to experience enough of just those normal natural births... not every birth is going to be like it is in the textbook but that doesn’t mean there’s something wrong.” (Kylie)

In order to prevent the use of ‘unnecessary’ interventions, some women suggested that a change in the training of obstetricians is needed.

“I think OB’s should have to shadow a midwife or something. I think there should be some sort of joint training, where the OB’s get to see more normal and hands off births. Like, this is normal. This is fine. This is okay.” (Kylie)

4.4.3 Lack of Support

The third main theme for why women did not choose the hospital as their place of birth is support. The women felt that the hospital care was impersonal, that they were just a number in the system, and some even related poor support by care providers in hospital to a less safe birth. There were also many women who had previously had a bad experience with the hospital staff. In the hospital, there were simply very few friendly faces for these women, which resulted in their sense of support and safety being eroded.

4.4.3.1 *The hospital provides impersonal care*

Birth is an intimate and loving event; however, the dichotomy between this tender moment and the hospital environment was stark for many women.

“There’s all these people walking around and you don’t know any of them and you’re there trying to have such a sacred moment.” (Elizabeth)

In this type of environment, where there are so many people rushing around, and yet none of them seem to be invested in getting to know you, women felt as if they were simply a number in the system.

“I feel it can be rushed, that you’re looked at like another number, that you are probably going to have your baby delivered by somebody you might not know.” (Holly)

It is not just the doctor's face that can be unfamiliar, but rather, a doctor can come in, deliver a woman's baby, and then leave, all without the woman even knowing his name.

Below, a woman recalls her experience with the doctor who delivered her child:

“I didn't know the doctors name. When I was filling out the paperwork for his birth certificate I remember asking the nurse and she said some doctors name, so I put that down. I was talking to a friend a few weeks later and I was like, 'yeah, it was this doctor that delivered my baby' and she's like, 'oh, short little Italian guy?' and I'm like, 'no... he was tall and had red hair.' So it's the wrong name on the birth certificate!” (Wilma)

These women expressed a sense of hurt and dissatisfaction due to the impersonal care that they received in the hospital. Being unable to even name the doctor who delivered their child had a huge impact on these women's view and trust in the system.

Another aspect of impersonal care is the amount of people who are involved in each woman's pregnancy, birth, and postpartum care. In the comment below, one participant describes her experience:

“It was awful from beginning to end. My assigned OB was on sick leave and they didn't have someone permanently assigned to cover for her, so I had 4 different OB's assigned to me plus my family doctor. [...] So I had 5 people involved in my care, which as you can imagine, is really easy for things to slip through the cracks and for people to not follow up.” (Wilma)

This participant was not alone in her dissatisfaction with the hospital care. Many actually went on to illustrate how one person, such as a midwife, who supports you and provides continuous care for you throughout pregnancy, birth, and postpartum, actually results in a safer birth. Continuous care by one individual who knows the woman as a person and not just a number, allows for better and more proactive care.

“I felt like home birth with a midwife was safer than other models. Everybody's very into you and they know you very well, right? So if something does go awry, even if just a little bit or if there's something to monitor, they see that more quickly I think, because they know you so well. And you feel more comfortable disclosing information to someone who you view as a confidant and a friend, versus someone you view as solely a medical professional.” (Holly)

Since hospitals must adhere to their regulations, the care each woman receives is created for the masses based on a textbook birth. The hospital system measures women based on deviations from the averages in a textbook, whereas a home birth allows women to be

cared for based on her individual needs. Once again, the women felt that this impersonal care in the hospital can result in inferior care.

“I would say another disadvantage to the hospital is that you are on a path that is generalized for the majority, but it may not be yours. You can get pushed along that way and things can go awry that wouldn't necessarily go awry if you had more control and freedom to do what is best for you and your baby.” (Holly)

These women chose home in order to allow their midwife to support them in their unique, and very personal, path to birthing their child.

4.4.3.2 I had a previous bad experience with hospital staff

Hospital staff was regularly discussed in the interviews. One woman said, “The anesthesiologist was amazing. He was great. Um... nobody else was.” (Wilma).

It was evident that many women, who had previously given birth in a hospital, chose home birth because they encountered unsupportive and sometimes even combative staff during their first birth.

“It was traumatic, just feeling like I'm arguing with obstetricians, who didn't seem to have any sort of faith in me or my beliefs or my baby. They pull that, ‘your baby's gonna die’ card quite easily. I just didn't feel respected. Then they took my baby and I didn't get my baby to my chest right away. I had been trying to advocate for myself so much that at that point I just kind of gave up.” (Danielle)

Comments like this one, “I wanted my birth to be the exact opposite of what I had the first time.” (Kim) were quite common, and many times it was referring to the attitude the hospital staff had towards the birthing woman.

“I didn't necessarily have a negative experience in the hospital but, not a positive one. It felt very condescending to me. I don't know whether it was because it was my first child or whether it was because I was 19 when I had him, but I felt very talked down to and I just thought, you know what, I can do this at home. I don't need this.” (Courtney)

4.5 Appreciation for Hospitals

It is important to note that it is not all or nothing. Every single one of the home birth women acknowledged the need for, and greatly appreciated the existence of, hospitals.

“I love that OB's are there, should they be needed. Hospitals are there, should they be needed. Without them it would be horrible, right?” (Kim)

All of the women respected the fact that hospitals save lives and that they have greatly contributed to the reduction in our mortality rate for both mother and baby.

“If you have any complications or risks then I think it has its place and I think it’s really great that it exists. Babies that maybe 100 years ago wouldn’t have survived, now they do and that’s fabulous and I think that’s great and I think we need it.”
(Wilma)

They openly support women for choosing to give birth in a hospital and they are thankful that interventions such as epidurals and c-sections are there for those that choose them or need them.

“The epidural is a wonderful invention. So is the c-section. There are situations where those things need to be employed and we're so lucky that we have maternal health that is at such a high level. [...] We need to have those options.” (Alyssa)

Most of the women even expressed that they would use the hospital system if they had risks and complications during pregnancy or birth. They did not view it in a ‘home birth or bust’ mentality.

“Some people don't have healthy pregnancies, so it's absolutely necessary to have that medical model of birth and that's why, when I decided to have a home birth, it was, like, ‘okay, only if it's the perfect circumstances’.” (Julie)

The women simply viewed it as an opportunity to try for a home birth, knowing that the hospital was there should it be needed.

“If I was transferred to hospital I would have been appreciative that it's there for the situation in which it's necessary. But, I'm glad that I can wait and make sure that it's necessary before I have to go there.” (Annalise)

These home birth women openly showed gratitude for the hospital system and expressed how it is advantageous for some women because it makes them feel safe, however, they felt that the hospital just was not for them, and instead, for them it was the home that gave them that sense of safety and comfort.

“Well, for some women, it does make them feel comfortable. Some women are comforted by heart monitors and nurses and epidurals and so on and so forth. And for those women, great, that's wonderful. You know, I'm glad that it's there for them. Some women find that calming and reassuring and relaxing. That’s great. But I'm glad it's optional, you know. I'm glad I don't live in parts of the U.S. where it's not optional. And I'm glad that I wasn't made to feel like I was putting my child in danger for not choosing that option.” (Annalise)

4.5.1 Home and Hospital Birth Safety

Many women expressed that they feel home birth is safe here in London, Ontario because of the amazing infrastructure and hospital system that we have. Without the obstetricians and the quick access to hospitals, they may not view home birth to be as safe. They also liked to emphasize that midwives are well trained, regulated, and carry a lot of equipment with them to each birth.

“It was explained to me that having your baby at home is the equivalent of having it at a Level 1 hospital, like a county hospital. And I agree with that. I mean, there's lots of people that deliver in the county hospitals. I was surprised with the amount of things my midwife brought with her. It was a lot.” (Holly)

When asked if one is safer than the other, one woman responded with the following:

“I would hope that they are equally safe for the right patient. [...] Not everyone can have a home birth. It's as simple as that. And if my water breaks and there's meconium in the water, I won't be having a home birth either. I'm not taking any risks. So it's got to be the right client, period.” (Alyssa)

While some women expressed that they felt home birth was more safe than hospital birth, “in the right circumstances, I think home birth is safer” (Julie), the majority of the women agreed with Alyssa, that both home and hospital are equally safe for the right woman.

One of the things that made home birth safe for these women was that at home you have two midwives with you who are specially trained in vaginal birth. That is two people that are there to provide continuous medical observation. With an obstetrician in hospital, you only have one nurse and then the obstetrician comes in at the last minute to catch the baby. This idea of having two people to care for you, where there are no other distractions from other patients in the next room, was very appealing in terms of safety to many women.

“I was induced with my son and they still had to pull an OB out of surgery. I didn't have immediate access to a doctor and I was *in* the hospital. [...] They knew that they were inducing me, that at a specific time they are starting the drip, that baby was coming, and even so they had to pull the OB out of surgery. I was pushing with the nurse there and the OB just came in and caught him. That's about all he did. [...] Here, at home, I have two people with resuscitation equipment and two are solely there for me. Not anybody else. They are solely there for me. So yeah, for normal birth I think it's safer. A normal, healthy, low risk birth it would be safer to have it at home because you get two people attending solely for you.” (Kylie)

Women also trust in the regulations of midwifery. They feel safe in choosing home birth because they know the midwives are regulated and will act according to their rules.

Midwives in Ontario do not want a high risk woman to birth at home and have something go badly because then it would put all home births at risk through the possibility of losing that option.

“The midwives aren't going to let you birth at home if it's not expected to go according to plan, right? They protect their right to birth at home just as much as you want to birth at home.” (Holly)

Not all women talked about home birth safety in terms of morbidity and mortality rates. Some brought an interesting perspective of mental health.

“I think it's more safe for the health of the mom, and her experience birthing. [...] After having my second, I felt amazing and super awesome. I felt much more positively about my second birth [at home] than my first birth [in hospital]. So, from the mother's perspective, I think that's one reason why home birth is much safer... mentally... if that's what she chooses.” (Laney)

4.6 Barriers to Choosing Home Birth

Even though home birth is legal in Ontario and we have regulated midwives to support women in their home births, every single woman expressed facing barriers along the way. This aspect of home birth seemed to dominate the narratives.

This section of the results will show implications for change and policy. It illustrates where we need to focus in order to create a fully inclusive and supportive birthing system. We need to make our system a more equal system that supports all birthing choices for all women.

4.6.1 Criticisms and lack of support for home birth

Most women cited criticisms from family, close friends, and society in general as barriers to choosing home birth. They were constantly told that their decision was not the right decision and that they needed to re-evaluate their choices and choose hospital instead of home.

“I would say the hardest part was that you had to always defend what you were doing.” (Holly)

In order to overcome this onslaught of opinions and stay the course for a home birth, these women had to dig deep and remain strong knowing that their choices reflected their belief system and their needs. Going against society and family is a very difficult situation to encounter. Unfortunately, this was the reality for the majority of the women.

“I think other people think you're a crazy hippy. People think you're stupid. They think that you've done no research. They can't even fathom that maybe you have a completely different viewpoint than them. [...] People don't know anything about it and because of that they're very fearful of it. And very, like, ‘oh my God, why would you do that, you're putting your life and your child's life at risk, and how could you start out, you know, just not caring about your child like that?’.”
(Tammy)

For just over half of the women, one of the hardest critics to overcome was their spouse or partner.

“My husband for the first home birth... not a fan. He was not for it. He was like, ‘I don't want to do this. I believe in you, I trust you, so I'm going to go with your decision, but I don't want to do this’. And I proved him wrong. And we did it.”
(Carmalina)

This notion of “proving them wrong” creates an us-versus-them mentality, instead of an inclusive and supportive birthing system. This divisive attitude exists on both sides of this issue, as explained by one of the women participating in the research who used to be a labour and delivery nurse, and is now a NICU (Neonatal Intensive Care Unit) nurse. She knows firsthand the type of stigma that hospital workers have for home birthers.

“I'm acutely aware of social stigma, especially with my colleagues. I don't talk about my choice, at all. I really, honestly, avoid the subject completely. I worry that one day they're going to ask me, ‘who's your OB? Who'd you pick?’ [...] They have a real feeling about midwifery and for them, home birth is akin to child abuse. So I really avoid talking about it with colleagues, at all costs. [Midwifery is viewed as] a lower level of care, a lower standard of care. I think that some of them would go as far as to say that it's a neglectful choice. But that's their world. That's what they ‘know’.” (Alyssa)

Unfortunately, this is the type of environment that a home birther would encounter if they chose to transfer to the hospital during labour. Although some women did not encounter this intense criticism, many women encountered a simple lack of support. One woman said the following about her family:

“I don’t think there is ever that full support, but I think after the first [home birth] they just realized that I’m going to do what I wanna do and so they didn’t say much about it.” (Carmalina)

The women expressed a feeling of sadness regarding this lack of support and the realization that they will never have full support from their family. The pressure of wanting their support can be a huge limiting factor for women to choose home birth.

4.6.2 Misconceptions and lack of information around home birth

A lot of the lack of support actually stems from a lack of information, or misinformation. Therefore, focusing efforts into improving and correcting the societal knowledge around home birth may be the best place to start in order to create a system that supports all women in all birth choices.

In order to accomplish this, a couple of the women suggested going back to the basics by adding birthing knowledge into our education system.

“I didn't know any different because you're never taught that in high school and growing up. You take this parenting class but they never touch on actually giving birth. We don't learn this stuff growing up. We don't. So when we grow up and think about having a baby, we automatically think about it in a hospital. That's what it's always been depicted as. That's how it always is in the movies.” (Carmalina)

However, since it is not currently taught to all high school students, many women simply stumbled across home birth. When the hospital did not seem to fit in with their needs and comfort levels, these women were lucky enough to find people who were willing to introduce them to the idea of home birth.

“I’m really glad people who I know who had home births talked about it and told me about it because I wouldn’t have known otherwise.” (Cindy)

However, relying on word of mouth to spread the information “puts a lot of onus on the people who have home births” (Kim) and there’s already so much stigma attached to these women, so speaking out is difficult for many. As a result of this, one woman took the knowledge translation of home birth to a bigger level by suggesting ways to get the information out there to women of child bearing age, and the rest of society. Wilma said

we needed more “things like this research project”, as well as ways to talk “about it more broadly”. Her suggestion was a media campaign.

“There’s lots of public education and awareness campaigns for all kinds of different issues. I mean, we used to think that AIDS was something you could catch by coughing on someone and through public education and awareness that stigma changed.” (Wilma)

Along with the simple lack of information, there were also a lot of misconceptions about home births and midwifery in general. Simple things such as ‘I’d rather have a hospital birth, so I chose an OB’ and ‘I’d rather have a free OB than pay for a midwife’ were common concerns that home birth women regularly encountered regarding their choice.

“When I said I had a midwife, they immediately thought I *had* to have a home birth. And I was like, ‘no, you can actually choose’.” (Danielle)

“‘So who pays for it?’ I get that question a lot and so I’m, ‘Oh, no. It’s entirely covered by OHIP. I don’t pay a cent’. Like, it’s covered, and it actually costs the health care system less money to have a midwife and to have your baby at home than to have your baby in a hospital. So it’s less strain on the system and it’s free for the client, for the end user.” (Wilma)

4.6.2.1 *The generation gap in support for home birth*

Another barrier that home birth women encountered was the differing of support levels based on which generation a woman was discussing her birth with. Some women talked about how supportive their grandparents were when discussing a home birth.

“My grandma actually was a surprising supporter of it. [...] She’s had 8 kids [...] 5 or 6 of them at home. But this was a completely different generation. My dad was born in a farm house at home and she told me [...] ‘When I heard you had a midwife I was so glad and I’m so happy you’re having the baby at home’.” (Wilma)

While some mentioned their grandmother's having home births, others had to go back another generation saying their grandmothers were born at home, but then gave birth in a hospital. Although it was not a specific interview question, none of the women indicated that their mothers gave birth at home. Many women mentioned how older women typically are more uninformed than younger women of childbearing age.

“Women of my mother's generation have no idea. They don't even understand what a midwife even is.” (Tammy)

This shows a drastic shift in the way Canadian and Ontario culture views birth over the last three or four generations.

4.6.3 Birth is fear driven in our society

Since this generation does not have the home birth role model from their parents, they either get a hospital narrative from their parents, or they search for their own information elsewhere. One of the most common media outlets that women talked about was the TLC show, ‘The Baby Story’.

“Watch TLC. Watch The Baby Story. When I watch those shows, I’m scared. Like, how is this supposed to depict birth? They cut it and manufacture this birth experience that is so unrealistic. These women are just screaming and they’re horrible [...] And in my head I’m thinking, no wonder women are scared to do this! This is terrifying! It is utterly terrifying.” (Carmalina)

It is evident that women (and men) are being raised in a culture of fear surrounding birth.

“With my first I had some fear before the birth because growing up in our culture, that’s something that people fear. ‘Oh my god, it’s painful and traumatic’.” (Danielle)

Typically, the home birth women did not believe this or did not let it dominate their thinking. Yes birth can be painful, but it does not have to be fear filled and traumatic. It should be respected because things can go wrong, but it does not have to be overly medicalized. These were big barriers in ideology that these women had to overcome and contend with. These ideologies became the most apparent when speaking with other parents. For some reason, when parents meet and speak with a first time pregnant women, it has somehow become appropriate and almost customary to tell this pregnant woman their most horrible and traumatic birthing stories.

“Women love to do that too. I’ve been in groups of women who are like, ‘oh yeah, my birth was ...’ and they have all these negative things to say. And they love telling newly pregnant first time moms their traumatic stories and it’s just hard to listen to that, but it’s almost like they want to trump each other.” (Danielle)

With so much fear surrounding birth, people have almost guttural reactions when a woman says she is planning to birth at home. Since they view birth to be traumatic and dramatic, then they are adamant that all birth should take place at a hospital. Society has a hard time understanding that some women have a different viewpoint and that these

women actually pull strength and comfort and safety from their homes, instead of from the hospital. This is a large barrier that will take time to break down.

4.6.4 Lack of informed choice and knowledge for first births

The participants expressed how our society is not being educated on all of their options. Most women do not even know that they have options, therefore how are they supposed to be able to make an informed choice if they do not even know there *is* a choice? As a result, over half of the women participating in this study had their first birth in a hospital.

“I think people don’t even realize that they’ve got options. They just think, ‘I have to go to the hospital and I have to have an obstetrician deliver my baby’.” (Lauren)

It was only after experiencing one (and sometimes two) hospital birth(s) that women started actively looking for alternative options. One woman had a bad hospital birth with an obstetrician involving forceps with her first child, so she changed her care provider to a midwife with her second child, but noted:

“With my second, I’m not really sure why we even planned a hospital birth. In a way it just seemed easier because I didn’t know anyone who had a home birth, so I couldn’t wrap my head around it. Like, what do you do, where do you set up, what do you need?” (Danielle)

4.6.5 Re-normalizing birth

I specifically asked all of the women how we can combat all of these issues and barriers. The main response was that our culture needs to increase their awareness about different ways to birth, we need to share all types of experiences, and we need to talk about birth and all birthing options from early on in life so as to normalize birth discussions.

This starts by talking truthfully with our children when they are young and adding birth education into the education curriculum.

“People have been conditioned to believe that birth is some medical event that needs to be in the hospital. For example, my oldest, he started JK, and there’s a grandpa there and when I was very pregnant his granddaughter said something about ‘why does she have a baby in her belly?’ and he said ‘well, she went to the hospital and ordered her baby and is going to go back and pick the baby up’. And I thought, see, it already starts. It just starts so young that how do you undo that?” (Danielle)

Once we start to change the next generations knowledge of birth from an early age, then we need to continue the education by continuing to talk about it:

“Sharing our experiences, telling people, showing people, talking about it. It’s that normalization. We’ve got to normalize these things. Home birth is not scary. Show people ‘The Business of Being Born’. Show people the studies that conclude that home births are safe. [...] If people want a hospital birth with epidurals, that’s great too. Just make sure people know that there are choices and allow those people to make those choices based on full and accurate information.” (Carmalina)

We need “more awareness. I think just telling people that it’s... you don’t have to be a hippie to have your baby at home.” (Wilma)

In other words, talk about all birth options, as much as possible. Remove the stigma of certain choices for birth by normalizing birth in general.

4.6.6 Lack of midwives

All of the previous barriers were the result of our societal metanarrative. Lack of information and support from family, friends, and society in general caused emotional and knowledge barriers that these home birth women had to overcome. However, there were also physical barriers that some women encountered. The main one was a lack of midwives.

“Not everybody gets a midwife. There’s just not enough space. So I think that’s a barrier.” (Wilma)

“Odds of getting a midwife that has an opening to fit you in during your birth month is hard. It’s really hard. [...] We need so many more midwives.” (Kim)

“With my first I didn’t get a midwife. I had tried to get a midwife, but I didn’t get one. I was on three waiting lists and never got one.” (Danielle)

As one woman stated, this barrier impedes our health care beliefs as it goes against one of our foundational qualities in our public health care system: accessibility for all.

“Accessibility is a bit of an issue I think. One of the laws of health is related directly to accessibility, and we are not fulfilling that when it comes to midwifery care. [...] People are being turned away left, right, and centre.” (Alyssa)

The solution is to hire more midwives, however there are not enough people choosing midwifery right now to meet the demand. This is where reducing the societal barriers for

women to choose home birth could also increase the knowledge for people to know about midwifery so that they may choose it as a profession right out of high school.

There's also an issue with a lack of support for midwives by others in the medical fields.

“With my first I didn't get a midwife. [...] And it's almost like some people were happy for me because I didn't get one. Even my family doctor, because I think she envisioned me going to a forest with a bucket of water and just having my baby. Like, I don't know if they understand that midwives are trained very well and they can handle emergencies and if they can't, they know what to look for to transfer.” (Danielle)

Pregnant women go to their family doctors when they are pregnant, and then when they are far enough along they are referred to an obstetrician. We need to have both options presented to women so that they can make informed decisions for themselves.

“Making sure that doctors recommend [midwives] to women. [...] But I know a lot of doctors don't support midwives for whatever reason.” (Carmalina)

“They need to recognize that a midwife is a health care practitioner and is part of the health care system [...]. These women went to school for 4 years to learn how to catch babies. They know what they're doing.” (Wilma)

Throughout the interviews, many women voiced a passion about birth and as a result of the support that they received from other home birth women and midwives, and because of all of the barriers that they had to overcome, there were quite a few that hoped to become part of the needed change for the future.

“As soon as my kids are bigger, I'm going to go back to school. I want to be a midwife.” (Carmalina)

4.6.7 No alternate choices

Women who had bad first births in hospital sometimes had no other options but to choose home birth for their second.

“My choice to have her at home wasn't so much that I wanted a home birth, it was that I didn't want a hospital birth and there aren't any other options.” (Wilma)

Unfortunately, our system is not currently built to support all birthing mothers. There could be an alternate choice though: an independent birthing centre run by midwives.

“I may have picked that independent birth centre, just because it was that in between. Right now it's either hospital or home. We need a birthing centre so badly. [...] If somebody's not completely comfortable with home birth, but they

don't want hospital, they don't get that in between choice. There's nothing in between. We so need birth centres for those women. [...] You're one extreme or the next. You're hospital or home. There's no in between. So having those independent birth centres... I think they would be incredible." (Carmalina)

Although many women themselves would not choose a birth centre, simply because they loved the comfort that their individual home provided them, they did view a birth centre as a great stepping stone to introducing people to a version of birth that is not centered around the hospital.

"If people maybe aren't sure about having a home birth maybe that's a nice option. They may feel safer and more reassured." (Charlotte)

However, a few women voiced their concerns that "a birthing centre just kind of seems like a tunnel to a hospital." (Danielle). They worried that a birthing centre could be attached to a hospital; therefore women are still really close to the interventions, regulations, and impersonal care that lead them away from the hospital. They also worried that women who want a home birth may be persuaded to choose a birth centre instead, and therefore never get to experience the therapeutic properties that their home could provide during birth.

Even though a few women voiced their concerns about birth centres, the majority of the women showed interest in such a facility and talked about the options and choices that this could add to our health care system.

Chapter 5

5 Discussion

This thesis aims to explore the perceptions and experiences of home as a place of birth in London, Ontario, Canada, by asking the questions, “Why do women choose home as a place to give birth?” and “What barriers do women experience when they choose home as a place to give birth?”.

This chapter discusses the results more fully within the broader constructs of home as a place of ontological security and therapeutic landscape. Key findings from the results are summarized with the addition of explanations and possible reasons for the emergence of certain themes and what they mean for policies within the health care system. I will then take a look at how home birth has unique therapeutic landscapes at varying scales and how we can use these to better address the needs of home birth women. Limitations, applications to policy, and implications for future research will also be discussed. The aim is to develop a framework to better inform and serve those individuals who choose home birth, while understanding their motivations for doing so.

5.1 Summary of Findings

This section of the discussion will mimic the layout of the previous results chapter by analyzing each major theme. This will include why women choose home birth, why they do not choose hospital, concerns around safety and the benefits of hospitals, and barriers that women encountered along the way. All of these themes will continually be tied back into the therapeutic landscapes framework that is used as a foundation for this thesis.

5.1.1 Why Give Birth at Home?

It was important to address a gap in the literature by looking at both positive and negative aspects of birthplace on health. Many studies that looked at choice of birthplace focused on the negative aspects of the hospital, so this thesis aimed to contribute to our understanding of the home as a place of birth and its possible benefits by looking first and

foremost at the positives of the home. I wanted to know what it was about the home that encouraged women to birth there, and not just what it was about the hospital that pushed people away.

Almost all of the participants spoke about the fact that birth is a normal and natural process. As a result, they wanted birth to be a normal and natural occurrence in their lives and believed home to be the best option for this mentality. Thus, to many of the interviewees, if something is normal, it should take place in your home, not a hospital. This was a key starting point for why home was a natural fit for these women. It seemed like the logical and most appropriate choice given their views on birth. The perception of home as a natural place to give birth emerged through the interviews and this viewpoint was reinforced by the fact that women see home as a place for comfort, control, and safety.

5.1.1.1 Comfort at Home

For most of the participants, simply being at home changes the entire birthing experience, since they do not have to try to make themselves comfortable in an unfamiliar space. Once at home, participants indicated they could just relax and enjoy their surroundings and the natural calmness that their home exudes. With the type of attachment to their homes that was shown in the results, why would these women not want to experience one of the most joyous days of their lives in it? It only makes sense that women with this sense of belonging and women who view their home as a place of ontological security would feel more comfortable and safer in their home, instead of in the strange, unloving, and unpredictable environment of the hospital.

One of the possible reasons for why the home is calming is the fact that the home is entirely one's own space. Everything that you look at has been carefully selected and placed there by its owner. Everything that the woman comes into contact with during the course of her labour and birth has a story and meaning behind it. There is a sense of belonging, not just for the women, but also a belonging for their unborn child. The women reported that the home is where many of their happy memories were created and it is where they chose to raise their families. Participants agreed that it only seemed

fitting to create a new memory in their home by welcoming a new addition into their family there.

5.1.1.2 Control at Home

Several of the participants reported that being in control in their home was one of the reasons why they chose to give birth in their home. The notion of control in this case included fairly simple concepts, such as controlling who entered the room, but it also included the notion that they knew they could say ‘no’ when they wanted. In the hospital, they may not have that confidence or the knowledge to say ‘no’. Also, the women agreed that women should not be put in this position of opposition that can often occur when delivering in a hospital. There was consensus that the birthing woman should always be supported and allowed to be in control. Therefore all choices, including those as simple as who enters the room, should be posed just as that: a choice.

Instead of being put in a situation where they may lose or have to ‘fight’ for their control in a hospital, women chose the home as their place of birth. Simply being at home eliminated any power dynamic that tends to exist in a hospital. The women perceive control within their home. Thus, they perceive themselves to have control over everything that happens in it. This develops a sense of security built upon the knowledge that they will have options and be included in the decision-making process. This was a substantial tenet of what made the home the best choice for these women. The empowerment and sense of achievement that was gained is an important part of the birthing process, and for home birth women, they are able to find this element at home due to the power and control that their home provides them.

5.1.1.3 Support at Home

Many home birth women described their support network during birth as the reason they were able to succeed with a home birth. It was interesting to see how their language around the therapeutic nature of the home started to shift, with some of the women beginning to include their support network in their concept of a therapeutic landscape. Participants phrasing started to shift from ‘I’ to ‘we’ and they talked about the physical,

psychological, and emotional support that the people around them provided. The support network created a form of safety net that held these women up when they were at their weakest point and prevented them from failing when they themselves started to lose hope. Many women experienced a lack of support during their first births in hospital and, as a result, made sure they chose home birth for their next pregnancy and surrounded themselves with a support network that would be more sensitive of their feelings and believe in them. This helped establish their home as a therapeutic environment during their birth.

These feelings and ideas of safety and health were not just determined by space (the physical location of home), but also by place (the meanings in their environment and who they surrounded themselves with). The therapeutic nature of the home started to expand to become more than the place of home and also included the personal space that was created by the woman's support network. This is consistent with work by Smyth (2005) who talks about a 'therapeutic networks' category of therapeutic landscapes, and this shift in language definitely addresses this aspect of the framework.

5.1.2 Why Not Give Birth in a Hospital?

As with their reasons for choosing home, their ideas and concerns against delivering in a hospital could be grouped into the same three main themes of comfort, control, and support.

5.1.2.1 *Lack of Comfort*

Women want to feel comfortable during their labour; however, entering a brand new environment can be a very scary thing. A good therapeutic environment will most likely be a familiar one, which could be a large contributing factor in why these women choose to stay away from the hospital, and instead choose to have their babies at home. It is also important for some women to be able to mentally walk through their birth ahead of time. It helps to picture where they will labour, how they will feel, in what position they will deliver the baby, and where they will rest after the hard work is done. This mental imagery is easy to create and become comfortable with when the environment is one that

the woman is familiar with, such as the home. When women had never seen the hospital birthing unit, this became a big stumbling block for them. A solution to this would be to bring back hospital tours at the local hospital so that women have the opportunity to familiarize themselves with the birthing floor and the birth suites.

5.1.2.2 Lack of Control

It was common for women who previously experienced hospital births to report feelings of disappointment with the overall experience. This tended to be grounded in a lack of control. Many believe that a downfall of obstetric care is that they tend to keep you uniformed and therefore unable to make decisions. It was indicated in the results that, if the doctor does not educate a woman and instead just tells that woman what they are going to do, then they will not have to take the time to explain things in order for the woman to participate in the decision-making process. Basically, it is much easier and faster if the word of the obstetrician is elevated to the point where the woman simply listens and obeys. The problem is that this causes the power to shift from the woman to the medical staff, and home birth women do not want this. Participants argued that they feel much better when they are part of the decision-making process and the hospital tended to take this involvement away from them.

Similar to a lack of decision-making abilities, women voiced the issue of rules and regulations. The sentiment was that hospitals have too many rules and regulations that are built for the textbook labour and delivery. Women felt that choosing a hospital birth meant that they had to choose to ‘submit’ and give in to all of the rules, regardless of whether they aligned with their birth plan or personal requests. Rules and regulations, especially those around “clocks”, did not aid in the delivery process and instead just added stress to an already stressful environment. If they are scared that their bodies may not follow a perfect textbook labour plan, in which case a cascade of interventions will be forced on them, then they will be unable to fully relax and feel comfortable in that birth space. This fear is one of the main reasons why these women do not feel that the hospital is their safe and therapeutic landscape for birth.

5.1.2.3 Lack of Support

During previous hospital births, women complained of many unknown faces rushing in and out of their labour room. As attested by those who had previously given birth in a hospital, facts were written down, procedures were hurried, names were not known, and stories were not shared. There simply was no time for that. When the obstetrician entered to deliver their child, many women found it unsettling that they had never met this obstetrician before and had no relationship whatsoever with this person who would become a part of this very personal moment. This experience did not create the type of loving and supportive environment that many expected and wanted.

This sense of impersonal care and lack of support resulted in many of the women experiencing harsh tones from staff because they asked too many questions or they complained too much. Since hospitals must adhere to their regulations, the care each woman receives is created for the masses, based on a textbook birth. This is essentially a one-size-fits-all approach. The hospital system measures women based on deviations from the averages in a textbook, whereas a home birth allows women to be cared for based on her individual needs. Not only did these women have lack luster, and in some cases horrible and traumatic, hospital birth experiences, they also felt that this impersonal care in the hospital actually resulted in substandard care. With so many people rushing about and multiple medical providers caring for a woman over the course of her pregnancy, labour, and birth, many found that this created a lack of continuity of care. For example, a busy obstetrician can read notes from varying nurses over the course of a woman's labour and then compares these to what the typical labour should be. There isn't a consistent person there to note small changes over time that an individual woman may show. By not having one dedicated medical professional that is there to monitor the woman over time and be able to pick up on small changes, this shuffle of providers, or lack of continuity of care, actually creates a lesser level care. However, a midwife at a home birth is there for that woman, and only that woman. They are there to watch how the woman is dealing with labour and can note subtle changes over time. This can result in the identification of "pink flags" and can alert to possible minor issues before they become major issues. By having the continuity of care of one trained medical

professional in labour, it does not only increase the support that a woman feels, but it also increases her confidence that her support team is able to address her individual needs a lot faster and better than the flurried environment of the hospital.

5.1.3 Appreciation for Hospitals

Even though the home birth women did not choose to give birth in a hospital, they still had several positive things to say about the hospital system. They were thankful the hospital was there, should they require it, because they know that without hospitals and obstetricians, our maternal and infant mortality rates would not be as low as they are today. They were also thankful it was there for those women who feel safer in the hospital compared to birthing at home. The home birth women understand that home birth is not for everyone because many people would feel terrified to birth at home, just like many of them would be very uncomfortable and possibly traumatized if they gave birth in a hospital. They appreciate that hospitals are an amazing part of our health care system; however, they felt that it just simply was not for them. Instead, for these women it was the home that provided them that feeling of safety and comfort. The same sense of safety and comfort that other women gain from the hospital. It is important not to look at one as better or more desirable than the other. They are simply different.

In terms of safety, many viewed home and hospital to be equally safe (in low risk pregnancies) with regard to physical safety of mom and baby, but it was interesting that many women also brought up the issue of mental and emotional safety in birth. These parts of safety are exactly what ties into the therapeutic landscapes of home. Home birth is much safer for the mental and emotional well-being and safety of women who choose home birth. They do not feel safe in a hospital. They do not feel as if they can relax and wholeheartedly trust their birth team around them. If they do not feel safe and they are unable to relax in their environment, then how can we expect them to safely bring a child into the world? Home is where they are most comfortable, where they feel the most confident in their abilities as birthing women, and where they have developed a sense of ontological security. Therefore home, due to the therapeutic landscapes that it offers, needs to be the location in which society supports them in choosing.

5.1.4 Barriers

It is important to highlight here that 100% of the woman who participated in this research expressed facing multiple barriers when it came to choosing home as their place of birth. The barriers that women faced around choosing home birth dominated the discussions and stories of the in-depth interviews. This was a shocking discovery for me and one that I hope is taken very seriously by our government, policy makers, health care system, medical professionals, researchers, and society as a whole.

First and foremost, we need to find a way to address the criticism that a home birth woman typically has to endure. This criticism comes from family members, friends, spouses, and even complete strangers. Women are constantly being told that their decision is not the right decision and that they need to re-evaluate their choices and choose hospital instead of home. These barriers arise because they are encouraged to choose someone *else's* therapeutic landscape, instead of their *own*. Society as a whole feels most comfortable, and in the safest environment, when women give birth in a hospital. However, these women feel differently from the majority of society, and as a result, they are often forced to explain why the home is their therapeutic landscape and defend this aspect of their beliefs. Society as a whole has a hard time understanding that some people have a different sense of what makes an environment safe.

In order to overcome or combat this criticism, many expressed the need to prove something to the 'dissenters'. They wanted to prove that they could, and would, do it, and as a result it became an us-versus-them situation, instead of a supportive environment. Sometimes when people dig their heels in, they become stubborn about their stance, and they try to achieve it at all costs. The same can be said for those who believe that the hospital should be the only option. This was illustrated in the results when the NICU nurse said she could not even mention that she chose a midwife, let alone a home birth. That her colleagues were so against home birth that they would go so far as to say it was "akin to child abuse" and a "neglectful choice". It is unfortunate to see that this woman has to be so careful about talking about her pregnancy and birth in fear of the backlash that she knows she would receive. This is precisely the type of environment that a home

birth woman would encounter if she chose to transfer to the hospital during labour. These nurses are so set in their beliefs that it would most likely affect their ability to calmly and kindly care for a woman in need. Many home birth women talked about how there would most likely be an ‘I told you so’ comment from hospital staff, friends, and family if they ended up transferring to the hospital. The two sides are adamant that they are right, which is creating a hostile and unsupportive environment. Instead, we need to focus on creating a birthing system that supports all women in all birth choices, depending on what is best for them and their needs. In birth, we need to constantly be open to the idea of something going wrong and possibly needing a transfer to hospital. If we make it an us-versus-them competition, our outcomes may suffer. We need to rid (or at least diminish) this stigma of “home birther” so that they do not feel they need to prove anything. With full support, they are more likely to make a quick decision to move to hospital if it is needed.

Another barrier that should be addressed is the lack of support that many women encountered. Sometimes, the only supportive person that a woman had was her midwife. It is especially difficult when the woman’s spouse or partner is not on board or when her mother is not supportive. Those were the two support people that really affected a woman’s confidence and enjoyment in her decision and journey. As a result, when their midwife was the only person on their side, women would stop telling people about their choice to try a home birth because it would turn into arguments and they always had to defend themselves. There was never anyone with them that could come to their aide with the latest research or support them after a particularly hostile conversation by reminding them that they made the decision that felt best for them. The lack of family and spousal support created a very lonely environment. The lack of talking about their choice actually prevented them from having the support they so desperately needed. In one particular case, when my call for research participants was posted online, one woman remarked at how shocked she was when reading through the responses to the ad. She could not believe how many people she knew who had had a home birth. The opportunity to have the support she needed was right there for her to tap into, but because of this metanarrative against home birth, these women withhold voicing their decisions and therefore exclude themselves from the opportunity to create a supportive community around them. Maybe if this community was easier to find, due to less stigma attached to

the title "home birther", then these women would be able to talk more openly about it with the knowledge that the supportive community is behind them. It is so much easier to talk about issues that go against the norm when you know you are not standing alone.

Part of the process in addressing the criticisms and lack of support that home birth women receive also involves clearing up misconceptions that people have about midwives and home birth and creating a culture of knowledge around all birth choices. Some of the common misconceptions were that midwives could only perform home births and were not properly trained to work in a hospital and that an obstetrician was the only care provider that was covered under our provincially funded health care system. Clearing up these misconceptions and laying a foundation of birthing knowledge for future (and current) generations is essential in reducing the barriers women face when choosing where they want to give birth. In order to create an equal system of support, we first of all have to inform society that there are multiple options, and that the hospital isn't their only choice. Then we need to teach them that both options can be viable for the right people and that the system can actually benefit by supporting all women in their birthing choices. This may require a large and deliberate effort by home birth supporters and the government in order to educate the general public about many of these misconceptions, issues around safety, cost effectiveness on our health care system, and how our system is built in order to safely support a home birth.

This lack of information was particularly prevalent in certain generations. With the shift of birth location from home to hospital over the past century, home birth drastically decreased, creating multiple generations of women (and men) who viewed the hospital as the only safe place to give birth. Midwifery was regulated in Ontario in 1991, and since then the rate of home births have slowly been increasing. However, since the average age of participants in this research was 33 years old, midwifery was not regulated at the time their mothers gave birth to them; therefore home birth was not a viable option. Since a lot of birthing knowledge is passed down from mother to daughter, many of the participants talked about tension between them and their mothers because of their opposing viewpoints around birth and the options in location where birth can take place.

The reported pressure placed on women from society and from family members alike to deliver in the hospital is based on a widely believed notion that the hospital is the safest place to give birth. These beliefs are most likely coloured by the birth experiences of parents and grandparents whose generations were made to believe birth must be performed in a health facility with a doctor present. This could be a key demographic that we may need to target if we are to change the current metanarrative. Past generations are continuing to place their personal bias on the current generation, therefore continuing to perpetuate hospitals as the only choice. It is important to look at how births took place one and two generations ago and how this could cement in the minds of these past generations that hospital is the only choice. Home births may have been unsafe because midwifery was not regulated back then and home birth was not a part of the medical system. That is very different today. The techniques that were used in hospitals in past generations were also very invasive and had many poor outcomes, therefore it may have made birth seem more scary and less natural to the generations who experienced this.

This generation of women is the first of its kind. They are being pulled back to the home because that is where they feel safe and secure. However, today's generation of women are meeting resistance from previous generations of women, which is creating a large barrier that is difficult to overcome. Since it can be these older generations of women who typically educate us and help support us during our childbearing years, then a lot of our information and support is coming from an uninformed or misinformed generation. This does not mean that older women provide the only obstacle, misinformed or one-sided hospital providers also add to the misinformation and lack of support, however, many women mentioned this barrier in familial and motherly support as a difficult barrier to overcome. This is a very important situation to consider when trying to enhance the narrative of these women because their knowledge was in no way handed down to them from the generation directly above them. In order to re-create a system where birthing knowledge is passed down from mother to daughter, we need to educate everyone, not just the current childbearing women, that birth is natural and home birth can be safe for those who choose it.

Along with the criticism, lack of support, and generational gaps in knowledge, another barrier that many women encountered was a lack of informed choices during their first birth. Since their mothers had hospital births and society tends to depict hospital births as the only reasonable option, many women did not even know there was another option. As stated in the results, just over half of the women who participated in this research had their first birth in a hospital. Some participants explained that the women who choose home birth may be those who, after experiencing their first birth in hospital, found that something was missing or that it should have gone better or differently. They spoke about how women choose home birth because they experienced the ‘normal’ birth that society says they should have and then decided they wanted something better or different.

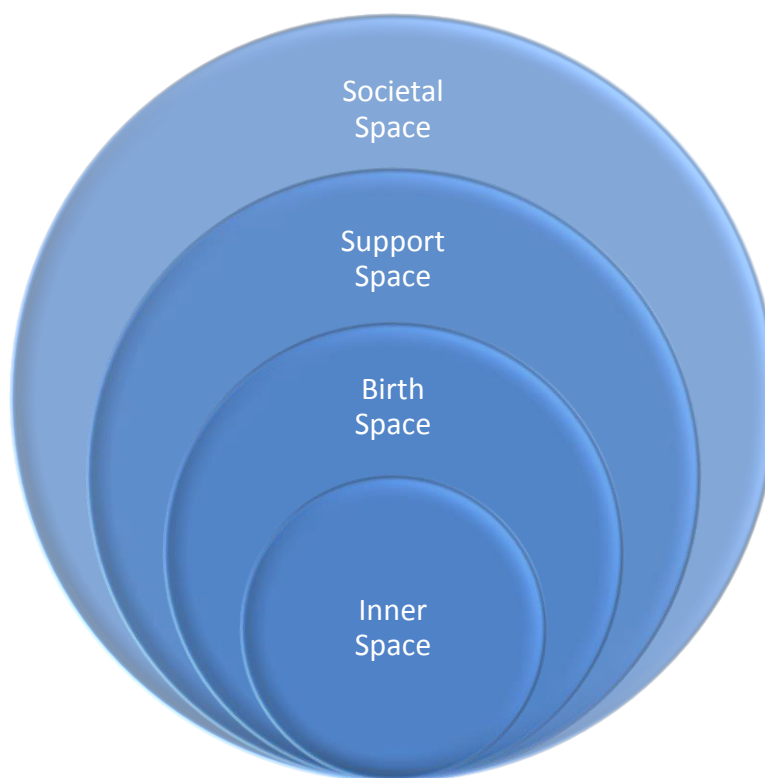
With all of the previously mentioned lack of education and knowledge, we are creating the largest barrier for first time moms, especially those who are younger and do not have many friends who have already had children. Many women expressed that they wished they knew about home birth prior to having children because their first birth experience ended up being very traumatic. They did not discover home birth until they were immersed in the parenting world and met other moms who had given birth at home. Once they found these people, home birth clicked with their needs and they knew that it would fit with their beliefs and safety issues more than a hospital birth. As shown in the results, a large contributor to not choosing home birth for a woman’s first birth was her lack of knowledge and unanswered questions about how a home birth worked. Had these women had this knowledge and network of home birthers before their first baby, they could have made an informed decision from the start about where they would like to give birth, instead of being forced to experience a ‘normal’ birth by societal standards, which left them feeling disappointed and in some cases traumatized. If the home birth narrative could be broadcast to society, then maybe we won't have to wait for women to experience this lack luster birth themselves. Maybe we can build a metanarrative so that all women can make an informed decision for their first birth, instead of following the status quo for their first and then discovering their voices and options for their second or third.

Improving and ultimately removing all of the above barriers will be key in truly making our health care system accessible for all women and for all birth choices.

5.2 Scales of Space for Therapeutic Landscapes of Birth

Wilson (2001) identifies a gap in the literature for therapeutic landscapes when it comes to discussions about scale. Ten years earlier, Gesler (1991) asked the question ‘On what scale is place encountered?’, however this concept of scale has been largely overlooked. Only two studies were found that looked at varying scales that therapeutic landscapes were experienced on. Parr (1999) notes the difference between individual and collective therapeutic landscapes, while Gastaldo et al. (2004) finds that therapeutic landscapes are experienced on levels other than the physical. They specifically look at the therapeutic landscapes of the mind and note how restrictive the framework of therapeutic landscapes is if we place the physical environment at the centre of this concept. In this thesis, I have had the privilege of studying therapeutic landscapes and the ‘space’ of birth over varying scales. It was discovered that the physical location of birth could only account for one of the four identified birth spaces and that therapeutic landscapes were actually created and experienced on a range of other scales.

Figure 1: Scales at which women experience the therapeutic landscapes of birth



When looking at the factors that influence where a woman chooses to give birth, it became clear that the comfort, control, and support were created and experienced at varying levels of themselves and the society around them. As a result, the psychological, emotional, physical, familial, political, and societal ‘spaces’ of birth were encountered at larger and larger scales.

All of the spaces shown in Figure 1 are representing the different scales in which the therapeutic landscapes of birth can be created and experienced. As you move up and out in scale, each space is being influenced by a wider and wider group of people. The following is a description of each scale in which women create and experience the therapeutic landscapes of birth.

Inner/Personal Space

This inner space is influenced by the unique combination of knowledge, values, and mental preparedness for each woman. This includes her individual attitude and beliefs towards birth, the knowledge around birth that she has gained over her lifetime, and everything else in her head that pertains to pregnancy, labour, and birth. If a woman is knowledgeable about all of her options and is given freedom and support to choose what suits her needs, all of this information will lead this woman to her ideal place of birth. For example, if a woman believes birth to be a natural process and has the attitude that birth should be a normal thing that occurs in an everyday normal setting, then this woman will choose a place of birth that is most likely to meet her inner values, desires, and needs. If a woman believes that birth should be a calm and uninterrupted process, feels confident that her instincts are her best guide, wants to be a part of the decision making process throughout her pregnancy, labour, and birth, and values autonomy of her body, then this woman will choose a place of birth that is most likely to meet her ideal inner therapeutic landscape needs. This scale of the therapeutic landscape of birth is created and experienced based off of the inner or personal space.

Birth/Environmental Space

This space focuses on a woman’s immediate environment and the place that she is physically in. This addresses Smyth’s (2005) ‘therapeutic spaces’ category of therapeutic

landscapes. This is where a woman's intrinsic feelings about her house come into play. Her feelings of comfort, control, support, and safety come from her immediate surroundings. In this case, it is the home itself and her intrinsic feelings of belonging and ontological security that create her therapeutic landscape. It is the pictures of her family lining the bookshelves, the feeling of ease that comes from walking around her house instead of pacing in a hospital hallway, it is her favourite snack food stocked in her pantry. It is the ability to go about her regular life, even when she is in labour. The environment reminds her and confirms with her inner space that this is a normal part of life. Her home grounds her and allows her to relax. This experience of home as a healing environment, in regards to its physical space and the meanings attached to it, create a sense of relaxation. This scale of the therapeutic landscape of birth is created and experienced in the physical birth space.

Support/Family Space

The people and support system that surrounds a woman during labour and birth determines this space. This consists of her care providers, spouse or partner, doula, and other family and friends. Some of the women indicated that as long as their support system was there, the physical space or location did not matter as much. This addressed Smyth's (2005) 'therapeutic networks' category of therapeutic landscapes. Even when the physical location of birth was not what they had planned, they still felt as if they had a very therapeutic environment because of the people and support system surrounding them. The love, comfort, relaxation, and safety that many women attributed to their home, others felt that it was actually the family and friends that you surround yourself with that truly make a house a home. So even if a woman chooses or transfers to the hospital, if she is able to find her therapeutic landscape through the people that she has around her, then she will be able to bring those feelings of love, comfort, relaxation, and safety with her. Therefore, a woman's therapeutic landscape can be created and experienced on a scale with many other human beings, where her therapeutic needs are met through her support space.

Societal Space

This space addresses the health care system, medical professionals, government policies, and society as a whole. This is the largest scale in which the therapeutic landscapes of birth are created and experienced. Like Parr (1999) notes, therapeutic landscapes can be collective in scale. We know there is a current metanarrative of ‘hospital is best’ and that is due to the fact that the majority of people and professionals personally find this location to best suit their therapeutic landscape needs. However, although this is a collective scale of therapeutic landscapes of birth, it is not currently inclusive of all therapeutic needs for birth. Our current societal birth space is not understanding to the fact that everyone views the world with a slightly different perspective. As a society, we need to acknowledge that our personal viewpoints should not be placed above the viewpoints of others. The creation of this metanarrative has created a system full of obstacles and barriers for anyone who does not prescribe to the ‘hospital is best’ perspective. If society is able to change their metanarrative to be inclusive of all birth choices and all birth locations, then this would reduce the amount of disconnect that home birth women would experience between this societal birth space and the other three smaller scales of support, birth, and inner space. By changing our societal space to be inclusive, this would create a more therapeutic and supportive environment for all women regardless of what place of birth best suits their therapeutic landscape needs. If this occurred, women would be free to develop their own therapeutic landscapes in the three smaller scales and allow their unique needs to dictate what birth choices are best for them, instead of feeling pressure to listen to the therapeutic landscapes of the metanarrative or societal space. This scale of the therapeutic landscape of birth is created and experienced in the societal space, and due to its large scale, it currently creates some of the largest barriers for home birth woman to overcome.

Those are the four spaces that represent the varying scales in which the therapeutic landscapes of birth were created, experienced, and described by the women in this research study. Although the scales can be viewed as distinct and separate entities, there are also certain values that may subtly link all of these scales together. This includes values of safety, certainty, and trust. Women feel safest when they have support from

society, from the people around them, and from their immediate environment. They also feel safest when they are doing what they believe to be right. These same situations also bring feelings of certainty in their choices and trust that they are doing the right thing. When a woman is able to experience these values of safety, certainty, and trust at all birth scales, then a true therapeutic landscape of birth was able to be created and experienced by a woman. We need to work at all scales in order to create a system that can equally support all women in their decision of place of birth. If we can build a society with a health care system that supports both home and hospital births, then that gives full freedom to women to make the choice that best suits them. They will not feel pressured into choosing hospital birth because that matches the therapeutic landscape of her mother, friends, or society as a whole. Society and the health care system will acknowledge that each woman needs to choose the location that best suits her and her needs.

If we build a hospital system that supports the therapeutic landscapes of all women, then women will not choose home birth because of impediments in a hospital birth. For example, she will not be forced to choose a home birth because of a hospital policy that limits the number of support people that a woman is allowed to have to one or two people. If a woman seeks her therapeutic landscape through people, then we need to support that aspect by eliminating this barrier. If we address this and many other hospital barriers, then instead of choosing home because they do not want the hospital, women can be free to choose whichever location best fits with all of their other scales of therapeutic landscapes of birth.

If we can create an environment in which all women are comfortable in, such as a home-like hospital setting or a system that respects a woman's bodily autonomy, then this will give women more personal choices and freedoms when deciding which location best suits her and her needs for a birth. This means opening up our local hospital to birth tours again, allowing women to become comfortable and familiar with their environment before labour begins. This means creating a system where she is more likely to know the people surrounding her. This means addressing many of the barriers that the home birth women in this research experienced and described.

Overall, it may mean that instead of the greatest influence for the choice of birth place coming from the societal space scale, the scale that should have the most influence on a woman's choice of birth place should be the inner or personal space scale. The three larger scales should comprise of an inclusive society, a support network of people she loves and trusts, and a home-like hospital setting. As a result, the reasons for why women choose home birth will be able to be centered around their inner and personal ideals. This means that a woman has true free choice and that the system would be fully supportive of all options. Ultimately, a woman should be able to freely experience and follow her own therapeutic landscapes at all four scales of space.

5.3 Recommendations

This section of recommendations has been directly influenced by the experiences and perceptions described by the home birth women in London, Ontario, Canada. Although many recommendations go beyond the explicit conversations that were involved in the interviews, the content in this section is created out of the experiences and themes shared by the women.

One of the first areas that require addressing in our birthing system is the need to better support women when they choose home. Our system should fully support both options so that women can freely pick the option that is best for them. Understanding the barriers women face when choosing their preferred birth location is essential to the establishment of a health care system that encourages equal and fair access for all women. This should take into account their individual needs when it comes to their environment and their feelings of comfort, control, and support. To operationalize this, we need to provide all pregnant women with the informed and unbiased choice of choosing care from an obstetrician or a midwife. We need to create a health care system that fully informs all women of this choice.

Potential policy applications for this are numerous. Our current health care system does not currently have a policy that requires family doctors to inform newly pregnant women of all of their options for birth. To create a birthing system that better supports all women, additions to provincial or federal policy could be made to introduce a standard practice,

whereby family doctors will be required to supply unbiased information to newly-pregnant women regarding both obstetricians and midwives. They may even be encouraged to start further conversations to ensure women know they have options in pregnancy, labour, and birth pertaining to such elements as location, support people, ways to labour, and many other aspects. In addition, there are not currently enough midwives to meet the present demand for midwifery care, therefore new legislation will need to include the creation of more midwifery positions so that all women who want a midwife are able to access this type of care. This type of legislation would also mean that women will not be prevented from having a home birth due to their inability to access a midwife. Lastly, system wide change needs to start with the current health care professionals. As previously stated, approximately 90% of obstetricians in Canada do not support home birth (Vedam et al., 2012). Further research should be conducted in this area in order to understand what aspects of home birth are not supported by obstetricians. It is generally unknown to the literature whether the lack of support is based in misconceptions, monetary consequences, knowledge gaps, perception of the lack of safety, or the inadequacy of the health system to fully support such an option. It makes sense that they do not support home birth for all women, because that is unrealistic and unsafe. Some women are high risk and require a NICU or another hospital-based support. However, for low risk women who meet certain health criteria, obstetricians should support home birth because our current home birth system is built to accommodate this and research has shown home births in Canada to be safe (Janssen et al., 2002; Hutton et al., 2009; Janssen et al., 2009). Ontario midwives are mandated to follow specific exclusion criteria and transfer care to a hospital and/or obstetrician when a woman is not, or is no longer, low risk.

If the above statistic indicates that approximately 90% of obstetricians do not support home birth under any circumstance, then it becomes an area of education and policy development that is paramount to improving the current birthing system. Not only do we want women to be supported and informed about all of their options, but we also want to create a safe environment if women end up transferring from a home birth into the hospital. A deeper integrated health care system that accommodates home birth as a viable, respected option, with stronger support from obstetricians can better ensure an

easy transfer and reduce or eliminate judgments and harsh language from staff to home birth women. Researching the level and type of support offered by obstetricians and other medical professionals, addressing their concerns, and creating new policy to more fully integrate home and hospital birth choices, is essential in achieving the goals of this research study.

Hospital policies must also be analyzed in order to address many of the weaknesses and barriers experienced by women. This can be as simple as creating more home-like environments in the hospital or increasing the options for more support people to be in the birthing room, or it can be as complex as addressing the lack of true informed consent and discussions between hospital staff and the birthing women. One option for addressing some of the hospital-based barriers is the creation of alternative places for birth.

Presently, a woman in London, Ontario can only choose between hospital and home. There are no other choices or middle ground. A compromise can be a birthing centre. There are currently only two birthing centres in the whole of Ontario, and they are only pilot projects in Toronto and Ottawa with no guaranteed future. This study can be used to show that more options, in regards to the type of environment available to give birth, will mean that more and more women will be able to find a place of birth that fully meets their individual needs. If new policies could be implemented in order to encourage the creation of more birthing centres across the province, then this will provide more options for all birthing women to find a place of birth that is comfortable, controlled, supportive, and safe. There is a lot of work to be done in this area and we need to strive to create hospital and alternative birthing environments that meet the therapeutic needs of all birthing women.

Hospitals and hospital staff were a large barrier for women, and were a major deciding factor for over half of the women in choosing home birth. Although needs around comfort and support were not typically met in a hospital, issues around the loss of control in a hospital setting were more closely attributed directly to the hospital staff. Moving forward, nurses and obstetricians should be aware of the fact that women do not just want to have decisions made for them. Their autonomy is very important to them and they feel safer when they are fully educated about all of their options so they can have a sense of

control and make the best decision for them and their baby. This sense of power should always remain in the woman's hands; it should never be switched over to the obstetricians, nurses, or midwives.

Another aspect of this power dynamic that needs to be addressed is the rules and regulations that exist in a hospital. Being in control is an essential part of most of these women's therapeutic landscape of birth, therefore there needs to be a way in which women have control over which regulations and interventions will apply to them. Birth is already a daunting experience that can be overwhelming, and home birth women do not want to lose the small amount of control that they may have for this very important experience. By keeping the power and control in their hands, it helps them feel safe and allows them to more fully relax, knowing that they are in good hands. It is interesting to note that home birth comes with many "rules and regulations" around who is a good candidate, what is deemed safe during labour and delivery, and when transfers need to take place. However, there was not a single woman who complained about these "rules and regulations". In fact, many women mentioned them as a safety net that allowed them to trust in the system and their midwife because they knew they were in good hands and that the system was structured and integrated in order to properly and safely support home birth. Therefore, it is not the rules and regulations that in and of themselves are barriers for these women. The difference with midwifery and home birth is that any regulation comes with a full discussion between the midwife and the woman and there is a conversation about whether it is a textbook or generalized rule for the average birthing woman, whether or not there are unique aspects of this woman's birth that may alter how the regulation applies, how important the regulation is, what the consequences of not abiding by it are, and what the timeframe is for when the woman needs to make a decision. Using the results section as a guide, a recommendation in the creation of hospital policy would be to create policy requiring health care providers to have a full conversation with each woman to fully inform her of all of her choices. It was made clear that even in the hospital, most of the "rules and regulations" are still a choice, but they are not necessarily presented as that. Some women had the strength and personality to fight for what they wanted, but many did not know they could say "no" or did not have the strong personality that is needed in order to do so. My recommendation would be to

address this issue by making it clear to hospitals and hospital staff that women should always have a choice in what happens to them, their body, and their baby, and that choice should come with a conversation with the doctor or nurse about pros and cons of each of their options. This is how true informed consent is reached, and it was clearly indicated by the home birth women that this was lacking in their previous hospital births.

Lastly, and quite possibly the most difficult areas to address, are the barriers that exist due to our societal knowledge. Criticisms and lack of support from family, friends, and society can largely be addressed through increased education and knowledge around all birth, but specifically around home birth. We need to normalize birth again, reduce the amount that fear is used to drive birth choices, and replace this fear with accurate and evidence-based information. All ages can benefit from this increased knowledge and it will create a more cohesive society that better matches the health care system that we have.

5.4 Contributions

The findings and recommendations discussed in this study are essential foundations for further academic and policy analysis in the fields of health geography and women's health. Globally, this study is one of only a few of its type and, as such, has provided numerous, important contributions to the literature, with potential impacts to domestic health policy.

Midwifery was officially regulated in Ontario in 1991. Since that time, to the best of the author's knowledge, only 2 Canadian studies have focused on why women choose home birth; 1 of these are solely an Ontario-based study and none have used therapeutic landscapes as a theoretical grounding. Also, only one study on this topic has been completed globally from a geographical perspective. This study was completed almost three decades ago, studied the New Zealand context, and was led by a health practitioner (Abel and Kearns, 1991).

From a geographical approach, the analysis presented in this thesis is essentially unlike any of its kind. Not only does it build on a relative paucity of literature in this particular

subfield of health, but it does so by introducing a new approach to its study and thus introduces different perspectives and understanding for a question that has garnered little academic attention. It further uses sense of place in the home environment as a theoretical underpinning and explicitly studies which aspects of the home environment are paramount within the choice of home birth. This study established new perspectives for why women are persuaded away from a hospital birth and contributed new perspectives on women's experiences within an urban setting.

The research also contributes to the literature by being the first in the 21st century and under arguably the most modern health care system. Lastly, it is the first of its type to be led by a geographer, rather than a health industry professional. This research will strengthen the understanding of therapeutic landscapes and its applicability to home birth and similar studies focusing on birthing location and will assist in doing so by giving modern context to this particular topic. It is hoped that, given the above-noted lack of previous research, this thesis will provide a foundational guide for future research.

This thesis has also contributed to the literature regarding the different scales in which women experience the therapeutic landscapes of birth. To this author's knowledge, the concept of scale in therapeutic landscapes has only been studied on two occasions, none of which look at home birth. It was found that therapeutic landscapes of birth can be experienced across the growing scales of i) inner/personal space, ii) birth/environmental space, iii) support/family space, and iv) societal space. This new knowledge could be used to further inform health policy regarding home birth in Ontario. This research shows that women use all of these scales when deciding where to give birth, therefore specific policies could be built to address barriers at varying scales.

By understanding why women choose home as their place of birth, we can start to acknowledge that their choice is grounded in safety and comfort; that it is not a frivolous decision made from a lack of knowledge, or incorrect knowledge; and, that their choice is the best location for them. As a society, we need to acknowledge that health care cannot be a one-size-fits-all mentality and that some women require a different environment during labour and birth, compared to others. Considering this, policy needs to support the

view that home birth and hospital birth are the right choices for different people, and therefore should be equally supported within a modern health care structure.

Although 30 interviews were completed, saturation was reached between 12-15 women. The implications of this are two-fold. First, future academic methodologies focusing on qualitative studies of home birth should ideally seek to interview around this saturation point. Fewer interviews may not garner the required breadth of experiences, while a greater number may provide redundant responses, which could disguise more unique findings. Second, reaching saturation this early suggests that women's experiences within the London, Ontario context are quite similar. There may be the ability to apply this realization to similar contexts within Ontario and Canada, respectively. Due to the consistency in answers this will lead to a more focused way to inform future policy.

This study also supplies a number of potential policy contributions focusing on such aspects as hospital environment, hospital staff protocol, alternative birthing locations, and knowledge mobilization within the health care field. By providing the foundation for future policy alternatives, this study lays the groundwork for a progressive approach to birth, where women's perspectives and preferences are considered in tandem with prevailing knowledge and practice in obstetrics. Such studies as this can give more visibility to the perceptions of the hospital environment versus a home environment and can, at the very least, assist hospitals in making their own environments more welcoming to those who require their birthing services.

5.5 Research Limitations

Despite the careful conceptualization and execution of this study, a few important limitations with respect to the methodology and context must be noted.

First, my belief system, perspective, or bias became very apparent to me as I was coding and analyzing the interviews. I began my methods chapter by explaining that I come from a unique background that can fill a gap in the literature. I am a health geographer, not a medical professional; therefore my questions and focus are quite different from that of most of the other researchers. I also set myself apart by indicating that I have a unique

place within the insider/outsider realm. I'm an outsider because I have never given birth, let alone had a home birth; however, I have attended home births in a supportive role. As a result, although I'm an outsider, I can understand the needs and experiences that home birth women may have walked through and I can "speak their language". In essence, I felt that I was the perfect balance between insider and outsider. However, as I was transcribing, coding, and analyzing interview data, I realized that I did not fully acknowledge or understand my own perspective and biases. Although I have not had a home birth myself, I tended to identify with home birth more than hospital birth. As a result, I was an outsider who identified closely with home birth women and may have subconsciously acted as an insider. Therefore, despite attempts to balance between insider and outsider and consequently reduce or eliminate bias in my interviews, examples of this bias do exist.

This personal perspective helped inform my in-depth interview guideline questions, therefore resulting in a couple slightly biased questions. For example, I asked women about the advantages and disadvantages of the "biomedical model of birth" and the "woman centred model of birth". Although these terms were extracted from other literature, it painted a picture for each of the options and influenced the type of response that I received. In order to attempt to address this issue of bias, I excluded the specific answers from the identified biased questions while writing my results chapter. However, the terminology was used by the women at different points in the interviews, therefore the results section does include some quotes using "medical model" as a synonym to the hospital. The other question that I identified bias in was the question, "was there a time you thought hospital was safer?". This of course implies that hospital is not safer than home birth. I asked this question slightly differently for each woman, so I was careful to exclude answers in interviews that I asked it in a biased or leading manner. I actively made an effort to eliminate this bias when reporting results, however, as with all interviews and qualitative based research, there is inherently bias in our discourse.

Second, this is a unique case study focusing on London, Ontario, Canada. While findings and contributions have theoretical applicability to a broader context, this may not prove to be the case. Adjacent regions may return dissimilar results and find contradictory

conclusions if studied from a similar perspective. Thus, the scope of the study may limit overall impact.

Third, due to the scope of the study, only one therapeutic landscape was studied. Interviewing women who chose a hospital birth would have allowed for a direct comparison between the experiences of the groups and would have added another degree of depth to the analysis.

Last, it should be noted that this study interviewed women in one temporal frame. A number of these women were pregnant at the time of the interview. It was outside the scope of the project, but it would have provided additional context to also interview those women post-birth to study whether their births went as planned and/or whether they would choose home birth as an option for subsequent pregnancies.

5.6 Directions for Future Research

Future research direction could include studies incorporating interviews of women who experienced hospital births. Direct comparison of the two unique experiences in the same study could allow for a direct compare and contrast of preferences, which could help refine policy to allow for the two choices to coexist. This type of research study could help create an inclusive and comprehensive understanding of why women choose many different types of births and birth locations.

In addition, future research should seek to further limit bias pertaining to the insider-outsider dichotomy. Although difficult, the ability to remove personal or perceived favouritism towards a certain outcome can allow for more objective results from inherently subjective studies.

Additional research could incorporate the study of women throughout their entire pregnancy, birth, and postpartum period. This would allow for the collection of first-hand experience documenting a woman's thought process and chronicling what specific aspects were involved in their decision making process. Following the women through a small postpartum period could allow for some debrief conversation around how the birth

experience went, how it differed from what they expected, and whether or not they would choose home birth again.

It would also be interesting to study different medical providers and look into why there is an issue with support of home birth. We know that 90% of obstetricians do not support home birth, so this will be an important area of focus, however we also need to know what support there is from general practitioners and family doctors, and whether they do or do not support home birth for similar reasons as obstetricians. From here, some more detailed policy analysis and educational opportunities could be recommended in an effort to create a more cohesive maternal health care system with a strong foundation of support and healthy relationships between all medical care providers.

Lastly, future research could build upon the geographical extent of this study by expanding the scope. There could be merit in comparing geographical regions of similar population, geographical location, or political context (e.g. London CMA vs Waterloo Region) to see if experiences parallel or diverge from the findings discussed herein; to determine whether the same barriers exist within these different contexts; and, whether reasons informing the choice of birth location are consistent. Expanding our knowledge of women's experiences of home birth across more contexts and broader area catchments can thus further help inform applicable policy by expanding the overall depth of knowledge in the field.

5.7 Conclusion

This research aimed to fill a gap left by previous home birth studies by approaching Canadian home birth from a human geography standpoint. In-depth interviews were analyzed within a therapeutic landscapes framework using NVivo as a primary analysis tool. The intent was to answer questions of 'Why do women choose the home as their place to give birth?' and "What barriers did women experience when choosing home as their place of birth?".

Home birth rates are on the rise (Edwards, 2005; Sjoblom, Nordstrom, & Edberg, 2006; Murray-Davis et al., 2012), therefore it is important for research to understand why

women choose the home as their place of birth. This can help determine how we can support these women in the future through the normalization of all birth location choices, increased midwifery practices, the creation of safe home-like environments in birth centres and hospitals, and other relevant measures. Research shows that birth outcomes are improved when midwives are actively integrated into the health care system (Hutton et al., 2009). This allows women to choose home birth when their home is where they have developed a sense of ontological security and is the woman's best therapeutic landscape.

It is hoped this study will act as a catalyst to enhance discussions between home birth women, midwives, and policy makers in London, Ontario, Canada to help change the public metanarrative that currently overpowers the importance of listening to these women's home birth stories. By analyzing their needs and barriers they have experienced, we have the opportunity to create a health care and birthing system that is inclusive and equally supportive of all women and all birth choices. All women should feel supported in giving birth in the location that they feel most comfortable, and it is the innate feelings of comfort, control, and support when in their home, that encourages home birth women to choose home as their place of birth.

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Appendices

Appendix A: Studies asking a similar question to this thesis

Survey-Based Studies

Author & Year	Location	Accredited home birth midwives (with insurance) / Publicly Funded / Support from Hospitals?	Researchers Background	Question	Methods
Lindgren et al., 2010	Sweden	Yes; but very few (Yes) / Yes; but only in very specific cases / No	Nursing, Midwifery, Reproductive and Perinatal Health, Health Care, & Health Sciences	How do women perceive risk and manage risk when choosing a place of birth?	Mail questionnaires with 727 women for 1025 births that took place between 1992 and 2005. A nationwide study using thematic content analysis
Kukulu & Oncel, 2009	(Rural) Turkey	Yes; but many rural women do not use these midwives (Yes) / Yes / No	Nursing	Why do mothers choose to have a home birth?	Face-to-face questionnaire with 392 women asking demographic information and open-ended questions.
Boucher et al., 2009	USA	Yes, but only in 23 states (Yes) / No / Yes & No; ACOG warns physicians not to provide back-up support for home birth midwives	Midwifery and Nursing	Why do women choose home birth?	Secondary content analysis of an online questionnaire from 160 women asking one open-ended question: "Why did you choose home birth?".

Author & Year	Location	Accredited home birth midwives (with insurance) / Publicly Funded / Support from Hospitals?	Researchers Background	Question	Methods
Fordham, 1997	UK	Yes (Yes) / Yes / No	Doctor and Medical Science	If you were pregnant, where would you like to give birth and what are the advantages and disadvantages of giving birth in a hospital and at home?	Mail survey with 241 women, aged 20-40 years, asking demographic information, history of past births (if any), open-ended questions about current knowledge of birth options, and multiple questions about advantages and disadvantages of home and hospital births using a Likert scale. Statistical analysis included the Wilcoxon interval test, the Kruskal-Wallis test, and a chi-square test.
Longworth et al., 2001	UK	Yes (Yes) / Yes / No	Health Economics, Social Science and Law	What is the relative value that women have attached to key characteristics associated with maternity care?	Two focus groups of 10 women (one group who had home births, the other had hospital births) to determine the key characteristics. Then they surveyed 257 women who had given birth in the past year using a discrete choice approach of differing scenarios (pair-wise comparison). Conjoint analysis and regression models were run.
Pavlova et al., 2009	Netherlands	Yes (Yes) / Yes / Yes	Health, Medicine, and Life Sciences, and Obstetrics and Gynecology	What influences a woman's decision in choosing her obstetric care and place of birth?	Face-to-face questionnaire with 78 women asking 7 discrete-choice questions (binary situations). Statistical analyses included a utility level choice model, chi-square test, Spearman's test, regression models, likelihood ratio tests, and McFadden pseudo-R-square tests.
Murray-Davis et al., 2014	Canada	Yes (Yes) / Yes / Yes; but almost 90% of obstetricians do not support home birth	Midwifery	How do women decide to give birth at home or hospital and why do they choose one birthplace over another?	214 self-administered surveys using a 7 point Likert scale and open-ended questions. Questions included sources of information used when deciding a birth place, reasons for choosing the birth place, and their decision-making priorities. Descriptive statistics produced in Excel and open-ended questions were analyzed thematically.

Interview-Based Studies

Author & Year	Location	Accredited home birth midwives (with insurance) / Publicly Funded / Support from Hospitals?	Researchers Background	Question	Methods
Viisainen, 2000	Finland	Yes (No) / No / No	Public Health	How do women (and couples) who birth at home deal with the risks of giving birth at home instead of in hospital?	In-depth, unstructured interviews with 9 women and 12 couples who planned a home birth within the past 3 years. Used qualitative analysis support software for text analysis.
Viisainen, 2001	Finland	Yes (No) / No / No	Public Health	What are the reasons for and experiences of planning a home birth?	In-depth, unstructured interviews with 9 women and 12 couples who planned a home birth within the past 3 years. Used qualitative analysis support software for text analysis.
Jouhki, 2012	Finland	Yes (No) / No / No	Nursing Science and Health Sciences	What are the reasons for choosing a home birth and where did the women seek information about home birth?	In-depth interviews with 10 women who planned a home birth within the past 15 years.
Sjoblom et al., 2006	Sweden	Yes; but very few (Yes) / Yes; but only in very specific cases / No	Midwifery, Psychology, and Nursing	What is the experience for women who birth at home?	In depth interviews with 12 women who had given birth at home in the past 10 years. A descriptive approach using a phenomenological-hermeneutic method for text analysis.
Cheyney, 2008	USA	Yes, but only in 23 states (Yes) / No / Yes & No; ACOG warns physicians not to provide back-up support for home birth midwives	Midwifery and Medical Anthropology	What made women choose to deliver outside the hospital?	Participant observation and serial open-ended interviews with 50 women using the theoretical framework of critical medical anthropology.

Author & Year	Location	Accredited home birth midwives (with insurance) / Publicly Funded / Support from Hospitals?	Researchers Background	Question	Methods
Abel & Kearns, 1991	New Zealand	Yes (Yes) / Yes / No	Midwifery and Geography	How accessible is home birth, why did women choose it, and what is the meaning of home as place of birth?	Informal, loosely-structured, in-depth interviews with 6 women who had a home birth in the last 5 years. Used therapeutic landscapes as their theoretical framework and a feminist approach by focusing on the women's experiences when analyzing text.
Edwards, 2005	UK	Yes (Yes) / Yes / No	Maternity Services	Why did women choose home birth, what risks do they have to deal with, how are needed relationships with their midwives developed, and how does all of this fit with obstetrics?	Four in-depth interviews with each of 30 women through their pregnancies until 6-8 months after birth. Interviews took place in the 1990's. A descriptive approach using the framework of feminism and postmodernism, along with content analysis for text analysis.
Murray-Davis et al., 2012	Canada	Yes (Yes) / Yes / Yes; but almost 90% of obstetricians do not support home birth	Midwifery	What is the decision making process that Canadian women go through when deciding to give birth at home?	Semi-structured interviews with 34 women who are currently pregnant and planning a home birth or have planned a home birth in the last 2 years. Used a constant comparative method for text analysis.

Appendix B: Characteristics of Participants

Pseudonym	Age	Employment Industry	# of Hospital Births	# of Home Births	Currently Pregnant
Carmalina	31	Administration & Entrepreneur	1	3	
Laney	27	Stay at Home Mom	1	1	
Kylie	29	Finance	1	1	
Wilma	32	Non-profit	1	1	
Danielle	38	Education	2	1	
Sandra	33	Health Care	1	0	Planning 1st Home Birth
Rachelle	27	Education	0	1	Planning 2nd Home Birth
Alison	35	Retail	0	1	
Noel	29	Health Care	1	0	Planning 1st Home Birth
Courtney	27	Education	1	3	
Lotus	31	Social Services & Education	0	1	
Debra	40	Stay at Home Mom & Social Services	0	3	
Tammy	38	Administration	0	0	Planning 1st Home Birth
Annalise	34	Education	0	1	
Nadine	38	Education & Health Care	1	1	
Jessa	33	Entrepreneur	0	2	
Lauren	38	Research	1	3	

Pseudonym	Age	Employment Industry	# of Hospital Births	# of Home Births	Currently Pregnant
Nora	38	Social Services	1	0 (transferred to hospital)	
Bridget	29	Health Care	1	1	
Kim	37	Health Care	1	1	
Catherine	30	Non-profit	0	0	Planning 1st Home Birth
Jennifer		Health Care	0	1	
Charlotte	34	Administration	2	1	
Alyssa	35	Health Care	0	1	Planning 2nd Home Birth
Holly	33	Social Services	0	1	
Elizabeth	36	Health Care	1	1	
Julie	30	Development	0	1	
Diana	27	Social Services	1	1	
Cindy	26	Entrepreneur	0	2	
Brooke	36	Stay at Home Mom & Entrepreneur	0	3	

Appendix C: In-depth semi-structured interview guide

Maternal Choice Regarding Place of Birth in London, Ontario: Examining Women's Perceptions

Preamble:

Hello my name is Caren Raedts, a Masters student in the Department of Geography at Western University. This study seeks to investigate why women choose to give birth at home in London, Ontario.

Introduction:

- How old are you?
- Are you married?
- What is your occupation?
- Do you own your home?
- How much does your life revolve around your home? Have you lived in this home for long? This neighbourhood? Where are you originally from?

Birth Background:

- What type of environment were you brought up in regarding birth?
 - o Did your mother have a home or hospital birth?
- When are you due / when did you give birth?
- Have you had previous births?
 - o Hospital or home? Tell me about them. Who delivered your baby? Were there complications? Do you view your previous birth(s) as a positive experience? Are there any traumatic moments from previous births that you would like to share with me?
- What type of birth do you envision?

Choosing Home Birth:

- Why did you choose home birth? How did you become introduced to home birth?
- Do you remember what prompted you to research this option? Family? Friend? Media? Has it always just been your way of life... you never considered another option?
- What is it about the *home* that encourages you to give birth here? Privacy? Knowledge or surroundings? Relaxed atmosphere?
- What do you like most about having a home birth?
- Do you hope to gain anything from this birth? Could you have gained this from a hospital birth? Empowerment? Self-discovery?
- Where and how do you plan to give birth? Bedroom? Bathtub? Birth pool? Stool?
- Why did you choose this specific location or method? Does that room have a special memory attached to it?

Health Care Use:

- Describe your overall health care use. Do you frequent a doctors office/emergency room/naturopath?
- Do you regularly visit a doctor? When you are sick, what types of medications do you take? Prescription? Over the counter? Natural therapies?
- How did you become aware of the midwifery clinics in London?
- Do you think that most women in London know about these midwifery services?
- Will you use any other types of health care services? What about services offered during prenatal? Labour and birth? Postpartum? Breastfeeding?

Support:

- Does your family support this decision?
 - o What does your support system look like?
- Do you want your children present?
- When your children grow up, would you want them to choose home birth?
- Did any of your friends or family show skepticism towards your decision? Have you been successful in educating them? Have their views changed?

Hospital Birth:

- Have you ever been in a hospital? What type of feelings do you associate with hospitals? Why?
- Did you tour a hospital birthing unit before you decided to give birth at home? If so, what did you like? What didn't you like? What feelings did you have?
- What are the advantages and disadvantages of the biomedical model of birth? Interventions? C-sections?
- Do you think it is possible to follow a natural/holistic model of birth in a hospital?
- Do you believe hospital birth is safer than home birth? Why or why not?
- If you currently don't think hospitals are safer, do you remember a time when you did view hospitals as safer for birth?
- Do you think hospitals are a needed facility for birth? Do they have their place?
- What are the main reasons why you didn't choose to have a hospital birth?
- Are there any barriers to a hospital birth in London?

Home Birth:

- What are the advantages and disadvantages of the natural/holistic model?
- Is home birth safer than hospital birth? Why or why not?
- In your eyes, what type of woman chooses to have a home birth?
- Are there any barriers to home birth in London?
- What were the biggest obstacles that you had to overcome in order to have your home birth?
- How could home birth be made better?
- If you had the option of giving birth at home or in an independent birth center run by midwives, which would you choose? Why?

Conclusion:

- Is there anything else you would like me to know about home birth and why you chose it?

Appendix E: Letter of information and consent

Maternal Choice Regarding Place of Birth in London, Ontario: Examining Women's Perceptions

Invitation to Participate in In-depth Interview

I am Caren Raedts, working under the supervision of Dr. Isaac Luginaah in the Department of Geography at the University of Western Ontario in Canada. I am currently doing a study on why women choose the home as their place of birth for labour and delivery in London, Ontario, Canada. I would like to invite you to participate in an in-depth interview as it would help our understanding of factors that influence women when deciding where they would like to give birth.

If you agree to participate in this study, you would be asked to answer a series of questions. The questions will cover information on issues such as your choice in location of delivery, your previous experience or upbringing with birth, your health care use, your experiences with health care workers and facilities, your support network for your birth, and any other cultural, social, or gendered reasons that influenced your choice in where you would like to give birth. During the interview discussion, digital voice recording would be done. Interview recordings will be transferred from the recorder into an external drive that is password protected. The information collected will be used for purposes of the study only. All personal information collected for the study will be kept confidential. This will be kept in a secured cabinet and password protected laptop, and will be destroyed five years after the study is completed. The findings will never reveal what individual people said and we will make all efforts to maintain confidentiality.

The interview should take approximately one hour to finish. There are no known risks with your participation in the interview, apart from discomforts related to talking about any negative personal experiences.

Your participation is completely voluntary and you may refuse to participate, refuse to answer any questions or withdraw from the study at any time. There is no consequence for withdrawing or not answering any questions. Answering these questions means that you are 18 years or older, are planning a home birth or have had a home birth in the last two years, and have agreed to participate in the study. You may keep a copy of this information sheet. There are no financial benefits for participating in this interview. A summary of results will be available upon request from Caren Raedts. You can also contact Dr. Isaac Luginaah if you are interested in getting feedback on results.

If you have any questions about the conduct of this study or your rights as a research participant you may contact the Office of Research Ethics at The University of Western Ontario or the primary researchers of the study:

Dr Isaac Luginaah
Department of Geography
The University of Western Ontario

Caren Raedts
Department of Geography
The University of Western Ontario

**Maternal Choice Regarding Place of Birth in London, Ontario: Examining
Women's Perceptions**

I have read the Letter of Information, have had the nature of study explained to me, and all questions have been answered to my satisfaction and I agree to participate.

Participant's Name _____ Participant's Signature _____

Date _____

Investigator's Name _____ Investigator's Signature _____

Date _____

Appendix F: Ethics approval



Research Ethics

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Isaac Luginaah
File Number: 105060
Review Level: Full Board
Protocol Title: Maternal Choice Regarding Place of Birth in London, Ontario: Examining Women's Perceptions
Department & Institution: Social Science/Geography, Western University
Sponsor:
Ethics Approval Date: April 21, 2014 **Expiry Date:** December 31, 2015

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Other	Translator confidentiality agreement	2014/02/20
Western University Protocol	Western Protocol - cleaned pdf version	2014/04/14
Board Recommendations	REB Recommendations - pdf version	2014/04/14
Letter of Information & Consent	Letter of Information/Consent - cleaned pdf version	2014/04/14
Recruitment Items	Recruitment Poster - cleaned pdf version	2014/04/14
Instruments	Interview script - pregnant women - cleaned pdf version	2014/04/14
Instruments	Interview scripts - women who birthed at home - cleaned pdf version	2014/04/14

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.





This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussions related to, nor vote on, such studies when they are presented to the NMREB.

The Chair of the NMREB is Dr. Riley Hinson. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000941.

—

Ethics Officer to Contact for Further Information

 Grace Kelly (grace.kelly@uwo.ca)	 Vikki Tran (vikki.tran@uwo.ca)	 Mina Mekhail (mmekhail@uwo.ca)	 Erika Basile (ebasile@uwo.ca)
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This is an official document. Please retain the original in your files.

Curriculum Vitae

Name: Caren Thayer

Post-secondary Education and Degrees: University of Western Ontario
London, Ontario, Canada
2007-2012 B.Sc.

The University of Western Ontario
London, Ontario, Canada
2012-2017 M.Sc.

Honours and Awards: Scholarship of Excellence
2007-2008

Queen Elizabeth Aiming for the Top
2007-2011

Natural Sciences and Engineering Research Council (NSERC)
Undergraduate Student Research Award (USRA)
2010

Danaher International Scholarship
2010-2011

Natural Sciences and Engineering Research Council (NSERC)
Undergraduate Student Research Award (USRA)
2011

Certificate of Outstanding Merit
2012

Natural Sciences and Engineering Research Council (NSERC)
Alexander Graham Bell
2012-2013

Western Graduate Research Scholarship (WGRS)
2012-2014

Ontario Graduate Scholarship (OGS)
2013-2014

Barry F. Beck Scholarship
2015

**Related Work
Experience**

Research Assistant
The University of Western Ontario
2009-2012

Teaching Assistant
The University of Western Ontario
2012-2015

Data Analysis Coordinator
Ministry of Education (Investing In Children - London)
2015-2016

Data Analysis Coordinator
Ministry of Education (City of Peterborough)
2016-present

Publications:

Raedts, C. and Smart C.C. (2015). Tracking of karst contamination using alternative monitoring strategies: Hidden River Cave Kentucky. *14th Multidisciplinary Conference on Sinkholes and the Engineering and Environmental Impacts of Karst.*