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THE ROLE OF CHOICE AND CONTROL IN WOMEN'S CHILDBIRTH EXPERIENCES

By

Katie M. Cook

Bachelor of Arts, Honours Psychology, Wilfrid Laurier University, 2008

THESIS

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in partial fulfillment of the requirements for

Master of Arts

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Author's Standpoint

The experience of childbirth is life altering and unique to each woman and her family. There is not one common definition of the "perfect" childbirth. Rather, each experience is valid and significant for distinctive reasons. Having not experienced childbirth myself, it is vitally important to practice reflexivity throughout the process of researching this phenomenon. I begin this process of reflexivity by noting here my standpoint – that is the opinions, values and biases that I bring to this work. I feel that each woman's situation deserves to be discussed with a sensitivity and gravity.

As a woman who has never given birth, I feel that I am both an insider (i.e. as a woman) and an outsider (i.e. having not given birth) in the context of my research. This requires me, as a researcher, to be clear about my objectives and sensitive to other women's experiences.

This study will take a feminist approach to this research. This will be accomplished by challenging the practices and assumptions of power structures, such as the medical system, that for centuries have largely determined how women give birth. Furthermore, a distal goal of this approach will be a call for reflection on the way that women and the medical system define "healthy" and "normal" childbirth. This critical perspective is necessary in order to realize any degree of change in Canadian childbirth practice.

Abstract

The current study seeks to understand the role of choice and control in both planning and giving birth. This study explores three research questions: 1) What are the key influences on women's birth plan decisions? 2) How do changes to a woman's initial birth plan impact her overall birth experience? 3) What is the role of choice and control in women's childbirth experiences? Narrative, semi-structured interviews were conducted with a convenience sample of 16 women who had given birth in Waterloo Region within the two years preceding data collection. The findings of this study cover five categories. The first category is the influences on women's planning process (e.g. family, care provider, books, prenatal classes). The second category is the impact that changes to a woman's initial birth plan have on her birth experience and this includes a discussion of transfers of care, pain management and medical intervention, and hospital stays. The third category is the role of choice and control in women's childbirth experiences and in this section the topics discussed include pain management techniques and care provider support. Following this, there is a summary of women's overall satisfaction with their experience. Finally, the fifth category of findings describes women's experiences with breastfeeding support after the birth of their children. A conceptual framework of the role of choice and control in women's birth experiences is proposed that contains three aspects: informed choice, flexibility and support.

Table of Contents

ACKNOWLEDGEMENTS ..... **I**

AUTHOR'S STANDPOINT ..... **II**

ABSTRACT ..... **III**

TABLE OF CONTENTS ..... **IV**

THE ROLE OF CHOICE AND CONTROL IN WOMEN'S CHILDBIRTH EXPERIENCES **1**

NATURE VERSUS CULTURE 2

MEDICALIZATION AND THE BREASTFEEDING RELATIONSHIP 6

HISTORICAL CONTEXT 9

HEALTH DECISION-MAKING 16

A NARRATIVE APPROACH 22

THE CURRENT STUDY 24

METHOD **25**

SAMPLING STRATEGY 25

RECRUITMENT 25

SAMPLE DESCRIPTION 26

PROCEDURE 27

DATA ANALYSIS 28

DATA QUALITY 28

FINDINGS **29**

INFLUENCES ON BIRTH PLANNING 30

CHANGES TO THE BIRTH PLAN 35

THE ROLE OF CHOICE AND CONTROL 43

OVERALL IMPRESSIONS OF CHILDBIRTH 53

BREASTFEEDING SUPPORT 56

DISCUSSION 58

KEY INFLUENCES ON WOMEN'S CHILDBIRTH DECISIONS 59

THE IMPACT OF CHANGES TO A WOMAN'S BIRTH PLAN ON HER OVERALL BIRTH EXPERIENCE 60

THE OVERALL ROLE OF CHOICE AND CONTROL IN WOMEN'S BIRTH EXPERIENCES 61

A CONCEPTUAL FRAMEWORK FOR CHILDBIRTH DECISION-MAKING 63

INCORPORATING CHOICE AND CONTROL INTO CHILDBIRTH DECISION-MAKING 65

RECOMMENDATIONS FOR PRACTITIONERS, WOMEN, AND MEMBERS OF THE LABOUR CARE TEAM 67

LIMITATIONS 68

FUTURE RESEARCH 69

CONCLUSIONS 70

REFERENCES 72

APPENDIX A: INTERVIEW GUIDE 81

The Role of Choice and Control in Women's Childbirth Experiences

The birth of a child is a pivotal time in the life of a mother and her family. The health and well-being of a mother and child at birth largely determines the future health and wellness of the entire family (World Health Organization, 2005). The outcome of childbirth, however, is not the only factor of importance. Some research suggests that the way in which a woman experiences pregnancy and childbirth is also vitally important for a mother's relationship with her child and her future childbearing experiences (Fox & Worts, 1999; Hauck, Fenwick, Downie, & Butt, 2006). Other research, however, questions the connection between the birth experience and future bonding (Eyer, 1992). The important issue related to current study, however, is that the experience of childbirth itself is momentous and deserves attention.

The current study considers women's experiences with particular emphasis on the role of choice and control during pregnancy and childbirth. This consideration is of particular importance because childbirth is a potentially life-changing event for women and their families. A better understanding of the factors related to women's overall experiences will help care providers and expectant parents when offering and attaining services. Childbirth is defined in this study as the period beginning with the onset of labour (beginning with uterine contractions) and ending with the birth of the child. Early motherhood is defined as the period beginning with the birth of the child and concluding one week after the birth of the child. For the purposes of this study, medicalization will be defined as "a social process in which bodies and social circumstances are defined from a biomedical perspective as requiring biomedical intervention" (Lorentzen, 2008, p. 52).

A review of the literature was conducted and is organized in the following way. It begins with an overview of current research on the importance of choice and control in childbirth. The impact of medicalization of childbirth on breastfeeding relationships is discussed briefly, with emphasis placed on maintaining the documented benefits of breastfeeding. Placing childbirth in historical and political context is essential because it provides a comprehensive overview of the factors that inform the current state of affairs. The history of childbirth is therefore presented, with a focus on North America and Europe, because this is where much of the available literature published in the English language originates. Following this history is a review of where childbirth practice stands today in relation to the medical system. Factors that are important to women when making general decisions concerning their health are then presented, along with a discussion of the context in which women make health decisions. Next is an overview of a narrative approach to research, with a focus on birth narratives. Finally, a critique of existing research on the topic is presented, with specific focus on the importance of taking a woman-centered approach to research, and consideration of a woman's experiences in the context of her family, care providers, media, and dominant cultural influences. In taking this critical approach, this study aims to fill these gaps in the existing research on women's experiences of childbirth.

Nature Versus Culture

One of the most prominent considerations related to childbirth is whether the main focus of mothers, partners, and care providers should be on the physiological and biological process of childbirth, or on the emotional, social, and cultural components. Essentially, "childbirth stands uncomfortably at the junction of the two worlds of nature and culture" (Oakley, 1980, p. 7).

That is to say that women's bodies and the biological process of giving birth do not exist separately from their social lives and a multitude of cultural influences.

The ways in which women define "natural" birth varies considerably from woman to woman, and from experience to experience. Women tend to define a natural birth not by a complete lack of biomedical intervention, but rather by their ability to make decisions and thereby form their own birth experience (Viisainen, 2001). For some women, a natural birth is simply one with which they feel most comfortable and safe, having very little to do with whether their baby is born at home or in the hospital (Cheung, 2001). The way a birth is planned often varies greatly from how the birth unfolds, however women report that maintaining the ability to construct this experience is central to a positive birth (Bauk, Fenwick, & Butt, 2006; Hardin & Buckner, 2004; Lavender, Walkinshaw, & Walton, 1999; Visainen, 2001). For the purposes of the current study, home birth and hospital birth are not dichotomized by naming one natural and one medical. Given the intimate and unique nature of this phenomenon, it is important to leave these definitions to the woman experiencing birth. Defining a natural birth is part of a dialectical birth process that must be negotiated between the woman, her partner, and her specific care providers.

One study suggests that birth is a dialectical process containing three stages (Kiaergaard, Foldgast, & Dykes, 2007). The first stage involves balancing the natural and the medical. Here, natural refers to the mind's ability to control feelings of bodily pain, whereas medical refers to the use of medical intervention to either augment labour or control pain. The next stage in this process is interaction among service providers (doctors, midwives, nurses) and a labouring mother. These interactions result in the third stage, a loss and regaining of control during labour.

This loss usually refers to physical pain and may be remedied through control of natural and medical remedies, decided through dialogue among team members including the woman giving birth, thus perpetuating the dialectical process. The level and type of medical intervention is not the single most important factor in a woman's experience of a natural birth (Kiaergaard, Foldgast, & Dykes, 2007). Allowing this cyclical process to unfold under the control of the labouring mother is the chief way in which a woman forms her own birth process.

There are a number of factors that contribute to women's retrospective attitudes towards their birth experience. The most prominent factors include control, choice in decision-making, social support, and efficacy of pain control (Fox & Worts, 1999; Gibbins & Thomson, 2001; Hardin & Buckner, 2004; Howell-White, 1997; McCrea & Wright, 1999; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004). Women define control as consisting of internal and external processes, both of which impact their feelings about the overall birth experience. Internal control refers to a woman's ability to control her feelings and expressions of pain, as well as her ability to make bodily decisions (for example, changing position freely) during labour (Hardin & Buckner, 2004; McCrea & Wright, 1999). External control, on the other hand, refers to a woman's ability to take part in decision-making concerning her birth, including medical interventions, sources and types of support, and where and how to give birth (Hardin & Buckner, 2004; McCrea & Wright, 1999). A lack of control is more likely to be associated with a negative childbirth experience, whereas feelings of both internal and external control are associated with a positive experience (Hardin & Buckner, 2004).

Studies show that when compared to more intangible social factors such as encouragement from a supportive partner or care provider, biomedical interventions are less effective in

constructing a positive birth experience (Fox & Worts, 1999; Lally, Murtagh, MacPhail, & Thomson, 2008). Despite seemingly effective advancements in pain management during childbirth, these approaches are less effective than those that do not rely on medical expertise. There is a strong tendency to turn to medical advancements to make birth as "easy" as possible while ignoring important social factors, such as the existence of sensitive service providers and a supportive partner (Lally, Murtagh, MacPhail, & Thomson, 2008). Despite this evidence supporting the importance of social factors related to pain control in childbirth, there seems to be an over-reliance on medical intervention for childbirth practice.

The concepts of separation and incorporation provide a clear way to think about the role of choice and control in the context of a medicalized system. Oakley (1980) presents the concept of separation versus incorporation in the historical development of the process of childbirth. Separation takes place when women maintain control over the birth process and it remains separate from other aspects of social life (Oakley, 1980). Women maintain decision-making power with regards to their bodily decisions and are able to give birth in their own homes or in a hospital with the health care provider of their choice, or with no health care provider at all. Furthermore, women remain in control over deciding who will be present at the birth of their child, including partners, family members, friends, or a labour doula (a trained birth assistant). Some would argue that separation is still possible within the medicalized system of childbirth. Some hospitals remain committed to instinctive, woman-led approaches to birthing and early motherhood, for example, the practice of "rooming in" whereby the infant remains in the same room as the mother for the duration of their hospital stay post-birth (Wittmann-Price, 2004).

However, these practices are not required or available in all regions and are not practiced by all health care providers at a given hospital.

Incorporation is the process whereby women's reproductive rights, including childbirth, are mastered by members of the dominant, mainstream social group—in this case, health care professionals (Oakley, 1980). The medicalization of childbirth has been so deeply incorporated into mainstream ideology that placing birth under the control of trusted "experts" has become the norm. In this way, the natural (i.e. biological) process of childbirth is emphasized whereas the cultural (i.e. social) aspects of childbirth are considered outside of the realm of healthcare providers (Oakley, 1980). This emphasis on birth as a solely biological process, to be maintained by the medical system (rather than the woman), has implications for the way in which women experience planning and giving birth, as well as the relationship that they develop with their newborn infant.

Medicalization and the Breastfeeding Relationship

The benefits of breastfeeding are many and have been well documented. Some of these benefits for the infant include resilience against infectious disease, healthy weight gain, and motor and cognitive development (Akmen, Kuscu, Yurdakul, Ozdemir, Solakoglu, Orhon, Karabekiroglur, & Ozek, 2007; Evanhouse & Reilly, 2005; Law, Dunn, Wallace, & Inch, 2007; Moore, 2001; Picaud, 2007; World Health Organization, 2005). Some of the benefits of breastfeeding for the mother include decreased risk of certain cancers, and faster postpartum healing (Danforth, Twoeoger, Hecht, Bernard, Colditz, & Haninson, 2006; Else-Quest, Hyde, & Clark, 2003; World Health Organization, 2005). Although breastfeeding is a natural, biological

process, it is not to be taken for granted. There are a number of factors during labour and delivery that can negatively impact the establishment of a healthy breastfeeding relationship between mother and infant. Breastfeeding is an intricate process that requires a number of bodily processes to work in a synchronized fashion in order for an infant to properly latch onto the breast and receive the nutrients contained in breast milk (Smith, 2007). The numerous medical interventions used in hospitals to induce, monitor, augment, and assist labour impact the infant's ability to breastfeed in the hours, days and weeks following birth (Smith, 2007). Use of anesthesia to control the mother's pain, for example, can make it difficult for an infant to stay sufficiently alert after birth in order to latch for the first time (Block, 2009; Smith, 2007). Furthermore, research suggests that separating mother and baby immediately after birth, a practice that is common in many delivery rooms, has a negative impact on the development of a healthy breastfeeding relationship (Block, 2009; Smith, 2007; World Health Organization, 2005).

There are also a number of social factors that act as barriers or supports to the development of a breastfeeding relationship. Women tend to rely on various support systems for assistance with breastfeeding, including lactation consultants, peer support, family members and partners (Gill, Reifsnider, & Lucke, 2007; Grassley & Eschiti, 2008; Ingram & Johnson, 2009; Kronborg, Vaeth, Olsen, & Harder, 2007; Mickens, Modeste, Montgomery, & Taylor, 2009). Support from experts, family members, peers and partners can increase the duration of the breastfeeding relationship. Women who take part in peer support groups and/or have access to a home visitor who assists with breastfeeding note increased self efficacy and access to relevant knowledge related to breastfeeding (Kronborg, Vaeth, Olsen, & Harder, 2007; Mickens, Modeste, Montogomery, & Taylor, 2009). In addition to the effects that medicalization can have

on breastfeeding, social factors are also an important issue to consider in the initiation and maintenance of the breastfeeding relationship.

A study in Hamilton Ontario conducted in 1999 found that only 85% of women were breastfeeding upon leaving the hospital and that 55% of these women switched to exclusive formula feeding within the first two weeks after delivery (Sheehan et. al, 1999). Given the documented health benefits of breastfeeding beyond the first three months of life, it is quite concerning that such a high number of women are not breastfeeding beyond two weeks postpartum (Picaud, 2007; Smith, 2007; World Health Organization, 2005). Further exploration of the impacts of various birth practices on the development of an effective breastfeeding relationship is needed in order to better understand the impact that the aspects of medicalized birth potentially have on new mothers and their infants.

In Waterloo Region, Grand River Hospital has set out to encourage the establishment and maintenance of the breastfeeding relationship. This is evident in the philosophy of their "Baby-Friendly Hospital Initiative", as stated on the hospital's website:

> Breast milk is the optimal food for babies up until the first year of life and beyond. With this in mind, we provide support, education and practical advice about how to breastfeed your baby. Our nurses, doctors. midwives and lactation consultants will encourage and assist you in order to have a successful breastfeeding experience. (Grand River Hospital)

Grand River Hospital also offers the "New Mother Support" program. All new mothers who give birth at Grand River Hospital have access to the support of a lactation consultant while in the hospital, as well as for the first month of their child's life. Additionally, Grand River

Hospital does not give free formula samples to every new mother upon leaving the hospital. Instead, new mothers are provided with informational brochures as part of the New Mother Support program and are offered the resources needed to feed their child in the way that they choose.

In 2007, Region of Waterloo Public Health conducted a study on infant feeding in the region. They found that 48% of infants were breastfeeding exclusively at birth, while 61% of infants were breastfeeding exclusively upon leaving the hospital (Nadler, 2007). This difference was explained by the fact that many infants receive supplemental formula while the breastfeeding relationship is being established in the first days after the birth. Two weeks postpartum, 40% of infants were exclusively breastfed (Nadler, 2007). This information suggests that in Waterloo Region, where the current study took place, breastfeeding is supported through hospital-run programs, however there is much room for improvement in breastfeeding rates, with less than half of infants exclusively breastfeeding two weeks after birth.

The importance of choice and control during childbirth has been well documented in the research, as well as some of the impacts that medicalized childbirth can have on the breastfeeding relationship. In reviewing these factors, it is also important to understand how birth came to be a medicalized process during the previous centuries.

Historical Context

The ways in which women give birth in North America have changed significantly during the past three centuries. Before the 19th century, midwives controlled childbirth practice, attending births within the homes of their clients (Benoit, Carroll, & Westfall, 2007; Ratcliff, 2002). Midwife literally means "with woman", placing pregnant and labouring mothers at the

center of midwifery practice (Klima, 2001). The role of the midwife was to consult with the birthing woman and act as a coach and facilitator of labour based on the needs of the woman (Paterson, 2004). Beginning in the 19th century, however, advances in the field of science gradually led to the medicalization of childbirth. During the 19th century, doctors seeking to expand their practice viewed midwives as the prime competition with regards to controlling women's reproductive health. Consequently, midwives were characterized by one doctor during this time period as "filthy and ignorant and not far removed from the jungles of Africa, with its atmosphere of weird superstition and voodooism" (DeLee in Ratcliff, 2002, p. 121). This sentiment towards midwives, as expressed by obstetrician Dr. Joseph DeLee, represents one of the ways in which the practice of midwifery was attacked and supplanted by a more modern, purportedly safer, means of giving birth. At the time, this new way of giving birth was considered a highly advanced way of the future. As such, many women preferred to give birth in hospitals with medical intervention as their doctors advised. Making use of scientific advances became a sign of economic privilege, leading women and their partners to place a great deal of trust in the medical system. This trust strengthened and grew despite the fact that many women were dying of complications such as "childbirth fever" at the hands of obstetricians, who were often unconcerned with sanitary practices such as hand washing before entering the delivery room (Benoit, Carroll, & Westfall, 2007; Murphy-Lawless, 1988; Ratcliff, 2002). In spite of risks, trust in the medical system and the expertise of doctors continued to grow into the 20th century.

Although significant advances were being made within the growing movement of first wave feminism during this period, the focus of this movement was not on women's bodies.

Indeed, when the focus did begin to shift to women's control over their bodies, it was not towards childbearing. As feminist author Ann Oakley points out:

> Much of the early energy of organized feminism went into those aspects of the medical practice…which benefitted non-motherhood rather than those affecting the experience of motherhood itself. (Oakley, 1980, p. 134)

These early efforts were focused on supporting women's ability to choose non-motherhood following the introduction of the contraceptive pill. With the absence of a strong counter-movement to the medicalization of childbirth, it perpetuated into the 20th century.

During the 20th century, medicine's control of childbirth continued, with hospitals portrayed as the way of the future. In addition to medical advancements, financially it became much more practical to have a hospital birth. Hospital births became covered by universal healthcare insurance in Canada beginning in the mid-20th Century. As a result, many women were unable to afford a homebirth (Cassidy, 2006). By 1955, 99% of women in the United States were giving birth in hospitals, with comparable numbers in Canada (Cassidy, 2006).

Furthermore, at this time women were seen as "carriers"—of children, of household responsibility, and of disease (Murphy-Lawless , 1988; Oakley, 1980). As carriers of disease, women's perceived fragility was considered a burden to their husbands, with the remedy lying in the secrets of medicine. These perceptions led the male-dominated medical system to be so deeply ingrained in the mainstream ideology that alternatives were considered abnormal and even irrational. Women's reproductive rights had become almost entirely incorporated into the hands of the mainstream medical system (Murphy-Lawless, 1988; Oakley, 1980). Women relied

on doctors in every aspect of their pregnancy and delivery, as is evidenced in the following quote from British Family Doctor Publications in 1977:

> You decide when to see your doctor and let him confirm the fact of your pregnancy. From then onwards you are going to have to answer a lot of questions and be the subject of a lot of examinations. Never worry your head about any of these. They are necessary, they are in the interests of your baby and yourself, and none of them will ever hurt you. (quoted in Oakley, 1980, p. 10)

Women were instructed to put a great deal of faith in doctors, not to question the medical system, and to depend entirely on the medical field to secure for them a normal and healthy birth. Medical expertise had replaced maternal expertise (Oakley, 1980).

The degree to which the medical ideology had taken over pregnancy and childbirth by the late 20th century is well documented. In the late 20th century, Ann Oakley (1980) conducted a comprehensive study of women's experiences with childbirth, called the Transition to Motherhood Study. The findings of this work provide evidence that women's healthcare had largely been taken over by the medical system. For example, 100% of women reported having taken prescription medication during their pregnancies; 19% of women had x-rays during pregnancy; and 100% of women had had blood or urine tests completed during pregnancy. Furthermore, 93% of women who discussed the social or cultural aspects of pregnancy with their obstetrician were met with either silence or blatant indifference. Another study notes that of British first-time mothers who planned to give birth outside of a hospital with a midwife in attendance, approximately half gave birth in a hospital because of various indicators that marked the labour as "high-risk" (Creasy, 1997). When women were transferred to hospital, their

midwives were often required to relinquish decision-making power to the attending obstetrician, a factor that caused the birthing mother to become quite distressed (Creasy, 1997).

At the dawn of the 21st century, the story was very much the same for women giving birth in North America and Europe. Hospitals continued to be the primary location for childbirth. For example, a 2001 study reported that 99.9% of births in Finland took place in hospitals (Viisainen, 2001). In 2009, Jennifer Block published a pivotal book describing and critiquing the state of childbirth in North America. She noted that not only have midwife-attended births become less frequent, they have also become criminalized in many areas, particularly in parts of the United States. In some locations, midwives are not recognized legally as acceptable birth attendants and are therefore not only uninsurable, but also illegal. Furthermore, women who give birth in a hospital are often given few options when it comes to the level of medical intervention to which they will be subjected. Block (2009) notes that most women giving birth in hospitals today, even women whose pregnancy and delivery have not been labeled as "high risk", are attached to up to 16 different machines and monitoring devices, allowing them no opportunity to leave their hospital bed or practice natural forms of pain relief, such as changing position.

The degree to which birth has been medicalized is perhaps most clearly illustrated with a discussion of cesarean section rates. In Canada, 22% of births in 2006 were by cesarean section (Crossley, 2007), while authors suggest that cesarean sections are medically necessary in approximately 15% of births (Block, 2009). In other countries, these numbers are much higher, with cesarean section rates as high as 33% in the United States (Block, 2009). Increasing cesarean section rates are alarming because this procedure is major, invasive surgery and often

leaves women reporting less satisfaction with their birth and more pain and complications during recovery (Block, 2009; Crossley, 2007).

In recent years, midwifery has largely become an alternative reserved for those who can afford the additional cost and time commitment. The average midwife appointment lasts approximately one hour, whereas obstetrician appointments generally last seven to ten minutes (Baker, Choi, Henshaw, & Tree, 2005). In a fast-paced society where working overtime is often necessary in order to make ends meet, many women cannot afford the care of a midwife. Women of higher socio-economic status are more likely to hire a midwife (Baker, Choi, Henshaw, & Tree, 2005). To place this issue in a local context, in the Waterloo Region of Ontario, where the current study took place, midwifery is financially covered for all women under the Ontario Health Insurance Plan (OHIP).

Medicalization and the Re-Emergence of Midwifery in Ontario. During the first half of the 20th Century, midwifery care in Ontario had all but disappeared (Paterson, 2004). By the late 1970s, however, midwifery began to re-emerge as a result of consumer demand (Bourgeault, 2000; Paterson, 2004). Led in large part by the feminist movement, midwives worked to have their practice professionalized and covered by the Ontario healthcare system. By late 1993, midwifery care was integrated into the Ontario healthcare system, which made it accessible to all women in the province of Ontario (Bourgeault, 2000).

The integration of midwifery into the medical system required some changes to the way in which midwives practice. For example, midwives are required to assess pregnancies based on medical risk despite the view within midwifery that birth is a normal, healthy process. Based on risk analyses, midwives must refer women to a doctor if their pregnancy is deemed “high risk”.

Factors that lead a pregnancy to be classified as high risk include high blood pressure, diabetes, or a pregnancy of multiples (Paterson, 2004). Although government regulation holds positive aspects for midwifery—for example midwifery care is covered by the Ontario Health Insurance Plan (OHIP) and carries with it credibility and professionalism—surveillance by the medical system has changed the way that midwives practice. Midwives and their clients do not maintain agency and control over the birth process and the choices available (Paterson, 2004). One author notes, "this discourse of risk places new expectations on midwives, forcing them to assess pregnancies with the medical model as referent. This has the potential effect of removing the mother from the position of central decision-maker" (Paterson, 2004, p. 155).

The Public Health Agency of Canada has produced a document that was updated in 2001 entitled "Family-Centered Maternity and Newborn Care: National Guidelines". Although this document is not a statement of policy, it is meant to inform care providers including hospitals, family physicians, obstetricians, and midwives on the national standards for care during pregnancy, childbirth, and the postpartum period. The chapter of this document that is focused on labour and delivery defines birth as a natural, healthy process and states that women and their significant others should be consulted on decisions related to the birth of their child (Public Health Agency of Canada, 2001). Additionally, one of the guiding principles of this document is that policies and procedures should be focused on the physical, psychological, and social needs of the woman and her baby (Public Health Agency of Canada, 2001). This document, combined with the integration of midwifery into the Ontario healthcare system, provides insight into the current state of childbirth in Ontario. It would seem as though a shift back toward community- and family-centered childbirth is taking place in Ontario.

This history of childbirth practice both internationally and locally provides a broader picture of how birth came to be more or less medicalized and what factors influenced this process. It is also important, however, to consider how women come to make decisions about giving birth.

Health Decision-Making

The ways in which women make general health-related choices informs the decisions they make concerning their birth experiences. Studies have suggested that there are five dimensions to what authors refer to as "emancipated health decision-making" (Wittmann-Price, 2004, 2006). These dimensions include personal knowledge, empowerment, social norms, reflection, and a flexible environment (Kovach, Becker & Worley, 2004; Noone, 2002; Wittmann-Price, 2004). Figure 1, below, illustrates the connection between these five dimensions and emancipated decision-making.

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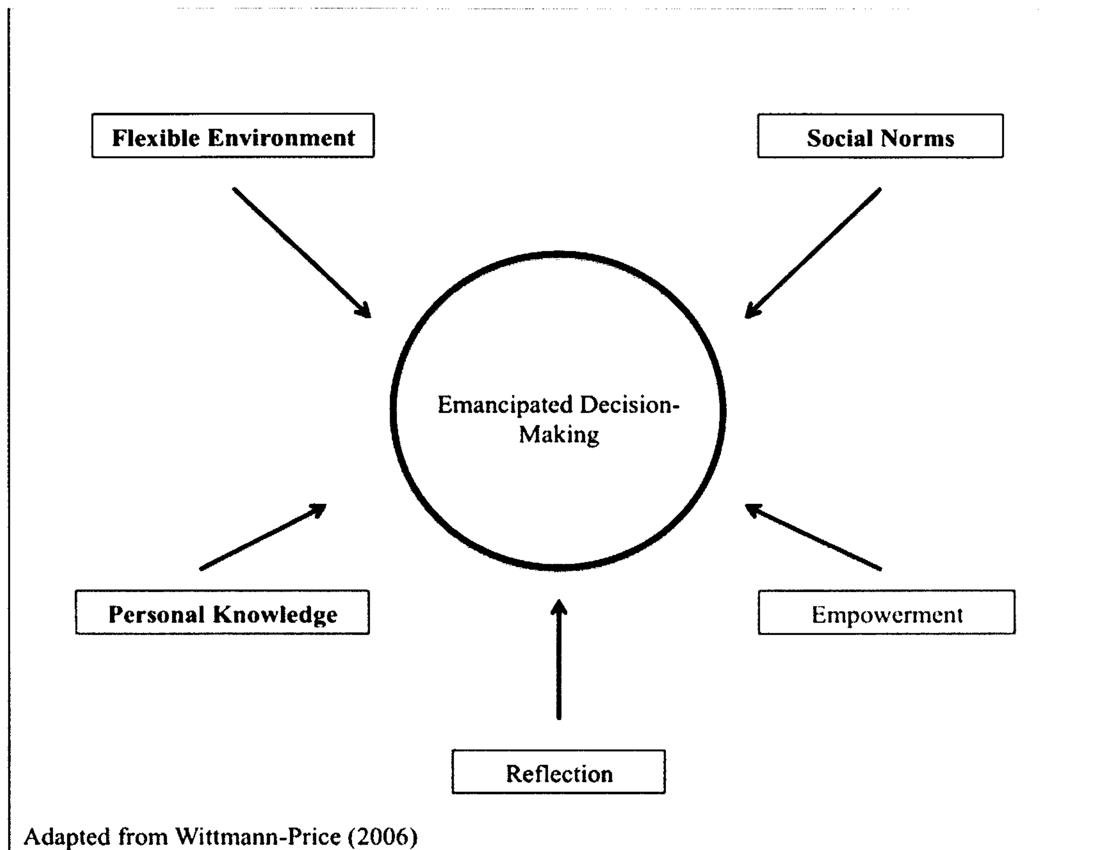
Figure 1: Model of Emancipated Decision-Making



According to this model, reflection is the process of questioning common practices that are based solely on authority or tradition (Wittmann-Price, 2004). This questioning is important in order for the individual to critically analyze both personal and professional information. Empowerment that is derived from knowledge promotes autonomy and independence and is also an important aspect of emancipated decision-making (Wittmann-Price, 2004). Personal knowledge, social norms, and flexible environment are described as most closely linked to a woman's satisfaction with her decisions and will be expanded upon further (Wittmann-Price, 2006). This model is used as a template in the current study for understanding women's decisions related to their chosen birth method. Rather than focusing on cognitive models that

describe the intricate process of making decisions, this model describes internal and external factors, both social and psychological, that impact an individual's decisions and satisfaction with those decisions.

Personal knowledge is related to the information that a woman seeks with regards to her health decisions (Brown, Carroll, Boon, & Marmoreo, 2002). The amount of knowledge that a woman obtains is dependent on the amount of useful information that is available to her. The ability to gain personal knowledge in making health decisions is also related to an increased sense of self-efficacy towards one's decision (Torres & Marks, 2009). It is particularly important to ensure that relevant and accurate information along with support in processing this information are readily available to women making health decisions (Woolfe et. al., 2005).

In addition to personal knowledge, individuals are influenced by a host of factors, including family, friends, health care providers, and general social norms (Brown, Carroll, Boon, & Marmoreo, 2002; Wittmann-Price, 2004). This influential relationship between a woman and social factors is dialectical. Care providers, specifically nurses and midwives, report that the opinions expressed by the woman in labour are one of the main factors in the care provider's decisions related to artificially inducing labour, for example by administering oxytocin to induce uterine contractions (Blix-Lindstrom, Johansson, & Christensson, 2008). Other factors include supportive partners or other informal supports, which have an impact on the way that women make decisions about their health (Lally, Murtagh, MacPhail, & Thomson, 2008; Woolfe et. al, 2005). A woman's awareness of these social factors and social norms can allow her to freely make health-related decisions (Wittmann-Price, 2004).

A flexible environment is also an important factor related to women's health decision-making. This factor becomes even more salient when a woman is making birthing decisions, particularly when choosing the physical environment in which their birth will take place (Block, 2009; Wittmann-Price, 2006). Rather than employing rigid guidelines and limited options, a flexible environment allows for dialogue between the individual and the care provider (Wittmann-Price, 2004). A flexible environment for decision-making is seen to increase choice and self-esteem, leading to greater overall satisfaction with the decision (Wittmann-Price, 2004). Note that the focus here is on the woman's satisfaction with her decision rather than the outcome or consequence of that decision. The current study discusses decision making similarly, with regards to women's retrospective view of the decision rather than the specific alternatives or consequences. With regard specifically to childbirth decisions, women report that in developing their birth plan, it is important to be well-informed by nurses, midwives, and doctors as to the range of choices available before making decisions (Cheung, 2001). Making birth decisions can be extremely overwhelming, particularly for first-time mothers, thus women rely on available information from their care providers (Cheung, 2001).

The point that becomes quite clear when reviewing women's health decision-making is that these decisions do not exist in isolation from the context in which they are made. When discussing individual mothers and their childbirth decisions, it is essential to consider the impact of surrounding factors. Bronfenbrenner (1977) proposed an ecological model for taking into account the context in which individuals live. This model places individuals in the context of microsystems (for example, family), mesosystems (for example, schools and peer groups), and macrosystems (for example, media, policy, social norms, etc.). Exosystems are related to

mesosystems and include factors that exist outside of the individual's direct experience and surroundings. These systems do not contain the individual, but do have an indirect influence on the individual and the contexts in which they live (for example, government agencies) (Bronfenbrenner, 1977). Researchers have noted the importance of examining these systems, or levels of analysis. The individual does not exist in isolation from these other systems, but rather exists in the context of them, constantly influencing and being influenced by these many factors (Trickett, 1984).

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Figure 2: Ecological Model of Childbirth

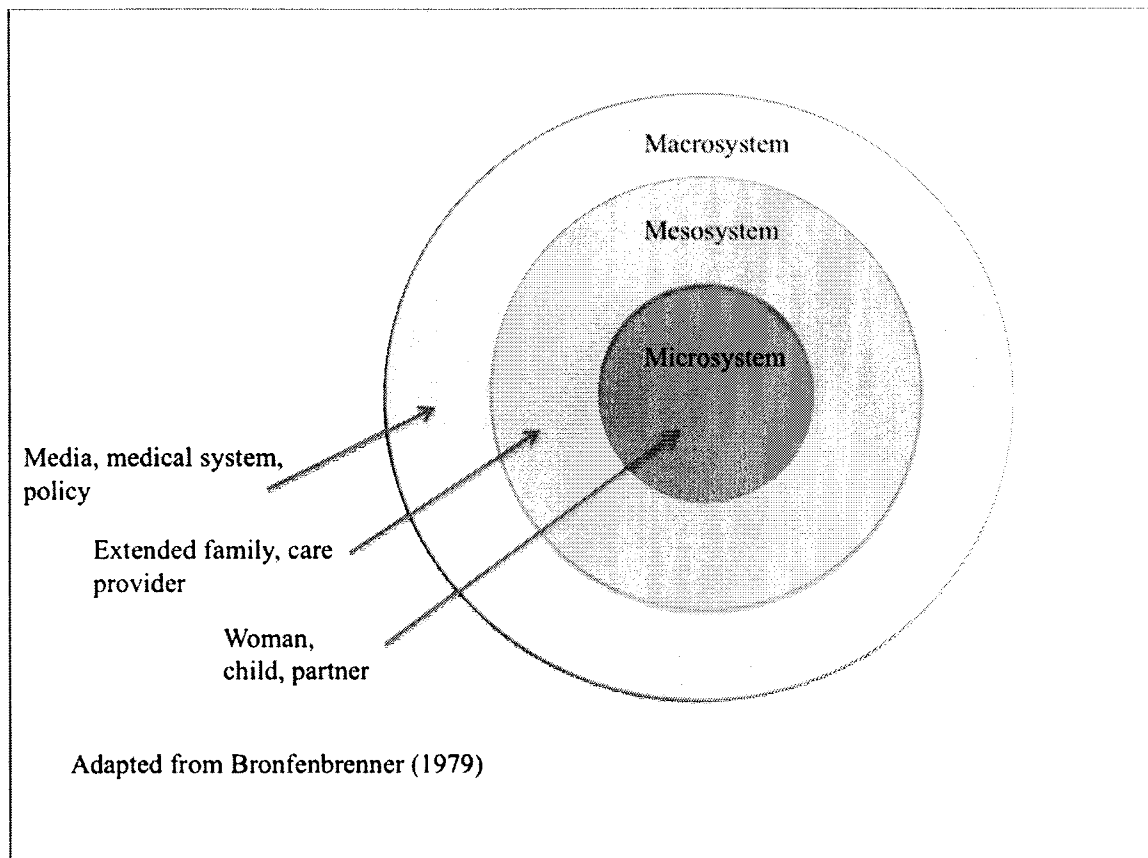

Figure 2, above, illustrates a basic ecological understanding of childbirth experiences, with three levels of analysis that incorporate some, but not all, of the influences on a woman's decisions and experiences in planning and giving birth. For simplicity, this figure includes three of Bronfenbrenner's levels of analysis—the microsystem, mesosystem, and macrosystem. In the center of this figure is the microsystem, the mother and her child, who are, during pregnancy and childbirth, inextricable from one another in terms of mutual impact. The woman's partner is also part of the microsystem. Surrounding a woman, her partner, and her child is a woman's extended family and healthcare providers, or the mesosystem. Midwives, nurses, and doctors are included in this level of analysis. These individuals are also influenced by the woman in labor in

the decisions she makes concerning her care (Blix-Lindstrom, Johansson, & Christensson, 2008). In the outer layer, or the macrosystem, we have culture and media, as well as the social and political climate. This level has an immense impact on both of the other levels of analysis. It is difficult for the individual woman to have an impact on these macrosystems, however, not impossible. This ecological model of childbirth provides a comprehensive way of thinking about and discussing women's experiences of childbirth.

A Narrative Approach

There are many ways to ascertain how women make decisions and how they experience birth, one of which is a narrative approach. Much of the literature on childbirth focuses on factors related to labour and delivery and does not consider the way in which a woman plans and experiences her birth, thus missing many insights regarding these processes. A narrative approach is useful for a number of reasons. Narratives can be valuable for developing a potential for social change, for example to implement policies that foster a positive birth experience for women and their families, as well as to make the experience more meaningful for participants (Rappaport, 1995). Having access to narratives is an empowering experience for research participants (Holloway & Freshwater, 2007; Rappaport 1995). Narratives also provide the researcher with a great deal of rich, deep data that contains a large amount of detail. Furthermore, narrative research has been demonstrated to have a positive impact on participants with regards to increasing self-esteem and enhancing one's self-image (Essers, 2009). Individuals use stories as a way of further understanding themselves and to evaluate and develop their sense of satisfaction (Bauer, McAdams, & Pals, 2008). Therefore, in addition to gathering

in-depth data, a narrative approach can be used to provide participants with a positive overall research experience.

To date, many studies using a narrative approach to research aiming to further understand the birth process from women's perspectives have had positive and encouraging results. Studies note that birth narratives provide an important way for women to share and make meaning from their experiences in the months and years following the birth of their child (Callister, 2003). Birth narratives serve as a way to connect women through their experiences. Women have noted that in both experiencing and sharing their stories, they felt more connected to other women who have given birth throughout history and across geographic locations (Callister, 2003). Both women and men tend to incorporate a great deal of evaluation into their birth stories, giving them the opportunity to further understand and make sense of this emotional and life-changing experience (Page, 2002). Furthermore, the benefits of telling these types of stories include sharing both the positive and negative aspects of the birth, as a way to further process these experiences (Callister, 2003). Beyond processing and sharing the birth experience, narrative research also assists in healing negative experiences women may have had during childbirth (Beck, 2006; Callister, 2003). Studies emphasize the importance of asking women how their birth could have been improved and allowing them time to vent and reflect on the aspects of their birth that were perhaps negative or not what they anticipated (Beck, 2006; Callister, 2003).

In sum, the literature suggests that choice and control are important to women during childbirth, along with the care of a supportive partner and sensitive healthcare providers. The development of an effective breastfeeding relationship is a vital aspect of the immediate postpartum period that can be negatively impacted by a number of factors related to the

medicalized model of childbirth. Childbirth itself has changed greatly in the past two decades, with a clear move towards the medicalization of childbirth in many parts of North America. Today, almost all births in North America take place in hospitals, where women and infants encounter a large number of medical interventions (Block, 2009). Furthermore, there are a number of factors influencing the way in which women make decisions about their health. Some of these factors include personal knowledge, social norms and a flexible environment (Wittmann-Price, 2004). These factors have an impact on the way women view and experience their decisions, which includes childbirth decisions. Although there is significant literature available on infant outcomes, there is a lack of research on women's experiences of childbirth. Specifically, research suggests that telling one's birth story, even in a research setting, has positive implications for processing and better understanding this experience.

The Current Study

The objectives of the current study are to understand women's birth planning, specifically the people and factors that impact birth method decisions, as well as to better understand how women's feelings and experiences of control impact their birth experience. This study explores the following research questions: (1) What are the key influences on women's birth plan decisions? (2) How do changes to a woman's initial birth plan impact her overall birth experience? and (3) What is the role of choice and control in women's childbirth experiences?

Predominantly, past research has focused on the health of the child in relation to his/her mother. This study builds on current knowledge via an in-depth investigation of the woman's experience of childbirth in the context of her partner, family, friends, care providers, media, and

cultural influences. It takes a holistic, woman-centered approach, emphasizing the importance of valuing women's birth experiences as well as considering choice and control in both the birth planning and delivery. A narrative approach to data collection was chosen as the most appropriate for answering this study's research questions. Narratives provide an opportunity for participants to tell their stories, emphasizing the parts of these stories that they deem most important.

Method

The current study used a one-group design with in-depth, semi-structured interviews. Interviews were used, as opposed to focus groups, because childbirth is an intimate experience that is unique to each individual woman and her family. In-depth interviews fostered a deeper inquiry into the complexity of each individual experience while valuing each woman's story.

Sampling Strategy

This study used convenience and snowball sampling strategies. Women were recruited on the basis of having given birth in Waterloo Region in the previous two years. Once women were recruited, they were asked to share the study information with other women in their immediate circle. The purpose of this strategy was to rely on the social connections of new mothers in order to build a sample of 16 women.

Recruitment

The study was advertised at a local organization, the Kitchener Downtown Community Health Centre, through a program called the Breastfeeding Buddies Support Group. This organization was chosen based on existing professional relationships rather than sample

characteristics. The Kitchener Downtown Community Health Centre (CHC) serves a wide variety of clients and has a number of health-related programs (including a breastfeeding support group for new mothers). A nurse practitioner at the Kitchener Downtown CHC, known to the principal research through another, unrelated research project, assisted with recruitment and snowball sampling at this organization. Another organization, LaLeche League was also approached for recruitment purposes, however the study was not advertised because the organization decided that it did not fit with their specific purpose, namely breastfeeding.

As participants were recruited, they were asked if they are aware of other individuals who may be interested in taking part in the research. The reason for this is that many new mothers, particularly those who attend breastfeeding support meetings, have friends and peers who have also recently given birth or who are about to give birth. Therefore, participants were recruited either through the Breastfeeding Buddies Support Group, or via word of mouth.

Sample Description

The sample of this study included 16 self-selected women who had planned and given birth within the two years preceding data collection. The reason for this time frame was (a) to speak with women who were still processing their birth experience and (b) to provide the opportunity for participants to develop new insights and reflections on this experience. Although 16 women were interviewed, there is audio data available for only 15 participants. All sample information and findings are based on these 15 interviews. The sample included nine primiparous women (women who have had one pregnancy and delivery) and six multiparous women (those who have experienced more than one pregnancy and delivery). Of the 15

participants, two primiparous participants were pregnant at the time of the interview and were therefore in the process of planning a second birth. All participants initiated breastfeeding with their infant. Additionally, all participants had a partner involved in the birth of their child.

In terms of care providers, one participant pursued the care of a general practitioner, 13 participants used a midwife (six of these women had their care transferred to an obstetrician), and one participant pursued the care of an obstetrician. Five participants hired a labour doula for their birth(s). Pseudonyms have been used to refer to participants individually to protect the anonymity of participants while at the same time referring to them using names, rather than the impersonal nature of participant numbers.

Procedure

Data was collected through in-depth individual interviews. The interview guide (see Appendix A) included two sections. In the first section women were asked about the development of their birth plan, as well as the factors that influenced this process. In the second section of the interview women were asked to tell their birth story, with probe questions concerning their overall feelings of control and choice in decision making, as well as questions to ask participants to reflect on and compare their planning to the actual birth.

During the interviews, women were presented with the two areas (i.e., planning and the birth story) and were able to decide how they would structure their story. Because each interview evolved organically, probe questions were used as a way to guide discussion. Individual probes were not used if they were covered through the woman's telling of her story or if they did not apply to a particular woman's experience. The interview lasted anywhere from 45

minutes to two hours and was open-ended in order to allow for the diversity and complexity of birth stories to be expressed.

Data Analysis

Data were transcribed by the principal investigator and analyzed using a phenomenological approach. Research has been presented that suggests that birth has been largely medicalized in North America and Europe. The literature also suggests that there are a number of factors that are important to women with regards to healthcare decision-making (i.e. flexible environment, personal knowledge, social norms) and that choice and control are very important to women during childbirth. However, there have not been any studies conducted in a Canadian context that consider both the process of planning a birth as well as the experience of giving birth

The data were coded using NVivo software. After all 15 transcripts were imported into NVivo each interview was analyzed. Codes were developed using the various parts of the birth story as a guide, for example planning, changes to birth plan, decision-making during birth, support during birth, and breastfeeding support. These codes were then analyzed further to gain a better understanding of how women constructed their experiences and which aspects of these experiences were emphasized by participants.

Data Quality

There are a number of measures that were taken in order to ensure the trustworthiness of the data. In order to bolster the credibility of the data, the researcher kept an audit trail throughout the course of the study. This was accomplished by keeping a journal of the research

process. This journal serves to document the process of the research as well as to document the researcher's developing thoughts and reflections with regards to the process. During data analysis, attention was paid to negative cases that disprove the developing understanding of women's experiences of childbirth. The researcher remained cognizant of possible negative cases in order to ensure that all possibilities were considered throughout the process of analyzing the data. Because the data are descriptions of participant's experiences with such a unique and complex nature, attention to negative cases was extremely pertinent to this study's trustworthiness.

Findings

This section is organized similar to the way that women's birth stories unfold. The main sections covered are influences on birth planning, the impact that changes in the birth plan have on women, and finally the role of choice and control in general throughout the birth process. Following these three sections, there is summary of women's overall perceptions of their birth experiences and a final section discussing the topic of breastfeeding support during the postpartum period.

Below is a summary table that describes the birth choices that women made and the actual birth experiences women had in terms of their attending care providers and place of birth. The purpose of this table is so that the reader can gain a better understanding of the choices that women made prior to giving birth and how these plans changed for individual participants.

Table 1: Participant Summary Table

Participant	# of births	Midwife	OB	GP	Doula	Home Birth	Hospital Birth
1 Katrina	1	X →	X				X
2 Marlene	1	X				X	
3 Thelma	1	X			X	X	
4 Melody	1	X					X
5 Selah	2 (twins)	X →	X				X
6 Marcy	3	X →	X		X	X →	X
7 Carla (a)	2	X	X		X		X
8 Joni	2	X →	X			X →	X
9 Regina	1	X →	X		X	X →	X
10 Tessa	1	X →	X				X
11 Ella (b)	1 (preg)	X				X	
12 Jenna	4			X			X
13 Paige (b)	1 (preg)	X			X		X
14 Shelly	1		X				X
15 Lara	3	X					
TOTAL		13	8	1	5	5 (actual)	12

An arrow (→) indicates a transfer of care.

a) This participant had more than one child and experienced midwifery care and obstetrician care for subsequent births.

b) These two participants were pregnant at the time of the interview and therefore discussed their experiences with planning two births.

Influences on Birth Planning

When planning their birth, participants noted a number of resources that influenced their decision-making process. Some of these resources, such as partner, family members and care providers, influenced the decisions women made, while others, such as books, online information, and prenatal classes, provided women with information needed in order to make birth-related decisions.

The most often mentioned influence on participants' decisions was family, particularly female family members. Eleven of the 15 participants noted that one or more family members provided them with advice on planning their birth. Of these family members, the most

frequently discussed were the mothers and sisters of participants who had given birth in the past and shared their experiences, which either positively or negatively influenced participants' birth decisions. For example, one participant notes that her mother offered both support and knowledge:

> I had a really close relationship with my mom and talked to her, you know, probably daily throughout the pregnancy. My mom was also so supportive having had both my sister and I, like, vaginally and naturally. [She] was very supportive of, like, not being afraid of that. (Shelly)

Another participant noted her desire to have a birthing experience different from that of her mother, stating, "my decisions were more based on my mom's negative experiences. I was like, yeah, I'm not going there, we'll just do this differently" (Jenna).

In addition to the influence of female family members, participants noted the influence that their partners and care providers had on their birthing decisions. Participants discussed the desire to share their birthing experience with their partners and to incorporate their partner's wishes into the birth. For example, one participant recalled her decision to have a home birth, "my husband is not a big fan of hospitals either, so it was, so he had a bit of a say in it too and I thought we'd try to make it as comfortable as possible" (Lara). Yet another participant described her husband's role in choosing a team of care providers:

> With my husband...I mean, he was very good at reading up on stuff, he even asked about the midwife thing the first time around and he was actually more into it than

> I was, he was thinking that we maybe wanted a doula the first time around as well because his sister had a doula and said it helped a lot. (Carla)

The role that partners played in the birth planning process was important and had an impact on participants. One woman did not feel that her husband was interested in planning the birth of their first child. She said, "well, I will say my ideal, in my ideal world, my husband would have been more involved in planning, he would have had more of an interest in it, but he didn't, he doesn't, and I'm used to that in our relationship (laughs)" (Marlene). She also noted, however, that she was able to plan her ideal birth knowing that her husband would support the decisions that she made:

> It was mostly me and I knew what I wanted and I had a clear sense that this was my birth, and if my husband had wanted to be more involved, then certainly I would have been open to that, but he didn't and so it was essentially my birth and it was going to happen the way I wanted it. (Marlene)

Care providers proved to be another important influence on women's birthing decisions. Women in this study viewed their care providers as not only sources of information, but also sources of experienced knowledge on making informed decisions. One participant recalls how her midwife helped to inform her on the birth process:

> We talked about pain management and different options, that kind of thing. We talked about the actual delivery and she pulled out, like, you know the pelvis bones in a little bag and showed me how it all would happen and, um, she just always answered questions I had. (Tessa)

Another participant noted that she and her midwife shared a similar philosophy of childbirth and that this helped her in making birth-related decisions, "I think that it helped that the midwives have a similar philosophy that I do…I think that a lot of who you are using, having the same philosophy helps" (Lara). Another participant also noted the importance of her midwife's general philosophy on birth, "I went to meet with the midwife and really connected well with her, really liked her philosophies on birthing being a very natural process and I really like the time that midwives spend with their clients" (Joni). These participants emphasize the importance of a woman's care provider in helping to plan her birth.

Participants also noted a number of resources that they used in order to gain information concerning their birth choices. The main resources that participants used included books, prenatal classes, the media and other women. Participants noted the importance of having these resources available to them in order to adequately prepare for their birth. One woman discussed her interest in childbirth preparation:

> The stuff all interested me, so I found myself reading a lot on my own and kind of educating myself…so I found a lot of the stuff, you know, when you go with a midwife, they have stuff they have to talk about at each meeting…I had already done my reading on it. (Paige)

Another participant discussed how a particular book helped to inform her on her birthing decisions. "*What to Expect When You're Expecting*. That book was, it really helped me out for my entire pregnancy and kind of prepared me a little for labour and delivery" (Melody). Another participant had opinions regarding the books that she read while planning her birth as well:

> I think when I look at the books…the one thing I loved about the Ann Douglas one, *The Mother of All Pregnancy Books*, is that it was written like someone talking to their girlfriend about being pregnant. (Carla)

For this participant, it was important for information to be accessible and easy-to-understand while still being useful and relevant.

Other participants ($n = 4$) took part in local prenatal classes in order to prepare for their birth. Participants discussed the usefulness of prenatal classes in terms of their pain management preparation. One participant recalls, “we went to a really good…pre-birth class and she taught our husbands lots of good things including some spots on your body where the pressure’s good” (Lara). Another participant, while discussing her experiences in a prenatal class, states, “it just gave me more information than anything else and it helped me be prepared for the whole experience” (Melody). One participant was a childbirth educator and a labour doula who had attended hundreds of births and she also discussed the importance of taking part in prenatal classes as an expectant mother. “It’s crazy, you taught for 15 years, why are you taking prenatal classes? Well, it’s because I wanted to be in a different mindset and learn or look at things in a different way” (Regina).

One participant noted the presence of misleading information and the lack of useful information that she found in the media and from women who had previously given birth. Regarding cesarean sections, this participant noted, “I guess just because, like, in the media you see them like, everybody’s having them so what’s the big deal, you know?” (Selah). This participant, who ended up having a cesarean section, also stated:

> I almost felt mad at other moms and society, like, what is this secret, what is this dirty little secret that we're all keeping from each other? Like, why? Why didn't anybody tell me how horrible this was gonna be? I felt kind of mad that I wasn't part of the group or something, you know? (Selah)

This participant's experience highlights women's desire for accurate and relevant information when planning a birth. Whether this information came from books, prenatal classes, the media, or other women, it was important for women to have this information readily available.

Changes to the Birth Plan

The majority of participants (*n* = 11) experienced some degree of change to their birth plan during labour and/or delivery. These changes included decisions ranging from the use of medical intervention and pain control methods to the attending care providers and place of birth (home or hospital). Participants had varying levels of specificity in their initial birth plans. For example, one participant with a low level of specificity states, "I pretty much had my mental idea in my head. That was, I wasn't very picky, like, I wanted [the baby] delivered and safe and didn't want an epidural" (Katrina). Another participant said, "I knew I wanted to do it in the hospital and I wanted to try without an epidural and other than that I was like, whatever happens, happens and just, I'll keep an open mind so that the birth can be healthy" (Melody). A third participant stated, "[the] birth plan for us was, I think, intentionally vague with a lot of holes in it…at the end of the experience I wanted to be as healthy as I could possibly be and I wanted to have a healthy baby" (Lara). These three participants formed birth plans that were intentionally vague because they recognized that they could not predict how their birth would unfold. Other

participants had a high level of specificity to their birth plans. These participants tended to have specific ideas concerning their care providers, place of birth and medical intervention. For example, one participant stated, “I wanted as little intervention as possible and that was throughout the whole pregnancy, so that was probably at the top of the list, which really informed the rest of it” (Marlene). Another participant with a high level of specificity to her birth plan stated, “I worked in health care, I’ve worked in health care community services for a number of years, so I was pretty determined that I wanted it to be as non-medical as possible, so my intention in the very beginning was to have a natural childbirth with no pain medication what so ever” (Thelma). The level of specificity, to a large extent, determined the amount of flexibility women had in terms of changes to their birth plan.

Of the participants who experienced changes to their initial birth plan, the changes were most devastating to participants who experienced a great degree of change and/or little or no control over the changes as they were happening. The most drastic changes to women’s birth plans were as follows: a) the care provider who would deliver the baby (midwife versus obstetrician) and where the birth would take place (home versus hospital); b) the type of pain control techniques and amount of medical intervention that was used; and c) the length of time women stayed in the hospital and the adequacy of care they received.

Transfers of care. In total, 13 of 15 participants initially planned to have a midwife as their primary care provider. Of these, six women had their care transferred to an obstetrician at some point during pregnancy, labour or postpartum. In addition, three participants who planned to give birth at home were transferred to the hospital at some point during their labour. Both of

these types of changes to the initial birth plan impacted women's views of their birth experience. As these participants reflected, some recalled positive experiences, for example:

> I got good care from everyone at the hospital, especially at the birth, the people that were there. Even though it wasn't my ideal situation like home, I cannot complain about the care that I got by any means. (Regina)

> ...But so supported by the hospital. The nurses were awesome, like I could have gotten a crummy nurse and I got a nurse who was completely into that...and helped me nurse him. (Marcy)

> The nurses on the floor were amazing, like you would push the button and they would be there in a second because there's only so much my husband could do and feel comfortable doing. I needed a lot of assistance to get back and forth to the bathroom. (Selah)

Along with these positive experiences, however, a number of participants also had negative experiences with transferring care and/or transferring from birthing at home to the hospital. The following statements came from participants who had their care transferred from a midwife to an obstetrician:

> When I was readmitted for my blood clot, because I was officially under care of an obstetrician, they, the midwives, weren't given access to see what my blood tests were and things that they would get in a normal case, so that was a little bit frustrating. (Regina)

> It was scary and sad. It was just sad, you know, I felt like I was just starting to have this relationship with her [midwife] and really coming to terms with what I wanted and bang, it was all, it was all so fast, like, I just found out I was having twins and it was just all crazy, and then…I'm losing the woman who was going to protect me during my birth (Selah)

For these participants, having their care provider changed during pregnancy or delivery led to frustration and disappointment. Two participants discussed giving birth in the hospital after planning for a home birth:

> Like, just being there, I hated it and so I just, I had a bad attitude about the whole thing right from the moment we had to leave this house…but I couldn't control it, it was like this visceral response, like I just was not comfortable there. (Joni)

> I had monitors now strapped on to me and I was limited to only lying on my back and I couldn't be in any other position…It was all of a sudden a three ring circus rather than being, like, we no longer seemed the focus and we were not, I was not talked to really, it was just, let's read the machines…it really felt that way. (Regina)

Finally, one participant reflected on what she learned after giving birth in the hospital and feeling a loss of control in this situation:

> I have the experience of having a baby in the way that I know what my rights are and I know that if I go to a hospital I don't have to do everything that they tell me I

> have to do, and that irritates me that other women don't know that, they don't know what their choices are. (Paige)

For these participants who experienced transfers of care, this change to their birth plan had an impact on their overall birth experience. For some participants, the actual care that they received was positive, however the experience of drastic changes to their initial birth plan was negative.

Pain control plan and medical intervention. The way in which participants approached their plan for pain management and general medical intervention varied greatly. Some participants desired to keep their plan open while other participants were adamantly opposed to medical pain management, such as the use of epidurals or other medication. The circumstances in which women experienced a great deal of change to their plan for pain management and medical intervention can be grouped into three categories: 1) women who planned to give birth without pain management medication and in the end had to have some form of pain medication; 2) women who planned to give birth naturally at home and needed have labour induced at the hospital (one participant); and 3) women who planned for a vaginal hospital birth with a midwife and were transferred to an obstetrician and had a cesarean section (one participant).

A number of women planned to give birth naturally without the use of medical pain management and in the end had to have an epidural or other medication. This category also included one woman who planned to use a particular medication and discovered during her labour that this medication was no longer available. Below are their descriptions of some of these experiences:

> I wanted to have a drugless birth and…I did not want to give birth on my back. The first thing they did when I got into the hospital was put me on my back and I looked at the surgeon and was like…I don't know how people sit like this, it was the most pain I had been in the entire time and I was like I can't handle this and she's like 'that's why we're giving you drugs' and I was like no, just let me stand up! (Tessa)

> I felt like that was the turning point, I felt like I almost gave up at that point and I just said I can't, I need to have some medication. I really didn't want to before hand, but at that moment it was like I needed it, it was all I could do to wait until that person came in to do the epidural. (Joni)

> I still wanted to have a vaginal birth, natural if I could. Going through my prenatal classes I found out that at Grand River [Hospital], they actually don't allow you to have a natural childbirth with multiples, it's pretty much mandatory you have to have an epidural right from the beginning of labour. (Selah)

> It was just enough to kind of make me feel off…had someone said to me before, like, 'Nubain's not available anymore, these are your options', I would have said yeah, but I don't want Demerol, okay, I guess I'm going natural before I was right in the thick of things, I think it would have just affected me differently. (Jenna)

For some participants, the decision to use medical pain management was made with them, rather than for them. One participant stated:

> I think, like with the epidural, where I really didn't want it, the way it was presented at least wasn't, I guess I didn't feel like I had given up on not having it because of the way it was presented. (Katrina)

Another participant reflected on her decision to have an epidural after transferring to the hospital, saying, "this is one of those things that's control and choice, if you get too stuck on something you feel guilty afterwards" (Marcy). For these two participants, although the decision to have an epidural was not part of their initial birth plan, they expressed control over making this change.

The second category included one woman who planned to give birth naturally and had to have her labour induced with the use of medication such as oxytocin. The use of induction medication also led to the use of epidurals and other medical pain management. This participant in particular experienced a great loss of control when her birth plan changed drastically:

> I really wanted to give it more time to see if labour would come, still holding on to my homebirth idea…then the midwife said it's now 24 hours so we've gotta head to the hospital, so she was born in the hospital by induction as opposed to a more natural childbirth…so our plans changed a lot…I think emotionally, too, I just felt like this is so not happening the way it's supposed to be happening and there's this pressure for this to happen fast and making it happen fast that it is so unbearably painful, like, I just, if this is how it's going to happen then I need some relief because I can't go on like this. (Joni)

Finally, the third category included one participant initially planned for a natural birth with a midwife and was later transferred to an obstetrician because she was pregnant with twins.

Upon discovering that her babies were not in the correct position for a vaginal birth, this participant was informed that she would need to have a cesarean section. For this participant, finding out that her desired method of giving birth was not a possibility had a severe impact on her decision and left her feeling "defeated":

> I just felt defeated, like I have no choices now, like none. I don't have any choice in my birthing, nothing, these babies are coming and I have to have an operation. I have to have stomach surgery. (Selah).

Generally, participants who experienced a great deal of change to their birth plan in terms of pain management and medical intervention had a difficult time dealing with these changes and, overall, a more negative view of their birth.

Stays in hospital. A number of participants (*n* = 13) had some experience staying in the hospital for a period of time after the delivery of their child. Of these, four participants had not initially planned on transferring to the hospital and had planned a home birth. Three of these participants transferred to the hospital during their delivery, while one participant's child was transferred to the neonatal intensive care unit shortly after being born at home. Participants who had not initially planned on being admitted to the hospital reflect on their experiences below:

> It was definitely a very different experience and it wasn't what I wanted. I wanted to be home and just skin-on-skin with my baby and that's not what I had…I just pretty much kept my mouth shut because I knew that I had a very clear sense that the nurses were not very supportive of anyone who had had a home birth. (Marlene)

> I was in a lot of pain and they wouldn't allow [the baby] to stay with me unless I didn't take any pain killers, so it really felt like people were going against me in a weird way because…after a c-section, you get a ton of pain killers, but your baby still stays with you, right? (Regina)

> I didn't even, at that point, really get a chance to bond with them because I was so sick. I didn't want anything to do with them...I still felt really horrible and then the lactation nurse was coming in and harassing me and trying so hard to force my kids on me. (Selah)

For these participants, staying in the hospital was not a positive experience. The main factor that all of these participants had in common was the drastic change in their birth plans. For these participants it was not necessarily simply a transfer to the hospital that led to negative experiences, but rather an extended stay in the hospital.

Participants who experienced drastic changes to their birth plan tended to have negative recollections of these experiences. It is important to highlight that the factors most related to a negative experience include a) a great degree of change and b) little or no control over the changes as they were happening.

The Role of Choice and Control

Perhaps the most salient theme in the current study was the role that choice and control played in women's birth experiences. Women discussed feelings of control as empowering and encouraging and a lack of control as disempowering, frustrating and disappointing. For example, one participant stated, "giving women the power to make decisions and control what happens to

them, especially when there is a good outcome, is very empowering" (Jenna). For participants who felt a lack of control over the birthing process, their reflections on the experience were quite the opposite. One participant recalled, "I kind of felt defeated, like, you know, everything that I had been working for got taken away…I just felt defeated and kind of, you know, shit on a little bit" (Selah), while another participant said:

> I guess that's another word, and that's a horrible word, but defeated. Like, I really did feel kind of that way and I guess that sort of connected to feelings of control, you know, sort of like you have to just surrender to it, because there's nothing you can do. (Joni)

The central aspects of women's birth experiences and decisions included medical and non-medical pain management and support from care providers. In these areas, all 15 participants stressed the importance of having control of decision-making. Women's experiences of control/lack of control in the areas of pain control and care provider support are discussed below.

Pain control. Every participant (*n* = 15) included pain control techniques in their birth plan. Some women expressed a desire to avoid all medical treatment, including epidurals, morphine, and nitrous oxide, while other women desired to keep an open mind about what pain control methods they were willing to use. When the pain control plan changed during the labour or delivery, women expressed the importance of being able to make this decision rather than letting someone else make it (e.g., an obstetrician, midwife or nurse). For example, one participant remembers "in terms of pain management, it was all me and I was pretty vocal…like I didn't need much, no one needed to ask me what to do, like I was pretty sure of what I needed

in the moment" (Thelma). The pain control techniques that were used during labour and delivery can be categorized as "medical" or "non-medical".

Medical vs. non-medical pain control. Participants categorized pain control techniques as medical and non-medical, i.e., natural. Medical pain control included epidurals and medications such as morphine, Nubain® and nitrous oxide. Non-medical, or natural, pain control included things such as counter-pressure, breathing exercises, heat, visualization, water, and internal focus. Participants had both positive and negative experiences relating to their feelings of control in deciding what pain control techniques would be used. The following participant described her lack of control in maintaining the natural childbirth that she desired:

> It seemed to me the philosophy of the nursing staff, who were the ones who were in charge of the oxytocin, was let's get this going, let's keep this going and quickly and I didn't feel like their philosophy was wait a minute, you know, she wants to do this naturally, she's having trouble, let's reduce this dose. (Joni)

Several participants discussed the positive aspects of choosing which pain control techniques would be used:

> When you're not hooked up to anything, you've got complete freedom to move around during the labour process, whereas if you've got the pain management stuff, you have to be in bed because you're hooked up to stuff. (Shelly)

> I think, like, with the epidural, where I really didn't want it, the way it was presented at least wasn't, I guess I didn't feel like I had given up on not having it because of the way it was presented. (Katrina)

> I think that was the most important part for me, too, was I'm in control, it's my body, I'm strong enough to do this, people are going to tell you it's hard, it hurts, of course you're going to want an epidural, of course you want drugs…yeah, it's true, it's strong, it hurts, it's painful, and you get through it one contraction at a time. (Marlene)

Internal pain control. One of the interesting ways in which participants dealt with pain was "internal pain control". A number of participants ($n = 6$) discussed the importance of "going inside" themselves and dealing with the pain of childbirth internally. The following participants described what this process of internal pain control was like for them:

> I found at that point when I was just kind of in the dark, on my own, you can kind of go into your zone, go in a couple of layers while you're in the middle of a contraction. (Paige)

> I was just so focused on what was happening that, like I don't remember them…nobody had to say, like, it's time to push. Like, it just kind of evolved into that. (Ella)

> My safest moments were when I was entirely inside. I'm doing the work and I'm not – then it wasn't painful. It was painful, of course it was painful, but then it was 'cope-able', then it was 'deal-able' when you are allowed to leave, you are allowed to go inside yourself and just do the work you needed to do…the idea of wholly going inside yourself, but not in a way where anyone's pushing you in and you're having to take cover, but just in, like, fully encompassing yourself, being

> comfortable, being in yourself, being gone, being safe in that space…but that's not a losing of anything, that's just being safe inside myself. (Marcy)

> Your baby and your body are working together and I really felt like I had to take my mind out of it and just go away with my body and that totally worked and that was all I needed to do. (Joni)

> Women would often…deal with the pain either with an internal focus or an external focus, and so I kind of prepared for both…and I ended up using both, but I think my focus was mainly internal. (Thelma)

As these examples suggest, the ability to go inside oneself was strongly related to participants' feelings of safety during their labour. The connection between comfort and feelings of safety is an interesting one. One participant discussed the importance of feeling safe and how, for her, the ability to focus internally was diminished when her surroundings ceased to feel safe and comfortable:

> I had pushed for a long time with my eyes closed and I was okay with that and I felt safe…it felt like a really safe space to be in and I know that it felt really different when I got to the hospital and I know homebirth was the best option for me. (Regina)

For this participant, there was a marked difference in her feelings of safety after she transferred to the hospital and was no longer in complete control of her birthing process. For other participants, however, this feeling of safety and comfort came from birthing in the hospital:

> I was more comfortable thinking that I would be safe in a hospital…we chose these things because this is what made us comfortable and this is what made us feel safe, and if you feel comfortable and safe, chances are you are going to have a better delivery. (Shelly)

The important factor here is that participants felt safe in the surroundings that they chose and were therefore able to have a positive birth experience. The safety of a woman's environment also allowed her to deal with pain by going inside herself and focusing intently on what she was experiencing.

Care provider support. One of the main influences on women's feelings of control and satisfaction during childbirth was the support of her care team. In this case, care providers included midwives, obstetricians, nurses, labour doulas, and partners. Women reported both positive and negative experiences with their care providers throughout the birth process and discussed the importance of having a supportive care team. One participant stated, "I think the care team really, really matters to what choices women actually get to exhibit and which ones are reasonable risk analyses" (Marcy). This same participant discussed her comfort in giving situational control to the members of her care team:

> You just gotta go, it's okay because someone's in control of that, but they're dealing with my choices. They actually have the control at that moment, they actually are massaging the circumstances, but we all know how the play is supposed to come off, we all know what would be really wrong for me. (Marcy)

Other participants had equally positive experiences with their care providers. Trust was an important factor for many participants in the ways that they experienced support from their primary care providers:

> I really, really trusted in my midwife, and so I sort of thought that if she said we needed to do something, I'm not going to second guess her, I'm going to trust that this is what needs to happen and so I'll be okay with that. (Regina)

> The doctor who delivered in the hospital as well, had a great experience with him…he and the labour and delivery nurses were excellent together, like you could tell they had sort of a really good rapport, which made me feel comfortable. (Shelly)

> The obstetrician…I had never met her before, but she was very, she was very good. I mean, she very much, I think she got that this was sort of like totally outside my world, this whole, the way this whole thing went on…she had this very calm and peaceful kind of caring nature about her. (Joni)

One participant recounts the level of comfort that she experienced with her birth attendant—a general practitioner:

> It was definitely nice to have a doctor who recognized that I have to do the hard work, so maybe I should be calling most of the shots, as long as they were safe. Um, and he was just so very go-with-the-flow like I was, so that was good. (Jenna)

Yet another participant discussed how she felt that her midwife would act as an advocate for her to maintain her birthing decisions in the event of a transfer from home to the hospital:

> Your midwife can be an advocate for you if you feel that you're not able to stand up to the doctors because doctors can be intimidating, that the midwives will advocate for you if you want. (Lara)

Paige describes her positive experience with her care team as a whole. She points out that her care team gave her the space to make decisions throughout the birth process:

> I feel like everybody kind of respected what I wanted and although I was open to suggestions, because I didn't know, I had never had a baby before, so if they had said to me 'this is the way I think you should do it', I probably would have done it, but they didn't (Paige)

Other participants had negative experiences with their care team. The majority of these negative experiences took place around the way that decisions were made during the birth. One participant recalls:

> Well, they told me I had to have the epidural because they were prepping me for a c-section and I had no choice. It was lose my baby or have a c-section was pretty much the conversation she had with me. And she said 'it's my job to get the baby out and make sure we deliver him alive so you're going to have a c-section. (Tessa)

This particular participant's primary care provider was a midwife, however her care was transferred to an obstetrician while at the hospital. Other participants also reported negative experiences with their care providers. One participant, who had an obstetrician for her first birth and a midwife for her second birth, recalls the difference in the support she received:

> I would hope that if it was that first time around and I had had a midwife, I probably would have been better informed as well, and I would have at least, if nothing else, had a better support network afterwards. (Carla)

There were a number of participants who had experienced the level and type of care offered by both an obstetrician and a midwife. One participant summed up her experiences as follows:

> I think the primary difference, like people can say 'what's the difference?' I think deep down in its core, the primary difference with midwifery is that they are uncomfortable so that the woman isn't. Doctors do not get down on their hands and knees. Doctors do not bend over, they do not climb in tubs, they do not come to your house, they do not, they are not uncomfortable (Marcy)

For participants, the care provider that attended their birth had an impact on the level of control that participants experienced. Women had both positive and negative experiences with both obstetricians and midwives, however when a lack of control over the birth was experienced, participants tended to reflect on the relationship with their care providers negatively.

Beyond the involvement of the main care provider (obstetrician, general practitioner or midwife), women also had their partner and/or a labour doula to assist them during and after labour. Five participants hired a labour doula to attend their birth. Participants described the role of the labour doula to be one of encouragement, emotional, and practical support. One participant reflected on her doula's role in pain control, saying, "I had [name of doula] reminding me if I was getting vocal, to use very low tones, low pitched" (Thelma). Another participant described how a close friend played the role of a doula during the birth of her child, "she was the

one that I have photos of doing back pressure, helping me walk in the hall, she was my woman, she was my best friend woman who did the birth with me, basically" (Marcy). Finally, Regina describes the many types of support that her doula offered:

> She really was the foundation in some ways…she made sure I had water, she made sure that the midwife had hot water compresses to put on my bottom, she made sure the tub was the right temperature, she was there as encouragement. (Regina)

Participants also noted the role that their partners played in supporting them during labour and delivery. Women noted the importance of having their partner close by during their labour for both encouragement and pain control techniques. For example, Ella stated, "at one point he said he needed to go to the bathroom and I got upset. I was like no, you can't go! (laughs) I need to hold your hands!" (Ella). The following two participants discussed the role of their husbands throughout the birth:

> I don't know what [was] keeping him awake, but he was supporting me the whole time and there was so much time I spend just standing with my arms around him and all my weight on him…and he was just there and strong the whole time, so he was a very important part of that experience for me, being supportive. (Marlene)

> He was so in it that he just flew with it. He was actually my person during it. He was the one doing the back labour…and helping me out, and he was there every time. Every contraction, he would be touching me, hand on my back, even if it wasn't for pain relief, it was just…I need to know you're there. (Marcy)

Other participants also noted that their partners played an advocacy role when necessary. For example, Jenna said, "he knew what I wanted, so I knew that he would be okay to…step in and say, 'well look, this is really not what she wants, is there another way?'" (Jenna). In addition to the formal support offered by midwives and doctors, participants also highlighted the support given by doulas and partners during their labour and delivery.

Overall Impressions of Childbirth

Participants were asked what words they would use to describe their overall birth experience. The responses to this question offer general insight into which factors are important to women when planning and giving birth. Below are quotations that characterize all women's responses to this question:

> It was instinctual, which was cool. For me, fascinating, it was absolutely incredible. Just, um, it was painful, but they mostly are and, I don't know, it was a good experience, it was a positive experience, that's for sure. (Paige)

> I felt, and still do feel, for myself personally as a woman, I have a huge sense of pride and I think a feeling of accomplishment that I did this, you know, I was able to have a baby, nurse, all of these things that, like, I just feel really proud of myself for having done that. (Shelly)

> I really felt like the birth was really the only part that was spontaneous and unpredictable and kind of…something I couldn't control and for a control freak that's kind of hard, but yeah, I just really felt like it was spontaneous and unpredictable. (Tessa)

> It's just so awesome, it's so awesome, it's such, such an awesome experience. (Ella)

> I think we monitor and intervene sometimes too much, and yes we save lots of lives, but there's this path we have to find to walk that's somewhere between too much intervention and going back to the day we lost all kinds of babies and moms…so yeah, I'd say my experience was very good. (Jenna)

> I would say it's miraculous…it was natural and miraculous…I think you forget a lot of the pain that you go through. (Shelly)

> I tell people it was horrendous pain, but I still got through it and women are capable of getting through it, you just have to trust yourself. (Marlene)

> I guess if I had to describe it, I would say that it was both the most difficult and the most rewarding thing that I have ever done. (Melody)

> It was fantastic and scary and empowering and terrifying all at once. (Regina)

From these participant responses, it is clear that the experience of giving birth is extremely powerful and important for women. Some of the words that were used multiple times included instinctual and empowering. Women reported that when they were able to follow their instincts and were well supported in this, they felt empowered in their ability to have a "painful but rewarding" birth experience. On the other hand, participants who experienced a drastic loss of control during their labour and delivery described their birth experience in a more negative way:

> I felt for my first labour that I was able to follow my instincts and that was so empowering, to have these instincts and to go with them and to see the outcome of

> them, that's amazing. Whereas with the second one, I mean, it wasn't about me anymore at all, or my instincts, it was these things that were being put into my body that were making me feel certain ways. (Joni)

> It was a pretty intense birth experience compared to what I thought and what happened, complete opposite. Not the same, like, at all. And it was so traumatizing to the point that I don't think I'm going to have any more kids. (Selah)

For the above-quoted participant, who was the only woman in this study who experienced a cesarean section, her negative birth experience had a large impact on her early experiences of motherhood. She was also the only participant who reported an experience of postpartum depression and directly linked her depression with the traumatic nature of her childbirth experience, as described below:

> I had the baby blues, like I guess everybody has. Like, you're crying for no reason when you went home and whatever, I'd just be crying for whatever, but then I started feeling okay and then it was probably two or three months after I started, getting really just down and all I wanted to do was sleep, I didn't even really want to take care of them. I just wanted to pump and go to bed. I didn't want to interact with them. I loved them, but I was just, you know, I didn't ever want to hurt them or I never not loved them, but I remember crying to my mom, bawling my eyes out, it was one of the first times that I was left alone, and saying 'mom, I think I regret this, I don't think I want them', you know? So that was hard. But at least I was able to recognize that it wasn't normal, and so we got help right away. (Selah)

This case is unique in that this participant did not experience labour, but rather was rushed to the hospital for an emergency cesarean section before she experienced any contractions. This participant also experienced a complete disconnect between her initial birth plan and the way that the birth of her children unfolded. In some regards, this participant's birth experience is the most extreme example of a loss of control during planning and the actual birth.

Breastfeeding Support

Every participant described the types of support that they received after the birth of their child(ren). The most common aspect of this postpartum period was women's first experiences with breastfeeding and the support that they received in this regard. Participants who had had a midwife ($n = 13$) discussed the fact that their midwife was in contact with them within 24 hours of the birth of their child and continued to monitor them for six weeks after the birth. Some of these participants' recollections of this experience are as follows:

> My midwife was here within 12 hours of her birth, or very early that morning…and she helped me with the breastfeeding and, you know, when she was here…she came here for the first three to five days and helped me with it. (Thelma)

> The midwives helped with everything. They taught me how to breastfeed. I paged them a number of times with breastfeeding concerns and questions and they just, they explained everything we needed to know. (Melody)

> The fact that we had the midwife and she came and checked and I had called her a couple of other times about questions we had afterwards and she either answered

> them or came by if it were something that she needed to look at. (Carla)

Other participants, however, did not feel that they were supported in establishing a healthy breastfeeding relationship. These experiences are as follows:

> They [nurses] made me pump, essentially, because I didn't know that I had the choice. I didn't know that I could say no, so while him [the baby] and my husband and all of the visitors were out in the room, I sat in the bathroom pumping. (Paige)

> The lactation consultant, I was really surprised that they sent her in so much and that they kept me so long, because they kept me until Thursday, so I was there Sunday to Thursday, solely because he wasn't latching and they couldn't figure out why, not even the lactation people could get him to latch. (Tessa)

> About 48 hours after, the lactation consultant came and she's like 'you have to feed your kids' and almost making me feel guilty that I hadn't breastfed them yet...and she's like trying to force it and she's squeezing my son's face and he was screaming and my colostrum hadn't even co me in yet, so I yelled at her and told her to get out and apparently she got offended and wouldn't come back. (Selah)

> Unfortunately, going through an OB, I mean, they don't take very, any time to educate you about breastfeeding, about what problems you may have, recommending you to get set up with support before you have the baby so that if you have problems you're kind of armed for potential success. (Carla)

> I felt like I was sort of pushing the breastfeeding thing when I thought maybe it would be pushed onto me and it definitely was not. I did not feel like

breastfeeding was advocated for at all. (Regina)

All of the above-quoted participants who had difficulties finding support for breastfeeding were under the care of an obstetrician for the delivery of their child and all of them gave birth in a hospital. Carla, for example, had a negative experience after giving birth to her first child in the hospital, whereas after the birth of her second child with a midwife, she felt very well supported in establishing a breastfeeding relationship. In this study, women with midwifery care reported being supported in the beginning of their breastfeeding experience whereas women who had a hospital birth were not always able to find the support that they needed in order to have the same positive breastfeeding experience.

Discussion

The current study set out to answer three research questions. These questions were 1) what are the key influences on women's birth plan decisions? 2) what impact do changes to a woman's birth plan have on her overall birth experience? 3) what is the overall role of choice and control in women's childbirth experiences? In this section, each of these questions will be addressed. Next, a conceptual framework is described that identifies what factors are important and relevant when a woman is planning for and giving birth. This framework includes three overarching themes: informed choice, support, and flexibility. These three factors will be discussed in relation to the three stages of the birth process, beginning with planning, followed by labour and delivery, and ending with the postpartum period.

Key Influences on Women's Childbirth Decisions

The findings of the current study suggest that women rely on the expertise of trusted care providers, such as midwives and obstetricians, in order to make birth-related decisions during the planning phase. Additionally, women rely on the childbirth stories and experiences that have been passed to them from their mothers, sisters and aunts to inform their own birth decisions.

Women also search for information outside of their care provider appointments in order to better inform themselves on the choices they are able to make around their labour and delivery. This information comes from books, prenatal classes, media and other women. Often, this information helps to prepare women for appointments with their care provider where they discuss the details of the birth plan.

Additionally, women may feel disappointed when they receive incorrect information, particularly concerning pain and the recovery period. Women do seek information from informal supports, such as casual conversation with other mothers, and this information has an impact on the ways in which women view and prepare for their labour. This suggests that although formal information is important, the informal support offered by other women is also a key influence on women's childbirth planning and needs to be relevant and accurate. Whether the influences on planning are positive or negative, the general understanding that can be derived from these findings is that that availability of accurate information and the existence of a supportive care team with which to discuss this information is the key to childbirth planning.

The Impact of Changes to a Woman's Birth Plan on her Overall Birth Experience

Previous research has suggested that when changes to a woman's birth plan are necessary, it is the amount of control that the woman maintains over these changes that is important to sustaining a positive birth experience (Bauk, Fenwick, & Butt, 2006; Hardin & Buckner, 2004; Lavender, Walkinshaw, & Walton, 1999; Visainen, 2001). In the current study, there are two key factors related to the impact of changes to the birth plan on women's childbirth experiences. These factors include the degree of change that takes place and the amount of control the birthing woman has over the changes as they are happening.

The most drastic changes to women's birth plans included transfers of care from home to hospital and/or from midwife to obstetrician, the use of medical pain control techniques and other medical interventions, and unexpected stays in the hospital after the birth of the child. Women who experience all of these changes and who have little to no control over the decision-making process as changes are happening tend to use negative adjectives when describing their overall birth experience. These negative adjectives include words such as defeated, frustrated and traumatizing. When women experience a smaller degree of change and maintain some level of control over the decision-making around these changes to their plan, the changes do not have a negative impact on their overall birth experience. This is connected to positive reflections on the overall birth experience, including words like fantastic, empowering, and supported. From this we can conclude that it is not simply the fact that the birth plan changes that leads to positive or negative feelings, it is the degree to which the initial plan is modified and, importantly, the degree of control that women have over the changes as they are happening.

When women are well-supported in making decisions and have a great deal of trust in their care providers to make decisions on their behalf, women have a more positive recollection of their experiences. This finding of a connection between control over birth plan changes and overall view of the birth process is consistent with the findings of a previous study (Hardin & Buckner, 2004). When women's care transfers from a midwife to an obstetrician, they tend to consult with their midwives before making birth-related decisions. Women who are supported by this type of consultation, are not likely to experience a severe loss of control. Women who do not have an opportunity to consult with their midwives on changes to their birth plan, or those whose midwives are no longer in control of the changes, experience a greater loss of control and therefore describe a more negative overall experience.

The Overall Role of Choice and Control in Women's Birth Experiences

A central finding of this study is that a woman's ability to remain in control of decision-making related to her childbirth experience is extremely important and the factors involved are complex. During labour women are often unable to make immediate decisions either due to emergency circumstances or simply because they are experiencing too much pain and exhaustion to feel able to make decisions. In these situations, the importance of birth planning is highlighted. Making decisions with one's care team prior to the beginning of labour results in a decision-making experience that is more efficient and positive during labour and delivery. Having a clear – whether verbal or written – plan that is communicated to the entire care team (including midwives, doulas, obstetricians, partners, and other birth attendants) before labour starts is essential. When this occurs, women trust in their care team to make immediate decisions for them, knowing that in reality, they are still in control. Consistency of feeling in control,

either directly or indirectly, is related to positive birth experience.

A central concern related to women's control over decisions is the choice of pain relief. Previous studies have discussed the interaction between various internal and external pain control methods (Hardin & Buckner, 2004; McCrea & Wright, 1999). In these studies, internal pain control tends to refer to a woman's ability to control her feelings and expressions of pain, as well as to decide how to deal with this pain—for example, changing positions. The technique of internal pain control describes a woman's ability to turn completely inward in order to focus on dealing with intense pain. This finding underlines the importance of being in a safe and comfortable atmosphere so that women can go wholly inside themselves in order to deal with the pain of contractions.

Feelings of safety and comfort have varying meanings for different women. For some, it means birthing at home and feeling safe in that atmosphere while for others, safety means birthing in the hospital, close to medical intervention should it be needed. This finding is consistent with previous research findings that women's positive or negative definitions of their birth have more to do with the woman's feelings of comfort and safety than they do with where they gave birth (Cheung, 2001). Despite the differences in definitions of safety, the commonality is that women need to feel safe in order to feel they can disappear inside themselves during labour and delivery. The findings of the current study suggest that this intense internal focus may be the most effective way for women to deal with the pain of childbirth.

The findings of the current study dichotomize "medical" and "non-medical" pain control techniques. Women plan for which types of pain control they desire, with most participants in the current study planning for either non-medical only or a mixture of medical and non-medical

techniques. This finding is not consistent with previous research in which women's definitions of "natural" did not necessarily relate to the level of medical intervention used (Viisainen, 2001). In terms of control, women desire to choose for themselves whether the pain management techniques they use will be medical or non-medical and when they will accept medical intervention despite having planned for a "natural" birth with little to no medical pain control. The centrality of the birthing woman's control over pain management techniques in her overall birth experience is consistent with the findings of the above-cited study (Viisainen, 2001).

The findings of the current study offer insightful responses to each of the study's research questions. A conceptual framework is proposed below in order to integrate these findings with the literature on childbirth and current understandings of health-related decision-making. This framework uses the findings of the current study, along with previous research, to extend the current knowledge on how women make decisions related to childbirth and what role choice and control play in this process. Following this conceptual framework are a number of recommendations for care providers, women who are planning to give birth, and individuals who are supporting women in their birth process.

A Conceptual Framework for Childbirth Decision-Making

The process of women's choice and control in making decisions related to their labour, delivery and postpartum period involves three core concepts: informed choice, support, and flexibility.

Informed choice. Informed choice involves providing women with access to relevant information and giving them the space to make decisions. This process plays an important role

in all parts of a birth, from planning through to the postpartum period. Informed choice is also one of the three core tenants on which the philosophy of the Association of Ontario Midwives is based (Paterson, 2004). When members of the care team practice informed choice, women not only have control over decisions but also the information needed in order to make them.

Personal knowledge refers to a woman's ability to contribute her own previous knowledge when making health-related decisions and is one factor in the development of informed choice. The concept of informed choice extends personal knowledge to also include information provided by care providers and other members of the woman's support team. The Wittmann-Price (2004) model suggests that personal knowledge and informed choice are important aspects of emancipated health decision-making for women. Maintaining the ability of women to make informed choices both before and during labour is therefore supported by the decision-making framework suggested by Wittman-Price (2004).

Support. The support that is available to women during planning and giving birth is connected to their ability to practice informed choice and impacts their overall experience. At all stages of birth planning and delivery, it is imperative for women to know that their care team will carry out their wishes for the birth and that they do not have to self-advocate alone in a stressful situation. Partners also assist women in making their choices clear to care providers and in dealing with the physical pain of labour. Partners play a key supportive role during labour by engaging in a wide range of activities, including massage, verbal encouragement, food preparation, caring for the couple's other children, and ensuring the details of the birth fall into place. One important aspect of support is trust and safety. Women who are adequately supported during labour tend to feel safe and comfortable. This support comes from people, such as care

providers, family, and partner, as well as physical space, such as the hospital, obstetrician's offices, midwives' offices, or home.

Flexibility. Flexibility allows women the space to make and carry out their decisions. In situations where initial decisions need to change, flexibility is key to the amount of control that remains with the pregnant, birthing or postpartum woman. Even in emergency situations, it is important for women, their care providers and their support team to remain flexible and communicate with each other effectively. This incorporates another aspect of the Wittman-Price (2004) model of emancipated decision-making – flexible environment. Flexibility is important in the birthing environment, in the individuals present and in the decisions being made.

These factors and the ways that they interact provide the general framework for understanding women's childbirth-related decision making. The following sections discuss the development of the birth plan, labour and delivery, and the postpartum period in discussing the interaction between informed choice, support and flexibility.

Incorporating Choice and Control into Childbirth Decision-Making

Developing the birth plan. For primiparous women, the development of a birth plan is generally the beginning of the relationship between the pregnant woman and her care providers. The way in which decisions are presented to women during this time informs the way that decisions will continue to be made throughout the birth process. As evidenced in the current study, women turn to their woman family members, partners, and care providers when seeking support and information regarding their birth decisions. These sources of support during the planning stage provide women with the information needed to make decisions and the flexibility

to change these decisions if necessary. Women need to be well supported in making decisions during this planning phase so that their decisions can be carried out by care providers and partners (or other birth attendants) during labour.

Labour and delivery. During labour and delivery, the birth decisions made during the planning phase often need to be re-evaluated and modified. There are a number of factors that contribute to the impact that changes to the birth plan have on women's overall birth experiences. What is important during labour and delivery is that a woman is surrounded by her previously established support system so that her decisions and desires can be carried out in a safe and appropriate way. When women remain flexible during labour and delivery and are well-supported, it is likely that they will remain in control of decisions. These decisions are generally based on the information provided by care providers and other members of the support system.

Postpartum. Perhaps the most prominent aspect of the postpartum period is the development of a breastfeeding relationship between mother and infant. The findings of the current study emphasize the importance of seeking information about breastfeeding prior to the birth so that if problems arise, women are prepared to deal with them and to seek the necessary support. Women mainly receive breastfeeding support from lactation consultants, nurses, and midwives. When this support system is in place for the woman before the birth of her child, it is easier for her to get the help needed in order to develop and maintain a breastfeeding relationship. It is also important for women to remain flexible concerning their breastfeeding relationship. When women have severe difficulties with breastfeeding, they sometimes use formula as a supplement for a brief period of time. The current study found that what was

important in this situation was women's ability to find support in ensuring that their child is fed while at the same time focusing on getting their breastfeeding relationship successfully established.

Recommendations for Practitioners, Women, and Members of the Labour Care Team

The clearest recommendation that results from the current study is that all members of the labour and delivery care team, including family, partners, nurses, doulas, midwives, and obstetricians, need to support women in making informed choices and negotiating these decisions during the birth process. This can be accomplished through consultation and information-sharing that begins during pregnancy and continues through the postpartum period. It is important for the birthing woman to remain at the centre of her birth experience and to be well-supported in making necessary decisions. Additional research is needed in order to better understand the ways in which care providers incorporate these concepts in their model of care.

The type of care that women in the current study received from midwives tended to incorporate the concepts of informed choice, flexibility and support that were discussed in this section. This would suggest that an increased availability in midwifery care is an important approach to ensuring that women have not only a healthy birth experience, but also one that is positive. Additionally, although midwifery care is covered under the Ontario Health Insurance Plan (OHIP), this is not the case in other provinces (for example, Prince Edward Island and Newfoundland). A first step in providing a choice over type of care provider to a wider number of women is to make midwifery care free and accessible for all women in Canada.

On their website, The Society of Obstetricians and Gynecologists of Canada (SOGC) state

the following in their beliefs:

> Women should have equitable access to optimal, comprehensive health care...women should have the information they need to make choices about their health...the Society has a responsibility to facilitate change in relation to health system issues affecting the practice of obstetrics and gynecology. (Society of Obstetricians and Gynecologists of Canada)

This statement by the SOGC suggests that their goals for practitioners are in line with the recommendations of this study. Future research with practitioners could shed light on the ways in which these values are implemented by individual practitioners. Incorporating the stated mission of the SOGC into obstetrical education is also an important step in ensuring that all practitioners carry out these beliefs.

Furthermore, The Public Health Agency of Canada "Family-Centered Maternity and Newborn Care: National Guidelines" are meant for all care providers, including midwives and obstetricians. These guidelines incorporate informed choice in a woman-centered model of care that focuses on the physical, psychological, and social needs of the woman and her baby (Public Health Agency of Canada, 2001). The findings of the current study suggest that these guidelines need to be further incorporated into the obstetric practice and education.

Limitations

One limitation of this study is the nature of the sample. The sample was made up of 16 self-selected women who contacted the researcher. Consequently, the diversity (e.g., ethnic, racial, sexual orientation, socio-economic) of Waterloo Region was not proportionately

represented in the sample. Additionally, the sample of this study did not equally represent the various ways in which women choose to give birth, including a variety of care providers and places of birth. Specifically, only one participant chose an obstetrician as her primary care provider from the beginning of her pregnancy, and only one participant chose a general practitioner as her primary care provider. Although a number of women had their care transferred from a midwife to an obstetrician, this represents a very different set of choices and circumstances than those of women who chose to who work with an obstetrician from the beginning of their pregnancy. In terms of the place of birth, the options in Waterloo Region are limited to giving birth at home or in a hospital. In other geographic areas, women have the choice of giving birth in a birthing centre and this choice may change the way that women make decisions and experience childbirth.

The theories and empirical studies discussed in this document are not exhaustive. Rather, the principle researcher focused the scope of the literature review so that the theories and studies that are covered provide a snapshot this topic at the time this document was written in 2010.

Finally, this study is very specific to the Waterloo Region in Ontario, Canada and the options that are offered to women in this area. The support and information available to women varies depending on location. The specific context in which this study was conducted must be considered when determining the transferability of these findings to other contexts.

Future Research

The findings of this study suggest that the way research is conducted can have a variety of implications. In order for the findings of this study to impact the way that childbirth is

approached, further research with a larger sample of women would need to be conducted. Additionally, it would be important to speak with women from a number of different geographic areas, ethnic backgrounds, sexual orientations, newcomer statuses, and socio-economic statuses in order to gain a better understanding of the ways in which women from across Canada experience childbirth. Finally, in order to make a substantial impact on healthcare providers, future researchers should consider the use of mixed methods. It is valuable to use quantitative methods in order to survey a large number of women in a given geographic area. At the same time, however, it is important to incorporate qualitative methods in order to expand upon and better understand women's stories. The ways in which women make childbirth-related decisions and the ways in which these decisions are negotiated during labour and delivery are complex and extremely dependent on the context in which women are birthing.

Conclusions

The current study provides a snapshot of childbirth experiences in Waterloo Region during the end of 2009 and the beginning of 2010. The recommendations from this study have the potential to impact the level and type of care that is offered to women in this region of Ontario. It is clear from this study that the particular type of care a woman chooses is not necessarily the most important concept related to her ability to maintain control over the birth process. In the current study, choice and control were more related to informed choice, flexibility, and support than they were to the individuals who were present in the room or the particular interventions that were chosen or necessary during a woman's birth experience.

This study provides a stepping-stone for future research studies aimed at better understanding the role of choice and control in women's childbirth experiences. In addition, this study gives service providers a framework on which to base the service that they provide to pregnant and birthing women. Finally, this study provides relevant and useful information for expectant parents in choosing the type of care they access during pregnancy, labour, delivery, and the postpartum period.

References

Akmen, I., Kuscu, M. K., Yurdakul, Z., Ozdemir, N., Solakoglu, M., Orhon, L., Karabekiroglur, A., Ozek, E. (2008). Breastfeeding duration and postpartum psychological adjustment: Role of maternal attachment styles. *Journal of Pediatrics and Child Health, 44, 369-373.*

Baker, S. R., Choi, P., Henshaw, C. A., Tree, J. (2005). I felt as though I'd been in jail: Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology, 15*, 316 – 342.

Bauer, J. J., McAdams, D. P., Pals, J. L. (2008). Narrative identity and eudamonic well-being. *Journal of Happiness Studies, 9*, 81 – 104.

Bourgeault, I. L. (2000). Delivering the 'new' Canadian midwifery: the impact on midwifery of integration into the Ontario health care system. *Sociology of Health & Illness, 22*, 172 – 196.

Beck, C. T. (2006). Pentadic cartography: Mapping birth trauma narratives. *Qualitative Health Research, 16*, 453 – 466.

Behague, D. P. (2002). Beyond the simple economics of cesarean section birthing: Women's resistance to social inequality. *Culture, Medicine and Psychiatry, 26*, 473 – 507.

Benoit, C., Carroll, D., Westfall, R. (2007). Women's access to maternity services in Canada: Historical developments and contemporary challenges. In M. Morrow, O. Hankivsky & C. Carcoe (Eds), *Women's Health in Canada: Critical perspectives on theory and policy* (pp. 507 – 527). Toronto, ON: University of Toronto Press.

Blix-Lindstrom, S., Johansson, E., Christensson, K. (2008). Midwives' navigation and perceived

power during decision-making related to augmentation of labour. *Midwifery, 24*, 190 – 198.

Block, J. (2009). Pushed: The painful truth about childbirth and modern maternity care. Cambridge, MA: DaCapo Press.

Bondas-Salonen, T. (1998). How women experience the presence of their partners at the births of their babies. *Qualitative Health Research, 8*, 784 – 800.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32*, 513 – 531.

Brown, J. B., Carroll, J., Boon, H., Marmoreo, J. (2002). Women's decision-making about their health care: Views over the life cycle. *Patient Education and Counseling, 48*, 225 – 231.

Callister, L. C. (2003). Making meaning: Women's birth narratives. *JOGNN Clinical Issues, 33*, 508 – 518.

Cassidy, T. (2006). *Birth: The surprising history of how we are born.* New York, NY: Publisher's Group West.

Cheung, N. F. (2001). Choice and control as experienced by Chinese and Scottish childbearing women in Scotland. *Midwifery, 18*, 200 – 213.

Creasy, J. M. (1997). Women's experiences of transfer from community-based to consultant-based maternity care. *Midwifery, 13*, 32 – 39.

Crossley, M. L. (2007). Childbirth, complications and the illusion of 'choice': A case study. *Feminism Psychology, 17*, 543 – 563.

Danforth, K. N., Tworoger, S.S., Hecht, J.L., Bernard, A.R., Colditz, G.A., Haninson, S.E. (2007). Breastfeeding and risk of ovarian cancer in two perspective cohorts. *Cancer Causes & Control, 18*, 517 – 523.

Else-Quest, N.M., Hyde, J.S., Clark, R. (2003). Breastfeeding, bonding and the mother-infant relationship. *Merrill-Palmer Quarterly, 49*, 495 – 517.

Essers, C. (2009). Reflections on the narrative approach: Dilemmas of power, emotions and social location while constructing life-stories. *Organization Articles, 16*, 163 – 181.

Evenhouse, E., Reilly, S. (2005). Improved estimates of the benefits of breastfeeding using sibling comparisons to reduce selection bias. *Health Services Research, 40*, 1781 – 1802.

Eyer, D.E. (1992). *Mother-infant Bonding: A Scientific Fiction*. Philadelphia, PA: Yale University Press.

Fox, B. J., Worts, D. (1999). Revisiting the critique of medicalized childbirth: A contribution to the sociology of birth. *Gender & Society, 13*, 326 – 346.

Friedman, S. H., Heneghan, A., Rosenthal, M. (2009). Disposition and health outcomes among infants born to mothers with no prenatal care. *The International Journal of Child Abuse and Neglect, 33*, 116 – 122.

Gaskin, I. M. (2002). *Spiritual Midwifery, 4th ed.* Sumertown, TN: Book Publishing Company.

Gibbins, J., Thomson, A. M. (2001). Women's expectations and experiences of childbirth. *Midwifery, 17*, 302 – 313.

Gill, S.L., Reifsnider, E., Lucke, J.F. (2007). Effects of support on the initiation and duration of

breastfeeding. *Western Journal of Nursing Research, 29*, 708 – 723.

Grand River Hospital. Childbirth Services. Retrieved April 9, 2010, from Grand River Hospital Website: http://www.grandriverhospital.on.ca/patient/childbirth/pat-bir-birth.cfm#null.

Grassley, J., Escheti, V. (2008). Grandmother breastfeeding support: What do mothers need and want? *Birth, 35*, 329 – 335.

Hardin, A. M., Buckner, E. B. (2004). Characteristics of a positive experience for women who have unmedicated childbirth. *The Journal of Perinatal Education, 13*, 10 – 16.

Hauck, Y., Fenwick, J., Downie, J., Butt, J. (2006). The influence of childbirth expectations of Western Australian women's perceptions of their birth experience. *Midwifery, 23*, 235 – 247.

Holloway, I., Freshwater, D. (2007). Vulnerable story-telling: Narrative research in nursing. *Journal of Research in Nursing, 12*, 703 – 711.

Howell-White, S. (1997). Choosing a birth attendant: The influence of a woman's childbirth definition. *Social Science & Medicine, 45*, 925 – 936.

Ingram, J., Johnson, D. (2009). Using community maternity care assistants to facilitate family-focused breastfeeding support. *Maternal and Child Nutrition, 5*, 276 – 281.

Kiaergaard, H., Foldgast, A.M., Dykes, A.K. (2007). Experiences of non-progressive and augmented labour among nulliparous women: A qualitative interview study in a grounded theory approach. *BioMed Central Pregnancy and Childbirth, 7.*

Klima, C.S. (2001). Women's health care: A new paradigm for the 21st Century. *Journal of*

Midwifery and Women's Health, 46, 285 – 291.

Kovach, A. C., Becker, J., Worley, H. (2004). The impact of community health workers on the self-determination, self-sufficiency, and decision-making ability of low-income women and mother of young children. *Journal of Community Psychology, 32*, 343 – 356.

Kronborg, H., Vaeth, M., Olsen, J., Harder, I. (2007). Health visitors and breastfeeding support: influence of knowledge and self-efficacy. *European Journal of Public Health, 18*, 283 – 288.

Lally, J.E., Mutagh, M.J., MacPhail, S, Thomson, R. (2008). More in hope than expectation: A systematic review of women's expectations and experience of pain relief in labour. *BMC Medicine, 6*.

Lavender, T., Walkinshaw, S. A., Walton, I. (1999). A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery, 15*, 40 – 46.

Law, S. M., Dunn, O. M., Wallace, L. M., Inch, S. A. (2007). Breastfeeding Best Start study: Training midwives in a 'hands off' positioning and attachment intervention. *Maternal and Child Nutrition, 3*, 194 – 205.

Lorenten, J. M. (2008). 'I know my own body': Power and resistance in women's experiences of medical interactions. *Body Society, 14*, 49 – 79.

McCrea, B. H., Wright, M. E. (1999). Satisfaction in childbirth and perceptions of personal control in pain relief during labour. *Journal of Advanced Nursing, 29*, 877 – 884.

Mickens, A.D., Modeste, N., Montgomery, S., Taylor, M. (2009). Peer support and breastfeeding

intentions among black WIC participants. *Journal of Human Lactation, 25*, 157 – 162.

Moore, M. L. (2001). Research update: Current research continues to support breastfeeding benefits. *Journal of Perinatal Education, 10*, 38 – 41.

Murphy-Lawless, J. M. (1988). The silencing of women in childbirth or let's hear it from Bartholomew and the boys. *Women's Studies International Forum, 11*, 293 – 298.

Nadler, Eve (2007). Infant Feeding Study. Family and Community Services Division, Region of Waterloo.

Noone, J. (2002). Concept analysis of decision-making. *Nursing Forum, 3*, 21 – 32.

Oakley, A. (1986). Feminism, motherhood and medicine – who cares?. In J. Mitchell & A. Oakley (Eds.), *What is feminism? A re-examination* (pp. 127 – 150). New York, NY: Pantheon Books.

Oakley, A. (1980). *Woman confined: Towards a sociology of childbirth.* New York, NY: Schocken Books.

Page, R. E. (2002). Evaluation in childbirth narratives told by women and men. *Discourse Studies, 4*, 99 – 116.

Paterson, S. L. (2004). Ontario midwives: Reflections on a decade of regulated midwifery. *Canadian Woman Studies, 24*, 153 – 157.

Picaud, J. C. (2007). Breastfeeding and human milk: What benefits for neonates and infants. *National Clinique et Metabolisme, 22*, 71 – 74.

Public Health Agency of Canada (2001). Family-centered maternity and newborn care: National

guidelines.

Rappaport, J. (1995). Empowerment meets narrative: Listening to stories and creating settings. *American Journal of Community Psychology, 23*, 795 – 807.

Ratcliff, K. S. (2002). Women and health: Power, technology, inequality, and conflict in a gendered world. Boston, MA: Allyn and Bacon.

Region of Waterloo Public Health (2007). Maternal and child health indicators for Waterloo region

Sciscione, A. C., Gorman, R., Callan, N. A. (1996). Adjustment of birth weight standards for maternal and infant characteristics improves the prediction of outcome in the small-for-gestational-age infant. *American Journal of Obstetric Gynecology, 185*, 544 – 547.

Sheehan, D., Bridle, B., Hillier, T., Feightner, K., Hayward, S., Kyong-Soon, L., Krueger, P., Sword, W., James, M. (1999). Breastfeeding outcomes of women following uncomplicated birth in Hamilton-Wentworth. *Canadian Journal of Public Health, 90*, 408 – 411.

Smith, L. J. (2007). Impact of birthing practices on the breastfeeding dyad. *Journal of Midwifery and Women's Health, 52*, 621 – 630.

Stockill C. (2007). Trust the experts? A commentary on choice and control in childbirth. *Feminism & Psychology, 17*, 571 – 577.

Trickett, E. J. (1984). Toward a distinctive community psychology: An ecological metaphor for the conduct of community research and the nature of training. *American Journal of*

Community Psychology, 12, 261 – 279).

Tommiska, V., Heinonen, K., Lehtonen, L., Renlund, M., Saarela, T., Tammela, O., Virtanen, M., Fellman, V. (2007). No iprovement in outcomes of nationawide extremely low birth weight infant populations between 1997 – 1997 and 1999 – 2000. *Pediatrics, 119,* 29 – 36.

Torres, R. Y., Marks, R. (2009). Relationships among health literacy, knowledge about hormone therapy, self-efficacy, and decision-making among postmenopausal health. *Journal of Health Communication, 14*, 43 – 55.

Viisainen, K. (2001). Negotiating control and meaning: Home birth as a self-constructed choice in Finland. *Social Science and Medicine, 52*, 1109 – 1121.

Waldenstrom, U., Hildingsson, I., Rubertsson, C., Radestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth: Issues in Perinatal Care, 31*, 17 – 27.

Westfall, R. E., Benoit, C. (2004). The rhetoric of 'natural' in natural childbirth: Childbearing women's perspectives on prolonged pregnancy and induction of labour. *Social Science and Medicine, 59*, 1397 – 1408.

Wittmann-Price, R. A. (2004). Emancipation in decision-making in women's health care. *Journal of Advanced Nursing, 47*, 437 – 445.

Wittmann-Price, R. A. (2006). Exploring the subconcepts of the Wittman-Price theory of emancipated decision-making in women's health care. *Journal of Nursing and Scholarship, 38*, 377 – 382.

Woolfe, S. H., Chan, E.C., Harris, R., Sheridan, S.L., Braddock, C.H., Kaplan, R.M., Krist, A., O'Connor, A.M., Tunis, S. (2005). Promoting informed choice: Transforming health care to dispense knowledge for decision making. *Annals of internal medicine, 143,* 293 – 301.

World Health Organization (2005). Make every mother and child count. WHO Press, Geneva, Switzerland.

Appendix A: Interview Guide

First, I wanted to thank you for taking the time to speak with me today. I understand that this is an extremely busy time for you and also a very significant time in your life. I am a student at Wilfrid Laurier University and am doing this research as part of a master's program in community psychology.

Generally speaking, today I hope to gain a better understanding of two aspects of your birth experience. It is important to hear about your experiences in order to ensure the quality of childbirth support in Canada, and specifically in Waterloo Region. First, I'd like to hear about the process of planning your birth and second, I'd like to hear about your labour and delivery. Every birth experience is unique and important, and so I will leave much of this time open for you to discuss the aspects of this process that were most important to you. I will ask questions along the way to make sure that we cover all of the topic areas, but for the most part, your experiences will guide the conversation.

As you can see, I will be tape-recording our conversation today. The reason for this is so that I can go back and listen to your story so that I can better understand it. It also allows me to remain focused on our conversation so that I do not need to take notes as we go and so that I don't miss anything. Is this okay with you?

Questions

The two main aspects of your experience that I'd like to talk about today are the process of planning your birth and then your actual birth story. We can begin wherever you feel comfortable and I will ask some questions along the way.

Part I: Birth Planning Probe Questions

How did your birth plan develop? Who was involved in developing it?

What were the main parts of the birth plan

What were the main factors that impacted the decisions you made about your birth plan?

Probe for family (partner, parents), friends, service providers, media, others

How did you feel about the final birth plan?

What aspects in particular were you happy/unhappy with?

What would you have changed about your birth plan or the way it was developed?

Part II: The Birth Story

Please tell me about your birth experience, beginning with your first indications that you were in labour.

Probes:

Who was the main decision-maker throughout the process?

How closely was your birth experience in line with your birth plan? if it deviated, how so and why?

How were your expectations of the birth experience met/unmet?

Looking back, is there anything that you would change about this experience?

Overall, how would you describe this experience?

I'd like t0o thank you for taking the time to share your experiences with me today. Once I've compiled all of the interviews and transferred them to an electronic document,

they will be analyzed. When everything is completed, I will send each participant a report of my findings.

Thank you again for your time. Do you have any further questions for me?