FROM CYBERSPACE TO THE HOME-PLACE:

INTERPRETING ONLINE COMMUNICATION

OF HOMEBIRTH IN CANADA

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ABSTRACT

This thesis investigated online communication of women utilizing a homebirth forum in order to understand why Canadian women are choosing homebirth methods instead of the mainstream dominant trend of hospital births, and how a sense of community is created through an online forum. For this research fifty posts were selected from fifteen different threads within the homebirth forum group on *BabyCenter*. The homebirth forum group was followed for approximately one month, and a total of thirty-four women are represented in the posting sample analyzed. Using content analysis techniques, four recurring themes were extracted – Control, Home, Hospitals, and Community – with at least four sub-themes for each identified. It was found that women choose homebirth for a myriad of factors but predominantly because homebirth allows for the ability to have a better sense of control, choice, and comfort over their birthing desires. As well, a sense of community is created in an online capacity because of the commonality of interests between the forum users. The solidarity of the homebirth community is built upon advice, empathy and situational understanding.

ACKNOWLEDGMENTS

DEDICATION

To Little Leo, faithfully sticking by my side for hours on end.

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CHAPTER 1
INTRODUCTION

For women across the globe, birth is an extraordinary and complex experience that varies from one culture to the next. Symbolic cultural meanings, birthing techniques, technologies, and practices are all important factors in how women and their partners construct their birth experiences. In Canada, the use of biomedical techniques and the medicalization of the birthing experience are commonplace. What happens when women start seeking homebirth advice from complete strangers and empowering one another through their shared experiences? Technology and communication advancements have shifted the way we interact with one another, particularly web-based communication via blogs, forums, Skype, Facebook and Twitter to name a few. Online resources such as *WebMD* allow users to self-diagnose ailments and diseases based on symptoms, and suggest cures ranging from basic home remedies to seeking emergency treatment immediately. Due to the rapid expansion of knowledge and communication capabilities, the once very private and intimate experiences of homebirth can now be shared publicly and virtually in a matter of seconds.

To many, an online forum is a mechanism for finding answers to questions about everyday topics. The online homebirth literature offers a variety of insights into how Canadian women develop a sense of community with one another, thus providing an understanding of how social relationships are developed by utilizing cyber-technologies. By methodically examining the discourses that emerge in the online homebirth literature from a critical medical anthropological perspective, it becomes apparent that communication between and among the homebirthers[1] represents intensely intimate community interactions that go well beyond casual daily

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[1] For simplicity sake the term "homebirthers" will be used throughout this research in reference to the women utilizing the homebirth forum.

conversations. My intent for this research is to investigate women's perceptions of the Canadian health care system (predominantly regarding medicalization of obstetric care), to examine how community is developed through online interactions, and to analyse the intricacies involved in online discussions of homebirth from the decision making process to post-partum discussions. In this research, I explore the online discourses of Canadian women as they are publicly shared on a specific homebirth website. For this reason, it is necessary to examine communication narratives of Canadian women through the medium of an online homebirth forum to better understand how community is defined and created as well as why, in our modern technocratic and medically dominated society, Canadian women choose or do not choose to have a homebirth.

1.1 Research Objectives and Questions

By examining the online homebirth postings of Canadian women, the intent is to gain a more thorough understanding of how women view home-birthing practices in Canada, as expressed in an online forum. The over-arching research question is: How do Canadian women create and sustain a homebirth community through the medium of an internet based forum? The three research objectives that are designed to answer this question are: (1) To explore how "community" is created through online social interaction; (2) to assess how broader trends in the Canadian homebirth movement are reflected in the forums; and (3) to consider what a study of an online site such as *BabyCenter* contributes to the anthropology of birth. Within each research objective sub-questions are posed in order to meet each objective.

In order to explore how "community" is created through social interaction two sub-questions will be addressed: (a) To what extent does a sense of community emerge from the critique of biomedicine? And (b) How is community understood through the critique of women's online writings?

The second objective is to assess how the broader trends of the Canadian homebirth movement are reflected in the forum. In considering this I will address these three sub-questions: (a) How do Canadian women view home-birthing practices in a medicalized and technocratically dominated society? (b) Why are women choosing – or not choosing – to have a homebirth? (c) Does the choice for homebirth represent a form of resistance towards medicalized hospital births?

The third objective is to consider what a study of an online site such as *BabyCenter* can contribute to medical anthropology and more specifically the anthropology of birth. In considering this, I will answer the following sub-questions: (a) To what extent is there a substantial gap within medical anthropological literature when it comes to examining online forums as a source of potential anthropological information? (b) How does the utilization of cyber-technologies and non-traditional research methods benefit medical anthropologists?

Overall, this research examines women's perceptions of the Canadian health care system through the examination of women's homebirth forums. From a theoretical standpoint, which will be explained in greater depth throughout this thesis, this research will use an interpretive anthropological method to understand the way that women perceive homebirthing options in Canada; how knowledge through an online medium shapes the way meanings about childbirth are constructed; and, more specifically, how a homebirth forum may create and sustain the identity of a Canadian homebirth community.

1.2 Methodology

Methodologically, this project relies on content analysis using a critical interpretive approach in order to identify the main themes within online womens birthing posts. By examining the language used in women's postings, dominant themes might emerge which aide in

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identifying: a) how a homebirth cyber-community is created and perpetuated among the women; and b) the central issues surrounding homebirth discourse. Basso (1990) and Hendricks (1988) use discourse analysis within their research to develop an understanding of the major themes within a society's language. By integrating elements used in discourse analysis into a focused content analysis, I will offer a more substantiated analytical framework upon which to base my findings. The postings which I will be analysing are a reflection of the personal experiences of homebirth and the experiential realities of the homebirth process. These posts reflect how the women feel within their social context and can therefore highlight positive/negative aspects of the larger social aspects within the Canadian medical system of obstetric care within Canada. Altogether, content analysis will allow me to examine how women's thoughts, feelings and questions of homebirth emerge within an online context as well as in the more dominant Canadian health care context.

The component parts of this methodology include: (i) critically examining the posts regarding homebirth written on the *BabyCenter* website by Canadian women; (ii) the use of content analysis to identify the dominant themes within the forums; (iii) exploring the themes found within the women's communication with one another in terms of how community is created within an online capacity; and (iv) framing my findings within the larger body of medical anthropology as well as cyber-anthropology and linguistic anthropology.

For this research I selected fifty posts from fifteen different threads within the homebirth forum group on *BabyCenter.* I found that these fifty posts were representative of the general conversations happening in the forum group. As a result, I had reached saturation and was not finding any new or significant themes emerging throughout the threads. I followed the homebirth forum group for approximately one month until I was satisfied with the range of

topics discussed. A total of thirty-four women are represented in the posting sample. These

threads – created by participants wanting to chat about a specific subject – include but are not

limited to:

1) homebirth experiences

2) homebirth scare tactics

3) homebirth pros and cons

4) how to convince others of their homebirth choice

5) homebirth dreams being shattered

6) "nay sayers"

7) negative feedback from others

8) homebirth research and tips

9) hospital births as "scary"

10) homebirth may be slipping away

The threads represent some of the more prevalent topics found within the forum group as

many of the participants write about their experiences, the need for homebirth education and

information, their thoughts on hospital births, and how others view their homebirth choices.

To choose posts that I used in my data set, I copied the threads to a document which I

then printed out and coded by hand. As I read through the posts I was able to extract certain

words which correlated to broader themes surrounding homebirth (refer to Appendix). To

demonstrate, "intervention" is associated primarily with the hospital theme. Within the threads,

the posts written by the participants differ in length depending on subject criteria. For example,

a post may be a short remark such as words of encouragement followed by an emoticon.

Likewise, other participants write a number of paragraphs if they are sharing personal

experiences which explain a detailed account of events – such as the moment from conception to delivery and everything in between. I found that the topic of discussion dictated the amount of interaction between the homebirthers, and the subject matter influenced the length of the postings. Personal experiences elicited longer, more in-depth responses.

Throughout the analysis of the postings there were several themes that emerged. These were grouped into four central categories: control; home; hospitals; and online community. These themes were then sub-categorized according to the data. Control, which includes categories and sub-categories of support, advice, power, and choice, is linked to how the homebirthers felt throughout their birthing experience. Control also overlaps with the hospital theme. Likewise, home is divided into four categories with corresponding sub-categories. These themes include: sanitary conditions; feelings; choice; and intimacy. Many of the posts reflect how the home is a clean and comfortable space that evokes intimacy and nurturing. Furthermore, the hospital theme has five categories with several sub-categories. These themes are imbued with negativity as many of the homebirthers perceive the hospital as detrimental to their birthing experience. The sanitary conditions and possible use of medical interventions permeate through the homebirth discussions. Lastly, online community is a theme developed by the analysis of the recurring categories regarding feelings, advice, encouragement, understanding, sharing, emoticon usage, and literary emphasis such as exclamation marks.

1.3 Significance of Research

Any consideration of homebirth requires that we engage with the literature on midwifery and non-biomedical prenatal and childbirth care. *Doulas* and midwifery are gaining more recognition from pregnant women interested in having natural births (Gabay & Wolfe:1997), either at home, a birth house, or in the hospital setting. The 2008 Canadian Census on Births

found that of the 380,660 births that occurred, 4,770 took place in non-hospital settings, a mere 1.3 percent of all births within that year (statcan.gc.ca 2008). Living in a medically dominated society, it is understandable that the percentage of non-hospital births is low, therefore this research highlights the importance of active inquiry into homebirth narratives for a potential glimpse into women`s reasoning for - or against - homebirth.

This research explores the reasoning behind women`s choices for homebirth and how a sense of community is developed through online social media. It will also bring to light a considerable gap within the anthropological literature. This particular research topic has not yet been examined in any depth and it is therefore my intention to address this gap and add a critical and analytical understanding of the online complexities of women seeking homebirth information. I am hopeful that this research will make a contribution to work surrounding maternal health and obstetric care in Canada by illuminating the personal experiences of homebirth shared by Canadian women. This includes providing information to potentially alleviate the perceived stigma attached to homebirthing, which will be discussed in more detail throughout the paper. Preliminary research suggests that for low-risk pregnancies homebirth in Canada is as safe (if not more so) as a medically assisted hospital birth (Janssen et al. 2002). Therefore, there is a definite disconnect between the number of homebirths and hospital births in Canada. For example, according to Statistics Canada, in 2008 there were 375,857 hospital births in comparison to 4,770 non-hospital births (2011:41). By examining this discrepancy utilizing content analysis techniques, an anthropological account of why Canadian women are opting for homebirths will result.

1.4 Research Data Source

The online site of this research is *BabyCenter.ca,* a sister-site of the larger United Kingdom based *BabyCenter.co.uk.* With an international following, *BabyCenter* websites are based in numerous countries including Saudi Arabia, Brazil, Russia and Switzerland. Each website is unique in that it is specifically designed to incorporate the cultural nuances of a region – most notably by the local language and slang used in articles (for example, the word "knickers" is used instead of "underwear" on the Australian website) as well as the online advertisements. The forums, however, contain posts written by the users – participants who utilize the websites' forum application to communicate with one another. Although the forums are moderated by *BabyCenter*, they are ultimately constructed by the content of the participants. The participants of the homebirth forum are uniformly women and I did not encounter any posts written by men. As stated on their website, the *BabyCenter's* main objectives are to promote healthy maternal care for mother and child, and to advocate - in an online capacity - a sense of community encompassing birth, pregnancy and maternity issues. The website provides information surrounding many facets of maternal care, birth, pregnancy and child-rearing but it is solely homebirth that I am investigating.

Within the forum, I have selected a number of different threads - branches of the forum that users use to talk about specific subjects within the larger forum body itself - on which to focus. Because I am working in a critical interpretive theoretical framework I will be examining words and phrases that are consistently used throughout the conversations among the participants. Drawing on the communication between the homebirthers I will then identify the primary themes to be analysed. Most prominently, the identifiable themes are comfort, power, education and control. These themes serve as the focus for the content analysis portion of my research.

My research approach is guided by the works of Obermeyer (2000); Simkin (1991); Basso (1990); Hendricks (1988); and Eckert (1992). In Obermeyer's research, although using a narrative analysis method as opposed to content analysis, themes extracted from the narratives of women's homebirth practices in Morocco serve to "define the traditional Moroccan ethnophysiology of birth" (2000:180). Likewise, within my own research I am utilizing a content analysis method to understand the dominant themes within the women's communication of homebirth in order to define what homebirth signifies in a Canadian context. Careful attention will be paid to dichotomies in the posts, such as the descriptive language associated with hospital births in comparison to homebirths.

1.5 Ethics

The Research Ethics Board (REB) at the University of Saskatchewan did not require that an Ethics Certificate be obtained because this research is centered on a publicly accessible website. In section 2.2 of the Tri Council Policy Statement: Ethical Conduct for Research Involving Humans, it is stated that "publicly available information does not require REB review when: b) the information is publicly accessible and there is no reasonable expectation of privacy" (2010:17). Some of the ethical issues that may arise from using online postings as a data source are that individuals may be unaware that their postings are available for everyone to view, as well as that some screen names, or "handles", could potentially reveal the identity of an individual. To ensure that my research protects the privacy of homebirth forum writers I have used pseudonyms in place of online screen names. The use of pseudonyms is important within this research context because some online forum writers create screen names which represent a year of birth, a last name, or other identifiable factors. The homebirth forum group selected in my research is publicly accessible and no membership is required in order to read the postings.

1.6 Theoretical Framework

Theoretically, this research is situated at the intersection of critical interpretive medical anthropology's casting of embodiment, cyber-anthropology's account of community, and the feminist approach to authoritative knowledge. According to Lock and Scheper-Hughes (1987) embodiment is a tripartite process wherein the individual and social bodies articulate with the body politic. Lock (2001) defines embodiment as "constituted by the way in which self and others represent the body, drawing on local categories of knowledge and experience" (483) and that the "embodied experience of physical sensations, including those of well-being, health, illness, and so on, is in part informed by the material body, itself contingent on evolutionary, environmental, and individual variables" (483). The theoretical question to which the research best speaks is how authoritative knowledge – as conceptualized by Brigitte Jordan (1997) as being the dominant knowledge system, in this context the medical system, which people inherently interact with in their social realm – fits within this understanding of embodiment. Specifically, my discussion of embodiment and authoritative knowledge will be grounded within the online experiential realities of Canadian women who are seeking or who have sought homebirth options.

1.6.1 Embodiment

Embodiment, in the sense that I am describing it, is a very fluid and on-going process. The women in my study will become a 'stage' for the various types of discourse – whether it be the Western medicalized environment, a very technocratic and mechanistic system, the cyber-mediated domain, where women and technology intertwine and inevitably become inseparable or a more grounded, and "natural" environment such as the one homebirth provides. In referring to the women as being a "stage" I am proposing that all aspects of society including the cultural,

political, technological, governmental, family and personal, will inevitably play a role in their

embodied experiences of the homebirth process as articulated in an online capacity.

In the article entitled *The Mindful Body*, by Lock and Scheper-Hughes (1987), the

authors' intent is to "critically examine and call into question various concepts that have been

privileged in Western thinking for centuries and which have determined the ways in which the

body has been perceived in scientific biomedicine and in anthropology" (7). Not only is this an

important starting point for understanding how the body is viewed across cultures, but it also

speaks to the importance of understanding the tripartite body. Specifically for my research, I am

focusing on the authors' view of how the individual, social and political bodies interact with one

another to shape the overall being – therefore shaping decision making and the rationale behind

those decisions. The individual body is at the core of my research as experience is

individualized and therefore creates a unique understanding of the processes to which one is

subjected. As Lock and Scheper-Hughes note, "the constituent parts of the body-mind, matter,

psyche, soul, self, etc.-and their relations to each other, and the ways in which the body is

received and experienced in health and sickness are, of course, highly variable" (1987:7). The

social and political bodies are fundamental to understanding the external forces which shape how

the women interact with the broader social world around them. This is in reference to external

factors including but not limited to homebirth legislation, criticism of homebirth choices from

friends and family members, the concept of control (particularly attributed to the technocratic

and patriarchal medicalized health care system), as well as the cyber-community itself.

The political body is of particular interest in that the social and individual body is

governed by the body politic which Lock and Scheper-Hughes believe capitalizes on "the

regulation, surveillance, and control of bodies (individual and collective) in reproduction and

sexuality, in work and in leisure, in sickness and other forms of deviance and human difference"
(1987:8). It is this political body that reinforces the dominant roles in society, and accordingly
shapes the individual and social body to meet its desired standards. Therefore, my theoretical
aim in this research is to explore the articulation of the individual body with the body politic as it
plays out in women's experiential realities of homebirth as demonstrated in an online capacity.

1.6.2 The Body as Machine

To reinforce my position of how the Western medical system is technocratic and
patriarchal, I draw on Barbara Katz Rothman's (1982) and Robbie Davis-Floyd's (1994) work to
understand how the medicalization of the reproductive process and birth is considered to be a
controlling and dominating force. Rothman states that "medicine is based not only on the
ideology of technological society, but also on the ideology of patriarchal society. Medicine is
androcentric and patriarchal, and its values are those of men as the dominant social power"
(1982:36). It is my understanding that because of this dominant medical discourse, alternative
birthing options are often deemed inappropriate and unacceptable by medical authorities. Davis-
Floyd writes:

> 'technocracy' connotes a society that supervalues and organizes itself in
>
> terms of its technologies and is bureaucratic, autocratic, and hierarchical;
>
> thus this term is an apt referent for contemporary American society.
>
> American birth is…defined by its management by technical experts, and
>
> thereby the hegemony of the technocratic model is extended into the
>
> cultural shaping of childbirth. (1994:1139)

The control of the patient is a key element in the medicalization of the birthing process
and within this there is often an inherent attitude of " the doctor knows best". Following

Rothman, then, the concepts of domination and superiority are fundamental in exploring the themes that emerge throughout the women's online discourse.

1.6.3 Cyber-Community

In order to understand how the experiential constructions of homebirth are articulated through the embodiment process and what role that authoritative knowledge plays within the women's online discourse, it is necessary to examine the key concepts of community as they are expressed in the anthropology of cyber-culture. Because this research relies heavily on using virtual media to understand a very corporeal experience, the work on the anthropology of cyberculture, as presented by Arturo Escobar (2000), is used to inform my theoretical perspective. Escobar states that there is a dramatic transformation happening between the modern meaning of society and culture because of the impact of technology and that "not only does this transformation offer itself clearly to anthropological inquiry, it constitutes perhaps a privileged arena for advancing anthropology's project of understanding human societies from the vantage points of biology, language, history and culture" (2000:56). In this sense, understanding the impact cyberculture has on cultural and social activities allows for insight into why computer-mediated forums are a popular outlet for users to communicate with one another as well as how community is created and sustained using a computer-mediated platform.

Cyber-anthropology is unique in that it enables the researcher to blend traditional ethnographic methods with a modern and technological approach. In terms of how community is expressed and experienced within cyberspace, my research is informed by Allucquere Rosanne Stone's explanation of virtual communities as "passage points for collections of common beliefs and practices that [unite] people who were physically separated. Virtual communities sustain themselves by constantly circulating those practices" (2000:507). In this research, the practices

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being examined are the ones surrounding homebirth communication between posters of the

BabyCenter forum.   By applying Escobar's concept of cyber-anthropology to the theoretical

positions of embodiment, authoritative knowledge and online communities, it is possible to

develop an understanding of how Canadian women situate themselves within the larger social

and cultural context of the Western medical system, pregnancy, cyber-technologies and

homebirth.

1.6.4 Medicalization and Subjectivity

Lock's (2001) discussion of "local biologies" – the arena where the individual and social

body meet, intertwined with environmental, political and governmental spheres – is applicable

here to emphasize that individual embodied experiences are shaped by external processes. What

is of importance is how these processes of the dominant technocratic medical system are being

internalized subjectively. A key question, then, is: Do the women writing in the homebirth

forum elicit signs of resistance to the medicalization of childbirth by wanting a homebirth,

acceptance of the medicalization of childbirth, or an amalgamation of both ideals?

Through this research, it is my intent to understand how the individual body is enacted

upon by the political body and its technocratic ideals. Many feminist scholars (Rothman 1982,

Davis-Floyd & Davis 1996, Davis-Floyd & Sargent 1996, Ginsburg & Rapp 1991, Browner

1996, Macdonald 2006) postulate that the medicalization of reproduction is inherently patriarchal

and therefore discourses on power and empowerment are paramount in the birth experience.

One of my main objectives is to understand how women are using their own sense of

empowerment, a concept also described as "authoritative knowledge" (Jordan 1997), in order to

embody their desired birth experience. Jordan states that authoritative knowledge is "the

knowledge that participants agree counts in a particular situation, that *they* see as consequential,

on the basis of which *they* make decisions and provide justifications for courses of action"

(1978:152). Applying this concept of authoritative knowledge to a study of how women embody

their experiences of the homebirth process through online communication strategies will

hopefully lead to an understanding of how Canadian women seeking to have a homebirth

exercise their authoritative knowledge while immersed in the larger technocratic medical system

and in their own cultural and societal milieu.

The dichotomy that I am particularly interested in exploring in this research is that of the

authoritative knowledge of the dominant medical system and how this interacts with the

authoritative knowledge of the individual body. Drawing on Davis-Floyd and Davis' (1996)

notion of intuition and authoritative knowledge I examine how intuition - as a form of

authoritative knowledge - is used in making decisions whether to seek and adhere to a

medicalized plan for birth or to select more natural options - such as a homebirth. Davis-Floyd

and Davis (1996) remark that because the West is technocratic and relies heavily on science,

intuition is often dismissed because it is not grounded in scientific explanation. Although the

authors' view intuition and authoritative knowledge from the perspective of the midwife, this

concept can undoubtedly be applied to a woman's own sense of knowing when it comes to the

birthing process. This knowing, then, is embodied as the woman's own authoritative knowledge.

1.7 Summary

In summary, utilizing and combining the concepts such as embodiment by Lock and

Scheper-Hughes (1987), Barbara Katz Rothman's (1982) framing of dominance within the

medical system, Arturo Escobar's (2000) concept of cyber-anthropology, Allucquere Rosanne

Stone's (2000) notion of virtual community, and Brigitte Jordan's (1978, 1997) construct of

authoritative knowledge, I am developing this theoretical framework in order to understand how

Canadian women represent their experiences of homebirth in an online forum. Analysis of the

women's discourse should reveal whether there is resistance towards the medicalized system and, if present, what form that resistance takes, for example, key terms used throughout the forums in opposition to dominant medical authorities as well as actions taken by the women throughout their homebirth process. Ultimately, the online content written by the women in the homebirth forum will allow me to assess how community is created within such a forum and, furthermore, will allow me to explore the reasoning that informs women's choices in regards to homebirth options. This will hopefully lead to an improved understanding of the broader cultural and social implications of women's homebirth choices such as social criticisms, support from medical authorities, and family situations.

1.8 Significance to Medical Anthropology

This work is intended to contribute to the anthropology of reproduction, birth and maternal health, offering an in-depth qualitative analysis of women's perceptions of homebirth within the larger technocratic arena of medicalized birth. The homebirthers' postings represent the major concerns with, and overall perception of the Canadian health care system which will enable the health care community to better understand the main priorities for mothers seeking homebirth options.   This research will also contribute to service provision for community-based agencies and accordingly to the individuals that use their services by encouraging respect from health care practitioners and government policy makers.

This research is also significant because, despite the considerable attention anthropologists have paid to childbirth and maternal health (Rapp and Ginsburg:1991; Rothman:1982, 2007; Martin:1987; Jordan:1978, 1997; MacDonald:2006; Cheyney 2008), there is a surprising dearth of information regarding how the use of cyber-technologies – in this case homebirth forums – impact women's maternal healthcare choices. In my research, the

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significance of this is heightened as Canadian women choosing homebirth is a group that is not well represented in the literature on pregnancy and childbirth.

This research also has the potential to highlight optimal – and deficient – initiatives regarding maternal health care and to investigate prevailing policies regulating homebirth practices and directives in order to better accommodate varying birth choices. According to Margaret Lock (2001), medical anthropological insights into biomedical practices allow for a better understanding of individual experience; therefore, I am examining how Canadian women represent their experiences of homebirth.

Most importantly, the main contribution of this research is to advance an understanding of how a homebirth community is fostered technologically through online interactions. This study will garner an understanding of how relationships are developed and an overall sense of how community is established by individuals not physically present, but sharing a connection through their mutual experiences and desires.

2.1 Introduction

Understanding the complexities of homebirth in Canada is essential to this research. There are a number of anthropologists who examine the dominance of the medical birth model in relation to women's own birthing ideals (Cheyney 2008; Martin 1987, 1992; Craven 2005; Johanson et al. 2002; Lazarus 1994; Davis-Floyd and Sargent 1996; Browner & Press 1996; Rothman 1982; Ginsburg & Rapp 1991) and they find that Western technocratic dominance is not only a hindrance to "natural" birth but it inherently instils in women that medicalized birth is the societal norm. This is problematic for several reasons: women are taught through salient dominant cultural ideals that their bodies are incapable of giving birth without some form of technological intervention; and the reliance on medicalized intervention further reinforces the view that doctors know best and any other form of birth – whether at home, unassisted or with a midwife – is unacceptable if not considered dangerous.

In this chapter, I examine literature on current homebirth practices and legislation. This includes a list of current provinces and territories that have regulated homebirth legislation as well as the small minority that have yet to do so. As well, it is important to understand the relationship between natural childbirth, including homebirth, and midwifery, as this will provide the framework in which ideas regarding what is considered "natural" are culturally grounded.

There have been numerous studies comparing the efficacy of homebirth and midwifery to that of medically sanctioned hospital births (Tyson 1991, Janssen et al. 2002, Fullerton et al. 2007, Miller & Skinner 2012, Olsen 1997). The results of these studies indicate that for low-risk pregnancies, homebirth with a midwife is a safe and viable option with less need for medical interventions such as caesarean sections, episiotomies, forceps and other medical instruments

(Tyson 1991, Janssen et al. 2002, Fullerton et al 2007, Miller & Skinner 2012, Olsen 1997). The

hospital-versus-home dichotomy is crucial for understanding the larger political and

governmental factors which ultimately regulate the cultural norms concerning maternal health

care needs. To understand why medical practitioners and many political bodies discourage and

often disprove of homebirth practices in contemporary Canada, a brief examination of birth as

presented from an historical perspective will reveal that the birthing practice - what was once a

woman-centered process - has become patriarchal and technocratic (Macdonald 2006, Craven

2005, Johanson et al. 2002, Cheyney 2011). Consequently, a dichotomy between the hospital as

good/safe and the home as bad/unsafe currently resonates through Canadian public cultures,

informing a negative attitude towards homebirth. Evidently, many women write in the postings

how they are often criticized and ridiculed by friends, family and co-workers because of their

choice to give birth at home. This undoubtedly perpetuates and reinforces the social stigma

attached to homebirthing and, in particular, sets women wanting a homebirth to become socially

isolated at a very meaningful time in their life.   Lastly, low-risk "normal" pregnancies are

another debate in the current hospital-versus-home discussion as there is an exorbitant amount of

money spent on births that do not require direct physician attendance (CIHI 2006) and women

can otherwise labour and deliver in the privacy and comfort of an alternate birth setting, such as

a private home or birthing centre.

2.2 A Homebirth/Midwife Historical Glance

In order to examine homebirth, it is important to understand the historical significance of

the role of midwifery. Midwifery has been a long-standing practice in Canada and its roots are

bound in historical and often political significance. Joyce Relyea, author of *The rebirth of*

midwifery in Canada: an historical perspective, provides in-depth academic insight to how the

rise of midwifery and homebirthing has gone through a series of social challenges and political

struggles since the early 17th century (1992). Relyea (1992) notes that "the history of midwifery

in Canada...is characterized by periods of suppression and rebirth" (159). Midwifery, therefore,

has been a long-standing tradition long before Canada became a nation, as the Aboriginal

Peoples who inhabited the land and the European settlers practiced midwifery (1992:159).

Stemming from the era in which New France dominated parts of Canada and the US, childbirth

"occurred in the home with the support of a neighbour or a midwife" (1992:160). Johanson et

al. further reinforce this fact by pointing out that, "until the 17th century, birth in most parts of the

world was firmly in the exclusively female domestic arena, and hospital birth was uncommon

before the 20th century, except in a few major cities" (2002:892).

Giving birth within the home was viewed as a normal, woman-centered practice as

there were no established medical clinics in remote rural areas. Neighbours, relatives, and

older daughters were often involved in attending the birth of a child as Relyea points out:

"some neighbours may have had midwifery preparation in their country of origin, others

may have pursued self study, or learned about childbirth from their own personal birth

experiences" (1992:161). It was this strong social bond that formed a sense of community

with women, and their experiences became the knowledge they relied upon and shared with

one another. Relyea notes that midwives "saw their work as a necessity, a neighbourly deed

which not be reimbursed" (1992:160). Burtch (1994) also reinforces the fact that midwives

were an integral part of the foundation of community building as he states "midwives seek

to restore a sense of intimacy and community throughout the birth process" (4). As time

passed, however, nearing the end of the 19th century, physicians - gaining in prominence and

numbers - began monopolizing ways to earn income; childbirth was an opportunity yet to be seized from the hands of midwives (1992:161). In doing so physicians,

> began to exercise both their power and influence to persuade women of
>
> the increased safety of birth with physician attendance, demeaning
>
> traditional childbirth as 'dirty and potentially dangerous'...thus births
>
> became increasingly the realm of the 'man with the forceps' who would
>
> come to your home. (1992:161)

One can only speculate on the thoughts and feelings of the women giving birth in the home with the doctor present and whether or not this was a desired preference. Before the invention of forceps men were present during difficult births as Johanson et al. note "...men had been involved only in difficult deliveries, using destructive instruments with the result that babies were invariably not born alive and the mother too would often die." (2002:892).

It was in early 1920 that the need for maternal care in the remote parts of Newfoundland was recognized by the Child Welfare Movement (Relyea 1992:162). This prompted the need for an organized group of women to begin a Midwives' Club, in which education and techniques were taught to practising and lay midwives (Relyea 1992:162). Many of the graduates of the courses were respected within their communities as one midwife who travelled to Newfoundland from Britain found the community midwives to be "...very good to their patients. They would stay in the home, cook and clean and wash. They are the salt of the earth" (Relyea, 1992:162).

During the 1920s, technological innovation and progression was beginning to rise, evidently leading to changes towards the attitudes of women wanting progressive maternal care. As Tony Dixon (1987) notes, many women's magazines shared in the technological embrace and "*Good Housekeeping* declared in 1926, 'childbirth is being lifted out of the realm of darkness

into the spotlight of science!'" (1097). Hospital births were gaining in popularity with women despite a larger percentage of birth-related deaths including sepsis and complications due to caesarean sections (1992:163, 1987:1097). Maternal mortality was also dependent on socio-economic status; during the 1930s in England it was recorded that women with husbands working in a manual occupation had lower mortality rates that women with higher mortality rates who were more likely to receive care from doctors and who had husbands in non-manual occupations (Johanson et al., 2002:892). It was by the 1940s in Canada that the "neighbourhood self help network, often referred to as the popular birth culture, was slowly disappearing" (1992:163), partly due to three dominant reasons: (1) the diffusion of community contacts in larger urban areas; (2) the issue of modesty among women who felt it was not appropriate to give birth in front of other children in the household; and (3) the advancement of medical technology was appealing to middle-class women who were being told by physicians and popular culture that giving birth was a dangerous time and it must be medically monitored (1992).

During the 1970s and early 1980s Canada had two nurse-midwifery associations: the Western Nurse-Midwives Association and the Ontario Nurse-Midwives Association. Through these associations, educational materials, course information and newsletters were administered, but as Relyea makes clear, "members generally fulfilled nursing roles in hospitals and were denied the right to call themselves midwives" (1992:165). Theories suggest that midwives soon developed an inferiority complex due to the dominant attitude of male doctors and cultural beliefs of medical superiority therefore creating a sense of distance between themselves and the women they served instead of the traditional feelings of compassion and community (1992:165). Because homebirth had decreased in popularity in Ontario, community nurses began halting their

homebirth services, leaving local homebirth enthusiasts to take up the cause and form their own

community groups (Bourgeault et al., 2001:53). The authors address the fact that,

> The "would-be" midwives that emerged from this group were not
>
> formally trained; they were women interested in promoting childbirth
>
> alternatives through helping at home births. Often their own home birth
>
> experience sparked their interest. (Bourgeault et al., 2001:53)

Soon after this cultural shift, women began expressing their discontent towards the

medicalized birth process and they wanted to regain the control over their births, bodies and the

freedom of choice for who delivered their baby (1992:165, 2001:53). In an attempt to resurge

the community support for homebirth, Relyea states:

> Women, often friends and neighbours, began to assist one another at
>
> childbirth resulting in the rebirth of the 'community midwife'. These
>
> women providing midwifery care in the community held courageously to
>
> the belief in a woman's ability to give birth. (1992:165)

It was only until the 1980s, that the initiatives and legislation of midwifery programmes

within regulated institutional settings were strongly upheld, such as integrated programs for

midwives including theoretical and practical training a more well-rounded and educated midwife

was to be the goal (1992:167). The government of Ontario implemented a Curriculum Design

Committee which included midwives, doctors, nurses and educators in order to assemble what

they believed to be the core teaching practicum for a midwifery program including: (1) emphasis

on "normal births" and the midwife as having expertise in this area; (2) the focus on a health

model of birth, as opposed to a medical model; (3) women have authority over their bodies and

midwives are to learn how to respond to "consumer needs"; and (4) quality of care means

continuity of care for a woman and her family (1992:167). Birth was returning to a woman-centered practise on that which was deemed to be "natural".

2.3 Natural Birth and Midwifery

The term "natural birth" was first introduced into medical discourse by obstetrician Dr. Grantly Dick-Read in 1933 with the publication of his first book entitled "Natural Childbirth" (1979:244). At the time, and for a number of reasons today, it was a controversial and contested practice for the management of pain during labour because it went against the dominant technocratic model of medicalized childbirth. It was not until Dick-Read's second book was published in 1944 entitled, "Childbirth Without Fear", that the general public and health officials viewed his techniques as having a positive impact on the childbirth movement (1979:244). Fear is what Dick-Read believed to be the number one factor of pain during childbirth; both the fear in giving birth as well as the social fear which is reproduced through stories and personal accounts of childbirth being extremely painful (2007:22). Personal fear and social fear are conceptual categories which take on two different meanings. For many women, the fear of having a child was due to the perceived pain that one may personally endure whereas social fear consisted of the stories and experiential realities of other women – usually related to negative situations – which reverberated throughout society. Breathing practices and relaxation techniques were the primary tools taught by Dick-Read in order to reduce the amount of intervention used by obstetricians during childbirth, such as forceps, mind-numbing anaesthetics and caesarean sections (1979:245).

From a medical standpoint "natural" birth and "normal" birth are similar but distinct. According to a Joint Policy Statement on Normal Childbirth from the Canadian Institute for Health Information (CIHI), a normal birth is defined as being spontaneous, low-risk, the baby is

born in vertex position, skin to skin contact is encouraged within the first hour after birth, and in

appropriate circumstances reliant on intervention to facilitate labour and a vaginal birth

(2008:1163). "Normal" birth is often associated with "natural" birth by midwives because it is,

in their profession, viewed as the naturally normative process by which to birth a baby

(Macdonald: 2006). A natural birth, however, is defined as "'existing in or derived from nature;

not made, caused by, or processed by humankind'. Childbirth is considered to be natural

childbirth when there is little or no human intervention" (CIHI 2008:1163). In this sense, the

body – and woman – is the one in charge of the birthing process. This definition of natural birth

is one to which I will refer in order to align what is considered "natural" in opposition to a

medicalized birth which infers the use of interventions within a hospital setting. Although the

CIHI definition states that "natural" birth is not "processed by humankind", the birthing woman

is not merely a passive vessel and her decisions and actions often facilitate birth. Likewise,

midwives aid in the birth process using techniques and remedies. Birth is a process and it is

indeed processed by humankind, however, "natural" birth, according to the above definition,

does not include medical interventions.

     Macdonald (2006) asserts that, "…midwifery works discursively through the idiom of

nature to affect women's knowledge and experience of their bodies and selves in pregnancy and

birth" (236). "Nature", in the sense that Macdonald is describing it, is intended to refer to

"instinct" or what is deemed to be "innate" when it comes to inherent birth knowledge.

Midwives maintain the rationale that women are inherently capable and strong enough to give

birth without medicalized interventions. As Macdonald succinctly writes:

> Closely linked to the iconic traditional midwife is the ideal of the natural
>
> birth that she attends. It is both the absence of biomedicine and the

presence of the knowledge and skills of the midwife as well as the

capable body of the birthing woman in a home setting that is crystallized

in the notion of the natural birth attended by a traditional, predemise

Canadian midwife. (2006:238)

The traditional midwife's role, as explained previously, was to be there for the birthing

mother and, with learned techniques and remedies, help the birthing body achieve its goal of

delivering the baby safely.

2.4 Current Issues in Midwifery

Increasingly, from the 1980s to present, medically assisted births became the dominant

model of birth in Canada. Cheyney (2008) highlights the fact that "the United States and Canada

are the only two high-income nations in the world in which highly trained surgical specialists

(obstetricians) still regularly attend normal, healthy, low-risk mothers in delivery" (254).

Currently, midwifery is "recognized as a legal and regulated profession in some Canadian

provinces and territories while in others it is not yet regulated" (CMRC 2012). Midwifery is

regulated in all provinces and territories across Canada except for Prince Edward Island and the

Yukon Territory (CMRC 2012). In Ontario, separate regulations are put into place for

Aboriginal midwives in that they are able to practice traditional midwifery with other Aboriginal

members and members within their Aboriginal community as well as given the title of

Aboriginal Midwife (CMRC 2012).

It is important to note that even though a tremendous amount of progress has been made

with regards to the legalization and regulation of midwives in Canada, there continues to be a

cultural divide between the established dominant system of medicine and the role that midwives

play within the patriarchal and technocratic medical system. Midwives are deemed as less

competent than medical physicians and are often the case of blame in a negative outcome of birth. According to Johanson et al., there have been few investigations into how midwives perform in such a medicalized environment (2002:893). A study conducted in the United Kingdom asked midwives to provide their understanding and perception of consultations with couples, both antenatal and postnatal, about their birthing experiences. The authors found that, "'a mechanistic and medicalized understanding of childbirth seemed to dominate the discussions" (Johanson et al. 2002:893) and that most midwives "'learned helplessness and guilt'...in which they were constantly threatened by blame" (893). Because midwives are not seen as equals within the medical profession there is an inherent power struggle that suggests midwives are "inferior" to the physician. Placing blame - should an incident arise while under the care of a midwife - can damage an individual's emotional and mental status by causing them to feel inadequate in their profession and subsequently internalize negativity about themselves which is therefore disempowering. Much of this inequality stems from the years of patriarchal dominance within the medical system as well as the inherent authority physicians have over their patients and those regarded as less educated – including midwives. An in-depth discussion regarding authority will be offered later in this thesis and will consider the role authoritative knowledge has surrounding homebirth mothers, midwives, physicians and the dominant technocratic medicalized model of maternal care.

2.5 A Canadian Homebirth Study Comparison

The following three studies provide an understanding of the efficacy and safety of homebirth practices. Over a twenty-three year period, it has been proven that the practice of homebirth is neither detrimental nor unsafe for women having low-risk births. Medicalized birthing institutions as well as physician regulated care are not necessary in all situations.

Between 1983 and 2006, there have been three comprehensive birth studies conducted within Canada in which hospital births and homebirths are compared based on a number of factors including: use of instruments; percentage of episiotomies; length of labour; hospital transfers for either mother, baby or both; age; socio-economic status; and fetal deaths. The importance of these studies highlight that homebirths are, in most cases (for a "normal" low-risk pregnancy), just as safe if not safer than hospital births - even though the current cultural trend is the preference of a hospital birth under the care of a physician. The following case studies are integral to this research because they emphasize the many reasons women writing in the online posts are in favour of homebirth and resist the technocratic models of birth. For example, these cases illustrate that overall episiotomy rates and caesarean sections are much higher in a medicalized birth setting, whereas in the homebirth group they are significantly lower. As I will demonstrate in the next chapter, this is significant to women seeking intervention-free births.

2.5.1 Study #1: Schneider and Soderstrom (1987)

The first study, conducted by Schneider and Soderstrom (1987) from 1976 to 1986, focused on women who were choosing to have a homebirth in the Ottawa region. The women ranged in age from 20 to 35 years old, with 86% being 20 and 34 (1987:1167). Almost half of the participants were multiparous (49.9%) and 78.6% had some form of post-secondary education (1987:1167). The authors found that for women who are either primiparous or multiparous, homebirth is a safe and viable option as opposed to giving birth in a medicalized hospital environment. This study is particularly interesting because even though these births took place within the home they were attended by a physician and a midwife during the active labour segments. In contemporary Canadian society, it is very rare that a physician would be present during a homebirth.

Schneider and Soderstrom comment that there are various reasons why women want to give birth at home, however, "the most common reason is that the woman has had a very negative experience in the hospital" (1987:1163). Indeed, a number of the women's postings reveal negative experiences while in the hospital setting. Schneider and Soderstrom also state,

> Many women fear the technical and often over-medicalized hospital
>
> birth...some people may consider the hospital a dangerous place which
>
> may lead to illness, while they think the home environment is protective
>
> by virtue of its supportive surroundings and its freedom from protocols
>
> and restrictions. (1987:1164)

The dichotomy of home-versus-hospital is important to keep in mind because as I will explain, the women's postings on the *BabyCenter* website demonstrate an apprehension to medicalized dominance and an embrace of the comforts of home, a similarity found within Schneider and Soderstrom's study. Another key fact found in the study is that, of the study participants, "only 3% were screened out for medical reasons...the latter group all delivered at home uneventfully, against medical advice" (1991:1165). Key here, is the phrase "against medical advice" (see also: Tyson 1991). Resistance against the medical system, as demonstrated throughout homebirth history, is not tolerated by mainstream physicians as they see their medicalized care as the only rational and safe way to have a child. As I will examine, homebirth group participants often write that they chose to have a homebirth against physician advice and that of the hegemonic ideal of medicalized hospital birth.

2.5.2 Study #2: Tyson (1991)

The second study considered here was conducted by Tyson (1991) between 1983 and 1988. This study examined 1001 planned homebirths with midwives in Toronto. This study

29

found that, of the 361 primiparous women, 245 remained at home while 116 required either the

mother or baby to be transferred to hospital during labour or within four days of postpartum, and

of the 640 multiparous births, 591 remained at home while 49 required transfer to hospital

(1991:14). Results indicate women having their first child were more likely to transfer to a

hospital than women who already had a child. Tyson's study revealed that of the women

transferred to hospital, 91 had spontaneous vaginal births, 34 had forceps deliveries, and 35 had

caesarean sections (1991:16). There were only two fetal deaths which included one at home and

the other at hospital (1991:16).

There are a number of indicators in Tyson's study that reveal why homebirth is a viable,

less-invasive alternative to medicalized hospital births. The study indicates that:

> Of primiparas who had vaginal births, either at home or in hospital, 50
>
> (14.8%) had episiotomies, 7 of which were performed by midwives at
>
> home and 43 by physicians in the hospital. Among multiparas, 20 (3.1%)
>
> had episiotomies; 3 were performed by midwives at home and 17 by
>
> physicians in the hospital. (1991:16)

Evidently, the likelihood of having an episiotomy in the hospital exceeds that in a

homebirth environment. Again, this highlights how the use of medical intervention is a

dominant trend within the hospital setting under physician care. The lower instance of

episiotomies in the homebirth group lends itself to the understanding of the natural environment

that the home setting provides during childbirth.

Similarly, much like the Schneider and Soderstrom's study, Tyson's discussion reveals

that, "it must be recognized that the current clients of midwifery care in Toronto are a self-

selected group of women who have sought a homebirth despite the threat of physician and legal

harassment" (1991:18). The patriarchal medical system is one of superiority and dominance, as demonstrated throughout medical history. Therefore when a woman defies the cultural norm, she is inevitably viewed as pathological and harmful to herself and her child (Craven, 2005). The results of Tyson's study found that "the Toronto homebirth population has a high rate of spontaneous vaginal birth, low rates of surgical intervention and episiotomy, and relatively low rate of perineal laceration that require sutures" (1991:18). These findings highlight and reinforce that for women who have a low-risk at home birth there is little need for medical interventions and that qualified midwives are capable of obtaining desired outcomes for their clients.

2.5.3 Study #3: Janssen et al. (2002)

Lastly, the most recent study, conducted in British Columbia between 1998 and 1999 by Janssen et al., once again concludes that home births, in most cases, are as safe as, and involve less intervention than, hospital births (2002). The key difference is that, as opposed to the latter two studies, this study tracked three participant groups: (1) midwife attended homebirths; (2) midwife attended hospital births; and (3) physician attended hospital births. Of the 862 women in the homebirth group only 33 had episiotomies, in comparison to the physician attended group where out of the 743 women, 114 had the procedure (2002:319). The episiotomy rate is also lower in the midwife attended hospital birth group where 62 women out of 571 had the procedure (2002:319). Midwives may view birth as a natural process and feel that there is not a pressing need for surgical interventions. Overall, Janssen et al. state that, "women who gave birth at home attended by a midwife had fewer procedures during labour compared with women who gave birth in hospital attended by a physician" (2002:315). The final outcome of the study affirms that "there was no increased maternal or neonatal risk associated with planned homebirth under the care of a regulated midwife" (2002:315).

2.6 Discussion of Studies

These studies set the context for this research project because they highlight the current trends in homebirth as well as the safety and effectiveness of a homebirth with a midwife. In all three studies there is solid evidence of the unnecessary need for medical intervention during most birth processes. The need for medical intervention is often unnecessary, yet according to Johanson et al., "obstetricians have increasingly taken over responsibility for normal birth" (2002:892). In Schneider and Soderstrom's (1987) study as well as Tyson's (1991) work, the opposition from physicians and medical authorities against women wanting a homebirth is indicative of the authoritative power within the established medicalized birth environment. Cheyney (2008) illustrates the dominance of medical authority by stating that, "...institutionalized racism and biomedical hegemony heavily structure access to maternity care and the extent to which women might exercise the right to choose where and with whom to give birth" (254). Rothman (1983) believes that the "medical reality" is a "socially constructed reality"; therefore, women seeking to avoid the medicalized model of birth are more apt to choose a homebirth:

> Once the institutional forces begin, the process is constructed in a manner
> appropriate to the institutional model. Once a labouring woman is
> hospitalized, she will have a medically constructed birth. (1983:269)

Women choosing to have a homebirth do so for a number of personal reasons but my study suggests that the overall factors include control over decision making, comfort of home, apprehension or fear of hospitals (including physician authority), and unwanted medical interventions. As discussed in this chapter, there is less interference with medical authority and unnecessary interventions - e.g. invasive episiotomies - when in the homebirth setting.

2.7 Homebirth Summary

This chapter highlighted the importance of situating the anthropological literature of birth in order to understand how homebirth and midwifery are integral and interconnected within the maternal care model of natural birth. Although midwifery has experienced periods of suppression and condescension by medical authorities, Macdonald (2006) reflects that by the 1980s:

> To the discourses of nature and tradition were added liberal feminist
> rhetoric of choice, rights, and health – reflecting diverse political
> alliances. The essence of this new midwifery was not to create another
> childbirth authority but to put control back in the hands of the women
> giving birth. (238)

Homebirth is predominantly about a woman's right to birth in the way that she sees as being the most beneficial to herself and her baby. Throughout this chapter, it has been established that homebirth is not as dangerous for low-risk births as medical authorities believe it is and that medical interventions occur less frequently in comparison to routine medicalized births. Yet, the birthing process is still dominated by the technocratic and patriarchal model of birth as many scholars note, (Macdonald 2006, Craven 2005, Johanson et al. 2002, Cheyney 2011), making it difficult for homebirthers to exercise their choices without some form of stigma and misunderstanding from those outside the homebirth community.

CHAPTER 3
HOMEBIRTH CONTENT ANALYSIS

Houses are frequently thought of as bodies, sharing with them a common

anatomy and a common life history. If people construct houses and make

them in their own image, so also do they use these houses and house-

images to construct themselves as individuals and as groups. At some

level or other, the notion that houses are people is one of the universals of

architecture. If the house is an extension of the person, it is also an

extension of the self. As Bachelard reminds us, the space of the house is

inhabited not just in daily life but also in the imagination. It is a

'topography of our intimate being', a 'felicitous space' with protective

and comforting associations, a rich and varied poetic images which

'emerges into the consciousness as a direct product of the heart, soul, and

being a man, apprehended in his actuality'. (1995:3)

<div align="right">

Janet Carsten & Stephen Hugh-Jones
About the House: Levi-Strauss and Beyond

</div>

3.1 Introduction

The above excerpt by Carsten and Hugh-Jones (1995) signifies what houses represent to

many of the women within the homebirth forum group, as they see the space as comforting and

protective. This chapter explores how women represent their decisions to have a homebirth in

Canada while living in a society where medical technologies are privileged over other health and

maternal modalities. As Ellen Lazarus states, "biomedicine, with its reliance on technology, is

both a forceful practice and a powerful ideology. It has a tremendous influence over how

women are thought of and how they themselves think about childbirth" (1994:25.) The

technocratic and medicalized system is the body politic and as Lock and Scheper-Hughes (1987) make clear "...the stability of the body politic rests on its ability to regulate populations (the social body) *and* to discipline individual bodies" (8). The body politic in this sense is the Canadian medical system which seeks to emphasize controlled hospital births as being the "logical" solution. Women who are choosing homebirth practices are therefore resisting the dominant medicalized political body and changing the standards for themselves and their children. By doing so they are creating a new individual body in which their ideals transcend normative values. It is their interaction with the social body – that of the *BabyCenter* homebirth forum – that aide in this transformation by sharing the commonality of homebirth interests. Although the dichotomy of home versus hospital seems to be a "black and white" opposition, it is more complex than that. Homebirth is becoming an increasingly accepted method within contemporary culture. The discussion here is not intended to challenge biomedicine in its entirety; instead, the intent is to suggest that there are significant aspects of homebirth which reflect how homebirth and biomedicine hold divergent positions and are valued differently in Canadian society.

There are many issues for women vying for alternative maternal care in a culture dedicated to the technological embrace of medical advancements, including criticisms from others for their homebirth choice and the stigma attached to homebirthers as pathological. In this chapter, I examine how homebirthers' post about hospitals as unclean spaces overly dominated by physicians, which, in turn, creates the perception of lessened or lost control over their birthing situation. These posts contrast with those that represent the home environment as comfortable and empowering. In order to assess how broader trends in the Canadian homebirth movement

are reflected in one on-line forum I focus my analysis on the hospital/home dichotomy, along with how concepts of stigma, education, power and comfort, emerge in the online postings.

3.2 The Complexity of Home

Heather Horst (2011) purports that "the concept of home is fundamentally linked to place and a sense of continuity" (29). This contextualization allows us to think of home as a place which is the starting point for further understanding about the structure and inherent nature of home. Shelley Mallett (2004) asks "whether or not home is (a) place(s), (a) space(s), feeling(s), practices, and/or an active state of being in the world" (62). The Pocket Oxford Dictionary defines home as: **1** *n.* place where one lives, fixed residence of family or household; **2** *a.* of or connected with one's home; carried on, done, or made, at home; **3** *adv.* to or at one's home; **5 at-home** in one's own house etc., at ease, familiar.

Although these definitions attempt to capture the meaning of home denotatively, there is no mention of the symbolic meanings or colloquial connotations of what home means to an individual or community. The significance of home is extremely complex and is inextricably linked to place and identity. As Mallett recognizes, "many researchers now understand home as a multidimensional concept and acknowledge the presence of and need for multidisciplinary research in the field" (2004:64). What is of importance is that, when describing the home, the general consensus is that it "…provide[s] a sense of place and belonging in an increasingly alienating world" (2004:66), and more importantly "the ideas about privacy, intimacy, domesticity and comfort…are also prominent and recurring themes in contemporary analyses of the meaning of home" (2004:67). As this chapter will demonstrate, for the homebirthers, home is a place of perceived security, cleanliness, comfort and ultimately a place for empowerment throughout the birth process.

3.2.1 Home as Clean, Hospital as Dirty

From an analysis of thirty-four posts, it is clear that homebirthers see hospitals as germ- and bacteria- laden places and, therefore, chose homebirth to avoid harming themselves or their babies. This thesis is not intended to question the sanitary conditions of hospital settings but to illustrate that the theme of cleanliness emerges in the posts as a way in which women argue that their home is the most appropriate venue for birth. These claims of cleanliness are imperative to express concerns for future policy work concerning homebirth mothers. This includes further investigation into hospital sanitization standards and protocols in order to understand the perceived stigma hospitals carry of being unsanitary. The following posts represent some of the comments from forum writers regarding the sanitary conditions of hospitals, and also their own feelings of fear with regards to hospital stays:

> I stayed at home as long as possible to avoid the hospital as long as
>
> possible...it's for sick people. (aliali28)
>
> I know it may sound strange for a Medical Administrator to even fathom
>
> a home birth, but I too have fears of infections and bacteria floating
>
> around the hospital and would prefer to give birth in the comfort of my
>
> own home. (Martha)
>
> I feel far safer in my own house with my own germs than hanging out in
>
> a germ sesspool[sic] at the hospital (I know hospitals are supposed to be
>
> clean, but our hospital is constantly under lock-down of some kind due to
>
> this or that infection spreading). (PeachPie)

My only reservations about hospital births are the increased risk of

infection (and the possible interventions that may have to occur as a

result of my platelets). (Krissy29)

I work as a PSW in long term care and get to see first hand the amount of

residents coming back from the hospital with things like MRSA, C-Diff,

ASBL, etc. The last thing I want is to put myself or my baby at risk for

contracting these bacteria. Home birth for me seems like the best way to

go as these bacteria aren't living in my house. (PeachPie)

These posts suggest that, for certain homebirthers, germs and bacteria are a major factor

in the decision to have a homebirth. Both *Martha* and *Krissy29* work in the healthcare field and

see firsthand the potential risks for infection; therefore, they feel that the home is the best choice

to avoid these perceived risks. Poster *PeachPie* is unique in that she recognizes that the home

also harbors germs, but they are different – maybe safer – than hospital germs. The decision for

PeachPie's choice for homebirth may be reliant on the fact that she is not exposing herself or her

newborn to foreign germs, but germs that she believes pose less of a health risk. Also unique, as

aliali28 writes, the hospital is for "sick people". This can be indicative of how she views

childbirth as not being an illness, as some mainstream physicians conclude that it is (refer to 3.4

Hospital Treatment and Interventions). As well, it is illustrative of her own personal fears

associated with illness that she would prefer to avoid.

These comments are suggestive of past experiences women have had in the hospital, what

they have heard from the experiences of others regarding hospital births, as well as the overall

perception that hospitals are considered unsanitary. As exemplified by Schneider and

Soderstrom (1987), one of the main reasons women were choosing homebirths was to avoid

technology and the overtly medicalized environment which could be laden with germs and bacteria. This is seemingly accurate for the homebirthers within this study.

3.3 The Concept of Choice

The sanitary conditions are not the strongest motivational factor for wanting a homebirth. Homebirth allows women to make their own choices. As Davis-Floyd remarks:

> For the laboring woman…her labor is uniquely her own. She eats and
>
> drinks and moves about at will. She gives birth in the place of her choice
>
> attended by the people and practitioners of her choice. And the
>
> practitioner does not respond to the variations in her labor in standardized
>
> ways. A midwife dealing with a stalled labor might invite one woman to
>
> dance, might ask another if she is afraid to give birth, and might suggest a
>
> long walk with a third. Her intuition will guide her to respond to
>
> individual circumstances in individual ways. But the focus stays on the
>
> birthing woman. It is her unique needs and rhythms that will be
>
> paramount in the unfolding of her birth. (2001:18)

When the medicalization and standardization of the birthing process have been removed, it allows for greater choice. As one poster describes, the concept of choice was paramount in her birth experience as well as listening to her own body, letting her authoritative knowledge and intuition guide her:

> I am so looking forward to the experience that I can only have at home,
>
> in my own comfort zone, doing things the way *I* want to do them, the
>
> way my body tells me I need to do them – and not having to listen to the

nurses and doctor tell me when to push and which way to lay down and

how to hold my legs, etc. (mama1*)*

When the desired birth plan is no longer attainable there is an apparent reaction of

disappointment and anger. This can be equated to a lack of choice in how the woman wants her

birth experience to be. For example, one poster who wrote under the thread entitled, *my dreams*

of a homebirth are shattered, indicated:

I am pretty frustrated and bitter with the whole medical system...and sad

to have missed out on my last chance to have a birth where I got to go

into labour naturally, be in my own space and have my wishes respected.

(LucyW)

This statement alludes to the fact that the medical system is to blame for *LucyW* not

having her desired birth experience. Her choice to have a homebirth was seemingly "stripped"

from her and therefore she is frustrated by the way that her birth event happened. *Krissy29* was

another poster who felt disappointment with her birth expectations due to giving birth in the

hospital setting:

Now, I was taking comfort in the fact that I was going to have my

midwife at the hospital so I wouldn't have to be in triage and there

wouldn't be all sorts of doctors and nurses coming and going from the

room and bringing with them all sorts of bacteria but that's all gone now

too. I am devastated. I keep voicing my feelings and concerns to my DH

[dear husband] and family and they just dismiss them and tell me that all

I should care about is that the baby arrives safely. Well, I'm not an idiot

and obviously my child's wellbeing is the most important thing but that

doesn't help my disappointment. (Krissy29)

Complications due to low platelets were what prevented *Krissy29* from achieving her goal of a homebirth. Although, nearing the end of the thread she did mention that she was able to have her midwife at the hospital for support, but an obstetrician-gynaecologist was her main care provider.   Likewise, *polly36* shares the same sentiments in that homebirthers – and presumably all women in general - all want the best outcome for their baby but the concept of choice is deeply rooted in the birthing experience:

It's very hard to explain to people who don't understand--we all want a

healthy baby and a good birth, but we also want a right to choose how we

give birth as women.

When expectations of the birthing experience are not met, women often feel as though they have failed both in some aspect of the birthing process (Macdonald:2006, Baston et al.:2008) and, perhaps more importantly, in fulfilling their own mother identity – the ideal mothering self that they have embodied and constructed. Penny Simkin (1991) argues:

…much more is involved in the outcomes of "a healthy mother and a

healthy baby" than coming out of it alive with no permanent physical

damage. The potential for psychological benefits or damage is present at

every birth. Caregivers have a great deal of influence on how each

woman will remember her experience. In addition to a safe outcome, the

goal of a good memory should guide their care. (210)

The above posts reflect that women highly regard choice as being one of the top priorities for their birthing plan. The choice to birth where they are most comfortable and with whom they want present is paramount in shaping the experiential construction of their homebirthing realities. Likewise, when the birthing choices homebirthers desire are not always available, the results are often damaging and can cause feelings of sadness, devastation and disappointment as numerous women in the thread "My Dreams of a Homebirth are Shattered" describe. The result is that homebirthers internalize and project a negative memory of the birth event. Ultimately, home represents the concept of choice – to choose how and with whom – the birth plan will go, whereas the hospital represents unsanitary conditions and the restriction of choices. The goal of having a healthy baby is paramount but is only one aspect of the entire birthing experience.

3.4 Hospital Treatment & Interventions

The medicalized process of birth often necessitates the insistence of medical interventions. This is imbued in the technocratic medicalized model of birth in a way that denounces women's bodies as being capable, and therefore medical assistance and intervention is needed for a safe and healthy delivery (Macdonald:2006; Cheyney:2008; Martin:1992,1987; Jordan:1997,1978; Davis-Floyd:2001,1994). When posting about hospitals, a majority of the women wrote that they were concerned about medical interventions and the pressure to accept them. Davis-Floyd summarizes the routine treatment a woman receives upon entering a hospital in labor:

> The standardization in hospital birth is dramatically evident in most
> modern hospitals. Upon entering the hospital, the laboring woman is
> taken in a wheelchair to a 'prep' room. There her clothes are removed,
> she is asked to put on a hospital gown, and a vaginal exam is performed.

Her access to food is limited or prohibited, and an intravenous needle is

inserted in her hand or arm. The external fetal monitor is attached to the

woman to monitor the strength of her contractions and the baby's

heartbeat. Periodic vaginal exams are performed to check the degree of

the baby's descent. All of these procedures in most modern hospitals are

routinely performed without scientific justification. (2001:7)

Women in the posts do not want these interventions as one homebirther succinctly states:

One of the reasons I chose a home birth was b/c [because] I knew it

would be harder to avoid unnecessary interventions in a hospital.

(3_pegasus)

Fox and Worts note, "a medicalized birth not only fails to empower the new mother but

may also reinforce her sense of dependency and inadequacy" (1999:331). By not wanting

medical interventions, the homebirther is positing herself as a capable, confident and powerful

body. Similar sentiments are also shared by another poster:

NOTHING about a hospital birth is appealing to me, nothing about

hospitals in general is appealing to me. I absolutely do not want anyone

trying to intervene in my birth, and I don't know how "nice" I would be to

any nurses who tried. (lovingmommy)

Even women who may have complications during their labour view hospital-

based interventions as undesirable:

If I had had a crazy 'non-typical' labor like that in the hospital there

would have been many, many interventions and I may not have had the

natural birth I'd hoped for. (twilight)

Twilight indicates that for women who have complications in the hospital setting, most are presumably, and inevitably, subjected to numerous interventions. As Fox and Worts (1999) found, "the use of medical technology undermined many women's confidence and, as a result, often generated a desire for more intervention" (339). Women may feel afraid when an unexpected complication arises and accept medical treatment without making an informed decision. One homebirther succinctly states:

> Doctors are trained to deal with complications and medical issues, and
>
> how to solve those problems. That's what they do. In fact, many of the
>
> complications arise *because* of what is done by doctors and nurses, and
>
> the drugs, and the interventions. They pull out the old risk-factor cards to
>
> scare mothers into doing what the doctors are trained how to do, to get
>
> the baby out quickly. (mama1)

Davis-Floyd makes note that, "in the technocratic model the discussion of options outside of conventional medicine is generally impossible due to the doctor's allegiance to technocratic approaches and ignorance of alternatives" (2001:13). Strongly upholding the duty as medical authorities, most doctors do not recognize the individual needs of patients and interventions are performed without prior knowledge or input from the patient. Davis-Floyd - along with numerous other proponents of alternative childbirth methods (Macdonald:2006; Cheyney:2008; Martin:1987,1992; Jordan:1978,1997; Davis-Floyd:1994) - argues:

> Mechanizing the human body and defining the body-machine as the
>
> proper object of medical treatment frees technomedical practitioners from
>
> any sense of responsibility for the patient's mind or spirit. Thus,
>
> practitioners often see no need to engage with the individual who inhabits

that body-machine, preferring instead to think of and talk about a patient

as 'the C-section in 112'. (2001:6)

This excerpt describes the way in which many doctors view their patients, highlighting how physicians utilize unnecessary interventions without considering the feelings and opinions of their patients. Davis-Floyd recognizes that because the medical system is hierarchical there is subordination over the personal preferences of individuals (2001:7). A newcomer to Canada posts about her fears of having a child in a new country:

…I can't get excited about going to birth in the hospital…I have never

had a baby in Canada and I have heard many horror stories about all the

interventions here so I am scared of the hospitals!! (Jenny_J)

For *Jenny_J*, who is moving to Canada from Australia, her choice for a homebirth is strengthened by what she has heard from other's about the use of interventions in Canadian hospitals. There is a definite perception that hospitals are considered a "scary" place and are therefore unsafe. For this reason, *Jenny_J* is in no way excited about giving birth in a Canadian hospital, despite never being to one and solely basing her opinion on what she has heard from others. Recognizing that the medical system is fraught with power inequities and de-individualization, one poster writes:

My only experience with hospital birth is through other women's stories,

and I've never wished that my experiences had been more like theirs.

(MommaBear)

Akin to the post that newcomer to Canada *Jenny_J* wrote, this post demonstrates that some individuals base their own personal choices on the experiences of others. Therefore, women who have had a negative birth experience may share their thoughts and feelings with

others, consequently reaffirming the societal attitude among homebirthers that hospitals and specialists are detrimental to having a positive birth outcome.

3.5 The Stigma of Homebirth

Women rely on their own knowledge in choosing what they feel is best for their situations which inherently provides a feeling of control, comfort and the freedom of choice. These constitute three dominant ideals in the domain of birthing (MacDonald 2006, Lazarus 1994, Cheyney 2008 and 2011, and Rothman 1982). The women in this online forum are seeking alternative birthing options despite the cultural norm of hospital births as the mainstream trend and the stigma associated with the homebirth community. As the homebirth posts demonstrate, many women express their feelings about the negative feedback from others, which can be equated to stigma.

Link and Phelon (2001) assert that "stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context" (365). As the posts discussed in this section illustrate, many of the women discussed how they were stigmatized by friends, family, and co-workers for their homebirth decisions. Amy Miller (2009) reinforces how homebirthers' are stigmatized by explaining:

> The medical model for birth clearly remains at the center as the cultural
>
> default. Women birthing at home often face the task of convincing
>
> friends and family that midwife-attended homebirth is a safe and healthy
>
> choice for both mothers and babies. (53)

The concept of stigma includes a number of different terms that women use to describe other's reactions to their homebirth choice. Terms that arise include: "crazy", "dangerous", and

"irresponsible". As will become apparent, friends and family are some of the main sources of stigma. As homebirther *Amanda81* posts:

> We had a beautiful, fast, uncomplicated home birth with our daughter last
>
> July and I couldn't be happier with the experience as a whole. For the
>
> most part my friends and family have been very supportive, but one of
>
> my very close friends has put a bit of a damper on things by several times
>
> referring to me as "one of those 'crazy' women" who has her babies at
>
> home. I know she doesn't mean anything malicious by her comments, but
>
> it's kind of bothering me. I certainly understand that home birth isn't for
>
> everyone, but as a good friend I would hope that she would be more
>
> supportive to me and my choices.

This represents how many women who opt to have a homebirth are perceived by others. Craven (2005) postulates how the larger political arena governing maternal health care make women out to be "pathological" if they defy the dominant trends and ideologies surrounding childbirth (195).   In response to *Amanda81's* posting, *scientist* writes:

> The negative reactions I have had were people saying, "well you are a
>
> rebel." While they were not meaning it as a compliment in any way.

In both instances *Amanda81* and *scientist* were resisting the governing ideology of medicalized childbirth and therefore were thought of as rebellious and insane. Craven (2005) crystallizes the way in which medical authorities devalue homebirthers by stating:

> The 'logic,' 'nature,' and 'commonsense' of medical authority around
>
> childbirth was central to medical officials' devaluation of homebirth and
>
> more importantly, homebirth mothers. (200)

Family members were also contributors to the negative views on homebirth, as poster *JaniceS* explains:

> My sisters screw up their faces & tell me I'm gross. In-laws told me I'm
>
> not going to record the event in anyway (get that, told me)! So guess
>
> what? None are invited to share the day (even though they said they
>
> wanted to be there).

Most often relatives and in-laws do not support the decision of homebirth because they fear for the safety of the baby. Because midwives are not generally considered specialists in Western society, the lack of physicians and access to immediate medical interventions cause a sense of disapproval for those less educated on the subject of homebirth and midwifery. Negative feelings about homebirth are often bred by a lack of education by those not within the homebirth culture. One homebirther writes:

> We had a LOT of negative feedback from people when we said
>
> "Midwife" and "homebirth". Some comments were basically that
>
> midwives were like voodoo witches, and homebirth was very
>
> irresponsible and basically we were putting our child's life at risk. A lot
>
> of fear comes from lack of education certainly, but also it comes from
>
> what experiences people have had. If you have had negative/scary birth
>
> experiences you assume birth to be a potentially deadly event that
>
> NEED[S] medical support. (valerie)

Sometimes, the individuals who are apparently "crazy" are those choosing to have a hospital birth, as demonstrated by *Alize4u*:

My family wasn't supportive of our choice for midwives and a

homebirth. They didn't say a whole lot, but it was quite obvious. People

more often say that I was "Brave" to have had my first at home - my

response is that I think you have to be Brave (or crazy in your case) to

have a baby at a hospital full of germs and viruses and staph infections

with complete strangers poking at your hoohoo, no privacy, intervention

happy docs, minimal aftercare etc.

In this passage *Alize4u* portrays that even though her family is seemingly against the idea

of a homebirth, she turns the situation around and purports that women who choose the dominant

ideology of hospital birth are the "brave" individuals. In her research with 50 women who

selected homebirth, Cheyney (2008) notes:

All of the women in the sample faced scepticism and accusations of

"selfish irresponsibility" and "unnecessary risk-taking" from friends and

family members who were not supportive of homebirth. Many noted that

although their own process of unlearning and relearning was challenging,

it did not compare to the difficulty of convincing their detractors. (258)

Medically supervised births are upheld as the ideal in Canada, but as these posts reveal,

there are a number of women within a particular social group who are modifying their personal

systems of beliefs to create a new cultural standard for themselves by choosing homebirth. As

demonstrated, friends and family members tend to be portrayed in posts as ill-informed about the

advantages and risks of homebirthing. The next section details just how homebirthers acquire

the knowledge necessary to make informed decisions about their birth plan.

3.6 Homebirth Education

It is apparent that the online homebirth community of women are exceptionally educated about the events leading up to labour and birth. The dedication to learning and research dominates the homebirth discussions. The dominant ideological trend in society is to rely on medical technologies. Ina May Gaskin (1996) provides an example of how mothers in Moscow gave birth in crowded hospitals in unsanitary conditions, including the use of reused needles and gloves despite the threat of HIV, merely because mainstream culture had such a stronghold on the reliance of medical technology and ignorance to traditional values and knowledge. Although this research was based on a Russian study, it demonstrates how individuals often follow the dominant cultural ideals of the time, instead of thoroughly assessing the benefits and risks. Gaskin (1996) asserts that:

> Despite the danger, almost no one chose to give birth at home, because any useful knowledge about pregnancy and childbirth that once existed among the members of the society had long since been destroyed. (297)

The traditional birthing knowledge ceased to exist in Moscow due to the reliance on medicalized maternal health care. For homebirthers, it is the opposite situation in that they are relying on education and the expertise of midwives to resurrect traditional birthing practices. Examples from the homebirth posts highlight homebirthers as being well educated about the birthing process and many of the discussions are laden with advice about research tips, movies to watch, books to read, and most significantly, references to the experiences of other women. Sacks and Donnenfeld (1984) examine how the decision-making processes to birth in either a hospital, birthing centre, or home is associated with knowledge about birth centres; they argue that the majority of those who choose hospital birth have no knowledge of alternative birthing

environments whereas the parents in both the birthing centre group and the homebirth group were aware of all three settings. Sacks and Donnenfeld's research suggests that parents choosing a hospital birth are often unaware of any alternative birthing environments, indicating the prominence of hospital-based birth. Interestingly, however, in the homebirthers' posts, they describe the situation as being one where they are often depicted as being ignorant of the risks associated with home – and midwife attended – births. Education is indeed essential to the women's decision-making process. Cheyney (2008) explains:

> For women to begin to challenge powerful and widely accepted hospital
> birth metanarratives, and to move into the realm of social action either by
> giving birth at home or by becoming alternative birth activists, many
> described first passing through what was often a long and arduous
> process of "unlearning and relearning." Women sought a new,
> authoritative knowledge as they "hungered for new information" and a
> "new way of seeing childbirth," especially as they attempted to "make
> sense of what happened the first time" in a previous hospital delivery.
> Alternative birthing knowledge was acquired though the Internet and
> books on midwife-attended birth, as well as through more informal
> knowledge sharing networks where women actively sought out midwives
> and other homebirthers who were willing to share their stories. (258)

Education, therefore, is integral to the homebirth dialogue. As exemplified below, many of the homebirthers are receptive to learning all they can about the risks and benefits of homebirth. As one poster describes:

You know that I'm very smart and have always made very educated

decisions after a lot of research. Why do you suddenly feel as though just

because I am pregnant I will suddenly start making bad decisions that are

unresearched and unsubstantiated? (Missy)

Likewise, posters reinforce that most people are ill-informed about homebirth because they are mired in the mainstream technological ideal of birth:

People sometimes just have a knee jerk response to anything "new". Before

doing any research I was much more like these people in my thinking. It's

just a lack of education, and why educate yourself on something that has

nothing to do with you? (NewMommy)

When people try to scare you out if it, it's because they simply don't

know all the facts. Today's society is so used to the medicalization of

birth that in many people's minds, there's just no other "safe" way to do

it. (MommaBear)

The next poster refers to television shows, describing the negative and often misleading influence they have on birthing decisions:

Our culture is heavily biased toward birth being an emergency - and who

can blame those who haven't really done the research - a few episodes of

"a baby story"[2] and anyone would think the same. (Elizabeth)

This poster describes inadequate education and in so doing offers a critique of the sources of information, seeing television programs as deficient learning devices.

---

[2] "A Baby Story" is a current TLC television series documenting the labour and delivery experiences of women – almost all being hospital births with some form of intervention.

Lastly, women choosing homebirth are doing so because they want to have the control over the birthing process, without medical interventions. Because of this, homebirthers seek to find information that will prepare them as much as possible for the birth process:

> I want to avoid all the needles and medication and deliver on my own
>
> terms. I have begun searching for books for reference on this subject and
>
> looking forward to learning as much as I can about delivering naturally.
>
> (Martha)
>
> I still have plenty of research to do, so any tips or advice would be
>
> appreciated! ☺ (elissa44)
>
> We had done our research, made our plan, took a crazy intensive 40+
>
> hour birthing class – I had no interest in other peoples uneducated
>
> opinions or criticism. (Alize4u)

These postings illustrate how the online homebirth forum writers encourage education on the subject and take pride in being educated. As Cheyney (2008) notes: "…homebirthers rely on and value multiple forms of knowledge during the childbearing year, and these are often seen as complementary" (259). Along with tangible knowledge there is also the embodied knowledge, or authoritative knowledge that women possess within themselves to make their decisions, as Cheyney (2008) describes:

> Although the acquisition of formal and informal knowledge through
>
> books and story sharing played a role primarily during the prenatal
>
> period, intuition, or "body knowledge," was discussed almost exclusively
>
> in the context of labor, delivery and the immediate postpartum periods.
>
> Mothers mentioned multiple forms of, or terms for, concepts like instinct,

intuition, and embodied knowledge as a means of describing knowing

that was not intellectual, rational, or logical, but more bodily and

experiential. (258)

Education as well as textbook, classroom, and clinical literature work in tandem to help

the mother make the most appropriate decisions. A number of women write that they understand

– should the need arise – that hospitals can help them deliver safely in an emergency situation.

As one forum writer states,

We also put a hospital bag together and I assured DH [dear husband] that

it wasn't set in stone and we could go to the hospital anytime. And if my

MW [midwife] recommended we go, then we would go - no questions or

hesitation. (scientist)

Knowing that hospitals are available to help in an emergency situation is indicative of the

authoritative knowledge to consciously and clearly make educated decisions in order to ensure a

safe delivery for mother and baby.

3.7 Power, Home and Control

The concept of power and the empowerment experienced by women who have a

homebirth are central to conversations – particularly those regarding homebirth experiences –

within the posts. Strongly linked to the concept of power is the notion of choice. This research

found that, within the homebirth forum, the ideology of power and the concept of choice are

interwoven in a complimentary approach so as to be inseparable within the discourse of the

homebirth community. Authoritative knowledge, a key concept defined by Brigitte Jordan

(1978, 1997) is understood to be the knowledge found within individuals to make the choices

that they feel is right at the time and to do so knowing full well the consequences of these

choices. As Jordan's research found:

> One kind of knowledge gains ascendance and legitimacy. A
>
> consequence of the legitimation of one kind of knowing as authoritative
>
> is the devaluation, often the dismissal, of all other kinds of knowing.
>
> Those who espouse alternative knowledge systems then tend to be seen
>
> as backward, ignorant, and naive... (Davis-Floyd and Sargent 1996: 113)

The dominant ideological trend of medicalized birth in Canada deems what type of birth

is appropriate by devaluing homebirthers and their choices as previously discussed. The

medicalized hospital birth rarely affords the patient the ability to make choices regarding the use

of interventions.   This results in a sense of disempowerment, emotional damage, and an overall

negative birth experience. As Lazarus notes, "in biomedicine, control is limited by the power

held by the medical profession...because the doctor-patient relationship is asymmetrical, power

becomes domination" (1994:30). There is a clear connection to Lock and Scheper-Hughes'

theory on the body politic because it asserts that individuals within the social body are controlled

by the dominant political body.

Penny Simkin (1991) explores women's experiences of birth over a 20 year period to

examine how positive or negative experiences had long-lasting effects. She found that women

who had positive birth experiences felt a sense of accomplishment and greater control than those

with negative birth experiences. All of the women in Simkin's study claimed that control was an

important issue: "...highly satisfied women tended to feel in control, those in the less satisfied

group still recall having little or no control" (1991:27) Control also emerged in the homebirth

postings. Women write that within the home they feel empowered and in control:

I feel like at home you have soooooooo much control and you have all

your stuff handy and you're in your own space. At a hospital someone

else is in control and you're kind of at their mercy. (PregnantinCanada)

I am completely convince[sic] the women at home are more in control

and have better births in general. (SnowBunny)

Am I the only person in the world who finds the prospect of a hospital

birth more nerve-racking than a homebirth? I'll be in my own space with

control over my environment and the ability to really calm and center

myself. Anything can happen in a hospital, you can have any kind of

doctor and any kind of nurse and interventions are more common in

hospitals. (HopingHealth)

[The midwives] let me be in control of my own labour and delivery and I

am so grateful for that. (Team_Mom)

I think the best thing about midwives and home birth is that you are in

the drivers [sic] seat to make informed decisions all along the way.

(MommaBear)

   In one comment, a homebirther writes that her husband, who was apprehensive about a

hospital birth, felt more control and empowered in the home environment as she states:

...he felt very empowered and helpful being in his own environment and

being able to pull things together with the MWs [midwive's] at the last

minute. At the hospital he believes he would have felt uncomfortable and

powerless/helpless. (MommaBear)

These examples highlight how the home is inextricably linked to power and control. Metaphors such as "in the driver's seat" represent the control that *MommaBear* had in her homebirth experience. The control that homebirthers have at home over their own birthing situations strengthens their ability to make choices which they feel are best for themselves and their babies. MacDonald (2006) writes that women are "naturally capable and strong, their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and the interventions of physicians in a hospital setting" (236). Harnessing the natural power of the female body and accepting birth as a normal function - instead of a medical situation - homebirthers assert their own authoritative knowledge to give birth the way they feel is best. By doing so, they are challenging prevailing cultural norms and demonstrating the fact that women are strong, and capable. Cheyney further reinforces how authoritative knowledge "...combined with lived experiences of personal power and the cultivation of intimacy in the birthplace fuel homebirth not only as a minority social movement, but also as a form of systems-challenging praxis" (2008:254). As Lock (2001) notes, "...the coproduction of biologies and cultures contributes to embodied experience, which, in turn, shapes discourse about the body" (478). Women seeking homebirth are collectively embodying an alternative knowledge in opposition to the mainstream medicalized birth environment. Rejecting notions of the body as a "broken machine" (Martin 1987,1992) that only medical interventions can fix, homebirthers are re-inscribing the body as powerful and capable, ultimately transforming the current discourse which tends to view the female body as broken. The home, for homebirthers, symbolizes the power and control not always found in a hospital setting. Embracing their own authoritative knowledge about how they want their birth experiences to be transcends normative values predominantly experienced with hospital births.

3.7.1 The Power of Comfort

Comfort was another main concept found within the forum and the home seemed to be a symbolic representation of the need for relaxation and peacefulness during labour and pregnancy. A number of the women write that they were happy to be able to lay in bed curled up with their newborn, instead of lying in a hospital bed:

> Best part was not having to transfer anywhere at any point in the labour,
>
> and being comfortable and in control (as much as possible!) as well as
>
> snuggling into our own bed with new baby immediately after birth.
>
> (MommaBear)
>
> Being able to go freely between my own bedroom and bathroom and
>
> have my husband crank some great tunes was just what I needed during
>
> labour. I felt less self conscious and more comfortable at home.
>
> (Sabrina)
>
> He was born at 12:45am on March 26 in the comfort of my own bed!
>
> (sasha1983)
>
> But the chances are pretty good that you'll be sleeping in your own bed
>
> an hour or two after your baby is born with your little one snuggled in
>
> your arms. (Cupcake)
>
> I still can't believe I had an unmedicated home birth! It was so nice to
>
> cuddle in bed afterwards. The midwives have been visiting us at home, so
>
> we haven't had to venture outside at all. (Global360)
>
> I chose homebirth with baby #3 just for the privacy and respect I would
>
> receive in my own home. (JT5566)

From these posts it is clear that many homebirthers associate the home as the ideal for comfort, control and privacy. For example, *Global360* makes reference to being able to "cuddle" with her newborn in her own bed, right after the birth. For *JT5566,* comfort can be characteristic of privacy and respect which she received in her own home. It can be understood then, that the hospital setting represents discomfort, lack of control and no privacy. Power and comfort are two dominant and important criteria for women choosing to have a homebirth. Possessing the power to control situations allows for women to feel comfortable in their environment. As this research has found, power and comfort are interlinked with regards to homebirth. This point is reinforced by Johanson and Newburn (2001) who argue that "mothers' overall satisfaction with the experience of childbirth is influenced by availability of choice and the sense of control" (1143). As previously illustrated, embracing the authoritative knowledge to know that a homebirth is the right choice evokes a strong sense of empowerment in the women. By utilizing this knowledge and power, homebirthers ultimately make the choices that they feel are best for themselves and their babies, even if it means challenging the current ideological principles of the medicalized model of birth.

3.8 Homebirth as Resistance

As their on-line posts illustrate, homebirthers are resisting the idealization of medicalized births, even though they may not consciously be associating homebirth as a form of resistance. Cheyney (2008) regards homebirth as a "systems-challenging praxis" (254), in that homebirth in and of itself is a challenge to the cultural birthing norm. She states:

> Through the identification and voicing of discontinuities between
>
> experience and desire, the quest for reconciling versions of alternative
>
> birthing knowledge that honor embodied and experiential ways of

knowing, and the co-construction of authoritative knowledge via

informed consent, women who choose to birth at home with midwives

create new realities and explanatory models around childbirth. These new

realities are constructed through overt challenges to public and

metanarratives, as well as through direct action when women choose to

birth at home as an act of resistance and systems-challenging praxis.

(2008:259)

Education is key in developing this praxis:

Through the acquisition of knowledge and the lived experience of

personal power in birth, women who choose to deliver at home with

midwives claim a subjugated discourse as real and, in doing so, reject the

implicit claims of the dominant discourse or public narrative that backs

hospital birth. (Cheyney 2008:260)

The rejection of the dominant ideology of birth is unique because homebirthers are

freeing themselves from the cultural norm and allowing their own authoritative knowledge to

lead them to the most appropriate decision for their choice, yet they are marginalizing

themselves from the cultural ideal by choosing the homebirth model, therefore leading to the

perceived stigma experienced by many homebirthers.

As Davis-Floyd (1994) argues, the majority of practitioners and specialists disapprove of

homebirth because: 1) they are no longer in a position of power over the birth; and, 2) they

regard birth as a medical procedure that requires intervention. Cheyney (2008) reinforces how

homebirth defies the cultural norm: "the decision to birth at home is embedded in a refutation of

a public narrative (the medical model of childbirth) and a challenge to obstetricians as

indisputable experts" (257). Homebirthers are not explicitly stating their resistance to the dominant medical model of birth; rather they are expressing it through a reliance on their own authoritative knowledge and choosing a homebirth. It is this form of praxis, or embodiment, of the homebirth ideal that connotes resistance to the greater hegemonic ideal of hospital birth.

3.9 Chapter Summary

The representation of home differs from one individual to the next but, for homebirthers, it generally represents a place of security, comfort, cleanliness and ultimately a sense of control, as demonstrated throughout the postings. Women are choosing homebirth because they want to avoid unnecessary interventions, have control over the choices they are making, and be comfortable in their own space. Comfort, control and choice are central to the homebirth dialogue and, by embracing their own authoritative knowledge, the women are empowering themselves to create their ideal birthing experiences. The concept of embodiment is critical within the homebirth process as homebirthers are re-inscribing their bodies as being powerful and capable, as opposed to the technocratic and medicalized inscription of the female body as incapable and broken, therefore needing medical intervention.

For homebirthers, education is paramount and they educate themselves so that they can make informed decisions throughout the homebirth process. The stigma surrounding homebirth marginalizes homebirthers and this is apparent throughout the postings. By challenging the medicalized ideology of birth, homebirthers inevitably cast themselves as different, or apart from mainstream birth culture.

CHAPTER 4
COMMUNITY

4.1 Defining Community

Women who choose homebirth rely on support networks – such as an online resource – to share, educate and interact with like-minded individuals. Homebirthers represent an individual body which transcends normative values with the help and support of their interaction with the social body – the *BabyCenter* homebirth forum group. By drawing on their own authoritative knowledge, homebirthers seek alternative sources for information and support for homebirth issues. They do so for two main reasons: 1) the homebirth social group is that of a minority so resources are not readily available; and 2) homebirthers seek like-minded individuals to create a support network because their decisions are not always supported by those who adhere to the mainstream medicalized idealization of birth.

The way in which community and cyberspace are interlinked is important to medical anthropology because it allows anthropologists to understand how community is understood in an online context. To study a community without being physically present is a relatively new technique and this project demonstrates the effectiveness of cyber-mediated community research. The intent of this chapter is to describe how community is created within an online forum - specifically, how homebirthers create and sustain a cyber-mediated community - as well as to examine how the internet is an ethnographic site that, although not widely used in medical anthropological research, is a very important one. Lastly, issues of embodiment in an online context will be explored and how this is important to the way women empower themselves through cyber-feminism and technology.

Online forums provide a venue where women can educate, support and encourage one another to harness their own distinct sense of a homebirth community in an overtly medicalized

society. Hendricks (1988) suggests, "...ideological structures are created, in part, through discourses, defined as modes of talking related to [a] specific area of social life" (216). Through the simple act of typing posts, women are invariably creating and defining their own ideological structure of a homebirth community. By sharing research, experiences and advice, the women in the forums create a strong bond as a homebirth community. In turn, women are able resist the medicalization of maternity and maternal care. The four-part definition of community that I am using in this thesis is drawn from McMillan and Chavis (1986):

> The first element is *membership.* Membership is the feeling of belonging
> or of sharing a sense of personal relatedness. The second element is
> *influence,* a sense of mattering, of making a difference to a group and of
> the group mattering to its members. The third element is reinforcement:
> *integration and fulfillment of needs.* This is the feeling that members'
> needs will be met by the resources received through their membership in
> the group. The last element is *shared emotional connection,* the
> commitment and belief that members have shared and will share history,
> common places, time together and similar experiences. (9, original
> emphasis)

Applying this definition of community to my sample of postings, it is apparent that women who participate within the *BabyCenter* online forum adhere to all of these elements which constitute the development of an online community. Homebirthers are identifying themselves as a distinct community within the broader context of birth. Gupta and Ferguson (1997) argue that communal and individual identity is connected to the concept of exclusivity:

Identity and alterity are…simultaneously in the formation of 'locality'

and 'community'. 'Community' is never simply the recognition of

cultural similarity or social contiguity but a categorical identity that is

premised on various forms of exclusion and constructions of otherness.

This fact is absolutely central to the question of who or what it is that

'has' such identities (a group? an individual?), for it is precisely through

processes of exclusion and othering that both collective and individual

subjects are formed. (13)

I have discussed how the stigma of homebirth has marginalized many women and, for the

homebirthers, it is this exclusion that also brings them together in a collective social capacity.

The dominant ideology of birth does not coincide with their desired birth experiences, thus they

seek alternative avenues to find other women with similar desires. The following two sections

build upon the notion of community and how women develop and sustain a homebirth

community within a cyber-mediated context.

4.2 A Community of Support

Support from others within the homebirth postings is imperative for creating the

foundations of community. It was apparent throughout the homebirth posts that women

appreciated the communication with one another and felt as though they belonged to a group of

other like-minded individuals. Flueriet (2009) finds that, "emotional support is comprised of

offers and expressions of love, caring and encouragement...and informational support is any

'advice, information, or guidance' given to the pregnant woman" (50). Evidence of both

emotional and informational support is abundant throughout the posts. Derks et al. (2008)

suggest that computer-mediated-communication (CMC):

makes it possible to find similar others who share specific interests or

emotional needs, and it is as convenient to share emotions with these

others as it is with friends in real life, resulting in the development of

new close and intimate relationships in CMC. (772)

One of the unique aspects of CMC is the ability to use emoticons (emotion-icons) to

provide an emphasis of expression within the posting. Within this research project I have

interpreted the emoticons as being transparent, and there could be underlying complexities that I

did not engage with in this thesis. The homebirth postings are often punctuated with the use of

emoticons – such as winking, and smiling faces, hearts, as well as hugs and kisses (xoxo). As

described by Derks et al. (2008):

Emoticons can be considered a creative and visually salient way to add

expression to an otherwise strictly text-based form. In the same way as

non-verbal cues in F2F [face-to-face], emoticons also help to accentuate

or emphasize a tone or meaning during message creation and

interpretation…they help to communicate more clearly a current mood or

mental state of the author…thereby also providing additional social cues

about this person. (777)

Exclamation marks are also commonly found features and generally lead the reader to

assume that the writer is excited, happy, or offering additional emphasis. Many of the women

share that they are glad for the support they receive and also encourage support. For example,

one homebirther writes:

Thanks everyone for the support and advice. No matter what anyone

says, I'm going to do what I feel is best, and what I'm most comfortable

with. I'm lucky to have such a supportive partner and mom, it's the in

laws I feel the need to win over! So glad I found this group ☺ (coolmom)

This excerpt illustrates how the homebirther is glad she found the forum group, particularly for the advice and support she received. As examined earlier, support networks for the decision to have a homebirth are often hard to find and many of the women write about how the homebirth forum group is very supportive. A sense of membership and inclusion, as called for in McMillan and Chavis' (1986) definition of community, emerges clearly here. Another homebirther writes:

At least the other homebirth mamas on this board will always support

you! ☺ (Cabin_Days)

At the end of this message - and the previous post - is a smiley face emoticon indicating that the homebirther is happy. Other references of support from the women include:

Reading this post was so encouraging! I look forward to receiving

support from everyone here in the coming months! (RacingMomma)

I feel like I chose the right decision for me and I wanted to extend a big

thanks to all of you who offered great tips and opinions that were such a

huge help! (Martha)

The other ladies on here have been equally supportive and amazing! I

appreciate all the encouragement and I'm keeping my fingers crossed too!

(Martha)

The home birthing community is such an amazing group of like-minded

women and I'm glad to be one of you :) And to those of you who haven't

yet had your home birth, I can't wait to read your stories - its going to

change your life forever and for the better! (Amanda81)

These passages reflect the importance the homebirth group has to women by being supportive and encouraging. All posters are unique in that they offer a temporal context. *RacingMomma*, for example, anticipates future encouragement and support and includes a perceived time frame in her post which leads to the belief that she will be invested in the homebirth community for at least a couple of months. Reading the other posts written by homebirthers ultimately made a difference to her, demonstrating the influence a community can have on a person. *Martha* writes about both the past and present support from the forum, and she recognizes the importance of the advice and tips in other posts. McMillan and Chavis' (1986) third requirement of community – an integration and fulfillment of needs – is met by this kind of supportiveness.

Amanda81 makes a direct reference to the homebirth forum as being a "community" filled with "like-minded" individuals. This portrays that she feels involved in and part of a specific group. Likewise, she offers stories from other posters and encourages homebirthers to write in. As well, her post includes a smiley-faced emoticon and exclamation points, indicating that she is happy and excited. It can also be presumed that the homebirth group represents stability in what may be a very unstable time. As *Krissy29* wrote:

I felt like nobody understood how I was feeling so I came here in the

hopes of finding people who might understand. I'm not looking for

sympathy, I just want someone to tell me they get why I feel the way I do

for a change.

Searching for the connection that she is unable to find in her life outside of CMC,

Krissy29 came to the homebirth forum seeking individuals who share similar experiences, like-

minded individuals with whom she can share and interact with at a time when no one else will.

Also, she came to the homebirth forum seeking a connection with others who can empathize with

her situation. Accordingly, McMillan and Chavis (1986) regard shared emotional connections as

the final element in their definition of community. Thus, throughout the preceding posts it is

evident that homebirthers have created a sense of community as based upon McMillan and

Chavis' definition.

The following posts represent how group members are receptive to, and encourage

updates and future details from each other. The use of exclamation marks exhibits excitement,

inferring that the posters are emotionally invested in their texts to one another:

> Yippee - way to go!!!! I'm so glad you are keeping us up to date!
>
> (MommaBear)
>
> So have a wonderful birth and tell us all about it! (Elizabeth)
>
> Good luck to all you ladies still waiting! It really is a beautiful
>
> experience! I feel so lucky that our home water birth went as planned,
>
> safe, with no complications. It was the best decision I've made.
>
> (NovaStar)
>
> Good luck! Feel free to post any other specific questions or concerns.
>
> There's no such thing as TMI [too much information] on these boards, as
>
> I've learned and am thankful for! 😁 (Brittany)

Homebirthers express themselves in a friendly and encouraging manner. The use of

exclamation points in *MommaBear's* post symbolizes that she is elated by the fact that the other

poster has had her baby. *NovaStar* and *Brittany* both use exclamation points and smiley-face emoticons for emphasis. Derks et al. (2008) relate that even though CMC may not provide what face-to-face communication can in terms of emotion, it can still convey highly emotional messages through text symbols – such as exclamation marks:

> We assume that reduced visibility of emotions strengthens emotional
>
> style and content, and makes it easier to express emotions, especially
>
> when individuals find it difficult to express them in real life. It may be
>
> more difficult to recognize emotions with reduced visibility, however,
>
> especially when they are not very intense. Yet, the more explicit nature of
>
> text-based emotion displays may make up for this difficulty. (769)

Derks et al. (2008) also point out that, "various authors have also suggested that women's more frequent non-verbal displays, especially smiling, could be reflected in a more frequent use of emoticons" (777). As reflected in the posts, there is strong evidence of the use of emoticons and exclamation marks within the homebirth forum.

These examples portray the community of support upon which women choosing homebirth rely to help make informed decisions and embrace the feeling of acceptance within the prevailing medicalized culture. Confronted with dominant expectations of hospital and medicalized birth, homebirthers discursively seek out members in society who harbour similar beliefs and attitudes toward the birth process as their own. Importantly, communicating in a text-based environment can elicit similar emotional responses as though the community were physically present.

4.3 Community

This research is unique in that it has relied on the use of cyberspace to understand a very corporeal experience that women encounter: birth.   In this section I explore how the internet is a valuable ethnographic site not primarily used by medical anthropologists in order to better identify current issues within social health research. As Arturo Escobar articulates, anthropology and science and technology studies (STS) have become increasingly integrated in recent years and ethnographic works range from "...studies of reproduction and medical technologies, gender and science...virtual reality, virtual communities and cyberspace" (2000:59-60). Therefore, understanding how the internet is a viable instrument for ethnographic projects is important. The discussion in this section focuses on the definition of "virtual community", the ways in which the internet is used by homebirthers as an educational resource, the dynamics of support that take place within a virtual community, and the distinction between "real" and "virtual" interaction.

The homebirth community is comprised of women who, at a particular stage in their life, seek commonality in others regarding their particular needs and wants. These common interests include, as described earlier, the desire for education, advice, and support. As defined by Snyder (2006) "a community is people who have greater things in common than a fascination with a narrowly defined topic" (92). Although this research rests on the definition of community as set out at the beginning of this chapter, the definition of community is difficult to fully ascertain as Mitra (1997) argues:

> It is relatively difficult to (and perhaps fruitless) to arrive at a definitive
> description of community because that itself is a provisional construct
> changing in meaning as new technologies of communication
> evolve...what remains constant, however, is the notion that communities
> require interaction and involve people. (56)

Regardless of the definitional challenges, this research is premised on the fact that the

foundations of a community rest on the individuals interacting on the basis of a discernable or

perceived commonality among them. Authoritative knowledge is central to this concept of

community as Davis-Floyd and Sargent (1996) note: authoritative knowledge "is the knowledge

that within a community is considered legitimate, consequential, official, worthy of discussion,

and appropriate for justifying particular actions by people" (113).   Benedict Anderson (1983)

suggests that "communities are to be distinguished not by their falsity/genuineness, but by the

style in which they are imagined" (15). To this, Watson (1997) adds that by focusing on the term

imagination, "the judgement of community is rightly returned to the minds of the participants

involved rather than their detached observers" (120). Reinforcing this point, Fox and Roberts

(1999) conclude that "the debate about whether cyberspace interactions amount to 'community'

fractures along lines of whether community is to be seen as real and essential, or as a social

construction dependent on imagination" (644). For the homebirth community, the online

construction of their experiences is an amalgamation of a real and imagined community; it is

constructed by the homebirthers to play an essential role in their life which is not being filled by

the "real" world. Yet the constructed online community plays a very real and tangible role in the

lives of those who engage in it. The members are not only connected by a common theme but

they also perpetuate those connections by showing support for one another through, among other

things, being empathetic to other members' situations. They feel as though they belong to the

homebirth community and, as previously exhibited, they are grateful to have found a supportive

and understanding social group.

Watt et al. (2002) suggest that CMC "...can take a very real position in people's lives"

(61), particularly for individuals who are stigmatized or have unconventional beliefs. An online

community group often enables the support needed to overcome issues and gain acceptance. Homebirthers are frequently stigmatized due to their beliefs and choices surrounding birth; therefore, the online homebirth community creates a support network on which the women can rely. As Gupta and Ferguson (1997) remark:

> Rather than conceptualize resistance in a disembodied duel with power, we would like to emphasize a little-noted aspect of it, which clarifies the connection with place making and identity. That is, we find it useful to think of resistance as an experience that constructs and reconstructs the identity of subjects. Resistances, as Foucault insisted, 'produce cleavages in a society that shift about, fracturing unities and effecting regroupings, furrowing across individuals themselves, cutting them up and remolding them, marking off irreducible regions in them, in their bodies and minds. Just as the network of power relations ends by forming a dense web that passes through apparatuses and institutions, without being exactly localized in them, so too the swarm of points of resistance traverses social stratifications and individual unities'. (20)

The homebirthers are essentially place-making and identifying themselves as a unique group because of their resistance to the dominant hegemonic ideology of birth. A study conducted by Nettleton et al. (2002) revealed that more women than men rely on the internet for social support, particularly with regards to health-related related issues seeking commonality from others. Nettleton et al. also concluded, "...the internet provided an opportunity for social exchange, comfort, laughter, and encouragement within what many perceived to be a supportive environment" (183). Within the homebirth postings many of the women write that they are glad

to be in such a supportive environment, perhaps suggesting that those outside the homebirth community are less supportive.

4.4 Internet as Ethnographic Site

The role of the internet in ethnographic research is, according to Arturo Escobar (2000), not new. What is new, however, is the way science and technology studies (STS) are becoming more prominent within the sphere of the social sciences, including anthropology. The blurring of boundaries between STS and medical anthropological inquiry allows new opportunities for scholars to pose questions no longer defined by traditional ethnographic parameters. Escobar (2000) believes that:

> [STS] fosters exchange between anthropologists and other disciplines
>
> involved in STS, such as philosophy, cognitive science and
>
> linguistics...the proper task for an anthropology of science and
>
> technology is to examine ethnographically how technology serves as
>
> agent of social and cultural production. (60-61)

This research project relied on cyber-technology to understand how homebirth community is constructed and sustained. Women seeking a social group suited to their current ideological framework of birth utilized the forums to educate and encourage each other despite the lack of face-to-face interaction. This is, however, juxtaposed between the use of internet technologies and an online homebirth community. The homebirth community is resisting the medicalization of birth yet embracing a technologically-mediated community dedicated to natural and anti-technologized birthing. As Escobar notes, "while nature, bodies and organisms certainly have an *organic* basis, they are increasingly produced in conjunction with *machines*...the organic...is not necessarily opposed to the technological" (2000:62). Therefore, it

can be established that even though members of a society are in opposition with a certain technological structure, it does not mean that they are dismissive to all technologies present. The internet allows women the access to social networks in which they can embrace the homebirth attitude. As Escobar (2000) explains, using the internet as an ethnographic site allows for an in-depth understanding of social processes and discourse not visible without the use of cyber-technologies. As noted by Miller and Slater (2000), "the idea of an Internet ethnography has come to mean almost entirely the study of an online 'community' and relationships – the ethnography of cyberspace" (21).

Evidently, this research project lies at a critical intersection for bridging the gap between cultural studies and technology, thus affording insight into health issues not widely attainable in traditional ethnographic approaches. Kleinman (1977), speaks of how clinical anthropology is essential for medical anthropologists. By taking the term 'clinical anthropology' and replacing it with 'cyber-technologies', Kleinman's point is still valid in that the use of technology as an instrument to further understand the health-seeking behaviours of individuals is imperative to medical anthropological inquiry. As Kleinman states, "its relevance for studying the impact of cultural beliefs and social networks on the utilization of health services is unmistakable" (1977:12). Indeed, medical anthropological engagement with a technologically-based community has provided an understanding of how Canadian homebirthers represent their birthing choices as well as the broader medical system.

4.5 Boundaries in Cybercultural Communities

The online posts examined in this thesis indicate that the individual body interacts with the social body – the homebirth forum group – in a cyber-mediated capacity. Allucquere Rosanne Stone (2000) suggests that "...boundaries between the subject, if not the body, and the

'rest of the world' are undergoing a radical refiguration, brought about in part through the mediation of technology" (517). The individual body is interacting with the body of technology to create a hybrid sense of the self. The body is present, but in a liminal state as it interacts with others "there" but not in the physical sense. Sadie Plant (2000) recognizes that cyberfeminism is important for women and affirms that:

> …complex systems and virtual worlds are not only important because
> they open spaces for existing women within an already existing culture,
> but also because of the extent to which they undermine both the world-
> view and the material reality of two thousand years of patriarchal control.
> (325)

Not only are women empowering themselves by creating an online space where they feel a sense of understanding, they are undermining the patriarchal control and the ideological, technocratic and medicalized health care system. As Victoria Pitts suggests:

> Debates about the Internet in feminism and cyberstudies have focused on
> to what extent 'cybersubjects' are free to create new identities,
> relationships and communities in virtual , disembodied space or, put
> more simply, how and to what extent they are empowered by virtual
> technologies. (2004:34)

This research has found that women are, in fact, creating a sense of empowerment for themselves by utilizing the internet as a space for opportunities to interact with and build upon communities that fit into their societal needs. Pitts (2004) states, "cyberspace has been imagined as a liberatory realm where women can transgress gender roles, invent selves and create new forms of knowledge" (33). Crossing the boundary from the "real" to the "virtual" enables

homebirthers to acquire a new reality where their opinions matter and their feelings are considered. This can be understood as a form of resistance against the hegemonic ideology of medicalized birth, however it may not be considered a form of conscious resistance – an intentional resistance.

Donna Haraway's (2000) conceptualization of the cyborg body as produced through technological advancements and salient cultural metaphors speaks to and strengthens the conceptualization of blurred boundaries between the body and technology. Haraway believes that:

> The machine is us, our processes, and aspect of our embodiment. We can
> be responsible for machines; they do not dominate or threaten us. We are
> responsible for boundaries; we are they. Up till now...female
> embodiment seemed to be given, organic, necessary; and female
> embodiment seemed to mean skill in mothering and its metaphoric
> extensions. (315)

Not only are women embracing the authoritative knowledge to empower themselves as individuals, they are interacting with technology in a way that makes their separation from computer technology impossible. To reemphasize an earlier point, the homebirth group seeks to attain a birth with the least amount of technological intervention necessary, one based upon nature and being "natural" a very corporeal experience. Yet, by utilizing the homebirth forum they are entrenched in a technological community, a seemingly technological embrace juxtaposing nature and technology.

CHAPTER 5
CONCLUSIONS

5.1 Summary of Key Findings

This research has examined the representations of homebirth in Canada from a critical medical anthropological perspective. The examination of homebirth from a historical perspective allowed for a greater understanding into the patriarchal regimes that medicine has created since its inception. What was once a very woman-centered practice became dominated by medical technology, androcentric physicians, and patriarchal authority. Women's bodies were no longer seen to be capable of birthing without the assistance of medical interventions. The hegemonic medical system, advanced as the only "right" choice for childbirth, permeated Western culture so much that those who opt not to engage in a medicalized birth are viewed as pathological and "crazy". Understanding how the individual body, social body and body politic interact with one another led to an understanding of embodiment process for women seeking homebirth advice in a cyber-mediated context. The individual woman seeks the experience of a homebirth, while interacting with the social body – that of the homebirth forum group – allows for affirmation and acceptance of the embodied choice for homebirth, while defying the political body of medicalized hospital births. Importantly, women are not necessarily opposed to hospital births - they recognize that if medical attention is needed they will seek it - but they embrace the ability to exercise their own power and choices which inevitably brings comfort, a desired factor that home birth provides.

Following the methodological approaches of Obermeyer (2000), Simkin (1991), Basso (1990), Hendricks (1988), and Eckert (1992) to undertake a content analysis of a homebirth forum, I found that comfort, choice, education, and power are recurring concepts significant to homebirth mothers. Being educated about homebirth and accepting advice and information are

important to homebirthers because they can make informed and educated choices about their birthing plan. The concept of choice, and having the ability to choose where to birth, with whom, and the type of birth empowers women. With almost all homebirthers, comfort was represented as being incredibly significant. Comfort is discursively associated with the women's education, choice and power. Homebirthers resist the medicalized ideology of birth by relying on their own authoritative knowledge and trust that their bodies are capable of birthing without medicalized intervention. The women, therefore, reject the medicalized version of childbirth. The choice for homebirth often carries with it stigma, largely caused by a lack of education on the topic among those not within the homebirth society. This stigma has negative repercussions, both mentally and emotionally, but with the support from others on the forum the women find solace and support.

The homebirth community is evidently very supportive; the forum that is the site for this research is filled with positive praises, advice and educational resources. There is evidence of solidarity among the members as they encourage replies from others and incorporate timeframes regarding how long they will be participating in the community. Within the larger hegemonic cultural context where medicalized birth is an idealized norm, the homebirth community is marginalized but seeks to define itself despite the prevalence of hospital births (Nettleton et al., 2002).

Although the strict definition of community is contested (Mitra, 1997), the major components of a community are comprised of like-minded individuals with a common goal. Therefore, the online forum is indeed a community created by a group of women and sustained through their common goals of homebirth, and to celebrate homebirth experiences. Ironically these women are sharing advice and experiences about a very corporeal experience, while

utilizing technology as a venue to do so. This leads to the construction of boundaries and embodiment in cyberspace.

A hybrid sense of self is created when bodies and technology interact. In a homebirth forum, the women are interacting with technology to empower their physical bodies without ever making "real" (face-to-face) connections with the individuals with whom they are exchanging conversations. Haraway's (2000) conception of the cyborg body strengthens the argument of the inseparability of nature and technology. The body becomes a vessel upon which technology is played out, particularly in terms of computer-mediated-communication.

The internet as an ethnographic site is pertinent for conducting cyber-mediated medical anthropological studies as it provides a new venue for understanding social health problems. As Escobar (2000) notes, online ethnographic research is not a new concept but the ways in which STS and social studies are becoming more enmeshed in one another leads to different possibilities for understanding various social issues. This research project examines an online homebirth forum from a Canadian perspective to provide insight into why women are choosing homebirth methods and how community is created and sustained online. As such, it offers a unique insight into the homebirth discussion.

5.2 Research Limitations

This research project focused on one homebirth website to explore how women express their birthing choices vis-à-vis dominant cultural emphases on medicalized and hospital-based childbirth. One on-line forum is not necessarily representative of all and therefore the results of this study are limited in scope and generalizability. It is uncertain whether or not all women who choose homebirth do so for reasons demonstrated throughout this study, but the primary goal

was to show how one group of online homebirthers leverage the same cultural logics in representing their own birthing choices.

Using the internet as a site for ethnographic research could pose potential problems due to the lack of face-to-face communication, consequently there is a level of uncertainty about the true identity of those in the forum group. As Fox and Roberts (1999) note, "such perceived virtual features of a person may be wildly inaccurate as a consequence of the medium's anonymity" (646). MacKinnon suggests (Fox and Roberts, 1999) that "on-line interactions are conducted by 'personae' and that the actions and feeling expressed in postings may not be mirrored either physically or symbolically by their creators" (646). Therefore, a margin of error exists in that some homebirthers may not in fact be who they present themselves to be, which could lead to misrepresentations. It is presumed that the women are talking about experiences which they have personally had, but there still exists the potential for fabrication.

Some scholars, according to Miller and Slater (2000), claim that "the Internet appeared at precisely the right moment to substantiate postmodern claims about the increasing abstraction and depthlessness of contemporary mediated reality" (5). That is, according to some, the internet seems to be a chasm devoid of human embodiment and therefore lacking in cultural relativity and production. This research has found otherwise, that the internet generates and perpetuates cultural ideals not often present within dominant ideological systems. As Watt, Lea and Spears (2002) make clear "social psychological theories of new communication media from the telephone onwards have tended to downgrade or even deny the sociality of new media" (62). This could be in part because media technologies do not account for the actual physicality of human interaction, therefore it is seen as a lesser "social" system of communication.

In regards to community, Mitra (1997) believes:

Participation through the Internet becomes an individualized activity

where the 'human touch' is often lacking. Indeed it can be argued that

such humanization would detract from the notion of community because

it is antithetical to the way we have been naturalized to think of

communities. These arguments are central to technophobes who have

argued that technology is dehumanizing.... (56)

There will always be a debate surrounding whether or not internet and technologies make culture; or if they hinder cultural process and therefore destroy traditional social norms of interaction. This research has found that cultural constructs, such as community, are created in an online capacity, and for homebirthers this is a positive cultural construction. Traditional norms of communication are not destroyed, they are created and reinforced through the online homebirth community, thus taking a very real position in the participant's lives.

Another limiting factor within this research is that I was unaware of the underlying sociological variables that frame the identity of the women utilizing the homebirth forum. This included factors such as: socio-economic status, immigration status, ethnicity and sexuality. Undertaking a project in which the principal investigator has no interaction with the participants limits the amount of sociological knowledge obtained. Because I had no interaction with the homebirthers I was only able to obtain details which were divulged throughout the threads.

5.3 Contributions to Medical Anthropology

Throughout this research project I have noted the uniqueness of integrating medical anthropological research with an online cyber-mediated platform. As Marilyn Strathern describes, "interdisciplinary collaborations seem to promise innovation and creativity…interdisciplinary conversations hold out the hope of new sources of synergy"

(2006:201). Applying research methods that medical anthropologists are familiar with e.g. qualitative interviewing, participant observation, cross-cultural comparisons, and combining these with other disciplines – such as science and technology studies – allows the researcher to integrate non-traditional methods in order to solve modern health care issues.

I have relied on research from prominent anthropologists, feminists and sociologists who study the cultural complexities of birth. Applying Lock's (2001) concept of embodiment and incorporating this into Haraway's conceptualization of the cyborg body produces a blurring of physical and technological boundaries. Technology and anthropology meld in order to understand how homebirthers embody the homebirth community. Applying research concepts from various fields allows for new insights into contemporary phenomena.

Women appear to be joining online communities in order to get advice and encouragement for their homebirth decisions, to challenge the stigma they encounter, and – ultimately – to embrace the choice to be and become mothers on terms that they had a greater hand in setting. Future research could extend this study by exploring the impacts that online forums are having on maternal health movements and women's health care activism.

APPENDIX
THEMATIC RECURRENCES

Thematic Recurrences Found in Posts

1) Control

    a) Support

        i) Friends

        ii) Family

        iii) Midwives

        iv) Partners

        v) Homebirth posters

    b) Advice

        i) Education

        ii) From Others

        iii) Textbooks

        iv) Movies

        v) Classes

    c) Power

    d) Choice

2) Home

    a) Sanitary Conditions

        i) Clean

        ii) Own Germs

    b) Feelings

        i) Calm

        ii) Familiar

        iii) Relaxed

iv) Control

c) Choice

e) Intimate

f) Safe

3) Hospitals

   a) Sanitary Conditions

      i) Germs

      ii) Bacteria

      iii) Dirty

   b) Feelings

      i) Powerless

      ii) Lack of Control

      iii) Helpless

      iv) Scared

   c) Emergency

   d) Interventions

      i) Caesarean Section

      ii) Forceps

      iii) Drugs

   e) Unsafe

4) Online Community

   a) Feelings

      i) Happy

      ii) Glad

      iii) Empathy

      iv) Sadness

v) Disappointment

b) Advice

   i) Movies

   ii) Books

   iii) Research

c) Encouragement

   i) Praise

   ii) Luck

d) Understanding

e) Sharing

f) Emoticons

g) Literary Emphasis

h) Stigma

   i) Friends

   ii) Relatives

   iii) Co-workers

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