Why women freebirth: a modified systematic review

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Introduction

In the United Kingdom (UK) some women decide to opt out of National Health Service (NHS) or independent midwifery care and freebirth. A 'freebirth' is when a woman chooses to birth at home or in another non-medical setting, without a trained professional in attendance (Birthrights 2017a). Miller (2012:407) asserts that women who freebirth are a stigmatised group, stating that they are perceived as '*doubly deviant*' due to their choice to home birth and decline trained professional care. This can cause conflict between health care professionals and women (Feeley & Thomson 2016a). Feeley et al (2015) suggest that freebirthing increases the potential risk for morbidity and mortality in both mothers and infants, relating this to Loughney et al's (2006) findings on morbidity with births accidentally occurring at home without a trained professional present.

Freebirthing is not illegal in the UK and no woman can be forced to birth with a trained professional present unless she lacks mental capacity (Birthrights 2017a). There are no UK statistics on the number of women who choose to freebirth. However, the Association for Improvements in the Maternity Services (AIMS) (2020) reports that freebirthing rates and the number of women seeking advice regarding freebirth has increased since the COVID-19 pandemic. This increase is not just a UK phenomenon — the Australian College of Midwives (2020) reported that 3 per cent of 1000 women who were reconsidering their care were contemplating freebirth.

Feeley et al (2015:4) undertook a meta-thematic analysis to answer the question *'Why do some women choose to freebirth?',* finding minimal empirical research. They found four suitable studies from 2008–2012; none were UK-based. Data were analysed into four themes: rejection of medical and midwifery models of birth; faith in the birth process; autonomy and agency (Feeley et al 2015:6). These themes are similar to the findings of a subsequent scoping review (Holten & de Miranda 2016) regarding women's motivations for having either a freebirth or a high-risk home birth. Further research has been undertaken since these reviews, including UK research (Feeley & Thomson 2016b). This paper reports a modified systematic review; a method following the principles of a systematic review but more suited to small-scale

research (Aveyard 2019). The review continues to address the question '*Why do some women choose to freebirth?'*. It is hoped that this will enable further understanding of the experience, with some UK perspective, which has not been possible in a review on this topic previously. The results will hopefully inform contemporary maternity care.

Methods

Search strategy

The electronic databases Emcare, CINAHL, and MEDLINE were searched in December 2019. Keywords and phrases used included: 'freebirth*', 'unassisted birth*', 'unassisted home birth*', 'unassisted childbirth', 'unattended birth*', 'unattended homebirth*', 'birth* outside the system', 'free-birth*', 'do-it-yourself birth*', 'DIY birth*' AND 'wom?n', 'wom?n's', 'client*' AND 'choos*', 'choice', 'select', 'motivation', 'prefer', 'want', 'decide'. Due to limited results (CINAHL and Emcare had the largest number, at 14), and the sociological nature of the question, ASSIA, a database for applied social science (Aveyard 2019) was also used. Additionally, OpenGrey was searched in a pursuit for grey literature (Aveyard 2019). Reference lists of the research papers included were examined, together with the previously mentioned scoping review (Holten & de Miranda 2016) and meta-thematic synthesis (Feeley et al 2015).

Papers were included if they were qualitative primary research exploring the reasons women choose to freebirth, English language only, full text and less than 10 years old. A five-year limitation was initially applied but subsequently extended to 10 years, due to the scarcity of primary research.

Critical appraisal

Included papers were critically appraised using the Critical Appraisal Skills Programme (CASP) qualitative research appraisal tool (CASP 2018). Two papers were excluded at full text level due to quality; there was no or minimal discussion regarding aim, methodology, demographic, data collection, validation, ethics or data analysis. While the remaining eight studies all chose appropriate methodology for the aims of the research, there were varying limitations in recruitment methods and

demographics. In addition, validation and data saturation were not always evident. Table 1 outlines the basic characteristics of the papers reviewed.

Table 1: Summary of the basic characteristics of each paper reviewed.

Author, year, country	Theoretical framework	Sample size	Data collection
Brown (2009), United States	Grounded theory	n=9 All freebirth	Interviews
Miller (2009), United States	Grounded theory	n=127+6 All freebirth	127=freebirth narratives from the internet 6=interviews
Lundgren (2010), Sweden	Phenomenological life world approach	n=7 (4=freebirth)	Interviews
Jackson et al (2012), Australia	Qualitative interpretive study	n=20 (9=freebirth)	Interviews
Feeley & Thomson (2016b), UK	Interpretive phenomenological approach	n=10	Narrative reviews, interviews
Hollander et al (2017), Netherlands	Mixed methods	n=28 (7=freebirth)	Interviews
Lindgren et al (2017), Sweden	Reflective lifeworld	n=8	Interviews

Hollander et al (2017) and Jackson et al (2012) included data related to women with differing birth experiences (high-risk home births and freebirths), presenting the results in one paper. Hollander et al (2017) state that the motivations of both groups were so similar that assimilating them into one study was appropriate. Lundgren (2010) included both women who freebirthed and those who had a hospital birth as it included exploration of decision making when an attended home birth is not available in public health care. While it may be argued that only papers focusing solely on freebirth should be included for review, these studies were utilised due to the limited research available.

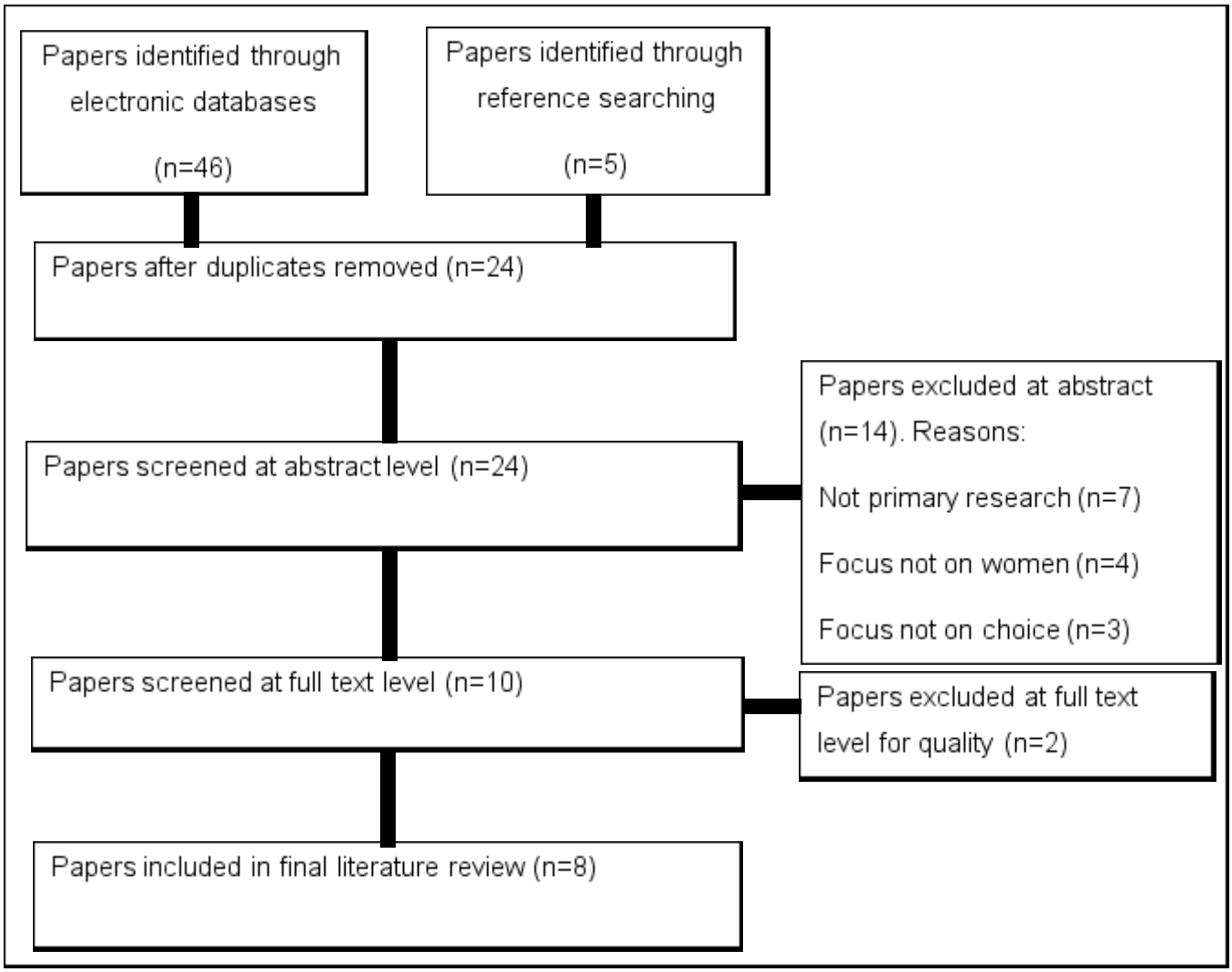
Qualitative method of analysis

Codes deriving from keywords or phrases were tabulated and subsequently themed (Aveyard et al 2016).

Findings

Eight papers satisfied all the criteria for inclusion (see Figure 1). Two papers were excluded at full text level due to quality: there was no, or minimal, discussion regarding aim, methodology, demographic, data collection, validation, ethics or data analysis. While the remaining eight studies all chose appropriate methodology for the aims of the research, there were varying limitations in recruitment methods and demographics. In addition, validation and data saturation were not always evident.

Figure 1: Flow diagram showing the paper selection process.



PRISMA developed from Liberati et al (2009).

Twenty codes were identified and formulated into four themes: rejecting maternity care; trust; power and spirituality.

Rejecting maternity care

Women frequently recognised that, within standard maternity care, risk assessments were carried out using a framework not corresponding to their perception of risk (Hollander et al 2017, Feeley & Thomson 2016b). Hospitals were perceived to have iatrogenic risks (Hollander et al 2017), a lack of emotional safety (Jackson et al 2012) and postnatal care that would negatively affect bonding and child development (Brown 2009, Hollander et al 2017), therefore freebirthing was the safest option (Miller 2009).

It was identified that maternity care is based on inflexible and impersonal guidelines and protocols that did not consider the individual woman (Brown 2009, Feeley & Thomson 2016b, Hollander et al 2017, Rigg et al 2017). Guidelines cause intervention, which women perceived to negatively affect natural birth by increasing stress and decreasing safety (Jackson et al 2012, Feeley &Thomson 2016b, Hollander et al 2017, Rigg et al 2017).

Power

Power was sub-themed into ‘addressing the power imbalance’ and ‘the power of the health care professional’.

Addressing the power imbalance

Women who freebirthed asserted it was the only way to have true choice, autonomy and responsibility for their decisions about birth (Hollander et al 2017, Lindgren et al 2017, Rigg et al 2017) enabling them to eat, drink and mobilise, which the system was seen not to allow (Brown 2009, Rigg et al 2017). Having a midwife present, even if known, would interrupt the birth process, preventing the woman from maintaining her power (Lindgren et al 2017), therefore the woman must become her own midwife (Miller 2009).

Feeley & Thomson (2016b) found some women discussed their choice in reference to negative life experiences, such as rape and mental health disorders, which made control a necessity. This aspect of power was only reported in this study. It could be

postulated that this is due to the researchers requesting an initial unstructured narrative account from each participant, enabling the women to consider and express their thoughts alone and without time constraints. The results were particularly robust as it was the only paper to attempt validation of results from all participants. Validity is important in qualitative research to ensure that the participants' truth has been accurately voiced and not distorted by the researchers' interpretation (Holloway & Galvin 2017).

In addition to discussion surrounding control and autonomy, partners were frequently recognised as being important in the power balance, whether by having power themselves and influencing the women (Miller 2009, Lundgren 2010, Feeley & Thomson 2016b) or by wholly accepting the woman's decision (Hollander et al 2017).

The power of the health care professional

Midwives and doctors were recognised as having power over women, explained through previous experience of lack of consent (Feeley & Thomson 2016b, Hollander et al 2017), coercive care (Brown 2009, Rigg et al 2017), or refusal of care (Brown 2009). Some women initially wanted an attended home birth, but felt midwives were not supportive of their choice (Rigg et al 2017), not truly autonomous practitioners (Feeley & Thomson 2016b), and too closely related to the medical model of care (Miller 2009, Lindgren et al 2017). Additionally, an attended home birth was not always an option in the health care system (Brown 2009, Lundgren 2010, Rigg et al 2017). Hollander et al (2017:429) refer to this as a '*negative choice*'; they were not free to make another choice.

The power of the health care professional did not always have negative connotations. Lundgren (2010) and Feeley & Thomson (2016b) both found that midwives could provide a positive power, giving women the confidence to freebirth by having empowered them during previous birth experiences. This finding was only located in Lundgren (2010) and Feeley & Thomson (2016b) in this review. This may be due to the variation in methodologies across the studies. It could be argued that the methodology of interpretative phenomenology and using narrative reports (Feeley & Thomson 2016b), and life world research with one open question (Lundgren 2010), enabled the participants to express positive views, rather than

semi-structured interviews where negative ideas may have been inadvertently suggested.

Trust

The concept of trust featured in seven papers (Brown 2009, Miller 2009, Lundgren 2010, Feeley & Thomson 2016b, Hollander et al 2017, Lindgren et al 2017, Rigg et al 2017), presenting itself in different ways: through the belief in physiological birth (Miller 2009, Lundgren 2010, Feeley & Thomson 2016b) and by a woman's trust in her own body and intuition (Miller 2009, Lundgren 2010, Feeley & Thomson 2016b, Rigg et al 2017) which is superior to professionals' knowledge (Hollander et al 2017). The trust these women had in themselves and physiological birth was reinforced by the support they found through people close to them (Rigg et al 2017), online forums, websites and textbooks (Brown 2009, Miller 2009, Feeley & Thomson 2016b, Lindgren et al 2017).

Feeley and Thomson (2016b) reported that some women believed community midwives did not trust physiological birth and their fear would cause them to feel unsafe. This was compounded by lack of continuity and having an unknown midwife attend. This finding is specific to an NHS context. However, the idea that being with someone who has a belief in natural birth makes a woman feel safe, can be supported by Rigg et al (2017) and Hollander et al (2017).

Spirituality

Spirituality as religion was discussed by Miller (2009) and Brown (2009). Women chose a freebirth as a spiritual event enabled them to connect with God (Brown 2009) or because using professional assistance is forgoing the power of God (Miller 2009). Miller (2009) coded 127 online narratives, followed by six interviews, to enable some validation, but stated that a reference to God was in a minority. Brown's (2009) paper was a sociology master's thesis, so it could be postulated that interviews and interpretations were less medically focused compared to other papers.

Other studies encompassing spirituality did so in reference to the experience of birth. Birth was more than the positive outcome of a live baby, but a profound life experience (Feeley & Thomson 2016b, Rigg et al 2017) which when accomplished

as a freebirth, empowered women into motherhood (Miller 2009, Lindgren et al 2017). Birth was also seen as an extension of the sexual event of conception (Brown 2009, Lindgren et al 2017), too private to have a professional present. As with God, this idea of privacy and sex was only discussed in two studies (Brown 2009, Lindgren et al 2017).

Discussion

The majority of the review findings reflect those found in previous work (Feeley et al 2015, Holten & de Miranda 2016). However, this review analysed primary research with a UK context (Feeley & Thomson 2016b) and has revealed two aspects not discussed in previous studies. First, some women opt to freebirth as they perceive community midwives as being fearful of physiological birth. Conversely, findings of Coddington et al's (2020) Australian qualitative study, which explored how home birth exposure affects midwives' practice, found home births better enabled midwives to understand physiological birth. Perhaps there is something specific to UK maternity practice that promotes fear of physiology. Second, how women's life stories had a significant influence on the choices they made. Consideration should be given to whether the women voicing this were truly listened to, or had the opportunity to build a trusting relationship with their midwife, enabling them to feel safe in sharing and expressing their needs.

It is interesting to note that some women in Feeley & Thomson (2016b) employed independent midwives for their antenatal and postnatal care yet still chose to freebirth. This is dissimilar to some women in Rigg et al (2017), who stated they attempted to access private midwives instead of freebirthing but were hindered by availability or cost. Jackson et al (2012) highlighted that one of the participants who chose to freebirth was a midwife herself. This only emphasises the complexities involved in the choices women make.

Overall, findings show that some women positively choose freebirth as it is most suitable for them, but for some women it is a negative choice. The studies consistently showed that lack of choice and control are reasons for choosing a freebirth; reasons relating to basic human rights (Birthrights 2017b). At the time of writing the world is learning how to cope with the COVID-19 pandemic. Maternity services have been challenged in providing choice for intrapartum place of care due

to pressures related to staff absence, skill mix and availability of ambulance services (Royal College of Obstetrician and Gynaecologists (RCOG) 2020). NHS England (2020) has provided guidance on suspending services due to staff shortages, to enable consolidation of care. Walsh et al (2020) state that in 2012 only two per cent of births occurred at home and 11 per cent in a midwifery unit, therefore some may argue that, at a strategic level, these were the correct services to temporarily suspend. However, Brown (2009), Lungren (2010) and Rigg et al (2017) all present findings demonstrating that, if there is no home birth service, some women would choose to freebirth. Therefore, the risk of freebirths increasing was known, in addition to the associated morbidity and mortality risk (Feeley et al 2015), yet services were stopped. It could be hypothesised that the lack of home birth services has potentially contributed to women making a negative choice to freebirth during the pandemic.

Implications for midwifery practice

This modified systematic review shows that midwifery practice can have a great influence on women, resulting in some making the decision to freebirth when they would have preferred a professional present. Midwives therefore need to consider the care they provide in relation to power and fear.

Cronk (2010:56) asserts that the power balance in a midwife–woman relationship has changed from one in which the midwife was initially a '*professional servant*', to one in which the midwife has become subservient to the medical model and women assume no power. However, the Nursing and Midwifery Council (NMC) (2019:4) states that midwives must '*work in partnership with women, enabling their view, preferences and decisions*'. Therefore, midwives should continue to reflect on personal practice, considering how to support women in their choices, in addition to considering if, and why, they have power over women, even if inadvertently. While this would encourage personal change, midwives must also continue to work together as a whole profession to give power back to women.

While deliberating the notion of power in a relationship, midwives should consider how they perceive risk and if this causes their care to become coercive or unsupportive. Conflict in risk perception is not new to maternity (Feeley & Thomson 2016a, Plested & Kirkham 2016) and to discuss this in depth would be beyond the

scope of this review. Downe & McCourt (2019) suggest that best practice involves evidence, which should be related to each woman at an individual level, enabling her to be supported in making decisions which concur with her perception of risk. Nonetheless, findings in this review show that women's perceptions of risk were undermined by the medical concept of risk and that they were not supported in the choices they made. A midwife has the challenge of ensuring women are at the centre and that their choices are recognised as valid.

It needs to be considered why some midwives are fearful of physiological birth, as found by Feeley & Thomson (2016b). With the extensive utilisation of obstetric settings for intrapartum care, perhaps midwives are not confident in, or supported to promote physiological birth. This has implications for midwifery education. According to the NMC (2019) midwives should optimise physiological birth, however educational settings, NHS trusts and the NMC will need to consider if the education and support provided enables midwives to do this.

This list of implications for midwifery practice is not exhaustive and improvement needs to be made systemically, not just by individual practitioners. NHS trusts, the NMC, the Royal College of Midwives (RCM) and RCOG, as well as midwifery and obstetric educational settings, need to consider how the findings of this review relate to the care that is provided to women. They must deliberate on what can be done personally and strategically to improve care and prevent women from making a negative choice to freebirth.

Limitations

There may be literature that was not reviewed due to limited databases being searched, minimal grey literature searching and only one additional search strategy being implemented. In addition, the papers were only analysed by one researcher as part of a Master of Science award; additional researchers may have provided extra analysis and given greater interpretation of results (Aveyard et al 2016).

Strengths

The last review of this topic was published in 2016 and did not focus solely on freebirth (Holten & de Miranda 2016). This review incorporates an additional five papers, found by a systematic search strategy. Four of these papers were published

post-2016, therefore there are contemporary data to analyse and it is the first freebirth literature review to include a piece of UK primary research.

Future research

The previous review focusing solely on freebirth (Feeley et al 2015) recommended exploration of freebirth in a UK context. This has now been accomplished by Feeley & Thomson (2016b) exploring why women choose to freebirth in the UK and Feeley & Thomson (2016a) studying women's experience of freebirth. With COVID-19 influencing service availability and the choices women make for their intrapartum care, there is now a gap in the research. Research is needed to explore the experience of women choosing freebirth during the global COVID-19 pandemic. This could enable maternity services to better understand women's lived experience and assist in planning services, should a similar event occur in future.

Conclusion

This modified systematic review has found and analysed qualitative primary research regarding why women choose to freebirth, generating four main themes: rejection of maternity care; power; trust and spirituality. It highlights that women make both positive and negative choices which lead them to freebirth. While the reasons given by women are complex, it is evident that individual midwives and the structure of maternity care influence these choices.

Most recently the COVID-19 pandemic has affected the services that are available to women and the subsequent decisions they make for their intrapartum care. The review has shown that, while there is now some understanding of why women choose to freebirth and their experiences of it in the UK, there is a need to explore women's experience of freebirth during the pandemic. This will ensure that all women's voices continue to be heard and considered in the planning and development of future service provision.

Author

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