Sexual & Reproductive Healthcare 37 (2023) 100866

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.elsevier.com/locate/srhc

Freebirth, the only option for women who do not fit into common practice– A Swedish national interview study

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ARTICLE INFO

Keywords:
Birth experience
Freebirth
Home birth
Qualitative method
Women

ABSTRACT

Objective: To explore women's experience of freebirth, as giving birth without the presence of a skilled healthcare professional such as a midwife.
Methods: Online semi-structured interviews with nine multiparous women in Sweden. A qualitative experiential approach, as described by Burnard, was followed for data analysis.
Results: The five main categories explored were: (i) previous negative experiences of hospital care as a reason for freebirth; (ii) receiving support for the decision of freebirth was crucial; (iii) longing for individual midwifery-assisted home-birthing support; (iv) to give birth in peace and in self-control, in the safe home environment; and (v) helpful support during labor and birth was appreciated.
Conclusions: The women in the study had a powerful and positive experience of freebirth, but individual midwifery birthing support was also requested. Easily available and respectful midwifery support should be offered to all childbearing women.

Introduction

Childbirth can either be regarded as a medical or a social event in a woman's life. From a medical perspective, interventions and patho-physiology are in focus rather than viewing childbirth as a normal physiological process centered on the birthing woman [1]. If maternity care is humanized, the woman is put in the center, and she will make her own decisions based on personal preference [2]. Maternity care, even when conducted according to best practice guidelines with the very best intentions, can result in trauma for the women involved. This trauma may cause some women to decide on home births [3].

A US patient registry study assessed neonatal mortality for single births, born in gestational week $\geq$ 37, infant birthweight $\geq$ 2499 g (no information was available for other background characteristics) for planned home births and planned hospital births by birth attendants (nurse–midwife or unidentified) [4]. For 2010–2017, there were 195,026 home births and 2,280,044 hospital midwife-attended births in the United States. In total, 87% of home births were categorized as intended/planned home births, and 9.2% were categorized as unintended/unplanned home births. The neonatal mortality rate per 10,000 births was 3.27 for hospital births, 13.66 for planned home births, and 27.98 for unintended/unplanned home births. These differences increased even further when patients were stratified for recognized risk factors. If the unintended home births were the same as freebirth was not described [4].

When comparing low-risk women who began labor in well-integrated settings who intended to give birth at home with women intending to give birth in hospitals (intended birthplace and not the actual place of birth), a *meta*-analysis based on 16 studies reported fewer birth interventions for those who intended to give birth at home. Women intending to give birth at home compared to at the hospital were less likely to experience caesarean sections, operative vaginal births, epidural analgesia, episiotomies, 3rd or 4th degree tears, oxytocin augmentation, or maternal infections. Regarding postpartum hemorrhage, the women intending home births were either less likely to experience hemorrhaging or did not differ from those intending to give

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https://doi.org/10.1016/j.srhc.2023.100866
Received 15 February 2023; Received in revised form 20 May 2023; Accepted 29 May 2023
Available online 2 June 2023
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birth at the hospital. There were no reported maternal deaths [5].

Out of 113,192 births in 2021 in Sweden [6], approximately 100 births were midwifery-assisted home births that had been granted and funded by the Swedish healthcare system. To be funded, a pregnant multiparous woman needed to be healthy with one baby in vertex position with the birth occurring near the due date. In addition, patients must have previously given birth without complications. An additional requirement was that the woman's residence had to be within a maximum of 20 km distance to a hospital in case there was an urgent need for medical attention. At the time of the present study, tax-funded, midwife-assisted home births were offered in two of Sweden's 21 counties. To give birth with midwifery support in a hospital setting is free of charge and there is no need to apply for funding [7].

Regarding outcomes of planned home births compared to hospital births in Sweden between 1992 and 2004, home births resulted in a higher probability of spontaneous vaginal birth than women who gave birth at a hospital. Of note, the women who gave birth at home were healthy, often multiparous, and had uncomplicated pregnancies. The home births were assisted by two midwives, with no other patients to care for at the same time, and did not have other disturbing moments as during a hospital birth [8].

Freebirth, also called unassisted birth, has been described as according to plan, giving birth at home or somewhere else without maternity professional care. Women choose not to have any midwifery support, medical treatment, clinical monitoring, or use of technologies during labor and birth of the baby [9–12]. The consequences of unnecessary interventions have been explained by women to be destructive to a physiological birth, leading to complications [10,12], leaving women with a sense of the hospital as a dangerous place with abusive care [14]. According to a scoping review, women's motivation for choosing an unassisted birth included resistance to the biomedical model of birth. A model that has been perceived as not meeting women's emotional or social needs and not respecting women's birthing rights [12].

Women with freebirth experiences express that professional guidelines have been viewed as serving the needs of healthcare professionals rather than those of an individual woman's preference [12]. Women who have given birth without a midwife or other healthcare professionals have previously experienced being forced by healthcare professionals to follow clinical procedures and guidelines [13]. If women have preferred a freebirth they have been met with suspicion, prejudice [14], anger, and threats and have been regarded as someone who make bad and risky decisions and is reckless towards their own and their baby's health [13]. The women's emotional equilibrium had been disturbed, especially when it was experienced as a self-protective measure for the midwife rather than genuine care for the woman and baby [13]. Women in a Swedish qualitative study described negative experiences of healthcare. They were met with superiority and authority and felt judged because of their wish for home birth [15]. Another Swedish study concludes that women express a conflict between, on one hand, inner responsibility, power, and control and on the other hand insecurity in relation to the outside, to other people, and to the social system. Women have expressed a wish to be cared for by a midwife is in conflict with the fear of not maintaining integrity and respect in this precious moment of birth [16]. Women need to receive respectful maternity care, and according to the International Confederation of Midwives, a midwife should protect and enhance the health of women [17].

The number of women giving birth with no midwifery assistance is not known. Even if there are only a few such cases, it is important to understand women's motives for giving birth without the presence of a skilled healthcare professional such as a midwife, due to the serious consequences of unassisted complicated births. Therefore, this study focused to elaborate further on women's freebirth experience in a Swedish context.

Methods

Study design

An interpretive paradigm [18] with a holistic-content narrative approach [19] was applied to gain a deeper understanding of the meaning of the complexity of women's experiences [18,19]. A qualitative descriptive study design was therefore chosen for our study to explore women's freebirth experience.

Participants and recruitment procedure

Women who had previously given birth unassisted were recruited from two Facebook groups. Inclusion criteria were Swedish-speaking women who had plans for freebirth or experience of freebirth. Exclusion criteria were unintentional freebirth. The study participants were recruited in 2022 from the Swedish home-based birth groups: *"Föda hemma- vår mänskliga rättighet"* (In English: Giving birth at home—our human right) (https://www.facebook.com/groups/hemforlossning/ and *"Föda hemma"* (In English: Giving birth at home) (https://sv-se.facebook.com/groups/6254309486/). These Facebook groups are directed at women with an interest in home birth with or without midwifery birthing support. Information about the study's aims and methods was posted on each site. Those who were interested in participating signed a written consent approval and sent the consent form via e-mail to one of the authors or posted their interest on the site. The first 11 women who wanted to participate in the study were invited, and another one was recruited by snowball sampling. The 12 women invited to participate were then asked for their preferences regarding the timing of the interview. Three of the 12 women chose not to proceed to an interview. In total, nine women were included in the study.

Data collection

Individually audio-recorded online semi-structured interviews followed an interview guide (Box 1) with opportunities given to elaborate further on the answers. Background characteristics were requested at the beginning of each interview, and these were: age (years), parity, number of freebirths, place of births, mode of birth, and home county. Data were collected by the second and third authors with one author taking notes during each interview between April 6, 2022, and April 8, 2022. At the end of each interview, participants were asked by the note-taker for additional questions based on the notes. Data collection continued until the experiences spoken of by the women started to repeat (data saturation). The length of interviews was between 19 and 52 min (an average of 33.5 min).

Data analysis

Data were analyzed according to Burnard's four qualitative experiential stages [20]. First, interviews were transcribed verbatim in a Word

Box 1
Interview schedule.

Please, tell me about your previous birth experience.
Describe the decision-making process for freebirth.
How did you prepare for the freebirth?
How did you feel about labor and birth during pregnancy?
Please, describe if you were supported during the freebirth.
What are your reflections on your freebirth?

document and were read several times, in order to gain a naïve understanding of the phenomena under study. Data were open-coded by reading each transcript note, and short phrases were added in the margins that did sum up what was said in the text, which gave an understanding of the general content. Second, the identified words and phrases were grouped and reduced in number by deleting duplicates, keeping the core meaning of the experiences intact. Third, a shorter list of categories was compiled, and we looked for overlapping or similar categories. These categories were further refined and reduced in number by grouping them together. The now-reduced groups of text were divided up into ten categories. In the fourth and last stage of the data analysis, each of the ten categories was marked by its own colour and then each transcript was worked through and data that fit under a particular category were marked with the according colour. Finally, all of the sections of data, under each of the categories were cut out and pasted on the document. Five main categories emerged that answered the question "So what?" that explained the women's freebirth experience [20].

Researcher characteristics and reflexivity

All authors are registered nurse midwives with maternity care experience; two are newly-educated midwives, and the other three have several years as clinical midwives, senior lecturers, and researchers. Two of the researchers have in-depth qualitative research knowledge. During the process of designing the study, and collecting and analyzing data, critical discussions were carried out with three of the authors and with, at the time, the two midwifery students.

Ethical considerations

This study received ethical approval from the department head and the midwifery program director at Uppsala University. Participants gave their written and oral consent to participate in the study, and they were unknown to the authors. The women were informed that they may withdraw from the study for any reason at any time, but no one chose to do so, and instead willingly shared their experiences without hesitation. Data were handled confidentially, coded, and stored at a secure server at Uppsala University.

Results

Study participant characteristics

In total, nine women participated in the study. They were aged between 27 and 64 years (for an average of 38 years) and had between two and eight children. Seven participants had given birth to their first child at a hospital and the other two had given birth at home (one assisted by a midwife and the other without a midwife). The women had one to four previous freebirth experiences (Table 1). One participant lived outside Sweden and the rest resided in seven of Sweden's 21 counties. Birth outcomes for participants were all full-term spontaneous vaginal births, of a single baby in vertex position. All but one gave birth unassisted to the child at home in an upright position. One woman gave birth in an ambulance on the way to a hospital, in a semi-recumbent birthing position.

Table 1
Background characteristics for study participants.

Participant No	Age (years)	Parity	No of freebirths	No of midwife assisted home births	No of hospital births
1	42	II	1	0	1
2	37	II	1	0	1
3	29	V	2	1	2
4	37	II	2	0	0
5	27	II	1	0	1
6	41	V	4	1	0
7	33	II	1	0	1
8	64	VIII	4	0	4
9	39	IV	1	2	1

Women's freebirth experiences

The five main categories that emerged were labeled: "previous negative experiences of hospital care as a reason for freebirth"; "receiving support for the decision of freebirth was crucial"; "longing for individual midwife-assisted home-birthing support "; "to give birth in peace and in self-control, in the safe home environment"; and "helpful support during labor and birth was appreciated" (Table 2).

Previous negative experiences of hospital care as a reason for freebirth

Based on previous negative experiences of hospital care, all women questioned the recommendations and guidelines given by their maternity care organization. Negative experiences of hospital care included non-respectful approaches taken by healthcare professionals, care delivered by routine, unnecessary interventions, being given unneeded pharmacological painkillers, and having to undergo treatment without consent. These negative experiences made the women in the study to decide on a freebirth in order to avoid similar situations.

Previous non-respectful approaches by healthcare professionals included not being listened to regarding the women's own preferences. The women, therefore, felt ignored and felt stressed, insecure, and not in control of the situation. One woman of eight children asked the healthcare professionals for a chair to rest on during labor instead of just lying on a bed, but the request was denied. She said: *"They just told me 'no, there is no time for you to sit on a chair'… but there was enough time, even if there would only have been for two minutes…that would have meant a lot for me to sit on a chair* (#8). Another multiparous woman explained: "*Just the thing that someone is doing something that you don't want, aren't prepared for or not even asked about"* (#3).

The women had previous experiences of labor care delivered by routine and had to argue for refusing unwanted procedures and interventions such as amniotomy, fetal heart rate assessment by fetal scalp electrodes, vaginal examinations, and pharmacological pain relief. The intervention of amniotomy was regarded by the women only as a convenience for the healthcare professionals, and the women experienced it as offensive and humiliating. One woman with five children said: *"There was no reason whatsoever to pop the bag, it was carried out only based on the professional's convenience for a quicker labor process"* (#3). Another multiparous woman explained that she had to be monitored at all times by the CTG machine: "*It was hard just to lay down on the bed and be connected to the CTG machine, to have a fetal scalp electrode on my baby, I was cut* [a perineotomy], *it was quite a failed childbirth"* (#8).

Vaginal examinations were often carried out by routine without allowing the women to refuse the procedure. They had experienced often unnecessary interventions, and the whole situation was unpleasant for them. One woman with two children described that three male medical students took turns on her by carrying out vaginal examinations during labor without asking for her consent for the procedure. After that traumatic experience, she needed professional treatment. She explained:

Table 2
Explored main categories.

Main categories
Previous negative experiences of hospital care as a reason for freebirth
Receiving support for the decision of freebirth was crucial
Longing for individual midwife-assisted home-birthing support
To give birth in peace and in self-control, in the safe home environment
Helpful support during labor and birth was appreciated

"*I was thinking to file a claim for damages, but I did not, they took turns on me by digging into my vagina for assessments, it was quite crushing actually, psychologically"* (#5).

Another non-supportive situation described by the women was healthcare professionals not assisting them to a body position of their preference after having to lie down for a vaginal examination. Furthermore, women were given pharmacological pain relief they did not ask for and did not need. Because of the pain relief they were given, they experienced side effects that caused them not to feel present during childbirth, leading to feelings of disempowerment. One woman with eight children said: *I got some kind of morphine derivate so I became a little far away, I didn't think I was involved in the childbirth* (#8).

Receiving support for the decision of freebirth was crucial

The women in the study regarded it as crucial to receive support for their decision of freebirth, but not all women could be open about the decision regarding freebirth, and they hide their decision from family, close friends, and healthcare professionals. Reasons to hide the decision included not being influenced by negative opinions and comments about them being irresponsible. The women did not want to be judged or to be worried; instead, they wanted to stay calm and feel safe. Two multiparous women explained:

"You need to feel safe when giving birth; the decision for freebirth should not be shared with those who you think will respond negatively." (#9).

"I had hidden the decision of freebirth. The first time I talked about home birth, I had to deal with such a lot of difficult things, lots of fears that were just heaved onto me. (#2).

The women were afraid of healthcare professionals' potential reactions to their decision regarding freebirth. If they had to seek medical help during labor for dystocia or because becoming unable to cope with the labor process, the women had planned to not explain the freebirth decision to the midwives, and instead explain that the labor progress progressed so quickly that they were not able to ask for help earlier. Some of the women were supported by the antenatal care midwife in the freebirth decision. Midwives encouraged the women to give birth at a place they felt safe. One woman with five children described that her midwife introduced the idea of home birth, something she previously had not considered for herself. After this, the woman started to consider the possibility of a home birth. She said: "[The midwife] *asked me: 'Maybe you would like to have a home birth? It doesn't seem as though you're that keen about going to hospital'* (#6). Another multiparous woman stated: "*The midwife was incredibly supportive, she gave me a kit for cord clamping, she said that she was not worried, because both you and I know that home birth is safer"* (#2).

The importance of having a good safety network was emphasized by women. One woman explained: *I felt that I had a good safety network in any case, my choices have been based on that I will receive help if want it* (#6). Most of the women received support and respect from their partner in their decision for freebirth. Partner support for the decision was crucial for daring to give birth at home. One woman with five children said: *"My husband said: 'You can do this; you know this is right for you'* (#6). Another woman explained: "*After discussions with my partner, we decided 'then we will have a freebirth'. After the decision it was so nice because then you knew, but there are always other options if you change your mind* (#3).

Support by 'the Swedish Homebirth Association' and social media such as Facebook was appreciated by the women. They came in touch with other women with previous home birth experiences, and those who planned to give birth at home and received advice. One woman with two children stated: "*I was participating in different Facebook groups, and I came in contact with doulas and midwives, and they shared their stories with me"* (#5).

The women also prepared their freebirth decision by gaining knowledge by reading books on, for example, how to proceed if the umbilical cord was around the baby's neck, or if labor did not progress. Some women had previous birthing knowledge obtained by previous healthcare education. Having some birthing knowledge made the women feel safe, and a sense of security and tranquility was experienced.

Longing for individual midwife-assisted home-birthing support

The women in our study would have preferred to have had midwifery support during their home births, but because of no available midwife for home births, or the long travel distance between their home and available midwives, in combination with a reluctance to give birth at a hospital they chose to have a freebirth. One woman with two children explained: "*You get that wisdom from a midwife, it can't be replaced, I have massive respect for childbirth, I would definitely want to have a midwife who understands me and has the same attitude "* (#2).

For other women, midwifery home birth support was not an option because of the financial aspect; they did not have enough money to pay for the service. Most of the women lived in a county not offering tax-funded home birth, and some women were, because of that, considering moving to a county that offered tax-funded home birth. One woman with two children described: "*For many it is an economical issue… although it's clear that it's an investment* [with midwifery support], *it's a certainty, it's insurance, you could say* (#5). Another multiparous woman said: *"Yeah, God, I did so much thinking. 'Is it possible to move temporarily to Stockholm?', but I don't have a home there. Yeah, so many thoughts about how it might be resolved"* (#1).

To feel safe during freebirth, the women planned to stay at home as long as it felt "good". If they came to regret their decision to give birth at home, or if difficulties were developed at home, they had the plan to go to the hospital for care, via an ambulance if urgent care was needed. The possibility to go by ambulance for a quick referral to a hospital made the women feel safe and secure giving birth at home. Two women noted:

"*I thought 'If it becomes chaotic we will have to go to the hospital', it's only 30–40 min to the hospital, so that's good.* (#1).

We can just phone an ambulance if it's 'no, shit, now it's going really quickly'. It was the reassurance of them saying that you can stay at home as long as possible, that's how the child ends up being born at home. (#3).

To give birth in peace and in self-control, in the safe home environment

The women appreciated staying in their safe home environment, feeling in control over the birthing process, and being responsive to their body's signals. Staying in their own home environment was regarded as vital in the freebirth decision. To transfer themselves from the home environment to a hospital was regarded as inconvenient and impractical, would interrupt the labor process, and was something to be avoided. One woman with two children said: *So nice to be able to be at home and not need to travel anywhere at all* (#4). Several women drew parallels to birthing animals; animals should not be moved during labor. It was regarded as common knowledge that animals who are feeling unsafe will be stressed and at risk for complications, and the women regarded this to also be true for birthing women.

Freebirth gave the women unique experience of giving birth on their own terms. Integrity, self-control, and self-determination over the birthing process were regarded as important for the women. They emphasized the value of trusting their own capability to give birth independently without depending on someone else. Two multiparous women explained:

I am the one who has all the power myself, … there's no one who is there interfering in any way, and taking away my ability to listen to myself and what I need … It was like some kind of extra alarm, in everything that applied to me, more focused than I have ever been in my life … it meant so very much to me to be able to do it all myself. (#9).

It's a really powerful thought pattern, having to travel to the hospital and hand yourself over to midwives and healthcare and'Do this for me', as if we could hand it over … it becomes so silly … you need to have the knowledge

yourself about what it is that's happening in your body. (#2).

Freebirth gave the women the possibility to be responsive to body signals without any disruptive elements. They felt a deep presence in the labor process that made them dare to follow and trust their body's signals. Feelings of being present, watchful, and empowered in the birthing process were mostly enhanced. One woman with two children said: *I could feel my own body. There was no one saying 'Now this is the way it is', and I was not completely cut off with examinations. I became empowered by it, in fact* (#1). To trust the female body's capability in giving birth was emphasized as important. Giving birth was not regarded as a disease, and therefore hospital care was not necessarily required. Not being in need of hospital care was important in order to maintain self-determination and autonomy. One woman with eight children stated: *If you rely entirely on your own ability to give birth, why would you travel to the hospital? You aren't ill* (#8).

Important, according to the women, was avoiding the medicalization and treatment of symptoms of a normal physiological labor process. The women regarded giving birth as a normal physiological process that, in most cases, has a positive result. Therefore, there was no point in preparing for worst-case scenarios. One woman with five children explained: *Childbirth is nothing artificial, it's these little miracles in everyday life, and you don't need to take a belt and braces approach in case something doesn't go the way it should* (#3). Labor pain was regarded as not dangerous or negative, but instead as a natural part of the birthing process that made pharmacological pain relief redundant. One woman with two children said: *Pain is not something that is necessarily bad, pain is a signal to the body about what's about to happen* (#7). The thought of giving birth at a hospital did evoke feelings of powerlessness and insecurity. The women preferred not to meet unknown professionals and to have to undergo unnecessary interventions because they regarded that as restricting their integrity and as disturbing elements during the birthing process. Two multiparous women stated: *I avoided all kinds of interventions, really nice! Safer.* (#7), and *It takes me a while to feel at ease with a person, and I want to have met the person beforehand, and if I don't feel at ease I already know that I can very easily lock myself up* (#2).

Helpful support during labor and birth was appreciated

One important aspect of the positive birth experience was the support received from a partner, midwife, doula, or friend. Mostly the women had a positive birth experience of freebirth, and no negative aspects were expressed. However, one woman described that she had needed support from others, but was nevertheless satisfied with her freebirth. Another woman described that she had expected a feeling of empowerment from the freebirth, but that feeling did not come.

Support by reminding the women about their own strength during freebirth was valued. One woman said that others cannot give birth to the laboring woman, instead, she has to find her own inner strength in order to give birth to her baby. One woman with two children said: *What you as a woman often need support with it's you and your inner strength,* [midwives] *will never be able to give birth for women, women have to find it themselves, within themselves. So I'm the one who gives birth (*#2).

Most of the women talked about receiving midwifery support remotely during the freebirth via short messages, video links, or telephone calls. Antenatal care midwives and midwives offering alternative medicine gave birthing support, which made the women feel supported and acknowledged. The support they received made the women able to stay at home during the whole birth. Two multiparous women said: [The antenatal care midwife] *has given good advice, and we have had Zoom and Skye calls, about how it can feel and so on* (#6), and *I texted her and phoned on some occasions* (#5).

Some of the women's partners had received midwifery support during pregnancy by being educated in accessing the cervix opening which eventually helped the woman to feel reassured and to cope with the freebirth experience with the assistance of an involved partner. Regarding partner support, one multiparous woman said: *Fantastic, and above all the support from my partner, he was involved because he was there and did practical things, it was not a nursing assistant who was running off to fetch a glass of water, he was the one who served me* (#3).

Discussion

Previous negative experiences of hospital and maternity care were reasons for women's freebirth preference. Receiving support for the decision of freebirth was reported as crucial. The women wished for individual midwife-supported home-birthing support, but such support was not feasible. To give birth in peace and in self-control at home was offered as an explanation for the choice of a freebirth.

A previous negative experience with hospital care was one reason to decide on freebirth in order to avoid similar situations. Women's decision to freebirth has been explained by previous negative experiences of hospital care [9,10,21], and maternity care [9,21,22]. The negative experiences—also referred to as the experience of "obstetrical violence" [23], including exposure to comprehensive use of medical technology [11], cultural discrimination, racism [21], disrespect [10,11], and abusive treatment by healthcare professionals [10], including being forced into unwanted interventions [9,10].

The women in our study had previously experienced that they needed to argue to avoid obstetric interventions they perceived to be harmful or unnecessary. Vaginal examinations had often been carried out by routine, without allowing women to refuse the procedure. Other women with freebirth preferences also have had previous experiences of not being asked for consent before a vaginal examination, which had left them traumatized and reduced their autonomy in the birthing process [10]. Because of the birth trauma women have experienced they had difficulties interacting with the newborn baby and with their partner during the postpartum period [22]. In addition, some women have developed mental illnesses such as post-traumatic stress disorder after a traumatic birth experience [9,22].

The women in our study expressed they were supported by their antenatal care midwife in the freebirth decision and were encouraged to give birth at a place where they felt safe. Our study as well as other studies shows that women giving birth without a midwife or other healthcare professional, assess the risk involved in giving birth by their own instinct and self-knowledge [10,13,16]. However, women could experience a lonely and heavy responsibility when figuring out facts about giving birth on their own and expressed a need for a midwife to confirm the process of birth and to receive support to reflect on the stages of labor instead of doing everything by themselves [15]. Our study as well as others [10,13,16] shows that proper care for homebirth is needed for safe care for women.

Previously in a Swedish context, women with a home birth experience have met supportive midwives and physicians who represented a personal perspective of birth [15], rather than having a professional approach. According to the International Confederation of Midwives, a midwife should protect and enhances the health of women [17]. Midwifery contributes to high-quality maternal care by optimizing physiological, psychological, social, and cultural reproduction processes, and timely preventing and managing complications [24]. Women in childbirth have been described to require holistic advice, support, and individual attention in the form of antenatal, perinatal, and postnatal care [1]. However, based on previous negative experiences of hospital care, the women in our study questioned the recommendations and guidelines given by the maternity care organization. Based on these previous negative experiences, women, therefore, have perceived births inside the healthcare system to be riskier and less safe than births outside the system [22].

Some of the women included in the study described that they had hidden their decision of freebirth from family, close friends, and healthcare professionals. The reasons to hide the decision were not to be influenced by negative opinions and comments about them being irresponsible. The women did not want to be judged or worried; instead,

they wanted to remain calm and feel safe. According to a scoping review, women who choose to give birth outside the system may be considered deviant because they reject mainstream birth expectations. These women may feel stigmatized and therefore want to keep their choice of freebirth a secret [12]. When women have told others about their decision regarding freebirth, reactions have varied from supportive to resistant. Resistance towards their decision was experienced as troublesome and stressful [10]. Women have therefore had the impression that there are many prejudices about freebirth in society that gave them reasons as to why they did not want to be open about their decision [10].

This study highlights the importance of receiving support for the decision of freebirth. Some of the women expressed that they were supported by the antenatal care midwife, their partner, the Swedish Homebirth Association, or social media in their decision to have a freebirth. Women have previously received support for planned home births from healthcare professionals by being involved in decision-making, being helped to understand information, being given enough time to consider different care options, and having their choices respected [9]. Social media is another source of support appreciated in the decision-making surrounding where to give birth [10–12]. Social media, such as Facebook, gave women the opportunity to talk with and receive advice from other women who had freebirth experiences. Others sharing their positive birth experiences strengthened women's decisions on unassisted birth. However, women reported being selective in the search for information, because much of the available information was based on risk in relation to freebirth [10].

The women in this study wished for individual midwife-assisted home birth support, but it was not possible because of long travel distances for midwives, lack of money to pay a midwife, or having no midwife available to assist during a home birth. If women were supported by midwives during a home birth, they believed their birth choices would be optimized and that they would feel more autonomous and in control than they would during a hospital birth. However, some women have expressed that true autonomy in the birthing process is only attainable without a professional present [12].

The women in the present study experienced a powerful freebirth. They appreciated staying in their perceived safe home environment. The women felt in control over the birthing process, were responsive to their body's signals, and they emphasized their body's capability to give birth. In another Swedish study, women who had experienced an unassisted planned home birth described they felt confident in their own capacity but vulnerable in contact with the maternity care system [16].

In a biomedical approach, childbirth has been regarded as a medical process where normality only can be judged in retrospect and medical knowledge is decisive in the kind of care that is offered. On the other hand, the women-centered approach stresses the normality of childbirth and explains birth as a female biosocial sexual process [1]. Unassisted childbirth has previously been portrayed as a sexual, potentially ecstatic, experience that requires privacy between the birthing woman and her partner [10,12]. Listening to, acting upon, and trusting one's intuition have been regarded as crucial, and intuition is more important than receiving a medicalized birth [12,15]. Giving birth has been regarded as intimate and private [10,12], requiring peace and quiet with as little influence from others as possible to enhance a physiological birth. Women have felt confident that they could manage birth without the presence of midwives. Their confidence was based on their prior experiences, and deep trust in themselves and their bodies' capability to give birth. Women have considered complications during birth and made risk assessments in their preparations for freebirth. If no one intervened or interrupted the birthing process, the risks of complications have been regarded as very small. However, the presence of a partner, doula, or midwife during birth has been described as reassuring for women in labor [10]. Women with experience of unassisted planned home birth have described that a midwife not only gives women childbirth support but also has a biomedical approach. The wish to be cared for by a midwife has been in conflict with the fear of not maintaining the integrity and respect they need in the unique moment of birth [16].

The opportunity to have waterbirth, a birthing position determined by one's own preference, a choice of a birthing support person, continuity of midwifery care, and uninterrupted skin-to-skin contact with their newborn baby have influenced women's choice to give birth at home [9]. Women who have had a home birth often felt empowered by the experience [12]. Therefore, it is of importance to give care to women having other views of childbirth and not only to the majority. Midwives need to establish a trustful relationship with the woman and be experienced as trustful even if not having a positive attitude to give birth at home [15]. Another study state that a challenge is to provide safe care to all women so that assistance from a midwife becomes a reality in all settings [16]. On the other hand, an alternative is to be offered continuity of care with a known midwife throughout pregnancy, birth, and the postpartum period [25].

Methodological considerations

This qualitative research followed the *Standards for Reporting Qualitative Research* Checklist [26]. All women participating in this study both wanted and gave birth unassisted at home, and had uncomplicated deliveries with a baby in good health. The majority of the women spoke about positive experiences. It is likely, that women who wanted freebirth but still for some reason have to give birth in a hospital would have other, more negative experiences of giving birth. If that had not been the case, the results might have been different. Therefore, a limitation of this study might be that women who had experienced childbirth complications did not choose to participate in the study.

Another limitation of qualitative studies is the small sample size and the difficulty of generalizing the results, even though a larger sample size may achieve similar results [27]. Therefore, the findings of this study may be transferable—with caution—to other populations. The findings, however, provide a unique insight into how freebirth can be experienced when everything proceeds normally. Thus, another limitation is whether the time perspective may have influenced women's experiences. For some women in this study, it has been a long time since they gave birth and for others, it was more recent.

In future studies, women who plan freebirths should be followed over time to determine how many women complete unassisted births at home, how many need unintended transfers to a hospital for the birth, and the outcomes for both mother and infant. It is of great importance to compare the incidence of maternal and infant complications between home and hospital births in order to be able to provide evidence-based maternity care to all childbearing women.

Conclusions

Previous negative experiences with hospital and maternity care were reasons for a freebirth preference. Receiving support for the decision of freebirth was reported as crucial. The women in the study wanted individual midwife-assisted home-birthing support, but that was not always possible. To give birth in peace and in self-control at home was offered as an explanation of the freebirth experiences. The women had powerful and positive experiences of freebirth, but individual midwife-assisted support was also requested. Easily available and respectful midwifery support should be offered to all childbearing women.

Funding

Non-financial support has been received.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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