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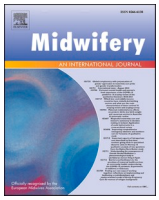

Review Article

Exploring women's motivations to freebirth and their experience of maternity care: A systematic qualitative evidence synthesis☆

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ABSTRACT

Background: Freebirth is currently defined as the deliberate decision to give birth without a regulated healthcare professional. Previous reviews have identified factors influencing women's decision to freebirth, yet there is limited evidence on what is the care experience for women who opt to freebirth.
Aim: To synthesise the qualitative evidence on women's motivations to freebirth and their experience of maternity care when deciding to freebirth.
Methods: We conducted a qualitative evidence synthesis using a sensitive search strategy in May 2022 and August 2023. Twenty-two publications between 2008 and 2023 and from ten different high-income countries were included. Thematic synthesis, underpinned by a feminist standpoint, was used to analyse the data.
Findings: Three main analytical themes were developed in response to each of the review questions. '*A quest for a safer birth*' describes the factors influencing women's decision to freebirth. '*Powerful and powerless midwives*' describes women's perceptions of their care providers (mostly midwives) and how these perceptions influenced their decision to freebirth. '*Rites of self-protection*' describes women's care experiences and self-care practices in the pregnancy leading to freebirth
Discussion: Freebirth was rarely women's primary choice but the result of structural and relational barriers to access wanted care. Self-care in the form of freebirth helped women to achieve a positive birth experience and to protect their reproductive self-determination.
Conclusion: A new woman-centred definition of freebirth is proposed as the practice to self-care during birth in contexts where emergency maternity care is readily available.

Statement of significance

Problem or Issue	The number of women considering to birth without the support of a healthcare professional in high-income countries appears to have increased in recent years.
What is Already Known	Research on this topic is limited. Previous negative experiences of maternity care, a wish to remain in control and to minimise disruption to physiological birth have been identified as factors influencing women's decision to freebirth.
What this Paper Adds	Freebirth was rarely women's primary choice but the result of restrictive policies, inequitable access, and unequal power relationships with care providers. In this context of reproductive injustices, women developed their self-care agency and used this during birth to protect their reproductive self-determination.

Introduction

Freebirth or unassisted birth is the deliberate decision to give birth at home without a regulated healthcare professional in countries where maternity care facilities are available and easily accessible (Jackson et al., 2020; Henriksen et al., 2020; McKenzie et al., 2020). The first reports of this practice appeared in the late 1950s in the USA, at a time of high medicalization of childbirth and lack of maternity care choices (Edwards and Kirkham, 2013). The last decade has seen an apparently increased number of women opting to freebirth (Summers, 2021;

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Table 1
Comparative of previous systematic reviews on women's perspectives of freebirth.

	Feeley et al., 2015	Norton, 2020	Macdonald et al., 2023
Question	Why do some women choose to freebirth?	Why do some women choose to freebirth?	What are the experiences of women who have planned unassisted home births?
Methodology	Meta-ethnography	Modified systematic review	JBI Qualitative synthesis
Included studies	Freeze, 2008, USA	–	Freeze, 2008, USA
	Brown, 2009, USA	Brown, 2009, USA	Brown, 2009, USA
	Miller, 2009, USA	Miller, 2009, USA	Miller, 2009, USA
	–	Lundgren, 2010, Sweden	Lundgren, 2010, Sweden
	Jackson et al., 2012, Australia	Jackson et al., 2012, Australia	–
	–	C Feeley and Thomson, 2016, UK	–
	–	–	O'Boyle, 2016, Ireland
	–	Hollander et al., 2017, Netherlands	–
	–	Lindgren et al., 2017, Sweden	Lindgren et al., 2017, Sweden
	–	–	McKenzie and Montgomery, 2021, UK

Summers, 2020; Bryan, 2018). Yet, the exact prevalence of freebirth is currently unknown, with varying local estimates of 3–20 % of homebirths (Lundgren, 2010; Vogel, 2011; Grunebaum and Chervenak, 2015; O'Boyle, 2016; Greenfield et al., 2021; Cooper and King, 2020; Schrøder et al., 2021 Sep 30). Given the number of homebirths in high-income countries is already low (≈1 %) (Sandall, 2015), it is likely that freebirth may represent just a small proportion of these. The lack of reliable records on the incidence of freebirth also means that the impact of this practice on maternal and neonatal outcomes remains currently unknown. Despite the relatively small size of this phenomenon, there has been a noticeable increase of academic interest in the topic in the last 20 years (McKenzie et al., 2020). Often framed as a controversial choice (Edwards, 2020) and a form of resistance to existing maternity care provision (McKenzie et al., 2020), academic discussion on freebirth has unearthed underlying ethical debates about the boundaries of women's autonomy in childbirth and the moral accountability for safeguarding the unborn baby (Dannaway and Dietz, 2014).

Most empirical research to date has exclusively focused on understanding women's individual motivations to freebirth. Previous reviews have identified traumatic or negative experiences of maternity care, the rejection of medicalised models of care, and unequal power dynamics with care providers as influencing factors in women's decision to freebirth (Edwards and Kirkham, 2013; Feeley et al., 2015; Holten and de Miranda, 2016; Norton, 2020; Buddingwood, 2021; Shorey et al., 2023; Macdonald et al., 2023). Only three of these previous reviews (Feeley et al., 2015; Norton, 2020; Macdonald et al., 2023) were systematic and included in combination 10 primary studies (see table 1), reflecting a limited amount of empirical evidence on freebirth. While these reviews have synthesized the evidence on why some women opted to freebirth, there is limited evidence on how women care for their pregnancy when considering freebirth. This systematic qualitative synthesis continues to explore women's motivations to freebirth, updating previous reviews with more contemporary publications, while also addressing the unanswered questions of what women's perceptions of maternity care are and what is their care experience in the pregnancy leading to freebirth.

Methods

Aiming to achieve a complex new understanding of women's perspectives on freebirth and not just a description and summary of primary findings, thematic synthesis was the chosen methodology for data analysis in this review (Thomas and Harden, 2008). Thematic synthesis is grounded on critical realism philosophy, in which the researcher's beliefs and perspectives mediate the process of synthesizing data and generating new insights (Tong et al., 2012). The lead reviewer (MVH) is a feminist, UK midwife and mother who made non-normative choices in her pregnancies (but not freebirth). Her feminist standpoint guided the interpretation of data in examining issues of power and reproductive agency reported in women's accounts of freebirth (Jefford and Sundin, 2013). Reflexive iterative discussions with FD and CK helped MVH to ensure her interpretations remained grounded in the review data. The protocol for this review was registered in the International Prospective Register of Systematic Reviews (PROSPERO), with number CRD42022325482 (Velo Higueras et al., 2022). This paper has been written in adherence with the ENTREQ guidelines for qualitative synthesis reporting (Tong et al., 2012)

Search strategy

Although more than fifteen terms have been identified to describe the phenomenon of interest for this review (McKenzie et al., 2020), following librarian consultation, search terms were limited to *freebirth* or *unassisted birth* as these are the most used in the literature. Following the strategy in table 2, searches were carried out in May 2022 and updated in August 2023. Further sources were located via manual backward citation chasing of selected papers, hand searching of Midwifery journals (such as RCM Midwives), and forward citation using the AI-based tool for bibliographic mapping *Research Rabbit* (Briscoe et al., 2020; Cole and Boutet, 2023). This search strategy was piloted as part of an initial scoping review: duplication of results provided reassurance the search was comprehensive, and no refinements were needed.

Screening

All results were retrieved into Covidence (Veritas Health Innovation 2023). Using the inclusion and exclusion criteria in table 3, MVH initially screened all entries by title and abstract to identify suitable papers, followed by full-text screening of selected papers to assess final inclusion in the review. FD and CK independently screened 10 % of the papers included at title/abstract stage and second read 10 % of included papers. Results from the screening process are reported in the PRISMA diagram (see Fig. 1).

Table 2
Search strategy based on PEO framework.

Population	Exposure	Outcome
Woman	Free birth	Experience*
Women	Free-birth*	Motivation*
Pregnant woman	Freebirth*	View*
Pregnant women	Unassisted childbirth	Choice*
Pregnant people	Unassisted birth	
Boolean operation		
(Woman OR women OR "pregnant woman" OR "pregnant women" OR "pregnant people") AND ("Free birth" OR Free-birth* OR Freebirth* OR "Unassisted childbirth" OR "Unassisted birth") AND (Experience* OR motivation* OR View* OR choice*)		
Databases		
CINALH, PubMed, MIDIRS, Intermid, Scopus, Ethos and EBSCO Open dissertations		

* Wildcard – used to capture variations of root words.

Table 3
Inclusion and exclusion criteria.

	Inclusion	Exclusion	Rationale
Timeframe	1st Jan 2007- Aug 2023	Prior to year 2007	The first empirical publication including women who freebirthed was published in 2006 (McKenzie et al., 2020)
Context	High-income countries*	Middle- and low-income countries	Freebirth is a term used in the context of high-income countries where access to healthcare facilities is relatively unproblematic (O'Boyle, 2016)
Language	English	Any other language	English is the dominant language in scientific literature
Methodology	- Qualitative - Mixed methods with qualitative data	- Quantitative	- Exploring women's subjective experiences and perceptions of freebirth requires a qualitative design
Type of publication	- Primary empirical studies - Thesis or dissertations	- Secondary sources - Opinion pieces or commentaries.	- Published or unpublished dissertations were included due to their rich data content.
Focus of paper (content)	Women's motivations and experiences of freebirth	Other outside-of-guideline care choices	Studies exploring the wider phenomenon of outside-of-guidelines care choices (without explicit inclusion of freebirth) needed to be excluded to increase the validity of the findings.

* Defined as per World Bank Group classification (2021).

Quality appraisal

Included papers were critically appraised by MVH using the Walsh and Downe framework (Walsh and Downe, 2006), modified by Downe et al. (Downe et al., 2007). This framework assesses scope and purpose, design, sampling, analysis, interpretation, reflexivity, ethics, and relevance. Quality ratings were assigned for comparison purposes (see table 4) but given the lack of consensus on score-based inclusion decisions (Butler et al., 2016), no papers were excluded on quality concerns. FD and CK reviewed 10 % of quality appraisal results for consensus.

Data extraction and analysis

Both participant's quotes and the original researcher's interpretations included in the findings section were extracted as data in this review. MVH took the lead in data analysis. Included papers were first read in their totality to generate familiarization with general context and findings. Initial line-by-line coding by content of each paper was conducted inductively, generating initial descriptive codes. These themes were later refined using an iterative process of cross-referencing between papers, looking for similarities and dissimilarities, until no further codes were identified. In a second phase of analysis, MVH developed analytical themes working iteratively, back/forth from the dataset and each of the review questions. Analytical themes were further developed by MVH in discussions with FD and CK, generating the new interpretations presented in this review. The GRADE-CERQual tool was then used to transparently assess the confidence in which the main findings represent women's perspectives on freebirth (Lewin et al., 2018).

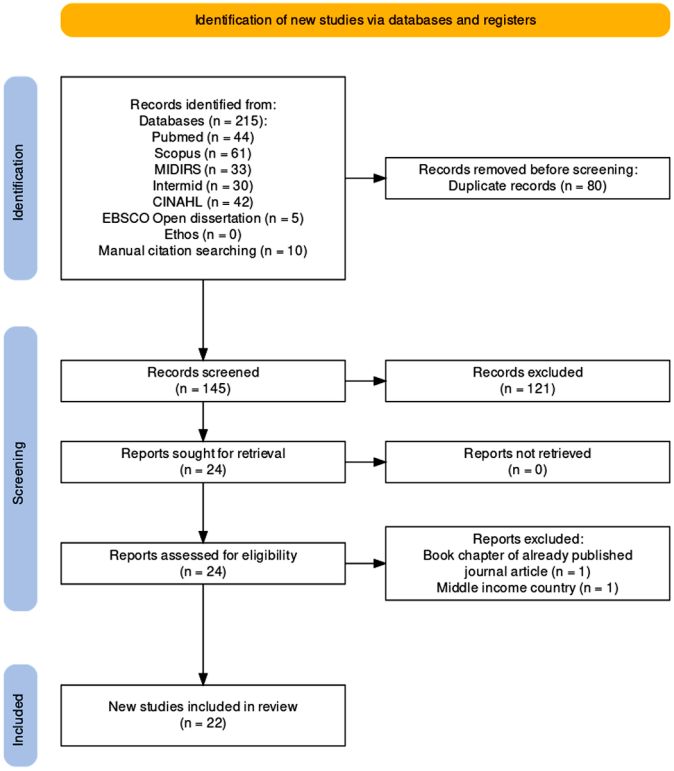

Fig. 1. PRISMA diagram of search results.

Results

A total of twenty-two papers were included in the review (see table 4). This compromised 2 dissertations, 19 qualitative papers and 1 mixed-methods survey study. Publication dates ranged from 2008 to 2023 and ten different countries: USA (n = 6), UK (n = 5), Sweden (n = 3), Australia (n = 2), Netherlands (n = 1), Norway (n = 1), Poland (n = 1), Ireland (n = 1), Canada (n = 1) and Denmark (n = 1). Most studies focused on understanding the *why* of women's choice to freebirth (Henriksen et al., 2020; Lundgren, 2010; O'Boyle, 2016; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; Miller, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023) or to birth "outside the system" (Jackson et al., 2020; Jackson et al., 2012; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022), and only eight studies (Brown, 2009; Lindgren et al., 2017; Lou et al., 2022; Johansson et al., 2023; Miller, 2012; Plested and Kirkham, 2016; C Feeley and Thomson, 2016; McKenzie and Montgomery, 2021) reported *how* women experienced freebirth or maternity care while making this choice. Studies exploring birthing outside the system combined unassisted births with assisted births, such as homebirths with risk factors (Jackson et al., 2020; Jackson et al., 2012; Hollander et al., 2017), births attended by unregulated birth workers (LeBlanc and Kornelsen, 2015), or homebirths with midwives (Sperlich and Gabriel, 2022). Although it was not always possible to differentiate between these subgroups from the researcher's interpretations, only quotes from women who freebirthed were included for data analysis in this review. Included studies incorporated data from 135 qualitative survey answers and 195 individual interviews, of which 152 were women who either freebirthed or considered it. The demographic profile of these women is difficult to outline as reported data varied between papers: 77 % of interviewees were multiparous, approximately 13 % primiparous and in another 10 % parity was not reported. Ethnicity was reported in only six studies (O'Boyle, 2016; Greenfield et al., 2021; Freeze, 2008; Brown,

Table 4
Study characteristics.

	Author, year, country	Aim	Methods	Sample	Data collection and analysis	Quality rating	Main findings
1	Freeze, 2008, USA	Not stated	Undefined feminist methods (dissertation)	$N = 74$ All freebirthed Primiparous and multiparous	Interviews ($n = 13$) Qualitative survey ($n = 61$) Unclear use of online forums entries Unclear method of analysis	C	After setting unassisted birth in historical context, this paper explains why women make this choice; the knowledge sources they favour; how they understand the concepts of safety, risk, and responsibility, and their complex and sometimes contradictory relationship with midwifery. It also examines midwifery, and to a smaller degree, obstetrical perspectives on unassisted birth, focusing on how birth attendants who are sympathetic to unassisted childbirth reconcile that with their training and experience attending births.
2	Miller, 2009, USA	Not stated	Undefined, appears grounded theory	$n = 127+6$ All freebirthed Parity not reported	Online birth stories ($n = 127$) Interview ($n = 6$) GT* analysis	C	Unassisted childbirth builds on the midwifery philosophy and women's intuitive body knowledge. Most women come to freebirth from midwifery but at some point in their journey, start to see a midwife as unnecessary. Despite their rejection of the medical model, women and their partners carried out interventions during birth like the ones a doctor or midwife would do.
3	Brown, 2009, USA	To explore women's motivations for choosing unassisted childbirth and the lived experience of unassisted childbirth	Undefined, appears grounded theory (dissertation)	$n = 9$ All freebirthed Primiparous and multiparous	Interview GT analysis	B	Women's motivations for choosing unassisted childbirth centered upon their desire to have control over their birth. This desire was reflective of their dissatisfaction with previous birth experiences. Women prepared for their unassisted birth doing extensive research about birth and how to handle complications. In case of need, they arranged transfer to hospital or back-up care by midwives or doctors.
4	Lundgren, 2010, Sweden	To describe women's experiences of giving birth and making decisions whether to give birth at home when professional care at home is not an option in public health care	Phenomenology life world approach	$n = 7$ Freebirthed or considered it Multiparous	Interview Appears IPA**	A	Homebirth is not publicly funded in Sweden. Women wishing to have a homebirth experienced barriers to access this service, which led them to consider unassisted birth as an alternative. Despite this, they mostly report positive support from their midwives, although stigma and being negatively treated are also present in their narratives of care. Some women felt left alone and punished.
5	Miller, 2012, USA	To examine the ways in which advocates and practitioners manage the stigma of unassisted childbirth	Not stated, appears part of wider ethnography study	$n = 21$ Initial 6 participants appear same as Miller 2009. All freebirthed Parity not reported	Interview Online birth stories ($n = 127$) Analysis not discussed	C	Freebirth is a deviant option even in communities that support homebirth. Women choosing this experience stigma that they managed in three different ways: hiding their plans and disclosing it only when it feels safe, passing by they are choosing a socially accepted option, or turning stigma around and becoming and advocate.
6	Jackson et al., 2012, Australia	To explore how women who make the choice to birth outside of the mainstream birthing system perceive the risks associated with birth and place of birth	Qualitative Interpretive	$n = 20$ Freebirth and high-risk homebirth Multiparous (freebirth)	Interview ($n = 20$) TA***	B	Participants perceived hospitals as a less safe environment that birth at home due to interference and overmedicalization. Women weighted up physical and emotional risks of all their options in making their birth decisions. Women who chose to birth outside

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Table 4 (*continued*)

	Author, year, country	Aim	Methods	Sample	Data collection and analysis	Quality rating	Main findings
							the hospital were highly educated and undertook further education and training to mitigate risks during birth outside-the-hospital.
7	LeBlanc and Kornelsen, 2015, Canada	To uncover New Brunswick women's reasons for planning an unassisted birth	Undefined qualitative	$n = 9$ Freebirthed or unregulated birth attendants Parity not reported	Interview General thematic coding	C	Predominant motivator for women was the need to maintain autonomy during birth, often in response to previous disempowering experiences in hospital. Women sought midwifery care but were unable to access this as midwifery is not a licensed profession in the setting of this study. Some found unregulated lay midwives while others opted to birth unattended.
8	O'Boyle, 2016, Ireland	Not stated	Case study	$n = 4$ All freebirthed Multiparous	Interview Analysis not discussed	D	The women in this paper were unable to access midwife-attended homebirth. They depended on emergency services for hospital transfer. They hid their intention to birth unattended in order to avoid criticism and negative repercussions.
9	Plested and Kirkham, 2016, UK	To examine risk discourse as experienced by women who birth without a midwife or any other healthcare professional in the UK	Phenomenology, reflective lifeworld research	$n = 10$ All freebirthed Primiparous and multiparous	Interview Hermeneutical analysis	A	Women reported a culture of fear and defensive practice in maternity care. Fear based 'risk-talk' is used as a scare tactic to coerce women into approved choices; if women do not comply, they are labelled 'risk-takers' and can become ostracised and coerced by the maternity care system
10	C Feeley and Thomson, 2016a, UK	To identify and explore what influence women's decision to freebirth in a UK context	Hermeneutic Phenomenology	$n = 10$ All freebirthed Primiparous and multiparous	Narratives ($n = 9$) Interview ($n = 10$) IPA	A	Women's decision to freebirth is influenced by their personal backgrounds and previous experiences of birth. Woman-centred care is not always carried out by UK midwives, leaving women to feel disillusioned, unsafe and opting out of professional care for their births
11	C Feeley and Thomson, 2016b, UK	To explore untold aspects of the participants experiences to emphasize the conflicts and tensions they faced when enacting their freebirth choice	Secondary analysis of data collected in Feeley and Thomson 2016a		TA	A	Women faced conflicts with maternity care systems over their legal right to freebirth that could lead to child protection concerns being raised. This generated distressed for women, who used tactical planning to circumnavigate reprisals and interference from healthcare professionals.
12	Lindgren et al., 2017, Sweden	To describe eight women's experience of unassisted planned homebirth in Sweden	Phenomenology, reflective lifeworld research	$n = 8$ All freebirthed Parity not reported	Interview IPA	A	Midwives are perceived as representatives of a medical paradigm. A wish to be cared for by a midwife conflicted with the fear of not maintaining integrity and respect during birth. Giving birth unattended is understood as self-protection and taking on responsibility. Women make arrangements to make the birth safe but also encounter opposition and lack of support from maternity services.
13	Hollander et al., 2017, Netherlands	To explore the motivations of Dutch women who have chosen to give birth "outside the system"	Grounded theory	$n = 28$ Freebirthed and high-risk homebirth Primiparous and multiparous	Interview GT analysis	A	For most women in this study the choice for a homebirth in high-risk pregnancy or unassisted birth was a negative one, due to previous negative experiences with maternity care and/or conflict surrounding the birth plan.
14	Diamond-Brown, 2019, USA	To examine how structural limitations of the US healthcare system intersect with values in decision-	Secondary report of data collected in Brown 2009			B	Lack of informed consent and self-determination in previous experiences was central motivation for women opting to unassisted

(*continued on next page*)

Table 4 (*continued*)

	Author, year, country	Aim	Methods	Sample	Data collection and analysis	Quality rating	Main findings
		making processes about childbirth					birth. Women believed in the tenets of the midwifery model of care, but this was either unavailable, inaccessible or did not meet their expectations.
15	Jackson et al., 2020, Australia	To explore what motivates Australian women to birth outside the system	Grounded theory	Interview participants appeared same as Jackson, Dahlen and Schmied, 2012	Interview ($n = 20$) Narrative ($n = 8$) GT analysis	B	The choice to birth outside the system was motivated by a search for the best and safest circumstances for the birth. Previous negative experiences within the system taught women hospital care was emotionally unsafe. All but one of the women had tried to find a midwife to support them during birth, but they freebirthed because they felt they had no other options.
16	Henriksen et al., 2020, Norway	To describe Norwegian women's motivations and preparations for freebirth	Generic qualitative	$n = 12$ Freebirthed or considered it Primiparous and multiparous	Interview Content analysis	A	Women displayed a deep trust in birth as a natural process and their own capacity to give birth alongside distrust of the maternity care system. Overall dissatisfaction with previous experiences of maternity care and inadequate homebirth offer in Norway were the main motivators for freebirth. Most women sought midwives but planned freebirth as a second option if a midwife was not available.
17	Greenfield et al., 2021, UK	To explore the experiences of perinatal care of those who are due to have a baby in the first months of lockdown in the UK and how they feel about these experiences (Freebirth data subset)	Mixed-methods	$n = 72$ Considered freebirth Parity not reported	Online survey TA	A	All except one of the participants had not planned or considered freebirth before the pandemic. Barriers to access homebirth or rigid protocols to access birth facilities (like restrictions around birth partners) led some families to consider freebirth during the COVID-19 pandemic. Freebirth was a back-up plan in case they did not manage to secure their preferred birth choice.
18	McKenzie and Montgomery, 2021, UK	To understand women's experiences of undisturbed physiological birth by exploring the narratives of women who have freebirthed their babies in the United Kingdom	Undefined qualitative, appears part of wider study	$n = 16$ All freebirthed Primiparous and multiparous	Interview Voice centred relational method	A	All women accessed various health services at some point within their journeys. Women described using their embodied knowledge during birth to guide the process and interpret the baby's movement. They described speedy, instinctive births that appear to reflect the fetus ejection reflex. Undisturbed physiological birth was both a deeply impactful and positive physical and emotional experience.
19	Baranowska et al., 2022, Poland	To examine the larger context of maternity services in Poland and identify elements of care contributing to women's decision to birth without midwifery and medical assistance.	Modified ethnography	$n = 12$ All Freebirthed Multiparous	Interview TA	A	Previous negative birth experiences with mainstream maternity service were the main motivation for women to seek alternative birth options. Patchy availability of homebirth service, lack of continuity of carer and rigid provision of care contributed to their decision to freebirth.
20	Sperlich and Gabriel, 2022, USA	To investigate the out-of-hospital birth decision-making of two clinically important and understudied subgroups of women: black women and women who have experienced childhood trauma.	Appears grounded theory	$n = 18$ Freebirthed or attended homebirth Multiparous (freebirth)	Interview GT analysis	A	Women with previous trauma and Black women chose out-of-hospital birth (attended or unattended) to avoid discrimination and repeated trauma. Women engaged in an extensive process of educating themselves about birth and their options. Women who sought attended out-of-hospital births were unable to enact their choices due to diverse obstacles that led them to opt for unattended birth.

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Table 4 (*continued*)

	Author, year, country	Aim	Methods	Sample	Data collection and analysis	Quality rating	Main findings
21	Lou et al., 2022, Denmark	To explore and understand women's motivations and preparations for freebirth	Qualitative	$n = 10$ Freebirthed or considered it Multiparous	Interview TA	A	Women considered freebirth due to negative previous experiences or perceived inability to recreate positive previous ones. Women used multiple sources of information to make informed decisions about their birth and to optimize their physical, mental and/or spiritual health.
22	Johansson et al., 2023, Sweden	To elaborate further on women's freebirth experience in a Swedish context	Qualitative descriptive	$n = 9$ All freebirthed Multiparous	Interview Experiential textual data analysis	A	Previous negative experiences with hospital and maternity care were reasons for a freebirth preference. Women wanted individual, midwife-assisted homebirth support, but that was not always possible. To give birth in peace and in self-control at home was important. Women had powerful and positive experiences of freebirth.

* GT: grounded theory.
** IPA: interpretive phenomenological analysis.
*** TA: Thematic analysis.

2009; C Feeley and Thomson, 2016; Sperlich and Gabriel, 2022) reflecting a majority of White women. When education was reported (Henriksen et al., 2020; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Lou et al., 2022; Jackson et al., 2012; Hollander et al., 2017), most women were highly-educated.

Quality of included studies was generally good, however varying limitations need to be noted. Papers by Jackson et al. (Jackson et al., 2020; Jackson et al., 2012) and Miller (Miller, 2009; Miller, 2012) appear to be partial reporting of wider primary research studies, therefore interview participants in both papers of each author appeared to overlap. In three papers, there was limited methodological discussion on the use of online birth narratives as data: in Miller (Miller, 2009), it was not clear how these stories were selected, Baranowska et al. (Baranowska et al., 2022) used them in line with ethnographic design to gain a better understanding of the phenomenon but it was unclear how they influenced the analysis of data, and in Freeze (Freeze, 2008) it was unclear how this data was selected, analysed or used in the final study. Other reasons for lower quality rating in the included studies were the lack of clarity in some areas of data collection or undefined data analysis methods (see table 4).

Three main analytical themes were developed in response to each of the review questions. '*A quest for a safer birth*' describes the factors influencing women's decision to freebirth. '*Powerful and powerless midwives*' describes women's perceptions of their care providers (mostly midwives) and how these perceptions influenced their decision to freebirth. '*Rites of self-protection*' describes women's care experiences and self-care practices in the pregnancy leading to freebirth. The GRADE-CERQual summary of review findings and confidence assessment are presented in appendix A. Thirteen key finding statements were generated, where six had high confidence, six moderate, and one had low confidence.

A quest for a safer birth

Women's journey to freebirth was in most cases the result of a complex process of decision-making, seeking a safer birth than what they had experienced in previous pregnancies. Personal or vicarious negative experiences of care were identified in fourteen papers as the common ground for women's decision to freebirth (Jackson et al., 2020; Henriksen et al., 2020; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; Jackson et al., 2012; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022). These experiences took place in hospitals, midwifery-led settings, and homebirths, ranging from dissatisfaction with the care received, to traumatic events of abuse, coercion, and unconsented practices.

> Nothing that can happen to me or my baby at home could be much worse than what my second baby and I experienced in hospital. I will never subject myself, my baby or my family to such an ugly, traumatic and dehumanising experience again'. (FB1, in (Jackson et al., 2020), Australia)

Only three papers reported cases where freebirth was a positive decision influenced by previous positive and empowering experiences (Lundgren, 2010; C Feeley and Thomson, 2016; LeBlanc and Kornelsen, 2015), or where freebirth was not a choice but a possibility women prepared for due to very fast previous births (Henriksen et al., 2020; Greenfield et al., 2021; Freeze, 2008). The previous negative care experiences influenced what mattered to women and what they perceived as safe care. Fourteen papers (Jackson et al., 2020; Henriksen et al., 2020; Lundgren, 2010; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; Miller, 2009; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Jackson et al., 2012; LeBlanc and Kornelsen, 2015; Sperlich and Gabriel, 2022) described women's belief that physical safety is best protected by minimising disruption to the birth physiology, while emotional safety is achieved by keeping control over the decision-making process. Women believed both elements of safety were threatened by institutionalised maternity care, where hospitals were perceived as sites of power that overmedicalise birth and/or '*strips women of their autonomy*' (Lou et al., 2022). Hospitals were seen as the safer option only if complications arose (Lundgren, 2010; Freeze, 2008; LeBlanc and Kornelsen, 2015).

> If I notice anything that is not OK then we will go to the hospital (…) but when I feel that I am healthy and my baby is healthy, I would be

more afraid of them. (Unnamed woman, in (Lundgren, 2010), Sweden)

In this quest for a safer experience, freebirth was rarely women's first option: most women in the included papers tried in the first place to secure access to a midwife-attended birth but they failed to do so due to structural barriers in homebirth provision. In studies from USA and Canada, the absence of regulated midwifery in certain areas restricted access to attended homebirths (Freeze, 2008; Brown, 2009; Miller, 2009; Diamond-Brown, 2019; LeBlanc and Kornelsen, 2015; Sperlich and Gabriel, 2022). In other countries, lack of available midwives (Henriksen et al., 2020; O'Boyle, 2016; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023) or strict regulation of midwifery-led services (O'Boyle, 2016; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; Diamond-Brown, 2019; Baranowska et al., 2022; Sperlich and Gabriel, 2022) made access to attended homebirth care difficult. For instance, some women were unable to secure access to midwifery-supported homebirths if they did not have '*anything other than a perfect obstetric history*' (Henriksen et al., 2020; Greenfield et al., 2021; Diamond-Brown, 2019; Baranowska et al., 2022), or lived within an established distance from hospital (Henriksen et al., 2020; O'Boyle, 2016; Johansson et al., 2023). Other women tried to hire an independent/private midwife as an alternative to publicly-funded care, but they were faced with similar barriers, with the addition of the financial cost of this option (Greenfield et al., 2021; Freeze, 2008; Baranowska et al., 2022; Johansson et al., 2023; Sperlich and Gabriel, 2022). The inability to access midwifery-attended homebirth made some women feel frustrated (Freeze, 2008), unsupported or '*being backed into freebirth*' (Greenfield et al., 2021).

Powerful and powerless midwives

Women's desire to have a midwife co-existed with a mistrust of institutional midwifery. This mistrust was based on two contrasting perceptions: midwives as powerful authorities aligned with the institutional system, or midwives as powerless practitioners restricted in their ability to support individualised choices. Seven studies (Freeze, 2008; Brown, 2009; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Jackson et al., 2012) reported how in previous pregnancies women had experienced power struggles with their care providers that eroded women's trust in healthcare professionals. Midwives, but also obstetricians, were seen as taking a position of authority or '*in charge*' during birth (Miller, 2009) for which women '*had no power to argue*' (Baranowska et al., 2022). The implicit primacy of care providers' technical knowledge over women's embodied one reinforced this power imbalance, making women feel their concerns, sensations or needs were ignored or dismissed (Brown, 2009; Diamond-Brown, 2019; Baranowska et al., 2022). To stay in control of their birth, women described needing to actively fight or resist this authority (Lindgren et al., 2017; Lou et al., 2022; Jackson et al., 2012), which was not always easy.

So my midwife had a total freak out on me and said she wanted to transport me and I said "NO!- (…) Listen to me, I know my body, I know my baby, I know birth- there is nothing wrong". I had to be forceful at a time I didn't want to be (…) (unnamed woman, in (Brown, 2009), USA,)

Alongside these power conflicts, in six studies women described institutionalised midwifery as medicalised, aligned with the obstetric model and unable to provide an alternative (Freeze, 2008; Miller, 2009; C Feeley and Thomson, 2016; Jackson et al., 2012; Sperlich and Gabriel, 2022; Plested and Kirkham, 2016). As midwives were perceived to *'medicalise the process through clinical checks and 'interfering' in the natural flow of birth'* (C Feeley and Thomson, 2016), their presence at birth was sometimes seen as a threat to birth safety. In contrast with these powerful figures, women could also see midwives as disempowered practitioners with limited ability to support their non-normative choices. This limited ability was related in ten papers with strict midwifery professional and employment obligations that forced midwives to work within certain regulatory parameters (Lundgren, 2010; O'Boyle, 2016; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Diamond-Brown, 2019; Lou et al., 2022; Hollander et al., 2017; Plested and Kirkham, 2016). Other papers also mentioned fear of bad outcomes or litigations as a strong influence on midwives' readiness to support out-of-guideline choices (C Feeley and Thomson, 2016; Lou et al., 2022; Hollander et al., 2017; Plested and Kirkham, 2016).

She just couldn't facilitate me with the homebirth—insurance is through the HSE so they can only operate under these very stringent conditions…' (Felicity, (O'Boyle, 2016), Ireland)

Despite these generalised negative perceptions of institutional midwifery, women longed to find a distinct midwife who would share their same values and listen to their wishes. Yet, eleven studies reported how fragmented models of care and lack of continuity of carer prevented women from building trusting relationships with the different midwives they met (Henriksen et al., 2020; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Sperlich and Gabriel, 2022; Plested and Kirkham, 2016). Midwives unknown to the woman were seen to bring uncertainty to the birth process, which made some women decide to freebirth despite the availability of publicly funded midwifery-attended homebirth care.

I knew that it would be the luck of the draw as to who would actually be there and it might not necessarily be that one of seven, or nine [midwives], that we'd really bonded with. So that was my whole worry. (Natalie, in (Sperlich and Gabriel, 2022), USA)

'I think it is important to know them [the midwives] and that they know me, what I want and my thoughts regarding birth, my prior experience, what I know about giving birth and stuff like that. Because if they don't, they just guess, … and most of the time they guess wrong'. (unnamed woman, In (Henriksen et al., 2020), Norway)

Rites of self-protection

Depending on when the decision to freebirth was made, women had diverse forms of pregnancy care. Most of those aiming to have a like-minded midwife at the birth engaged with usual in-system antenatal care (Henriksen et al., 2020; O'Boyle, 2016; Diamond-Brown, 2019). Those who considered freebirth from early stages of the pregnancy opted for in-between or out-system care. In-between care meant seeking ad-hoc consultations or accepting specific antenatal tests in combination with self-care (C Feeley and Thomson, 2016; Hollander et al., 2017; Sperlich and Gabriel, 2022; McKenzie and Montgomery, 2021). Out-system did not mean a lack of care, but varied self-care practices. Some women did similar clinical monitoring to what a midwife would do, like taking their blood pressure, auscultating fetal heart, urinalysis, or tracking fundal height (Freeze, 2008; Miller, 2009; C Feeley and Thomson, 2016; Hollander et al., 2017; Miller, 2012). For many women, self-care went beyond risk detection into positively *'setting the scene'* for freebirth (Jackson et al., 2020), focusing on nutrition, exercise, reducing stress, or meditation (Freeze, 2008; Brown, 2009; Lou et al., 2022).

In-between care or selective engagement was a self-protection

measure against negative encounters with health care professionals, that were reported in ten of the included papers (Lundgren, 2010; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Johansson et al., 2023; Hollander et al., 2017; Miller, 2012; Plested and Kirkham, 2016; C Feeley and Thomson, 2016). When trying to negotiate their care needs in the pregnancy leading to freebirth, women experienced new power struggles with care providers in the form of negative manipulation tactics, such as lying (Lundgren, 2010; Brown, 2009; C Feeley and Thomson, 2016), coercion using exacerbated risk discourse (Hollander et al., 2017; Plested and Kirkham, 2016), harassment (C Feeley and Thomson, 2016), threats to withdraw care (Freeze, 2008; Brown, 2009), or inappropriate referrals to social services (Hollander et al., 2017; Miller, 2012; Plested and Kirkham, 2016; C Feeley and Thomson, 2016). These negative behaviours made women feel stigmatised and judged, *'like a pariah'* (Lundgren, 2010), creating a great source of distress. In some cases, this experience compounded women's previous trauma, reinforcing their mistrust in the system and becoming the turning point that ultimately led to the decision to freebirth. In contrast, only five papers (Lundgren, 2010; C Feeley and Thomson, 2016; Johansson et al., 2023; Hollander et al., 2017; C Feeley and Thomson, 2016) included anecdotal reports of women meeting supportive practitioners whom they were able to discuss their plans with.

> how I felt, betrayed by the people I had trusted to take care of me, and that was when I realized I needed to start taking care of myself. (Unnamed woman, (Brown, 2009), USA)

Unable to negotiate care inside the system, and unable to discuss their plans, women kept their intention to freebirth hidden or only disclosed it to supportive individuals. Protecting their decision sometimes meant making pre-planned tactics to *'play the game'* (Jackson et al., 2020), such as booking an attended homebirth while planning not to call the midwives (Freeze, 2008), or calling late for help *'pretending it happened so quickly they didn't' get there in time'* (Jackson et al., 2020; O'Boyle, 2016; Freeze, 2008; Johansson et al., 2023; Plested and Kirkham, 2016; C Feeley and Thomson, 2016).

Self-protection also required women to engage in extensive research to inform their decisions, as reported in eleven papers (Henriksen et al., 2020; Lundgren, 2010; Freeze, 2008; Brown, 2009; Miller, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; Hollander et al., 2017). Women drew from diverse sources, such as professional advice from supportive midwives, midwifery textbooks, and informal peer support networks. This allowed women to utilise both technical and experiential knowledge to make decisions about their care and to create detailed self-care plans. To maximise the safety of their births, women *'prepared for everything'* (Jackson et al., 2020): some gathered basic equipment (Jackson et al., 2020; Lundgren, 2010; Freeze, 2008; Baranowska et al., 2022; Johansson et al., 2023), and others hired a doula or had a friend/relative present to provide emotional and logistical support (Lindgren et al., 2017; Lou et al., 2022; Johansson et al., 2023; McKenzie and Montgomery, 2021). To manage potential complications, women planned to drive to hospital (Jackson et al., 2020; Henriksen et al., 2020; Baranowska et al., 2022; Johansson et al., 2023), call an ambulance (O'Boyle, 2016; Lou et al., 2022; Johansson et al., 2023), or call their back-up midwife (Freeze, 2008; Brown, 2009; Lou et al., 2022; Hollander et al., 2017; Miller, 2012). Some also educated themselves and their birth partners to identify and respond to complications while waiting for help (C Feeley and Thomson, 2016; Johansson et al., 2023; Hollander et al., 2017).

While only one of the included papers explored specifically women's experiences of freebirth (McKenzie and Montgomery, 2021), other twelve papers (Jackson et al., 2020; Lundgren, 2010; Freeze, 2008; Miller, 2009; Lindgren et al., 2017; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022) included descriptions of women's perception of their birth experience. Women described their freebirths as positive, empowering, and easier than their previous births. For some, freebirth provided a healing opportunity for their previous traumatic experiences (Baranowska et al., 2022; LeBlanc and Kornelsen, 2015; Sperlich and Gabriel, 2022). On the other hand, women who had hoped to have a midwife also reported how they would have liked a midwife present to guide them through the most intense moments of birth (Lundgren, 2010; Freeze, 2008; Brown, 2009; Lindgren et al., 2017). Despite this, and regardless of what influenced women's choice to freebirth, women described how taking full responsibility for their birth journey generated a sense of personal transformation and empowerment. This was evident whether women ultimately freebirthed or not.

> It's as if his birth flipped a switch in me and I have been unable to stop taking back my sense of responsibility over my life on every level (Sun, (Freeze, 2008), USA)

> It was absolutely perfect; it was just the most incredible, wonderful experience of my entire life. I was just totally, totally transformed by that birth (Unnamed woman in (LeBlanc and Kornelsen, 2015), Canada)

Only two papers (C Feeley and Thomson, 2016; McKenzie and Montgomery, 2021) included a reference to perinatal outcomes, reporting that no major complications were experienced by either women or their babies. The impact of freebirth on future births was only explored in four studies (Lundgren, 2010; Freeze, 2008; Baranowska et al., 2022; LeBlanc and Kornelsen, 2015), with no apparent consensus: some women would decide to freebirth again as their primary choice, while others would still try to find a supportive, known midwife and if unable to do so again, repeat their freebirth experience.

Discussion

Consistent with the findings from previous systematic reviews on women's motivations to freebirth (Feeley et al., 2015; Norton, 2020), this review has identified what mattered to women who freebirthed in the included studies was not different than what matters to most women: to have a physical and psychologically safe birth, optimising physiological body processes and maintaining control over decision-making (Downe et al., 2018). This review has revealed how freebirth was rarely women's primary choice, but the result of previous negative experiences of care and a context of restrictive choice within maternity services. Faced with structural and relational barriers to access wanted care, women turned to self-care in the form of freebirth to achieve a safer birth experience and to protect their reproductive self-determination (see Fig. 2).

A context of reproductive injustice

Women's right to reproductive autonomy is recognised in all the countries of the included studies, however for most women in this review this did not necessarily translate into a de-facto ability to exercise it. Their narratives reflected a context of systemic institutional and relational injustices that denied them access to high-quality, personalised maternity care (Capo and Lazzari, 2022). Most women in this review initially sought a homebirth supported by a trusted known midwife. Yet, a series of structural barriers within maternity services restricted women's access to this care. The barriers reported in this review are not new: previous studies have already identified how restrictive criteria for homebirth care (Sassine et al., 2021), strict regulation of private midwifery practice (Rigg et al., 2017), unequal access to independent midwives (Symon et al., 2010) or restricted access to midwifery-led care for women with risk factors (McCauley et al., 2019; H Keedle et al., 2022) can turn homebirth into an option only available to few women. Being cared for by a known midwife in a relationship-based model of care enables women's non-normative birth

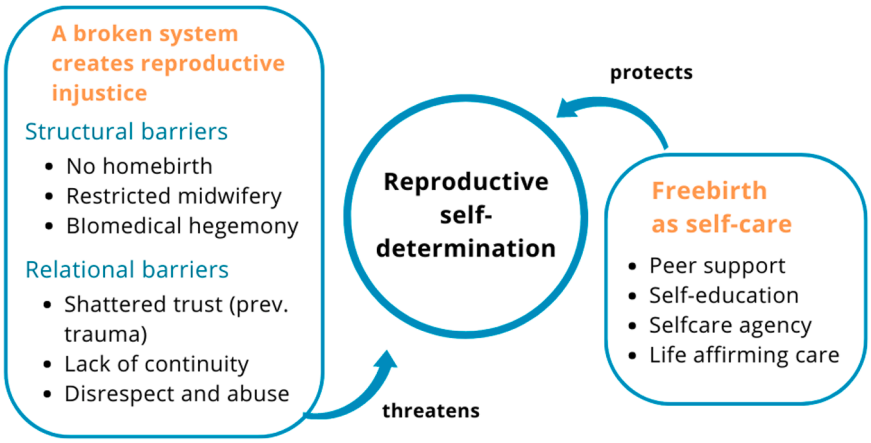

Fig. 2. Illustration of review findings.

choices (Feeley et al., 2020; Opdam et al., 2021; Townsend et al., 2023) and it can lead to a more empathic care experience (Sandall, 2017) but for women in this review, this was rarely an option. Except for New Zealand, no countries have yet scaled-up continuity of midwifery carer models to being the standard provision, with most initiatives in high-income countries located only in urban areas (Bradford et al., 2022), creating disparities in access to intrapartum care by a known midwife. Women not only experienced difficulties in accessing home-birth care with a known midwife, but they also faced difficulties in their relationship with healthcare professionals. In a context of biomedical dominance, midwives were perceived as powerless to support women with their choices. In line with previous research, midwives' lack of professional autonomy in this review was related to the negative impact of birth medicalisation and over-regulation of midwifery practice (Hunter et al., 2021; Small et al., 2022). By contrast, midwives were also perceived as too powerful, pressuring women to comply with standard care, which on occasions escalated to disrespect, abuse, and coercion. These negative behaviours are not rare in maternity care (Logan et al., 2022; Oelhafen et al., 2021; H Keedle et al., 2022; Freedman and Kruk, 2014) but appear to be particularly prevalent when women make decisions against guidelines (H Keedle et al., 2022; Townsend et al., 2023; Niles et al., 2021; Stoll et al., 2021; Langley, 2021; Woodman and Way, 2020; Jenkinson et al., 2017), with women being characterized as deviant mothers and stigmatised for it (Bayly and Downe, 2018). Disrespectful care is a well-known factor leading to avoidance of wanted care (Greenfield and Marshall, 2022; Finlayson and Downe, 2013), which in this review materialised as women not only choosing freebirth but hiding their decision from healthcare professionals to protect themselves from emotional harm.

Self-care in response to reproductive injustice

Healthcare services in the included studies failed to provide unrestricted, equal, free access to a wide range of options, which threatened women's ability to exercise their right to reproductive autonomy (Senderowicz, 2020; Ross and Solinger, 2017). In this context of reproductive injustice, self-care in the form of freebirth became the tool that allowed women to protect their reproductive self-determination (T. Morison, 2021). Self-care in response to inadequate mainstream health services is not a new phenomenon in women's reproductive health. In the 1960–70 s, the feminist self-help movement emerged as an alternative to inadequate and disempowering gynaecological care (Dudley-Shotwell, 2020). Like the self-help feminists, but with a modern twist in the form of online peer support communities, women in this review developed their self-care capacity by engaging in extensive research. This is not unique to women who freebirth: similar extensive self-education journeys have been reported when women plan home-births (Gillen et al., 2023), waterbirths with previous caesareans (Townsend et al., 2023), or other non-normative choices (Madeley et al., 2023). While self-education empowered all these women to advocate for their reproductive choices, women who freebirthed also used this knowledge to strengthen their own capabilities to care for themselves and their babies, becoming '*midwives to themselves*' (Miller, 2009). Women implemented similar rituals of care as those done by midwives to minimise disruption to the birth process (Reed et al., 2016), and by actively promoting and protecting the physiology of birth, they demonstrated a salutogenetic approach to care (Muggleton and Davis, 2022). Women also gathered equipment and made emergency plans to deal with complications. The extent to which women in this review developed their self-care agency provides enough evidence to justify a change in our definition of freebirth. Current definitions of freebirth are institution-centred, focused on the absence of healthcare professionals or their actions ("unassisted"), or emphasizing freebirth as a deviant behaviour where women opt out of recommended options ("out-side-of-guidelines"). Considering the findings of this review, a new definition of freebirth is proposed as "the practice of self-care during birth, where emergency maternity care is readily available". Despite the midwifery model of care seeking to empower women to assume responsibility for their health (International Confederation of Midwives 2014), the concept of self-care remains relatively unexplored in the maternity context. Only recently self-care has been advocated as an innovative approach to improve maternal outcomes in low- and middle-income countries (Shahil Feroz, 2022; World Health Organization 2022), where a context of "too little, too late" care negatively impacts maternal and neonatal outcomes (Miller et al., 2016). The discussion on self-care does not appear to have expanded into countries of "too much, too soon" care, yet women in this review used self-care to address the most prevalent issues in this context: the overuse of medical interventions, and the raising rates of birth trauma (Miller et al., 2016). In a similar manner that the self-help feminist movement led to improvements in women's health medicine (Dudley-Shotwell, 2020), understanding freebirth as a self-care practice could ignite new discussions about how to prioritise women's autonomy to achieve respectful maternity care (Puthussery et al., 2023). Defining freebirth as self-care instead of absence of care can also reduce the stigma associated with this practice, leading to improvements in women's experiences of care: instead of trying to dissuade women from freebirth, caregivers could strengthen women's self-care agency by sharing information to help them identify when further help is needed (Menage and Hogarth, 2022). Showing trust in women's ability to self-care and to make autonomous

decisions could in return restore women's trust in their caregivers (Lewis et al., 2017), increasing their access to attended care. Most importantly, redefining freebirth as a self-care practice refocuses our understanding of this phenomenon on the first-hand experience of women, reinforcing women's role as responsible agents in their birth.

Strengths, limitations, and future research

This qualitative evidence synthesis is the most comprehensive to date, including 22 publications from ten different high-income countries. The most important contribution of this review is the reconceptualisation of freebirth as a self-care practice during birth. Although most women in this review reported positive outcomes, it is unknown how freebirth impacts maternal and perinatal outcomes, and future research should also address this gap. Another strength of this review is the use of a feminist lens to guide the interpretation of data. This has allowed us to better understand how the context of maternity services, and the power dynamics within it, influenced women's decision to freebirth. As the main care providers in most of the included studies, midwives played a significant role in the reproductive injustices experienced by women; yet the experience of midwives who come into contact with women who freebirth is largely absent from the literature. Operating in the same context of maternity care, midwives may be both subject of and contributors to the power inequalities reported in this review, and their perspectives could provide further insight to improve our understanding of this complex phenomenon.

There were also limitations in this review. We restricted inclusion to papers of only high-income countries, as freebirth is currently considered only in contexts where medical facilities are readily available (Henriksen et al., 2020; McKenzie et al., 2020; Lundgren, 2010; O'Boyle, 2016; Greenfield et al., 2021; C Feeley and Thomson, 2016; Baranowska et al., 2022). The last decades have seen an advancement in the percentage of births attended by skilled health personnel globally (Delivery care [Internet] 2022), mostly via scaling-up hospital-based births (Hernández-Vásquez et al., 2021); yet some women in low- and middle-income countries are not using these facilities when available due to similar reasons than women who freebirth, such as perceiving hospitals as not necessary for normal birth (Montagu et al., 2011), experiencing negative interactions with healthcare providers (Morrison et al., 2014), or because the facility-based care is not culturally safe (Tucker et al., 2013). Shorey et al. (Shorey et al., 2023), recently argued that women in low- and middle-income countries may freebirth too, but further research is needed to understand if and how freebirth happens beyond high-income contexts.

Another limitation of this review relates to the sample in the included studies, that featured predominantly White, heterosexual, highly educated women. It can be argued the social location of these women facilitated their access to power to make decisions and the resources to act on them (T. Morison, 2021). Yet, anecdotal data from USA suggests Black women may be more likely to give birth unattended (Sperlich and Gabriel, 2022) and women and people identifying as LGTBQ have also been reported as more likely to consider freebirth (Greenfield et al., 2021), but their voices are largely absent from the literature. Given the impact of intersectional oppressions (such as racism, homophobia, social vulnerability, or low literacy) on women's ability to make reproductive decisions (Ross, 2017), further research on freebirth should seek to include these demographic groups. While some primiparous women were also included in the samples, data referring to these women was scarce, preventing further analysis in this demographic group. Finally, while for most women in this review freebirth was a response to reproductive injustices, anecdotal data within the included papers also referred to women for whom freebirth was a positive choice. As recently pointed out by Plested (Plested, 2023), it is possible the term freebirth does not adequately capture the experience of these women, demonstrating the need to continue exploring and conceptualising this complex and nuanced phenomenon.

Conclusions

Despite the diversity in the contextual and individual circumstances of the participants in the included studies, this review has revealed common themes in women's motivations to freebirth, their perception of current maternity care provision and their care experience during the pregnancy leading to freebirth. For most women, freebirth was rarely their primary choice, but the consequence of a context of restrictive policies, inequitable access, and unequal power relationships with care providers. In this context of reproductive injustice, self-care in the form of freebirth helped women to achieve a safer birth experience, protecting their reproductive self-determination and generating a sense of personal transformation and empowerment. A new definition of freebirth is proposed as the practice of self-care during birth.

CRediT authorship contribution statement

Maria Velo Higueras: Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Flora Douglas:** Writing – review & editing, Validation, Supervision. **Catriona Kennedy:** Writing – review & editing, Validation, Supervision.

Declaration of competing interest

The authors declare they have no conflict of interest, known competing financial interests or personal relationships that could have influenced the work reported in this paper.

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Ethical statement

Ethical approval was not required due to nature of the work being a qualitative evidence synthesis.

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Review registration

The review protocol for this study was submitted and registered with PROSPERO (The International Prospective Register of Systematic Reviews), registration number CRD42022325482

Appendix A. GRADE-CERQual summary of review findings and confidence assessment

GRADE-CERQual summary of review findings and confidence assessment

Review finding	Contributing studies	CERQual Assessment	Explanation	Sample quote
Review question 1: What factors influence women's choice to freebirth?				
Restricted or inconsistent access to attended homebirth services influenced women's decision to freebirth.	(Jackson et al., 2020; Henriksen et al., 2020; Lundgren, 2010; O'Boyle, 2016; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; Miller, 2009; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022)	High confidence	Despite moderate methodological concerns, the richness of the data across an adequate number of studies and countries was deemed enough to maintain a high confidence rating. No concerns in coherence or relevance.	*Nine of the 12 women wanted homebirths with midwives, but this was not always possible, creating the reason they planned to freebirth. Some women lived in areas where no homebirth midwives were available, or the nearest hospitals were too far away, so they could not plan homebirths. The lack of homebirth midwives or living far from the nearest hospital limited possibilities to have midwives present. Some women explained that they had made plans with midwives, but due to the midwives' working situations, they could not be sure if the midwives would be present when they went into labour* (Henriksen et al., 2020)
Women valued the opportunity to build a trusting relationship with their midwife, but fragmented models of care and lack of continuity prevented them from doing so.	(Henriksen et al., 2020; Freeze, 2008; C Feeley and Thomson, 2016; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Sperlich and Gabriel, 2022)	High confidence	Reasonable number of studies across 6 countries. No concerns regarding coherence, adequacy, or relevance. Minimal concerns regarding methodological limitations in 1 of the studies.	*Some women reported experiencing a lack of alliance with their care provider, or instances of discontinuity of care, regardless of previous negative healthcare interactions or discriminatory or insensitive care experiences. I knew that it would be the luck of the draw as to who would actually be there and it might not necessarily be that one of seven, or nine, that we'd really bonded with. So that was my whole worry. (Natalie in* (Sperlich and Gabriel, 2022)
Freebirth was rarely women's first option but the consequence of the inability to access acceptable care	(Jackson et al., 2020; Lundgren, 2010; O'Boyle, 2016; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Hollander et al., 2017; Miller, 2012)	Moderate confidence	Adequate number of studies from 8 different countries with moderate concerns about methodological limitations, minimal concerns about coherence, and no concerns about adequacy or relevance.	*One participant explained: 'Yeah, like, if that [a midwife] had been available, I would have been quite happy to have the midwife help me in my home have my baby, I never would have considered unassisted … I mean like I said, I never would have chosen to go down that path had the decision – I kind of felt like the decision was made for me, by denying me that choice'. (FB03 in* (Jackson et al., 2020)
Women want to have physical and psychologically safe birth. They want to keep control over decision-making and to avoid unnecessary medical interventions that disrupt the physiology of birth.	(Jackson et al., 2020; Henriksen et al., 2020; Lundgren, 2010; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; Miller, 2009; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; Jackson et al., 2012; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022)	Moderate confidence	Adequate number of studies from 9 different countries with moderate methodological limitations, and no concerns in coherence, coherence, adequacy, or relevance.	*We wanted the control and safety afforded when the others are kept out of the loop. We wanted a better outcome for mother and baby—the best outcome—without all the risks from the unnecessary interventions and such in the hospital (CLAUDIA in* (Freeze, 2008)*)*
Most multiparous women came to freebirth trying to avoid repetition of previous negative experiences of attended birth.	(Jackson et al., 2020; Henriksen et al., 2020; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; Jackson et al., 2012; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022)	Moderate confidence	Adequate number of studies from 8 different countries with minimal concerns about methodology and coherence (anecdotal contradicting data expressed in the underlying data), and no concerns in adequacy and relevance.	*They stated that, in their experience, midwives and obstetricians often did not ask for consent before performing invasive procedures (for example episiotomies, rupturing membranes, performing an assisted vaginal delivery or even a cesarean section). Many were traumatized by this during a previous delivery, which contributed to their decision to reject medical advice this time* (Hollander et al., 2017)
Review question 2: How do women who freebirth perceive maternity care?				
Disrespectful, coercive, or abusive encounters with healthcare professionals eroded women's trust in maternity services	(Lundgren, 2010; Greenfield et al., 2021; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; Jackson et al., 2012; Hollander et al., 2017; Miller, 2012; Plested and Kirkham, 2016; C Feeley and Thomson, 2016)	High confidence	Despite moderate methodological concerns, the richness of the data and external coherence with wider literature justified a high confidence rating. No concerns about relevance.	*In an attempt to overcome a previous traumatic birth, three participants booked a homebirth in their next pregnancy. Unfortunately, these women (Julie, Holly, and Cat), experienced negative interactions with their community midwives. This compounded their previous trauma which in turn led them all to change their birth decision to freebirth. These women felt that again they 'weren't being listened to' and that they were being 'manipulated' and 'bullied' for making informed decisions to book their homebirth.* (C Feeley and Thomson, 2016)
Women perceived midwives' ability to support them with their individualised choices as	(Lundgren, 2010; O'Boyle, 2016; Freeze, 2008; Brown, 2009; C Feeley and Thomson, 2016; Lindgren et al.,	Moderate confidence	Reasonable number of studies across 6 different countries. Moderate concerns regarding	*'I can understand from her [midwife's] point of view that she didn't really have a choice on it. I mean she wanted to be there. She just couldn't facilitate me with the homebirth—insurance is*

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(*continued*)

Review finding	Contributing studies	CERQual Assessment	Explanation	Sample quote
Review question 1: What factors influence women's choice to freebirth?				
limited by the regulatory obligations and by a context of defensive practice.	2017; Diamond-Brown, 2019; Lou et al., 2022; Hollander et al., 2017; Plested and Kirkham, 2016)		methodological limitations, No concerns regarding coherence, adequacy, or relevance.	*through the HSE so they can only operate under these very stringent conditions… I felt completely abandoned at that stage in the process.' (Felicity in* (O'Boyle, 2016)*)*
Institutional midwifery care was perceived to be aligned with the medical model and therefore not providing a true alternative of care	(Freeze, 2008; Miller, 2009; C Feeley and Thomson, 2016; Jackson et al., 2012; Sperlich and Gabriel, 2022; Plested and Kirkham, 2016)	Low confidence	Moderate concerns regarding methodological limitations and moderate concerns regarding adequacy (small number of studies from USA, Australia, and UK). No/very minor concerns regarding coherence and relevance.	*This research confirmed the importance of them being 'undisturbed' and feeling 'safe' during labour as well as how a midwife would 'medicalise' the process through clinical check and 'interfering' in the natural flow of birth: 'And I really felt that their presence would actually um be counter to what I believe should happen ummm and I felt that why am I actually inviting a midwife? I really thought about that.' (Jenny, int, In:* (C Feeley and Thomson, 2016)
Review question 3: What is the care experience for women who choose to freebirth?				
Women had diverse forms of perinatal care, varying from full in-system care, selective engagement with in-system care and self-care practices	(Jackson et al., 2020; Henriksen et al., 2020; O'Boyle, 2016; Freeze, 2008; Brown, 2009; Miller, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Diamond-Brown, 2019; Baranowska et al., 2022; Lou et al., 2022; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022; Miller, 2012; McKenzie and Montgomery, 2021)	High confidence	Despite moderate methodological concerns, the richness of the data across the widest number of studies and 10 countries justified a high confidence rating. No concerns about coherence, relevance, or adequacy.	*Most women (particularly for those who were free birthing for the first-time) sought assurance of their low-risk status via antenatal midwifery checks and decided that as long as the pregnancy remained 'normal' they would 'stay home' [freebirth].* (C Feeley and Thomson, 2016) *Most women interviewed either do no prenatal care or do all their own care—taking their blood pressure, analysing their urine, tracking fundal growth, and even monitoring heart rate with a hand-held Doppler monitor.* (Miller, 2012)
Women engaged in extensive research, using both technical and experiential knowledge to inform their choices and to maximise the safety of their birth.	(Henriksen et al., 2020; Lundgren, 2010; Freeze, 2008; Brown, 2009; Miller, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; Hollander et al., 2017)	High confidence	Minor concerns regarding methodological limitations, No concerns regarding coherence, adequacy, or relevance	*I had really done my research. So, it wasn't some impulsive, hippie-style… 'everything will be alright, man'. No. I had really done my research. (Charlotte). In the process of contemplating where and with whom to give birth, the women drew on diverse sources of knowledge and information, including conventional information sources such as health care providers, official healthcare websites and pregnancy books* (Lou et al., 2022).
Women implemented diverse self-care plans, including emergency plans, to protect the safety of their birth.	(Jackson et al., 2020; Henriksen et al., 2020; Lundgren, 2010; O'Boyle, 2016; Freeze, 2008; Brown, 2009; Miller, 2009; C Feeley and Thomson, 2016; Lindgren et al., 2017; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; Hollander et al., 2017; Miller, 2012; McKenzie and Montgomery, 2021)	High confidence	Despite moderate methodological concerns, the richness of the data across reasonable number of studies and 9 countries justified a high confidence rating. No concerns about coherence relevance or adequacy.	*One participant had prepared for: '… everything from, if my waters break and there is staining in the meconium we are off to hospital, if you know, if I'm feeling unwell – you know we went through a – I listed all the situations with my husband and I sort of said if this happens, then we need to transfer to hospital, if that happens then we need to transfer to hospital'. (FB08 in* (Jackson et al., 2020)*).*
Women hide their plan to freebirth to avoid negative repercussions from healthcare professionals or their support network	(Jackson et al., 2020; Henriksen et al., 2020; Lundgren, 2010; O'Boyle, 2016; Freeze, 2008; Lindgren et al., 2017; Lou et al., 2022; Johansson et al., 2023; Miller, 2012; C Feeley and Thomson, 2016)	Moderate confidence	Reasonable number of studies from 7 different countries with moderate concerns about methodology limitations, and no concerns about coherence, adequacy, or relevance.	*So, we made the decision to have the baby on our own and call out the midwife afterwards and just pretend it happened so quickly they didn't get there in time. Or not that they didn't get there on time, but we didn't have time to ring before.* (Jane, interview) (C Feeley and Thomson, 2016) *I had hidden the decision to freebirth. The first time I talked about homebirth, I had to deal with such a lot of difficult things, lots of fears that were just heaved onto me* (#2) (Johansson et al., 2023)
Most women described calm, peaceful, and positive births that led to personal transformation and/or empowerment	(Jackson et al., 2020; Lundgren, 2010; Freeze, 2008; Brown, 2009; Miller, 2009; Lindgren et al., 2017; Baranowska et al., 2022; Lou et al., 2022; Johansson et al., 2023; LeBlanc and Kornelsen, 2015; Hollander et al., 2017; Sperlich and Gabriel, 2022; McKenzie and Montgomery, 2021)	Moderate confidence	Reasonable number of studies across 8 countries with minor concerns about methodological limitations and coherence (2 individual testimonies contradicting this finding). No concerns about adequacy or relevance.	*All the women reported satisfaction with their birth experiences, using words such as "lovely," "awesome," "wonderful," "perfect," "exciting," "celebratory," "fun," "emotional," and "healing." Women who had previous hospital births said their experiences at home had been more peaceful and less stressful. Women described the simplicity, ease, and enjoyment of being home with their families, highlighting the unique opportunities for sibling involvement* (LeBlanc and Kornelsen, 2015).

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