Experiences of women who have planned unassisted home births in high-resource countries

Recommendations*

- Health care providers should engage in reflective practice about how systemic expectations impact the decision-making and experiences of births that occur at the margins or external to health care systems. (Grade A)
- Health care providers should provide perinatal health care that is respectful of and sensitive to the needs of women whose expectations and/or experiences of birth or birthing care are different from mainstream health care expectations and experiences. (Grade A)
- Guidance and processes should be developed to support access to health services for individuals and families who do not conform to prescribed pathways for access to health care services. (Grade A)
- Unbiased education and a context for discussion about unassisted birth should be developed and delivered to perinatal health care providers to raise awareness about the phenomenon and reduce further marginalization when persons who have unassisted births seek health care. (Grade A)

* Please refer to: JBI’s Grades of Recommendation

Information source

This Best Practice Information Sheet is a summary of evidence derived from a systematic review published in 2023 in JBI Evidence Synthesis.⁴

Background

Birth is an important time for women and families. Many women choose to birth with support and the direct care of health professionals (mainstream), while some women choose to have planned unassisted home births. An unassisted birth is planned to occur at home and without the assistance of health care providers (eg, midwife, nurse, physician). Unassisted births can also be referred to as freebirths and should not be confused with births recorded as “born before arrival.” A “born before arrival” birth is unplanned and occurs before a woman or birthing person can receive assistance from health care providers.

It is difficult to know the number of unassisted births in high-resource countries, as data about unassisted birth are often lacking or inconsistently recorded. This may be influenced by how data are captured or the stigma associated with unassisted birth, which may impact parents’ reporting of unassisted births. For example, parents may not have details of their baby’s birth recorded within official records, which are completed by physicians or midwives, and this may impact the accuracy of data.

Researchers have explored and examined the decision-making experiences of women who have unassisted births. Understanding how and why women choose to have unassisted births can provide important insights into how perinatal health care services can be improved.

In this review, we wanted to better understand the birth experiences of women who had planned unassisted home births. This understanding will help to support women and their families who choose to have unassisted births.

Objectives

The objective of this review was to identify, appraise, and synthesize qualitative evidence about the experiences of women in high-resource countries who have planned unassisted home births.

Phenomena of interest

Included studies explored women’s experiences of planned unassisted births at home. Planned unassisted births occur at home without assistance of health care providers. Health care providers include, but are not limited to, nurses, midwives, physicians, obstetricians, and paramedics. These providers are licensed to provide health care to women and newborns throughout the perinatal period, specifically during labor, delivery, and the postpartum period. Studies included women who had planned unassisted births in high-resource countries (Canada, the United States, Australia, New Zealand, Japan, countries located in Europe, and countries of the former USSR).
Quality of the research

All papers included in this review were assessed independently by 2 reviewers using the JBI critical appraisal checklist for qualitative research. Seven papers were critically appraised. One study was excluded due to low quality (defined as either a score of less than 6 out of 10 criteria on the critical appraisal list, or no evidence of ethical approval). The other 6 papers were included in the systematic review. The overall methodological quality of the included studies was moderate.

Findings

Papers included in this review were conducted in several countries including Sweden (2), United States (2), United Kingdom (1), the United States and Canada (1). All studies used interviews for data collection, with additional data collection methods including surveys, email correspondence, internet searches (postings, forum postings, websites), and internet discussion board posts. A total of 17 (unequivocal) findings were extracted from 6 studies, resulting in 4 categories, which were then aggregated into 2 synthesized findings.

Synthesized finding 1 (2 categories and 7 findings):
Navigating tensions within self, and between self and systems

The first synthesized finding illustrated how women navigated tensions between their own needs and expectations, and the mainstream needs and expectations of health care systems. Women experienced tensions between the reality of birthing outside of the mainstream and the benefits that accompanied support from health care providers. Tensions were particularly evident when women sought help or advice from mainstream health services.

“I phoned and said I have only one question I have given birth at home and how should I do with the placenta should I push it out or . . . Then I could hear how they started to fuss over the placenta. The whole conversation was about calming them . . . it’s no point in asking them I couldn’t get any answer and I had to finish the conversation instead.”

Women also experienced feelings of both confidence and uncertainty and had to navigate the inner tensions caused by these 2 types of feelings.

Synthesized finding 2 (2 categories and 10 findings):
Integrating and transcending physical experiences of birth

The second synthesized finding illustrated the power of birth and the multidimensional experiences of women who have planned unassisted home births. Women described their birthing experiences as influenced by forces external to themselves. Experiences of external birth influences led to the recognition of their own power during birth, and how the powers of their partners and time influenced birth.

“I have a strong ‘body knowledge’ and I can feel what is happening in my body . . . it was a fantastic experience . . . I felt when the head was crowning . . . and after that it was a break . . . and my husband in astonishment said . . . the baby’s eyebrow and nose are moving . . . he could see her face . . . And after the next contraction the whole head was out and after the next – the whole baby. First, I was worried because she was so quiet but her skin color was fine. She was so quiet because the birth was not disturbed. It was a very calm birth.”

Birth experiences were also significant in spiritual ways, which transcended the physical experiences for some participants. An unassisted birth was an opportunity to birth without distractions associated with hospital environments.

Conclusions

In this review, women’s experiences of planned unassisted home births highlight the tensions between their own birthing expectations and the expectations of the health system. Women who had unassisted births also experienced tensions when they sought mainstream health care services. These tensions were related to a lack of understanding of their birth experiences and a lack of processes to address their health care needs. Tensions were also internal, as women confronted feelings of confidence and their uncertainties about unassisted birth. Women described their experiences of spiritual or mystical connections during planned unassisted birth and how those experiences transcended the physicality of birth. More research is needed about planned unassisted birth experiences to improve understanding and processes that support women who have planned unassisted birth and who also seek mainstream health care services.

Implications for practice

The findings from this review illustrate variations of experiences for women who have planned unassisted births at home. Health care providers require greater awareness of the needs of women who have unassisted births so that they can provide better transitions to mainstream health care when women and newborns seek or need it. Processes must be developed to support transitions to mainstream perinatal health care for women who choose unassisted home birth. Opportunities for education about ways to work with women and families whose perinatal health care choices differ from mainstream expectations and reflective practice about planned unassisted home birth should be made available to health care providers in an effort to reduce stigma and discrimination.
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**POPULATION**
Women who have planned unassisted home births

**PHENOMENA OF INTEREST**
Experiences of planned unassisted home births without assistance from health care providers

**CONTEXT**
High-resource countries

**SYNTHESIZED FINDINGS**

- **Navigating tensions within self, and between self and systems**
  - Conflicting feelings and expectations
  - Tensions between their own needs and expectations, and those of mainstream health care systems
  - Inner tensions of confidence and uncertainty related to their birth experience
  - Challenges seeking support from the health care system

- **Integrating and transcending physical experiences of birth**
  - Powerful roles of self, one’s partner, and time during unassisted births
  - Internal power of their body
  - Transcending the embodied experiences of birth that occur for women beyond the body
  - Uninterrupted experience of birth, free from distractions

**RECOMMENDATIONS FOR PRACTICE**

- **Engage in reflective practice**
  - Health care providers should engage in reflective practice about how systemic expectations impact the decision-making and experiences of births that occur at the margins or external to health care systems. (Grade A)

- **Provide non-judgmental perinatal health care**
  - Health care providers should provide perinatal health care that is respectful of and sensitive to the needs of women whose expectations and/or experiences of birth or birthing care are different from mainstream health care expectations and experiences. (Grade A)

- **Develop guidance and processes**
  - Guidance and processes should be developed to support access to health services for individuals and families who do not conform to prescribed pathways for access to health care services. (Grade A)

- **Provide education to health care providers about unassisted birth**
  - Unbiased education and a context for discussion about unassisted birth should be developed and delivered to perinatal health care providers to raise awareness about the phenomenon and reduce further marginalization when persons who have unassisted births seek health care. (Grade A)
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References
Macdonald D, Helwig M, Snelgrove-Clarke E. Experiences of women who have planned unassisted home births in high-resource countries: a qualitative systematic review. JBI Evid Synth. 2023;21(9):1732-63

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