
ARTICLE

Giving Birth Outside the Health Care System in New Brunswick: A Qualitative Investigation

by Kate LeBlanc, BA, and Jude Kornelsen, PhD

ABSTRACT

Introduction: There is limited research data on unassisted childbirth (a planned out-of-hospital birth without the attendance of a regulated care provider) in Canada; this means that there is a lack of understanding of its prevalence and of the childbearing women's motivations. This study aimed to uncover women's reasons for planning to give birth in the absence of an attendant licensed to practice in New Brunswick, in order to create insight into mainstream maternity care practices through those who have rejected them.

Methods: In-depth qualitative interviewing with women who have had planned home births in New Brunswick in the past 10 years.

Results: Participants had a variety of motivations and influences that played in their decision to have an unassisted home birth, including deeply held beliefs about childbirth and the need to manifest these beliefs in their experiences of birth. Participants expressed their desire to be the locus of control in their childbirth experience and believed they could best accomplish this outside of the hospital setting. Influences included ideological stance toward birth, the attitudes of their families and friends, and birth stories they had heard.

Conclusion: This study demonstrates that when women's needs are not met by mainstream health services, some will choose to give birth in the absence of a skilled provider or independent attendant. This gives rise to the need for discussion between all care providers and parturient women to better understand unmet needs and unaddressed fears around hospital birth.

KEYWORDS

home childbirth, unattended birth, freebirth, natural childbirth, midwifery, pregnancy, parturition, women, decision making, motivation

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Kate LeBlanc is a student in the Midwifery Program of the University of British Columbia, in Vancouver, BC. She is president of the Midwives Association of New Brunswick and is the New Brunswick representative on the board of directors of the Canadian Association of Midwives.

Jude Kornelsen is an associate professor in the Department of Family Practice at the University of British Columbia, in Vancouver, BC. She is Co-Director of the Centre for Rural Health Research, Director of the Applied Policy Research Unit (APRU), and Honorary Associate Professor in the Medical School of Sydney University, in Sydney, Australia.

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RÉSUMÉ

Objectifs : Cette étude a analysé l'implantation des services de sages-femmes en Montérégie (Québec). Les objectifs étaient de déterminer si les services ont été mis en œuvre comme prévu et identifier les facteurs qui ont facilité ou entravé leur implantation. Les éléments étudiés comprenaient: les composantes organisationnelles; les types de services de sages-femmes prévus; le niveau de collaboration interprofessionnelle entre les sages-femmes et les autres professionnels en périnatalité; les activités de formation offertes aux professionnels et aux étudiants en périnatalité.

Méthodes : Cette étude de cas qualitative repose sur trois sources de données: entretiens individuels et groupes de discussion, documents légaux et administratifs et une base de données compilées par les sages-femmes sur les services fournis. Les données ont été recueillies et analysées entre Juillet 2012 et Mars 2013.

Résultats: L'implantation des services de sages-femmes a été accomplie en grande partie comme prévu. Ce succès s'explique par l'alignement de deux types de conditions favorables. Le contexte d'implantation constitue le premier type de conditions : politiques et règlements appuyant la pratique sage-femme, forte demande des femmes, soutien des professionnels concernés par l'implantation des services. Le processus d'implantation et la gouvernance constituent la seconde catégorie de conditions : structures et mécanismes efficaces de gouvernance, allocation de ressources et leadership exercé par un ensemble de professionnels.

Conclusion : Les leçons tirées de cette étude peuvent être appliquées à l'introduction de services de sages-femmes dans d'autres régions du Québec et du Canada où ces services ne sont pas implantés.

MOTS CLÉS

pratique sage-femme, soins et services périnataux, conditions d'implantation, intégration des soins et services.

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Caroline Paquet, SF, PhD

(**cand.**) est professeure agrégée au baccalauréat en pratique sage-femme à l'Université du Québec à Trois-Rivières (UQTR). Elle a travaillé à titre de sage-femme en Ontario, au Nunavik et au Québec et a participé à l'implantation de la maison de naissance de Nicolet (Québec). Elle poursuit présentement des études doctorales en santé publique (option organisation des soins) à l'École de santé publique de l'Université de Montréal (ESPUM).

Régis Blais, PhD est professeur titulaire au Département d'administration de la santé de l'École de santé publique de l'Université de Montréal (ESPUM) et chercheur à l'Institut de recherche en santé publique de l'Université de Montréal (IRSPUM).

INTRODUCTION

Giving birth out of hospital without the assistance of a trained and regulated professional is a phenomenon referred to as unassisted childbirth and emerged as an alternative birth movement in North America during the mid-20th century.¹ Since its emergence, unassisted childbirth has maintained a small but steady following. It is a means for the mother to give birth outside the strict parameters of medicalized birth and a way to meet the needs of a subculture of childbearing women who are critical of standard practice in childbirth.²⁻⁵ However, giving birth outside the boundaries of the health care system is a divisive subject, provoking both fascination and horrified interest among the public, the health care community, and the media.^{5,6} While women and families who choose this mode of birth are often vocal, the prevalence of unassisted birth is unknown because its adherents operate outside the realm of the hospital system and medical records. Consequently, research examining this phenomenon in Canada or countries with similar cultures and geography is limited.

Maintaining authority over their childbirth experience, which often involved avoiding the hospital environment, was key to actualizing the childbirth they hoped for.

The scant studies that do exist include as motivations for unassisted home birth women's reverence for their bodies and the birth process, their dissatisfaction with modern obstetrical care, and their need to exert personal control over labour and birth.⁵⁻⁷ Inquiry into this phenomenon has illuminated trends in public health care practices whereby women come to fear unnecessary medical intervention and choose to give birth outside of that system.^{1,5,8} A 2008 doctoral dissertation by Freeze situated unassisted birth within participants' larger systems of beliefs, including spirituality, strong commitment to family and children, and ecologically sustainable living. Women who gave birth this way commonly also practiced breastfeeding, co-sleeping, cloth diapering, attachment parenting, home schooling, and alternative medicine—practices that indicate mindful resistance to cultural trends.¹ Unassisted home birth in

response to a lack of access to midwifery care has also been documented.¹

There has been a lack of research on unassisted birth in a Canadian context; this study aimed to uncover New Brunswick women's reasons for planning an unassisted birth. In this study, the term "unassisted birth" means a birth that is not attended by a care provider licensed to practice in the jurisdiction in which the birth takes place; included under this term are births attended by independent traditional attendants or midwives trained in countries where the scope of practice may be different.

METHODS

This exploratory study used in-depth qualitative interviewing to document and understand women's experiences of giving birth outside the health care system in New Brunswick. A general thematic approach to coding the data was used.⁹ Ethics approval was granted by the University of British Columbia's Behavioural Research Ethics Board. Data were collected by a co-researcher who was a midwifery student from New Brunswick, a province that had not yet funded and integrated regulated midwifery. The researchers recognized the opportunity that a study of motivations for (and experiences of) planned unattended out-of-hospital births would provide for insight into the way maternity care is organized.

Recruitment of Participants and Collection of Data

The student researcher recruited participants and collected data in New Brunswick through a combination of advertisement in social media, electronic mailing lists, and word of mouth. Anyone who had given birth at home in New Brunswick without a licensed health care provider in the previous 10 years was included in the study. As midwives are not regulated or funded in New Brunswick, we included women who had given birth with an independent traditional attendant (in one case a care provider trained to practice in another country), as there was no support from the health care system for this arrangement and as there were significant systemic obstacles.

Potential participants e-mailed the researcher, giving consent to be contacted. Nine participants agreed to be interviewed, and interviews took place by telephone, by Skype, or in person when geographically possible. The interviews lasted from 15 to 55 minutes, the average length being 30 minutes. Prior to the interview, informed consent for the study was obtained from each participant through a consent form. All interviews were recorded in audio and

transcribed with the participants' permission.

Open-ended interviews were conducted to elicit descriptions of the participants' motivations for, and experiences of, giving birth unattended outside of New Brunswick's health care system. Questions included, "Tell me about your decision to have a home birth," "Had you thought about this before you were pregnant?" and "Would you have a home birth again?" Following the interviews, two participants personally followed up by e-mail with additional thoughts that elaborated on their answers to interview questions. After data collection was completed, the data were made anonymous by assigning each participant a number.

Analysis

The researchers independently reviewed the transcripts according to an open-coding approach, taking the following steps: (1) they immersed themselves in the transcripts by reading and re-reading for comprehension, (2) they categorized the data into emerging themes and codes, (3) they coded complete transcripts, and (4) they created an explanatory narrative corresponding to the emerging code structure.¹⁰ The co-investigators individually created code books (compilations of descriptors and corresponding definitions) based on the transcripts. A meeting of the researchers was then held via Skype to compare and reconcile any differences in coding. Minor differences in naming were noted; however, no significant variation in meaning was found. A revised code book was produced, and transcripts were re-coded. Another Skype meeting was held to review the emerging narrative.

FINDINGS

The women in this study had a variety of motivations and influences that shaped their decision to give birth at home, unattended by a care provider licensed to practice in New Brunswick. Within the context of this study, "motivations" were understood to be part of the inner drive of an individual, whereas "influences" referred to external circumstances that had the capacity to have or create an effect. This framework of motivations and influences resulted from an analysis of the data.

Participants in this study were fundamentally motivated by instinctively held beliefs about childbirth and by the need to manifest these beliefs in their experiences of birth. Maintaining authority over their childbirth experience, which often involved avoiding the hospital environment, was key to actualizing the childbirth they hoped for.

Influences on their decision to have an unattended home birth included their ideological stance, the attitudes of their families and friends, and birth stories they had heard. These themes (elaborated on later in this article) are illuminated by an understanding of the sociopolitical context of care.

Context of Care

Most participants, upon learning that they were pregnant for the first time, had sought midwifery care unsuccessfully, as midwifery is not a licensed profession in the jurisdiction of this study. Participants expressed their dismay upon discovering they could not access midwives and recounted being overwhelmed with the weight of having to decide to give birth in hospital, find an unlicensed birth attendant, or give birth on their own. Women who strongly desired a home birth described a sense of desperation in their search to find someone to attend them. One participant expressed irritation at her lack of options: "At first I was kind of angry that I couldn't get a midwife, and I couldn't get a doctor [to attend me at home] either. I felt like I wasn't given any options. Like, this is the way I felt comfortable doing it, but no one would help me." The moment she realized there was no publicly funded homebirth option she decided to give birth on her own. It is interesting that a few participants who had initially sought government-funded midwifery care were eventually convinced by their own empowering experiences that they would not choose a registered midwife if given the option. However, most participants stated that initially they would have strongly preferred a midwife to attend them at home. It is in this context that participants' motivations and influences can be understood.

Motivations

The predominant motivator for women in this study was the need to maintain authority over their childbirth experience by playing an active, dominant role. This was often in response to what they experienced in (or understood about) the hospital birth setting, which was viewed by all women in this study as disempowering. Describing themselves as independent individuals, the participants wished to avoid being given instructions that conflicted with their own intuitive knowledge. Participants said that in seeking to control their childbirth environment, they would not be forced to do things they did not want to do, thereby avoiding feeling disrespected and disempowered. These things included unwanted routine hospital protocols and procedures they often saw as invasive, uncomfortable, restrictive, and unnecessary.

I didn't want to be restricted, and I didn't want a lot of fetal monitoring, and I didn't want internal [examinations], and I didn't want to be told when to push again or how to push. I wanted it to be about me, and the only hands that touched my baby would care about my baby—not the rubbing, the suctioning, the arguing about what we do afterwards.

Women in this study stated that they sought an environment in which they could ensure that their experience would not be diminished or unnecessarily controlled by others. The desire for an unencumbered environment (i.e., home) was juxtaposed with the desire to avoid a restrictive setting (i.e., hospital).

For many of these women, avoidance of the hospital was closely linked to (or emanated from) previous experiences with the health care system. Over half the participants described negative previous prenatal or birth experiences in the health care system, such as being excluded from decision making or the informed-consent process, being bullied by care providers, or undergoing childbirth trauma. Participants spoke of their hospital experiences as first-time mothers who did not yet know much about pregnancy or birth. A few participants remembered how as young women they silently accepted care providers' decisions even though those decisions may not have felt right for them: "I didn't know my options, really. But it bothered me that he just made that decision for me. I wish I had been able to play a more active role."

One woman described herself as young and naive at the time of her first pregnancy. Despite this, she had a strong sense that her body "knew what to do" and that care providers were "doing all these things to me that didn't feel right." She recalled that giving birth at her hospital was frightening and disempowering: "The cervical checks! All the monitors!...It was petrifying. And you know, I didn't have horrible experiences, but it was just...They make you feel like you don't know what you're doing." About half the participants described their previous hospital births as traumatic. These experiences often produced or solidified a deep questioning of the entire medical system and informed the women's desire to give birth at home the next time.

However, despite describing previous childbirth experiences as traumatic, some of the women in this study spoke about how they accessed health care during the year of their unattended homebirth, primarily in the prenatal

and postpartum phases. Women who accessed prenatal care were motivated by their need to ensure that their pregnancy was progressing smoothly. A few had previously experienced an ectopic pregnancy or miscarriage and sought the medical assurance of fetal wellness. A few women completed their early pregnancy blood work in order to remain on file at the local hospital despite not wishing to have prenatal care for their whole pregnancy. This allowed them to have access to intrapartum or postpartum care (their "plan B").

Influences

Participants in this study were influenced in their decisions about the place and mode of childbirth by their ideological stance, their family of origin, and birth stories they heard from other women both about successful home births and about negative hospital experiences in New Brunswick.

Ideological Stance

Almost all participants displayed confidence that birth is a normal, healthy, physiological life process. Because participants saw birth as a natural aspect of life, they viewed the hospital setting, with its sterile environment, as unnecessary and inappropriate. Most of the women stated that if something were to go wrong, they would seek the necessary help. Otherwise, giving birth in hospital was not something they planned. To them, birth was more than a physical event; it was a spiritual rite of passage. In the words of one woman,

Birth, I feel, is supposed to be one of those experiences where you get to, as a woman, really realize your potential as a creator and a maker of life....So to go and have something like that stripped away and medicalized and controlled, I just didn't want to have anything to do with that.

In this context, birth was seen as something that did not need to be medicalized. Participants brought up the way in which previous generations gave birth without medical support and how animals give birth in the wild. Some women described birth as an event that should be part of the continuum of home life and did not view hospitals as fitting settings for healthy mothers or newborns.

An intrinsic part of participants' ideological stance was their intuitive sense—an inner "knowing"—that their labour was progressing as it should, along with a good feeling and a deep-rooted assurance that their birth would

be fine. In many instances, the women said that because of this strong intuition, they would know to access hospital services or whatever else was needed were something to go wrong. This was seen to be in stark contrast to the context of hospital birth and was one of the factors that they felt led to the devaluing of the visceral knowledge of their bodies. As well, traditional knowledge has been lost.

Family of Origin

Women in the study often emphasized the influence of their upbringing on their beliefs and decisions about childbirth. Some women depicted their mothers as independent, self-determined, educated, and liberal. They described their families as living outside society's margins, being open about bodies and life, seeing and doing things differently, and questioning the medical system or seeing it as flawed. Several participants said they came from families that did not have children vaccinated or families that focused on nutrition instead of allopathic medications.

I'd also grown up with a mother who was very independent, very proactive. We were never given medications as children. When we were sick she would say, "Go eat an orange."... And I was also taught through my childhood to question authority, to think for myself—all that good stuff.

Several participants considered their own birth stories, as told by their parents, to be traumatic narratives that had a strong impact on their own lives.

My own mother went to the hospital with me.... Basically she was held down and forced to have an epidural, and then I had a nuchal cord when I was born, so this was the pretext for immediately removing me from my mother's care....My mother remembers waking up from being on drugs and asking for her baby....She actually got up out of bed and wandered the hallways in the backless hospital gown looking for me, knocking on doors and looking for her baby.

This participant noted that her mother described her birth as a horrific event, and made changes so it would not happen again. One participant remembered stories of her grandmother's "twilight sleep," an amnesiac condition induced by injections of morphine and scopolamine, leaving the mother with no memory of her labour or

childbirth. Another recalled her sister's "horrendous" experience of being denied her request to hold her newborn for its first two days of life following an emergency cesarean section. Others told of being strengthened by parents' and grandparents' positive homebirth narratives. These women described their decision to give birth at home as something they had "always known" they would make. One recalled being present when her mother gave birth:

My mother had my sister in our house when I was ten. And she just did it like a champion and was so well supported....I was there with my mom when she gave birth with my sister, and it was a very beautiful experience compared to what I had heard from and what you see in movies and everything about, you know, the hospital.

The predominant motivator for women in this study was the need to maintain authority over their childbirth experience by playing an active, dominant role.

These descriptions of their mothers' giving birth without the assistance of a physician, medications, or interventions reassured these participants and gave them confidence in their ability to do the same.

Birth Stories

Stories of women who successfully gave birth unassisted at home were commonly recalled among the participants. Most participants recounted having known at least one other woman who had given birth in New Brunswick on her own or with an unlicensed attendant. Some participants were imbued with stories from an active community of women who had given birth at home; as one woman said, "It's kind of the crowd that I roll with around here." This idea that giving birth at home was positive and local was an important influence, as participants considered giving birth in the same manner. A few participants said it "set the stage" for making their decision. One participant remembered mentally reviewing each of her friends'

positive experiences to convince herself she could do the same. Another received positive encouragement from the example of a friend who had overcome the trauma of her first childbirth and subsequently had a successful unassisted home birth. Narratives and community appeared to matter greatly to participants, as both affirmed their ability to undergo unassisted childbirth.

Previous Home Birth in Another Province

A few participants who had moved to New Brunswick had already given birth at home in another province, with either a registered midwife or an unlicensed attendant. These women described these births variously as “spontaneous,” “physiological,” and “unadulterated.” They claimed that their early choices to seek alternative care had radically altered the trajectory of their lives and had taught them how to give birth naturally and on their own.

When women’s needs are not met by mainstream health services, some women will choose to give birth outside of the hospital setting even in the absence of a skilled care provider or independent attendant.

Satisfaction with the Childbirth Experience

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 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 sibling involvement, which made the event all the more fun and special for all. Participants also highlighted childbirth’s deeply transformative nature. As one woman said, “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.”

All the women asserted in hindsight that they had made the right decision and that they would rather give birth at home should they become pregnant again; even those who had faced complications maintained that they would not hesitate to do the same again.

I feel like this is what I did, and I wouldn’t change it. I would do it again the same way ‘cause I feel like I had a good experience. I did have some complications, but I felt like that was the only way at that point that I felt comfortable to do it, so I would definitely do it all over again.

DISCUSSION

Our study shows that when women’s needs are not met by mainstream health services, some women will choose to give birth outside of the hospital setting even in the absence of a skilled care provider or independent attendant. Open discussion of this phenomenon is required among all care providers in order to better understand parturient women’s unmet needs and unaddressed fears around hospital birth. Such a discussion will help determine how the health care system may expand to better meet the needs of all childbearing women.

Our study also showed that existing prenatal care in New Brunswick may not be meeting some women’s needs; participants consistently articulated and affirmed the need for autonomy and control over their pregnancy, birth, and postpartum experiences. The women expressed their dismay and frustration at their inability to find a care provider who would be accountable to them as they endeavored to define safe care for themselves and their babies on the basis of their own research, experiences, and intuitive inner knowing. They spoke out about emotionally and psychologically damaging experiences in hospital and asserted their right to have a trauma-free childbirth. These findings reflect the small body of evidence that some women, unsatisfied by modern obstetrical care, are choosing to give birth outside the bounds of the health care system in order to exert control over their experience and avoid unwanted interventions in hospital.^{1,5-8}

This study underscores the need for the health system to recognize the range of New Brunswick women’s experiences of childbirth and to acknowledge that birth intentionally happens outside of hospital walls. Knowledge gained through this study tells us that the mainstream health care system would do well to bolster its interface with women giving birth unattended at home. Most

women in the study indicated they would have chosen a registered midwife had one been available. The philosophy of the Canadian midwifery model of care—partnership with clients, continuity of care provider, informed choice, choice of birthplace, evidence-based practice, and collaborative care—intersects well with the care many participants sought, notably, in their first pregnancy.¹⁰

LIMITATIONS

The usual limitations of participants' self-selection in qualitative research are acknowledged. Additionally, women included in the study gave birth in a variety of circumstances. Some women gave birth on their own or with family present, whereas others gave birth with the support of a potentially skilled but not provincially regulated health care provider, such as a traditional birth attendant or a midwife trained in another country. These women may represent different populations.

CONCLUSION

Care providers working in accordance with the existing New Brunswick health care model would do well to incorporate a shared decision-making model. This may include the integration of harm-reduction strategies when women's needs and preferences deviate from standard guidelines and protocols. Our growing knowledge of women in New Brunswick who give birth unattended at home encourages us to consider this phenomenon in the context of how our health care system may expand its boundaries, with openness and respect for normal birth and the diverse ways in which women choose to give birth.

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