

Toward Conceptual Clarity: Out-of-Hospital Birth Practices and Freebirth Entrepreneurialism

by Krista Johnston and Christiana MacDougall

Abstract: There is a growing interest in giving birth outside of hospitals and healthcare systems. In our analysis of more than five years of qualitative research, we have noted the conflation of unregulated birth care with regulated midwifery care, a concern also identified by several professional midwifery associations in Canada. This is particularly concerning in a national context where midwifery remains insufficiently integrated and understood. Growing healthcare dis/misinformation and increasing politicization around healthcare have led to confusion for those choosing among different forms of birth care. In this article we differentiate among birth workers and practices, focusing on unregulated forms of care, including doulas, lay or traditional midwives, and other kinds of birth workers, as well as freebirth, or unassisted birth. This analysis paper provides information on the range of practices that healthcare providers may encounter and articulates areas of difference and overlap among forms of birth care. It also highlights strategies to address some of the unmet needs that are leading people to choose unregulated birth care.

Keywords: regulated midwifery; unassisted birth; freebirth; birth justice; reproductive justice; birth care; New Brunswick; Canada

Résumé : On observe un intérêt croissant pour l'accouchement en dehors des hôpitaux et des systèmes de santé. Dans notre analyse de plus de cinq ans de recherche qualitative, nous avons constaté une confusion entre les soins liés à l'accouchement non réglementés et les soins de sage-femme réglementés, une préoccupation également soulevée par plusieurs associations professionnelles de sages-femmes au Canada. Ce constat est particulièrement préoccupant dans un contexte national où la profession de sage-femme demeure insuffisamment intégrée et mal comprise. La montée de la désinformation et de la politisation en santé a semé la confusion chez les personnes qui doivent choisir entre différentes formes de soins liés à l'accouchement. Dans cet article, nous faisons la distinction entre les professionnels et les pratiques liés à l'accouchement, en nous concentrant sur les formes de soins non réglementées, notamment les doulas, les sages-femmes laïques ou traditionnelles et d'autres types de professionnels de l'accouchement, ainsi que sur l'accouchement non assisté. Cet article d'analyse présente les diverses pratiques que les prestataires de soins de santé peuvent rencontrer et précise les différences et les chevauchements entre les différentes formes de soins liés à l'accouchement. Il présente également des stratégies visant à répondre à certains des besoins non satisfaits qui poussent les gens à choisir des soins liés à l'accouchement non réglementés.

Mots clés : profession sage-femme réglementée; accouchement non assisté; justice liée à l'accouchement; justice reproductive; soins liés à l'accouchement; Nouveau-Brunswick; Canada

Authors: Krista Johnston is Associate Professor of Feminist and Gender Studies and Canadian Studies at Mount Allison University, located in Mi'kma'ki, along the Bay of Fundy, New Brunswick, Canada. Her research focuses on the interface between social action and social policy. She has published on motherhood, settler colonialism, and midwifery care. Her work is grounded in anti-colonial feminist commitments to reproductive justice, with a broad focus on the politics of care.

Christiana MacDougall is an Associate Professor of Sociology and Feminist and Gender Studies at Mount Allison University in Sackville, New Brunswick, located in Mi'kma'ki, the unceded territory of the Mi'kmaq people. Her research focuses on reproductive justice, mental health and mental illness, and the areas where these overlap. Christiana is committed to critically engaged research that can be used towards positive social change.

Introduction

While access to regulated midwifery care has contributed to the growth of home birth, a small—and growing—percentage of births intentionally take place outside of hospital and outside of the care of registered midwives. Such practices are referenced variously as unassisted birth, unattended birth, out-of-hospital birth, or out-of-system birth, but increasingly, they are called freebirth. There is growing scholarly interest in such practices, both because they seem to be increasing since the Covid-19 pandemic (Statistics Canada 2021) and because they reveal a great deal about potential gaps and shortcomings of existing pregnancy and birth care (Greenfield, Payne-Gifford, and McKenzie 2021; Shorey et al. 2023; Miani et al. 2021). Based on our research in New Brunswick, we identify shortcomings in emerging conceptualizations of this range of practices as “freebirth” and propose new approaches to differentiating among them. We argue that framing all out-of-system births as freebirth flattens various practices, orientations, and commitments of birth workers into an amorphous category that hides these important differences, with significant potential impacts for those seeking care, those providing care, and for those who are organizing around birth justice. We begin by differentiating between regulated and unregulated forms of out-of-hospital birth, describing birth practices that co-exist, overlap, and at times exist in tension, and demonstrate how different birth practices can be understood within the specific socioeconomic, geographic, and policy contexts in which they emerge. Furthermore, we develop a new conceptualization of freebirth entrepreneurialism to bring further specificity to the use of this term in the context of our study and more broadly. Given the ideological commitments of outspoken freebirth advocates, several of whom began their activism for alternative birth in New Brunswick, we demonstrate that conflating all alternative (to hospital) birth practices as freebirth risks undermining public understanding and assessment of medical advice and regulated midwifery. This confusion complicates attempts by those seeking care to navigate existing systems and may undermine fledgling midwifery programs in provinces like New Brunswick.

Literature Review

There is a growing body of literature focused on birth practices that take place outside of hospital and outside of the established health care system. The most common term used for such practices is freebirth, which is consistently defined along the lines of the definition proposed by Velo Higuera, Douglas, and Kennedy (2024): “the deliberate decision to give birth at home without a regulated healthcare professional in countries where maternity care facilities are available and easily accessible” (for similar definitions, see McKenzie, Robert, and Montgomery 2020; LeBlanc and Kornelsen 2015; Feeley et al. 2015). Like many other scholars, Velo Higuera, Douglas, and Kennedy (2024) use the term freebirth interchangeably with unassisted birth (McKenzie, Robert, and Montgomery 2020; Feeley et al. 2015), arguing that these birth choices often look similar in practice. This definition effectively separates home birth with a regulated midwife from all other forms of home birth, but we argue that it does not provide sufficient conceptual clarity to fully capture the many kinds of birth practices, and different kinds of birth care practitioners, that may be involved in out-of-hospital (and outside of healthcare system) birth. Furthermore, the definition of freebirth proposed by Velo Higuera, Douglas, and Kennedy (2024) and others relies upon the existence of birth care facilities at the national level, which may misrepresent significant issues of availability and access to care impacted by geographical and socioeconomic location *within* national boundaries. In the broader literature on freebirth, many associate freebirth with high-income countries (HICs). For instance, Shorey et al. (2023) use the term freebirth to reference

out-of-system births in high-income countries and use the term unassisted childbirth to reflect similar practices in low- and middle-income countries where professional maternity care is not widely available. This differentiation presumes that services available in one part of the country will be equally available and accessible across the country, which is not the case in Canada. As we have learned in our research with birth care clients, providers, advocates, and policy makers in New Brunswick, the absence of a robust and readily accessible regulated midwifery care program, combined with the challenges of rurality and geographic isolation as well as high rates of poverty and insufficient investments in reproductive healthcare has resulted in the growth of *both* unattended birth and freebirth in the province. Existing definitions that conflate these practices miss significant differences and further complicate attempts by those seeking birth care, as well as those providing birth care, to understand the differences and potential responses.

Theory and Methodology

The findings and analysis shared here are part of on-going research including two studies focused on the New Brunswick midwifery program, which began serving clients in one city in the province in 2017. Our work in this project has been governed by commitments to justice-oriented movements which centre racial, cultural, and gender diversity. Our thinking is informed by anti-colonial conceptualizations of bodily autonomy and sovereignty advanced by Indigenous theorists like Simpson (2017), Wilson (2015), and TallBear (2018), which direct us, as white settler scholars, to be led in this work by the Indigenous communities and activists doing this work and to continue to confront the ongoing violence of settler colonialism. Our work is also directed by the insights of Black feminist movements for reproductive justice and birth justice. As articulated by Loretta Ross and Rickie Solinger (2017, 9), “Reproductive justice is a contemporary framework for thinking about the experiences of reproduction. It is a political movement that splices reproductive rights with social justice to achieve reproductive justice... reproductive justice demands sexual autonomy and gender freedom for every human being.” Core to the work of reproductive justice activists is confronting the violence of anti-Blackness and the pervasiveness of ideologies of white supremacy. Finally, recognizing our own social locations, our work is driven by a commitment to challenging the individualized frameworks common in liberal feminism. This shows up in our work below by exploring how ideas of body-sovereignty and individual choice in birth work can become co-opted by movements that actually serve to perpetuate dominant relationships of power.

In 2019 we conducted research on service user experiences of midwifery care, holding in-depth interviews with clients of the new midwifery program in Fredericton, New Brunswick (MacDougall and Johnston 2022). Early in the study, we noted that the midwives and many of the clients of the midwifery clinic espoused commitments to access and justice. The clinic employs a progressive screening tool to prioritize clients based on social and economic location, and midwives and many clients were intentional in their use of inclusive language around gender and sexuality. We recognized the midwives’ emphasis on informed consent and bodily autonomy as core to midwifery and to birth justice. Initially, we understood comments by clients of the clinic in the context of this emphasis on autonomy. Our findings on the relationship between the regulated midwifery program and unregulated birth care practices were incidental; we were surprised to hear about freebirth at almost every interview. At first, these were subtle references, and we noted that participants often used the terms freebirth and unattended birth interchangeably. We became curious as interview participants told us about their consultations with freebirth attendants, relayed the stories of friends or acquaintances who had freebirths, and, eventually, some participants told us that they had also had freebirths with prior pregnancies. As we moved into the second phase of our research, tracing the development of the provincial midwifery program, we came to understand that the legal landscape for birth care in New Brunswick, the scarce access to regulated midwifery care, and the largely rural geography of the province have combined to create a particularly complex context for birth care. We also came to understand better that despite the emphasis on autonomy and freedom, some elements of freebirth movements directly counter the justice-oriented commitments of midwifery and birth justice.

Over the course of our research, we have completed 51 semi-structured interviews with birth care advocates, clients of midwifery services, regulated and unregulated birth workers, and those involved with policy development. Interviews were coded using Quirkos qualitative data analysis software during multiple rounds of qualitative analysis, moving from descriptive to analytical codes and themes through the many rounds of coding. The two authors each coded some transcripts individually, and then compared emerging codes and reached agreement on the codes we would use going forward. We then each coded the rest of the transcripts and repeated this process until we felt we had developed analytical codes that captured the nuance of the data with a reproductive justice focus. Following our informed consent process and the wishes of our participants, data is reported here using either pseudonyms chosen by participants or their real names; a small number asked not to be named or directly quoted (sometimes both), and their comments are paraphrased or included without attribution.

Birth Care in New Brunswick

Registered midwives provide prenatal and postpartum support as well as attending births in the hospital, at birthing centres (where these exist), and at home. Midwifery is regulated by provinces and territories across Canada, and midwives attended about 11% of births in 2021 (Canadian Association of Midwives 2021). In most provinces, the only way to have an out-of-hospital birth within the provisions of the healthcare system is with a registered midwife, but there is significant unevenness in access to midwifery care across Canada. In 2019 midwives attended 25% of births in British Columbia, compared to 15% in Ontario, 2.8% in Nova Scotia, and 0.7% in New Brunswick (Canadian Association of Midwives 2019).

New Brunswick was among the last Canadian provinces to implement midwifery care, opening one clinic within the anglophone health authority in 2017. Since then, the midwifery program remains available in only one clinic, located in the capital city of Fredericton, with a maximum equivalent of four full-time midwives. Clients must meet the criteria for a low-risk birth and live within the small catchment area of the clinic in order to receive care. Midwives are regulated as part of the provincial healthcare system, registered by the New Brunswick Midwifery Council, which is part of the Canadian Midwifery Regulators Council. They may attend births in the hospital or at their clients' homes, and they also provide follow up postpartum care both at their clinic and in clients' homes. Midwives in the New Brunswick program therefore provide hospital and home-based care, within the regulated health care system, operating at the interface of hospital and out-of-hospital care. Our 2017-2019 study with midwifery clients in the province found high levels of satisfaction with the program, as well as some structural and implementation challenges being faced by midwives and their clients (MacDougall and Johnston 2022). Since it opened, the clinic has maintained an extensive waiting list, and our ongoing research finds high levels of interest and desire for midwifery care.

The piecemeal, limited nature of the creation of the midwifery program and its implementation have had considerable impacts on the kinds of out-of-hospital and out-of-system birth practices we report on here. In addition, it is worth noting that the legal, socioeconomic, and geographic context of the province of New Brunswick present significant challenges for the provision of reproductive healthcare. New Brunswick is a small province in the Atlantic region with a rapidly aging population, a downward trending birth rate, and a largely rural geography, as well as income levels among the lowest in Canada (Government of New Brunswick 2023). In 2019, New Brunswick was recognized as the poorest province in Canada, garnering higher equalization payment rates from the federal government to cover healthcare, education, and other social services (Jones 2019). Although the province is located within one of the wealthiest nations, it is a low-income province. Like many provinces in the region, governments in New Brunswick have been reluctant, and at times hostile, to the expansion of many facets of reproductive health care, including abortion (Ackerman 2012; Foster et al. 2017). As we demonstrate below, these combined factors have had significant impacts on birth practices in the province.

Wolostoq, Passamaquoddy, and Mi'kmaw Nations have long-standing, ongoing, and sovereign traditions of welcoming new life into their communities through ancestral knowledge, land-based practices, and diverse medicine ways. Our research does not adequately reflect the breadth, depth, or lived realities of Indigenous midwifery and birth work in this region. Discussions around regulation, self-determination, and the reclamation of birth are not only ongoing—they are grounded in sovereignty, community priorities, and relational accountability. We acknowledge the limitations of our methodology and team in respectfully representing these Indigenous-led movements. Our initial findings reflect the ongoing emphasis among Indigenous communities on home and community-based birth, which is not new, but a continuation of long-standing practice that predates colonization. As one Indigenous interview participant explained:

For Indigenous people, that is community ... let us have our babies at home, let us have midwifery care so it doesn't feel like a clinical medical setting, which you know, a lot of people are curing some trauma with, and it's passed down trauma. We're hearing stories about young people now, and how they don't want to give birth because they heard about social services coming in and taking their parent's babies. Or, you know, just being in the system is a reminder of shitty things. (SP)

This powerful reflection echoes intergenerational experiences of medical colonialism, family separation, and state surveillance—realities that continue to shape Indigenous experiences with the healthcare system today. Returning birth to community is central to Indigenous midwifery resurgence and the “Birth Back” movement amplified by the National Council of Indigenous Midwives (NCIM) reflects the voices of Indigenous midwives and their communities (National Council of Indigenous Midwives 2014; 2019). This work is rooted in restoring wellness through body autonomy, returning culture to health practices, and centring family and community participation and care.

In the province of New Brunswick, this work of restoring Indigenous birth practices is underway. For example, the community of Pilick First Nation recently celebrated the first at-home birth in 85 years, guided by Elder Opolahsomuwehs and supported by the presence of registered midwives (Baker 2022). While significant, this milestone is also a reminder of the structural barriers that have interrupted Indigenous birth practices for generations—and of the ongoing resistance and leadership of communities reclaiming this inherent right. As Nathalie Pambrun, Michif midwife and Community Engagement Lead at NCIM notes,

Further action—including Indigenous-led research, secure and long-term funding, legislative recognition of Indigenous midwifery authority, and full access to Indigenous-designed and -governed midwifery education—is urgently needed. This work must be directed by Indigenous communities, midwives, and knowledge keepers, not only supported by policy shifts but grounded in restitution and Nation-to-Nation accountability.

Moving between Regulated and Unregulated Birth Care

Much of the literature on unregulated birth care focuses on motivations to seek or provide alternative care, and while motivations do show up in our data, our aim here is to provide greater conceptual clarity on different birth practices and the relationships among them. We begin by problematizing the common conception that all out-of-hospital care is unregulated care, pointing out the many ways in which those seeking unregulated forms of care may also make use of various kinds of regulated birth care. Indeed, there are many kinds of unregulated birth care, and many interface with the existing provisions of the regulated health care system. In some ways, they might even be seen as complementary. In our data, a range of birth practices are evident, often negotiating the line between regulated hospital-based care, regulated out-of-hospital care, and unregulated care which takes place outside of hospital and often outside of the healthcare system. In problematizing the assumption of a clear division between unregulated and regulated care, we gain a more fulsome understanding of existing birth practices.

Doulas

As an unregulated health profession, there is no legal definition or required certification for doulas in the province of New Brunswick. Doulas of New Brunswick is a professional organization affiliated with DONA International, which provides doula training and its own accreditation (DONA International, np). Doulas are therefore not part of the regulated healthcare system in the province, and they are contracted and paid privately by clients. Like midwives, they may support clients at home or at hospital births. Unlike midwives, doulas are not medical professionals, and they are not legally empowered to be the primary attendant at births. While doulas are unregulated birth workers, they often work within the regulated system alongside physicians, nurses, and midwives at hospital births, and alongside regulated midwives at home births. Perhaps because they work closely with midwives and the midwifery model of care, doulas are often confused with midwives, as indicated by some interview participants:

A lot of what I do is just explaining to people that I am not a midwife. This is what a doula is, this is what a midwife is. You know, they're [midwives are] clinical care practitioners, they can order tests. (SP)

I do a lot of doula work and so I work closely with midwives, of course, but also with OBs, with hospital care. (Genvieve)

The midwife takes more of the medical side, right. And the doula does more of the support. (Therese)

As discussed further below, some birth workers may call themselves doulas when they are actually attending births as unregulated (lay or traditional) midwives.

Lay Midwives and Unattended Birth

Home-based birth workers have a long history in New Brunswick. These kinds of birth workers are sometimes called traditional, lay, or independent midwives; they are usually trained through a combination of apprenticeship, self-education, and some formal education. Sometimes, lay midwives have received formal midwifery training at an accredited institution but their training does not meet the current standards for registration in the province; in other cases, they have decided not to obtain or maintain their registration. Lay midwifery is not included in the provincial health care system, and therefore clients of these services pay out of pocket. Under the New Brunswick Midwifery Act, only those registered with the Midwifery Council of New Brunswick may use the professional designation of midwife and attend home births. According to our interview participants, lay midwifery was widely practiced before the implementation of the Midwifery Act, and although the legal prohibition on this work has driven some lay midwives underground, the practice is still relatively common among those seeking alternatives to hospital-based birth.

I was around women who are unattended birth assistants, they call themselves, or lay midwives. And women who have been birthing at home without any support other than maybe these women, these lay midwives. (Christina)

Some lay midwives do this work to fill a gap in the provision of home- and community-based care. Nathalie Pambrun, Michif Registered Midwife, former head of the Midwifery Council of New Brunswick, and Community Engagement Lead at NCIM explains:

Lay midwives' work is a form of harm reduction to address critical gaps in regulated home- and community-based care. They're going to the margins to reach the folks who aren't being reached and that's where our health system transformation needs to go.

One participant saw her work in this capacity as a service to members of her community. Lisa explained: “You’re serving women. They ask you to be with them when they birth: end of story.”

In our interviews, participants sometimes expressed uncertainty about the nature of their care providers’ training, or they were reluctant to talk in more detail about what they did know. One participant, seeking a midwife through people she knew “who were midwives but couldn’t be actual midwives here” found care with a provider who was described as “more or less the same.” In reflection, Danielle said: “So I trusted that opinion. I don’t feel like I should have, but I did.”

In the instance of lay and traditional midwives, there is less interplay with regulated and hospital-based forms of care, though some clients of lay midwives *also* access regulated forms of care, piecing together various provisions to obtain the kind of birth care they seek. Sometimes, lay midwives support clients at hospital births but downplay their role in the provision of birth care and call themselves friends or doulas instead of unregulated midwives. As Lisa explains:

There were situations where we just get in the car ‘cause she [the birthing person] decided she wants to go and you go and you know, she pretends that she had no intent to birth at home, and she’s whatever. You lie. (Lisa)

In other instances, physicians may support their clients in seeking lay midwives to have a home birth. As one person told us,

I know someone who had an unattended birth, and they were able to have a doctor who was familiar with midwifery and was just, like, “I will help you to know if you’re at risk. And tell you if I don’t think you should do it.” (Erin)

In the comments of our participants, there is a great deal of conflation between lay midwifery, unattended birth, and freebirth. For instance, Genvieve explains:

To answer your first question, whether or not unattended and freebirth is different, I use them in the same way. That being said, if I was a doula who was working in a kind of a freebirth capacity, I might have different—I might think about that differently, but in terms of what I’ve seen, unattended and freebirth are pretty similar. (Genvieve)

In other interviews, participants used the terms “unattended birth attendant,” a confusing formulation which attempts to both hide and recognize the presence of an unregulated birth worker. Similarly, participants sometimes talked about a “radical” subset of lay midwives who eschewed regulation and regulated midwifery and worked in tension with those advocating for the implementation of a midwifery practice within the provincial healthcare system. While the birth practices themselves may look similar, we argue that orientation to regulation is a key factor differentiating between unattended birth (birth with a lay or traditional midwife) and freebirth, with most lay midwifery practitioners and clients exhibiting more readiness to negotiate across regulated and unregulated forms of care and freebirth practitioners taking a staunch anti-regulation position. Our data indicates that despite some confusion and obfuscation, freebirth is increasingly a form of birth care that falls completely outside of regulated healthcare systems and actively resists this negotiated relationship with regulation in many systems.

Free Market Freebirth: Against Regulation

In our research, it became evident that there was a stark difference among the forms of care we describe above as doula, lay midwifery, and unattended birth, and the kinds of birth work being offered by freebirth advoc-

ates. We refer to this group of birth workers as “freebirth entrepreneurs” and note that they combine free market monetization, aestheticization, and social media alongside an alignment with the unregulated wellness industry in the specific forms of care they provide. With roots in the region where this study took place, the Free Birth Society is one example of freebirth entrepreneurs, but there are many others (Dickson 2020; Butler 2020). In our study, people who wanted to birth outside of hospital but were unable to access regulated or unregulated midwifery care often found their way to the Free Birth Society and other freebirth entrepreneurs through word of mouth, internet searches, and social media. The principles of the Free Birth Society, including an active distrust and undermining of regulated midwifery in the region, may or may not have been what these people were originally seeking.¹

We use the term freebirth entrepreneur as a catch-all for a group of practitioners who are not regulated health-care professionals, and who claim expertise based primarily in lived experience and ideas about the naturalness of childbirth. Their services include the provision of various and often overlapping kinds of care such as information about pregnancy and birth (individually in-person, through online interactions, through virtual trainings, and in-person groups); prenatal care (visits with the pregnant person, virtual advice and check-ins, pregnancy support groups offered virtually or in person); being present at births; and other services of a similar nature.

While a suite of services is offered, by those with a variety of backgrounds, under the freebirth entrepreneur model, there are similarities across the types of care these communities and groups provide. Freebirth entrepreneurs often highlight the language of entrepreneurialism in their marketing, typically charging fees for service while operating completely outside of the formal healthcare system. These service providers frequently express low tolerance for pregnant people and other birth workers (e.g., doulas) who wish to interact with both the regulated and unregulated worlds of birth work. Indeed, the Free Birth Society specifically espouses ideas of birth as natural and cautions members that any involvement with regulated providers, from prenatal care to assistance at labour and delivery outside of their network, is antithetical to freebirth practices, insisting that members of their group fully reject the formal healthcare system to enter and stay within their community (Kale and Osborne 2025). This group, and others like it, represents a sector of unregulated birth workers where births may indeed be “unattended,” and the aim is to remain entirely outside of existing healthcare systems. Thus, we argue, freebirth entrepreneurs take a position that is explicitly opposed to any forms of regulated care. That is, they espouse unregulated and out-of-system birth practices only, sometimes to extreme ends (Kale and Osborne 2025).

Free Market Monetization

The freebirth entrepreneur approach to birth care is commodified and commercialized. Before the Covid-19 pandemic, some freebirth entrepreneurs were providing birth support for a fee of \$3000-5000; this included pre-natal support and information sharing and often being physically present at the birth but not intervening in any way. Judy explains the financial cost and lack of professional training associated with this kind of service:

So, for my unattended birth, that’s not available for people, I paid three thousand dollars to have my baby at home. That is not something that is possible for [many] women. (Judy)

And they aren’t as trained [as registered midwives], and they don’t have the equipment, and all that stuff. (Judy)

In recent years, freebirth entrepreneurs have begun to organize and share information online, including fee-based training sessions and webinars. Those seeking advice have increasingly found support online, sharing information, resources, and experiences. Despite stated commitments to “a global sisterhood,” “body sovereignty,” and “the return of the matriarchy,” the resources offered by freebirth entrepreneurs are accessed only

through paid registration in closed trainings and private memberships accessed through paywalled websites (Free Birth Society 2025).

Aestheticization and Social Media

As part of the wellness industry, aesthetics surfaces as an important aspect of the freebirth entrepreneur narrative. And as freebirth entrepreneurs eschew any involvement with healthcare systems, they often deliver this highly aestheticized service through online social media platforms, YouTube, and Substack. One participant, who did not want to be directly quoted, talked about one of the main actors in the Free Birth Society, who was locally based at the time, as beautiful, charismatic, engaging, and radical.

As the region has been so poorly resourced with respect to regulated midwifery for so long, many participants discussed the role of the internet and social media in finding information about out-of-hospital and out-of-system birth and finding information from freebirth entrepreneurs about “do it yourself birth.” Again, the aestheticized nature of this business model is evident in participants’ comments:

Before I got pregnant I was watching a YouTuber who had a home birth. And like I had followed them for a while and I had thought that it was a very like beautiful experience, you know, like the lights were dim, and she had her own clothes on, not like a hospital gown, and she had her family there, and the husband was super involved. I don’t know if they had a midwife, but I... that was where the idea of a home birth came in. And so, when I did get pregnant, I really wanted that, and then I found out that we had midwives here, so home birth was available, which was surprising to me ‘cause I hadn’t heard of it around here before. (Liza)

They know this [home birth] is what they want and then they get into the research rabbit hole where there was a huge world of unattended home births and a lot of times it is totally fine. I mean a lot of times people can give birth with no problems. But when there are those problems, we should have a midwife there. [Laughing] You know? Yeah, I think it’s sad when there’s somebody who wants a midwife and can’t have one. (Margaret)

Freebirth entrepreneurs are ideologically anti-system and anti-institution and, as we demonstrate below, this also further extends toward positions best described as anti-science, with strong alliances with many of the health conspiracies that gained traction during the peak of the Covid-19 pandemic and that continue currently.

Wellness Industry and Conspiracies

Over the last several years the Free Birth Society has adopted views that are explicitly against regulated midwifery, gender essentialist (for example, statements such as women are closer to nature and are meant to give birth), and transphobic (“gender critical”), as well as espousing some ideas about Covid-19 and vaccines that align with various alt-right and Covid-19 conspiracy theories.

We see this freebirth movement as part of the wellness industry, associated with healthism discourses, and increasingly and overtly aligned with a gender essentialist orientation including promoting transphobic and homophobic beliefs. There are also elements of cultural appropriation and a language of freedom that is deeply individualized. Freebirth entrepreneurs are deeply anti-authoritarian, as evidenced by their hostility to regulated midwives, with a strong mistrust of the state. As one participant from our interviews explains:

There’s a sort of anti-vax, anti-medicine, anti-institution, anti- whatever sector that connects to this that I think can also undermine what I think needs to happen, for example. It’s not just like, I want

the right to have my baby at home and these are the reasons that it can be safe, or this is why I want to do it—it's the, like, I don't trust doctors they're gonna give us needles and all this stuff.

Due to the ambiguous legal status of unregulated birth work, those involved in freebirth practices and freebirth community were often reluctant to be directly quoted while sharing their information, fearing legal and social repercussions. One study participant, who did not want to be quoted directly, shared her concerns about people calling themselves lay midwives who were part of this freebirth community, stating that these providers are actively against regulation and are anti-education, using the word “radical” to describe their overall orientation to birth. Another participant, who also did not want to be quoted directly, shared her experience of attending a meeting with freebirth advocates, where there were discussions that she felt were very “anti-midwife,” stating that those in attendance saw regulated midwives as a threat to those who wanted to birth outside the system.

While freebirth entrepreneurs often express commitments to evidence-based services and processes of informed consent using language similar to what one would expect from a regulated midwife, we argue that they are more aligned with the burgeoning wellness industry's orientation toward a for-profit, commodified, neoliberal version of healthcare and personal health responsibility. We see the increased profile of the freebirth entrepreneurs during the peak of the Covid-19 pandemic as an example of this, when many other ableist and eugenicist ideas about control of the body as a sign of a healthy/fit individual and narratives of personal responsibility circulated as part of an open distrust and undermining of government regulated and provided healthcare.

Consequences of the Lack of Conceptual Clarity

The lack of conceptual clarity about the various forms of birth care can be attributed to several factors. As demonstrated above, many forms of unregulated birth work intertwine with regulated forms of care offered within the healthcare system. Other forms of unregulated work exist completely outside of the system and the illicit nature of this work means that it may be difficult to discern exactly what kinds of training and experience care providers offer and what their central motivations and orientations for providing birth care might be. The consequences of the lack of conceptual clarity are myriad but are most worrisome for those seeking care. As one participant explained, “There's, again, not a strong understanding of what midwives are, what doulas are, what unattended births are.”

The confusion is not just among those seeking care but extends to those practicing in the medical system and there is concern that this has negative consequences for regulated midwifery in an area where it has been insufficiently resourced and understood. As one participant explained:

...there have been hospital transfers and that has coloured the perceptions of some health care providers in some centers as to midwifery care. Even though these individuals weren't using midwifery care, it's more in terms of home births. There's a fear of home births, I think, in some [health care] centers, just because they've seen these hospital transfers of those who have decided to freebirth at home and then something happens, and they go to the hospital and... they're seeing just what goes wrong. They're not seeing what goes right in terms of home birth. (Erin)

Recent data indicate that out-of-hospital births are likely to continue to increase, in both regulated and unregulated forms (McKenzie, Robert, and Montgomery 2020). As McKenzie, Robert and Montgomery (2020, 517) note, “the lack of appropriate midwifery services has been recognized as a factor in women's decisions to have UBWs [unregulated birth workers] at their births as opposed to regulated HCPs [health care professionals]”. They go on to note: “Linked to this is the rurality of some women's homes” (2020, 517). The scholarly literature includes several recommendations for addressing the growth of unregulated birth work, including harm reduction strategies, shared decision-making and renewed attempts to connect with those considering

unregulated forms of birth care (LeBlanc and Kornelsen 2015; Shorey et al. 2023). Perhaps most relevant to the context of our study however, the data also demonstrates that the expansion and fulsome integration of regulated midwifery will go a long way to mitigating the growth of organizations like the Free Birth Society. Indeed, many of the participants in our research who ended up having unassisted births indicated that they would have preferred a home birth with a registered midwife instead, a finding that echoes that of LeBlanc and Kornelsen (2015).

While we agree that out-of-hospital and out-of-system birth can be and often are part of a feminist commitment to community care and bodily autonomy, we are also concerned that freebirth entrepreneurs co-opt the history and language of feminist community-centered healthcare to align with specifically anti-feminist beliefs—especially those feminist beliefs and core comments that are based in justice-oriented approaches. A look at any of the Free Birth Society public facing pages will demonstrate commitments to the radical liberal feminism often perpetuated by white feminism. We argue that freebirth entrepreneurialism is an emergent source of birth information that may be attached to essentialist views about gender, hyper-individualism, and, at times, with conspiratorial orientations to medicine and science, and as such undermines the work that intersectional and Black feminists have advanced through the reproductive justice framework.

Conclusion

Clarifying the differences among forms of care is crucial to increasing informed decision making and safety and a crucial first step in undertaking further research on regulated and unregulated birth practices. Justice oriented frameworks for understanding the political nature of birth practices complicate how we think about choice. Rather than seeing choice as an individual level practice, reproductive justice and anti-colonial approaches emphasize that choice is always shaped by complex relationships of power and oppression. These justice-oriented approaches to thinking about birth allow us to understand how people make decisions about the type of birth care they will choose for many reasons and seek a variety of sources of information and care providers to support this choice. These choices are often based in difficult experiences with healthcare systems, including experiences of racism and violations of consent, sexual violence, and other traumas. A justice lens also allows us to see how centring individual choice can also contribute to maintaining relationships of power and oppression. The availability (or unavailability) of a range of forms of care will shape the extent to which people seek and consider alternative options.

The link between freebirth entrepreneurialism, conspiracy theories, and white, trans-exclusionary feminism has become particularly troubling. Based on this early analysis of incidental findings, we are concerned that freebirth entrepreneurialism lacks an analysis of power and gendered oppression and that, as a result, it could reinforce settler colonialism, white supremacy, gender essentialism, and other forms of oppression. For example, when freebirth entrepreneurs incorporate aestheticized aspects of Indigenous birth practices and appropriate the language of bodily sovereignty, they trivialize the ongoing and systemic harms of colonialism on Indigenous people and their birth experiences and practices, including a continued lack of access to Indigenous midwifery care, while benefiting from the harmful settler colonial romanticization of Indigenous cultural practices.

In the context of our research, we argue that rurality, the frequent closure of hospitals in smaller centres, and serious obstacles to widespread access to regulated midwifery care have fuelled the growth of a range of unregulated birth care practices, including freebirth. Some versions of unattended, out-of-system birth also undermine existing movements for regulated midwifery, birth justice, and reproductive justice in the region.

While motivations for out-of-system birth are being well studied, the possible relationship between motivating factors for out-of-system birth and choice of care provider (including no care provider) should also be explored more fully, particularly in the Canadian context. Motivations for providing out-of-system birth care should also be considered an important topic of investigation as this may point to problems and potential interven-

tions in maternity care. Clarity on the various approaches of out-of-hospital birth and out-of-system birth that consider their core orientations, such as the conceptualization we have suggested here, will enable more analytical power in further studies in this area.

Finally, while we have attempted to clarify some of the forms of care that are typically conflated as freebirth in the extant literature, it is also clear that there is considerable movement across regulated and unregulated forms of care, which should be embraced in contexts such as movements for Indigenous birth work. Recognizing that people will make the best possible decisions given their own needs, experiences, and desires is crucial to destigmatizing the choices that people make about their birth experiences. Although freebirth entrepreneurs are ubiquitous in online spaces and in some physical spaces in the region where we have conducted our research, our data indicates that most of those who sought or engaged in forms of unregulated birth care were not seeking freebirth, and we have no evidence to suggest that participants in our study endorse the more extreme positions of freebirth entrepreneurs. To the contrary, a central finding in our research is a strong desire for access to home birth with regulated midwives, alongside a commitment to equity and inclusion. Building on the conceptualizations introduced here, we will continue to examine the relationships between regulated and unregulated birth practices, and the rapid growth of freebirth entrepreneurialism.

Acknowledgements

The authors wish to acknowledge the contributions of the Conceptions & Care Research Advisory Committee; Christina de Haas, Community Research Consultant; the research participants who shared their insights with us; and our colleagues Sarah Rudrum and Katherine Dunbar, for ongoing conversation. We are particularly grateful to Nathalie Pambrun for their generous feedback regarding Indigenous midwifery. We gratefully acknowledge that this research has been made possible via funding from the SSHRC Insight Development Grant and Connections Grant programs, and the President's Research and Creative Activities Fund at Mount Allison University.

Conflict of Interest

We have no conflicts of interest to declare.

Endnotes

As we were finalizing this article, *The Guardian* released a series of articles, podcasts, and videos detailing the damning findings of an in-depth investigation of the impact of the Free Birth Society. Descriptions of the FBS and the actions of its founders confirm our assertions about the distinct nature of freebirth entrepreneurialism. For more, see Kale and Osborne (2025).

Works Cited

Ackerman, Katrina R. 2012. "Not in the Atlantic Provinces': The Abortion Debate in New Brunswick, 1980-1987." *Acadiensis* XLI (1):75-101.

Baker, Oscar III. 2022. "Pilick Celebrates 1st Community At-Home Birth in 85 Years." *CBC News*, August 27. www.cbc.ca/news/indigenous/wolastoqew-home-birthing-ceremony-1.6563198

Butler, Kiera. 2020. "The Terrifying Story of How QAnon Infiltrated Moms' Groups." *Mother Jones*. September. www.motherjones.com/politics/2020/09/the-terrifying-story-of-how-qanon-infiltrated-moms-groups/.

- Canadian Association of Midwives. 2019. "Midwives and Midwifery-Led Births." canadianmidwives.org/sites/canadianmidwives.org/wp-content/uploads/2021/03/Midwives-and-Midwifery-led-Births-2019.pdf
- _____. 2021. *Brief to The House of Commons' Standing Committee on the Status of Women*. May 21. www.ourcommons.ca/Content/Committee/432/FEWO/Brief/BR11386041/br-external/CanadianAssociationOfMidwives-e.pdf.
- Dickson, E.J. 2020. "QAnon Ideology Is Infiltrating the Natural Parenting Community." *Rolling Stone*. December. www.rollingstone.com/culture/culture-news/qanon-pastel-antivax-natural-parenting-community-freebirth-1098518/.
- Dona International. www.dona.org
- Feeley, Claire, Ethel Burns, Eike Adams, and Gill Thomson. 2015. "Why Do Some Women Choose to Freebirth? A Meta-Thematic Synthesis, Part One." *Evidence Based Midwifery* 13(1): 4–9.
- Foster, Angel M., Kathryn J. LaRoche, Julie El-Haddad, Lauren DeGroot, and Ieman M. El-Mowafi. 2017. "‘If I Ever Did Have a Daughter, I Wouldn’t Raise Her in New Brunswick:’ Exploring Women’s Experiences Obtaining Abortion Care Before and After Policy Reform." *Contraception* 95(5): 477–84. doi.org/10.1016/j.contraception.2017.02.016.
- Free Birth Society. 2025. www.freebirthsociety.com.
- Government of New Brunswick. 2023. *Income Fact Sheet: Summary and Statistics*. www2.gnb.ca/content/dam/gnb/Corporate/Promo/equality-profile/Final-Income-EN.pdf
- Greenfield, Mari, Sophie Payne-Gifford, and Gemma McKenzie. 2021. "Between a Rock and a Hard Place: Considering ‘Freebirth’ During Covid-19." *Frontiers in Global Women’s Health* 2 (February):603744. doi.org/10.3389/fgwh.2021.603744.
- Johnston, Krista, and Christiana MacDougall. 2021. "Enacting Feminist Methodologies in Research Toward Reproductive Justice." *International Journal of Qualitative Methods* 20 (January). doi.org/10.1177/16094069211016157.
- Jones, Robert. 2019. "‘Tough to Take’: New Brunswick Grabs Unwanted Title as Canada’s Poorest Province." *CBC News*, Dec. 18. www.cbc.ca/news/canada/new-brunswick/new-brunswick-poorest-province-equalization-payments-1.5400170.
- Kale, Sirin and Lucy Osborne. 2025. "The Birth Keepers." *The Guardian*, November 22. www.theguardian.com/world/ng-interactive/2025/nov/22/free-birth-society-linked-to-babies-deaths-investigation
- LeBlanc, Kate, and Jude Kornelsen. 2015. "Giving Birth Outside the Health Care System in New Brunswick: A Qualitative Investigation." *Canadian Journal of Midwifery Research and Practice* 14(3): 8–15.
- MacDougall, Christiana, and Krista Johnston. 2022. "Client Experiences of Expertise in Midwifery Care in New Brunswick, Canada." *Midwifery* 105 (February):103227. doi.org/10.1016/j.midw.2021.103227.
- McKenzie, Gemma, Glenn Robert, and Elsa Montgomery. 2020. "Exploring the Conceptualisation and Study of Freebirthing as a Historical and Social Phenomenon: A Meta-Narrative Review of Diverse Research Traditions." *Medical Humanities* 46(4): 512–24. doi.org/10.1136/medhum-2019-011786.
- Miani, Céline, Stephanie Batram-Zantvoort, Emma Pitchforth et al. 2023. "Out-of-Hospital Births: A Small but Growing Phenomenon in High Income Countries: A Viewpoint." *Journal of Asian Midwives* 10(2): 77–78.
- National Council of Indigenous Midwives. 2014. *Bringing Birth Back: Aboriginal Midwifery Toolkit*. indigenoumidwifery.ca/wp-content/uploads/2018/10/Aboriginal-Midwifery-Toolkit.pdf.

_____. 2019. *Diverse Pathways: Bringing Indigenous Midwifery Home*. https://indigenoumidwifery.ca/sites/indigenoumidwifery.ca/wp-content/uploads/2022/05/NACM_Booklet_DiversePathways_2019_REV5_PROOF2.pdf.

Ross, Loretta J., and Rickie Solinger. 2017. *Reproductive Justice: An Introduction*. University of California Press.

Shorey, Shefaly, Gabija Jarašiūnaitė-Fedosejeva, Burcu Kömürçü Akik, et al. 2023. “Trends and Motivations for Freebirth: A Scoping Review.” *Birth* 50(1): 16–31. doi.org/10.1111/birt.12702.

Simpson, Leanne Betasamosake. 2017. *As We Have Always Done: Indigenous Freedom Through Radical Resistance*. University of Minnesota Press.

Statistics Canada. 2021. *Births 2020*. www150.statcan.gc.ca/n1/en/daily-quotidien/210928/dq210928d-eng.pdf?st=tieuLCdi.

TallBear, Kim. 2018. “Making Love and Relations Beyond Settler Sex and Family.” In *Making Kin Not Population*, edited by Adele E. Clarke and Donna Haraway. Prickly Paradigm Press.

Velo Higuera, Maria, Flora Douglas, and Catriona Kennedy. 2024. “Exploring Women’s Motivations to Freebirth and Their Experience of Maternity Care: A Systematic Qualitative Evidence Synthesis.” *Midwifery* 134 (July):104022. doi.org/10.1016/j.midw.2024.104022

Wilson, Alex. 2015. “Our Coming In Stories: Cree Identity, Body Sovereignty and Gender Self-Determination.” *Journal of Global Indigeneity* 1(1): 1–14. www.jstor.org/stable/48717629.