Tensions and conflicts in 'choice': Women's experiences of freebirthing in the UK

Abstract:

Background: The concept of choice is a central tenet of modern maternity care. However, in reality women's choice of birth is constrained by a paucity of resources and dominant medical and risk adverse discourses. In this paper we add to this debate through highlighting the tensions and conflicts that women faced when enacting a freebirthing choice.

Methods: Secondary analysis of data collected to explore why women choose to freebirth in the UK was undertaken. Ten women were recruited from diverse areas of the UK via invitations on freebirthing websites. Women provided a narrative and/or participated in an in-depth interview. A thematic analysis approach was adopted.

Findings: We present three key themes. First 'violation of rights' highlights the conflicts women faced from maternity care systems who were unaware of women's legal rights to freebirth, conflating this choice with issues of child protection. 'Tactical planning' describes some of the strategies women used in their attempts to achieve the birth they desired and to circumnavigate any interference or reprisals. The third theme, 'unfit to be a mother' describes distressing accounts of women who were reported to social services.

Conclusion and implications for practice: Women who choose to freebirth face opposition and conflict from maternity providers, and often negative and distressing repercussions through statutory referrals. These insights raise important implications for raising awareness among health professionals about women's legal rights. They also emphasise a need to develop guidelines and care pathways that accurately and sensitively support the midwives professional scope of practice and women's choices for birth.

Keywords

Freebirth; unassisted birth; childbirth; autonomy; choice; legal

Introduction

A central tenet of modern maternity care in developed countries is that of 'choice' (International Confederation of Midwives, 2014; World Health Organisation, 2005). This concept arose through the 1990's from an interaction between political, feminist and consumerist cultural shifts which have become firmly embedded within the rhetoric of modern healthcare (Beckett, 2005; McAra-Couper, Jones, & Smythe, 2011). The concept of choice explicitly asserts that women have the right to make autonomous decisions about their maternity care thereby creating a move away from the passive patient under 'expert' decision makers to a partnership model in which women's needs and preferences are central to decision making (International Confederation of Midwives, 2014; Midwifery 2020, 2010; The Royal College of Midwives, 2012). It also includes the right to decline care even in life threatening situations (Birthrights, 2013c; McAra-Couper et al., 2011). In many countries the concept of 'choice' has been formalised through: legislating women's rights to autonomy (Birthrights, 2013c; United Nations, 1999); governmental policy (DH, 2010; Goldbord, 2010; Public Legal Education and Information Service of New Brunswick, 2015; US Department of Health and Human Service, 1997) and evidence based healthcare guidelines (NICE, 2014; World Health Organisation, 2005; World Health Organisation, 2014).

In the UK, since the 1990's a particular focus of policy (DH, 1993; DH, 2007; DH, 2010) and guidelines (Maternity Care Working Party, 2007; NICE, 2014; RCOG, 2013) has been to offer more choice and access to various birth settings (i.e. home, hospital, birth centres). Evidence highlights that for healthy women, out of hospital birth is safe and associated with positive outcomes such as increased vaginal birth rates, reduced medical interventions and increased maternal satisfaction (Brocklehurst et al., 2011; Burns, Boulton, Cluett, Cornelius, & Smith, 2012; NICE, 2014). However, the UK 2014/15 birth statistics (Health and Social Care Information Centre, 2015) demonstrate that 87% of women birth in hospitals, 11% in birth centres and only 2% at home, depicting current norms and an inequity of service provision. Findings from the NCT (2009), the Birthplace study (Brocklehurst et al., 2011; McCourt, Rance, Rayment, & Sandall, 2011) Royal College of Midwives (2011) and the Maternity Services review (NHS England, 2016) describe various factors that contribute to the inequity of homebirth provision and birth centre availability across the UK. These include local trust resourcing, staffing levels, organisational structures, on call demands,

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midwives lack of confidence, lack of management support and negative attitudes by the obstetric team. Within this context, critics argue that 'choice' is socially constructed, politically constrained and often inequitable (Beckett, 2005; Budgeon, 2015; McAra-Couper et al., 2011). It is suggested that the combination of dominant medical and risk averse discourses, within a technocratic culture of maternity care super-values certain choices over others, creating hegemonic birth practices (Kitzinger, 2005; McAra-Couper et al., 2011; Walsh, 2009).

A birth choice that sits outside of the 'norm' (i.e. a hospital birth) is freebirthing, sometimes referred to as unassisted birth (blinded for review). Freebirthing is characterised as an active decision to birth without trained health professionals present but where maternity care is readily available (Nursing and Midwifery Council, 2013). Concerns surrounding safety for mother and baby (Nursing and Midwifery Council, 2013), misconceptions about its legality (Birthrights, 2013d) as well as safeguarding for the fetus (Birthrights, 2013b), make it a controversial birth choice. Its subversive nature not only challenges hegemonic birth practices of both the medical and midwifery model of birth (Dahlen, Jackson, & Stevens, 2011; Edwards & and Kirkham, 2013; Feeley, Burns, Adams, & Thomson, 2015; Jackson, Dahlen, & Schmeid, 2012), it also brings the rhetoric of choice under scrutiny.

Commented [C3]: Tbh, I have finally understood what this is for!

Commented [C4]: I have just removed reference to uk/countries, not needed.

Literature concerning the phenomenon of freebirthing has primarily focused upon why women choose to freebirth. A meta-synthesis (blinded for review) of qualitative studies undertaken in USA (Brown, 2009; Freeze, 2008; Miller, 2009) and Australia (Jackson et al., 2012) identified common motivations to freebirth including: a rejection of the medical and midwifery model of birth, a previous distressing/traumatic birth experience, obstructions to homebirth provision and a lack of trust in maternity services. Due to a lack of insights into this phenomenon from a UK perspective, we undertook a study to explore why UK women chose to freebirth. While similar issues to those reported in the meta-synthesis were identified (blinded for review), what also emerged was the tensions and conflicts that women experienced when enacting their freebirthing 'choice'. In this paper we report on a secondary analysis of the interview data to provide new insights into how a maternity system that offers a rhetoric of choice is experienced as coercive, fearful and imbued with negative reprisals.

Methods

Design

For the original study, a hermeneutic (interpretative) phenomenological approach was adopted based on Heideggerian and Gadamerian philosophical hermeneutics (Koch, 1995). Hermeneutic phenomenology is an approach that interprets the phenomena in question, with the premise that all description is already an interpretation and that every form of human awareness is interpretative (van Manen, 2011; van Manen, 2014). Fundamental to this approach is that hermeneutical phenomenology does not seek new knowledge rather it seeks to uncover and express an understanding of the experience as it is lived (Koch, 1995; Smith, Flowers, & Larkin, 2010).

The purpose of a secondary analysis is to answer different research questions of the same data (Long-Sutehall, Sque, & Addington-Hall, 2010), which may illuminate a new perspective or a different conceptual focus to the original research (Heaton, 1998). It is a widely used approach in both quantitative and qualitative research (Long-Sutehall et al., 2010). The original research sought to explore the phenomenon with a broad research aim: 'Making sense of childbirth choices; the views of women who have freebirthed'. The two types of data collected – an unstructured written narrative and follow up interview - generated rich and complex data. In the first paper published from this study we focused on answering the research question 'Why do some women choose to freebirth in the UK?' (blinded for review). For the secondary analysis, we focused on untold aspects of the participant experiences to emphasise the conflicts and tensions they faced when enacting their freebirth choice.

Sample

A purposive and snowballing sampling method was used to recruit women to the study during September 2014. Known freebirthing websites were approached and consent was obtained to advertise the study. Women who had freebirthed in the UK, were over at 18 years old and were English speaking were invited to participate. All participants were provided with an information sheet, password protected email consent form, and consent

gained via email and verbally. Recruitment ended when no further participants came forward.

Data collection

Data collection comprised of two methods, an unstructured written narrative by the participants and/or a telephone interview carried out by the first author. Both methods involved participants being asked to describe their views, experiences and motivations of choosing to freebirth.

Participants

Participant characteristics have been published elsewhere (Feeley & Thomson, 2016). To summarise, 10 participants were recruited into the study; nine completed an unstructured narrative and 10 participated in an interview. The majority were Caucasian, the age range was 25-42 years, all were either married/living with a partner and all had higher education qualifications; six held degrees, with seven women continuing their education at the time of interview. Seven participants were in employment when the study was undertaken. Geographically, the women lived in different locations, thus their local maternity service trust differed for each woman. Collectively, the participants had experienced 15 successful freebirths during 2006-2014, with no adverse perinatal outcomes.

Ethics

Ethical approval was obtained from one of the ethics sub-committees at the second author's institution, and an amendment was approved in January 2015 (project number: STEMH 208). In order to ensure anonymity, a pseudonym has been used when reporting participant quotes.

Data analysis

In the original data collection, the first stage of analysis involved the transcription of the interviews by the first author. The hermeneutic circle was used to interpret the findings as it offers a theory and methodology for analysis; an approach which appreciates the dynamic relationship between the part and the whole (Lester, 1999). Through an iterative process the individual 'meaning' parts were viewed in context of the whole, and the whole was understood by the cumulative meanings of the individual parts (Koch, 1995).

The transcripts and the written narratives were uploaded onto MAXQDA (maxqda.com, 2015), a qualitative software management tool. This initial stage involved a general reading of each data separately, whereby initial thoughts, impressions and poignant phrases in relation to women's decisions to freebirth were identified. The second reading involved a line by line 'in vivo' method where the selected segments of text were assigned a code (Lewis-Beck, Bryman, & Futing Liao, 2004). The codes formed the basis of tentative themes, which were refined iteratively by returning to the data seeking confirming or disaffirming data (Kafle, 2011). This cycle was repeated until the final themes adequately represented the participant's motivations to freebirth (blinded for review).

For the secondary analysis reported in this paper, Braun & Clark's (2006) thematic analysis approach was used. All the transcripts were re-read in their entirety and an inductive method was used to identify key issues faced by women when enacting their freebirth choice. Codes were formed, which were subsequently grouped into sub-themes, and then into meaningful thematic clusters. This was an iterative process undertaken by both authors, and which involved returning to the data several times before the final themes were agreed.

Findings

In order to provide some context to the findings, we felt it important to emphasise how women's decision to freebirth was often associated with their need to opt out of the *'hoop jumping', 'conveyor belt'* system of maternity care, where they felt that policies and 'expertise' were super-valued. Women who freebirthed all held a firm belief in their capabilities to give birth unaided and chose to dis-engage in standard care due to a concern that their natural birth processes would be disrupted by unnecessary interferences or interventions. Furthermore for some a freebirth had not been their first choice, but rather made in lieu of their planned home birth being unsupported. All of the women had undertaken extensive research into birth physiology, planned for potential emergencies and knew how to engage with services if the event arose (blinded for review).

In this section, we describe three themes that highlight the tension and difficulties that women faced when carrying out ~~enacting~~ their freebirthing choice. The first theme *'violation of rights'* highlights the conflicts that women faced from maternity care systems

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Commented [C6R5]: This is the only phrase I can think of!

who appeared to be unaware of their legal right to freebirth, conflating this choice with issues of child protection. *'Tactical planning'* describes some of the strategies that women utilised in attempts to achieve the birth they wanted, while circumnavigating any interference by maternity professionals and/or preventing potential reprisals. *'Unfit to be a mother'* illuminates the distressing experience of four women who were reported to social services. ~~To provide transparency, the quotes used in the findings include the data source i.e. narrative or interview with its associated line numbers from the transcripts.~~

Violation of rights

Through various self-directed methods (e.g. accessing freebirthing websites), women were aware of their legal rights. For example, they were all aware of freebirthing being a legal birth choice; that engagement with maternity services was voluntary, and declining appointments and '*refusing care'* were protected by *'their human rights'*. Three of the women were able to discuss and share a freebirthing option with supportive care providers (such as a midwife who was a member of the Association of Radical Midwives or a Supervisor of Midwives). However, others referred to how their midwives were not '*clear about the law relating to freebirth, or human rights etc. as regards this situation'*:

> *I think I told her either immediately, or maybe at the second appointment, that I intended to freebirth ~~(~~although I didn't know that term then, so I was calling it unattended birth~~)~~. She informed me, ~~(~~incorrectly of course~~)~~ that it was illegal.* (Claire, interview)

One mother described how her decision to freebirth was *'met with suspicion and prejudice'* which was '*a horrible experience'*. Others were angry at the implied implications by professionals that their decision to opt out of 'normal' care meant that they were putting their unborn child at risk:

> *Not being willing to engage with health services at every point they want you to is not necessarily a precursor to putting your child at risk, and they need to learn to make that distinction better.* (Claire, narrative)

Commented [GT7]: Must say I don't like it here – it's not analysis - I reckon lose altogether and just include data source with pseudonym ??

Commented [C8R7]: This was in response to reviewer 1 though. Reading through I don't know where else to put it! Maybe here? – Ah now I have read on, I see what you mean. Yes agree.

Commented [GT9]: How can you have text in brackets when it was an interview?? Would remove?

Commented [C10R9]: Because we did this interview on a secure chat room-she didn't want to speak. Not sure how to convey that?

Some women experienced *'harassment'* from healthcare providers when they made a decision to *'disengage'* from aspects of their maternity care. One participant described how she and her husband were beleaguered by the community midwife after she had stopped attending appointments:

> *I think I was meant to see them at 24 weeks so at 25 weeks they started ringing me on a weekly basis and I was one of these people that I don't generally answer the phone if I don't know who it is. So they just left messages, I was umming and ahhing about what to do. Then they wrote me a letter to make an appointment um, and then finally they rang me my husband which I was actually quite annoyed about because I don't know, it seemed like a breach of confidentiality to me for them to be ringing my husband behind my back telling him that I hadn't been so to see a midwife since 16 weeks.* (Jane, interview)

Tactical planning

Despite women being aware of their rights, they recognised that opting out of the norms of maternity care placed them in a precarious situation. The majority of women interviewed had heard of situations (via online forums or personal networks) where freebirthing women had been reported to statutory organisations, such as social services or the police:

> *Well I know quite a few people that I don't know in real life but in online groups who have had freebirths who haven't called the midwife out afterwards have been referred to social services for putting their babies at risk and have had social services and police turn up at their door and that is not something that I want to happen.* (Jane, interview)

In order to circumnavigate harassment or potential reprisals some of the women made an active decision to keep their *'plans to ourselves'*:

> *I just didn't tell them, I didn't say shit to anyone, excuse the language* [laughs] *I did the pregnancy tests, I thought about it, I thought I'm not telling anybody, I'm just going to deal with this my own way and nobody knew.* (Holly, interview)

One of the mothers also referred to how the lack of opportunity to have an *'open conversation'* through fears of retribution created iatrogenic harm:

Commented [GT11]: We use this phase a lot as well – lose?

Commented [C12R11]: Done!

You know, you keep talking about reducing stress and that, but if you can't have an open conversation with your midwife because you are afraid of what she is going to say or what she is going to do, you know bringing in social services. That is a stressful situation and it is not a positive thing for a mother or a baby. (June, interview)

Women often referred to pre-planned *'tactics'* designed to mitigate the tensions in their freebirth decision and the attitudes of their midwives. These strategies were employed to ensure they had the birth they wanted, whilst still fulfilling a sense of obligation that they held to the maternity services. This was evident in the narratives whereby women '*planned a BBA* [born before arrival]*'* scenario by *'booking a homebirth'* while having no intention of contacting the midwives until after the birth had taken place:

So we made the decision to have the baby on our own and call out the midwife afterwards and just pretend it happened so quickly they didn't get there in time. Or not that they didn't get there on time, but we didn't have time to ring before. (Jane, interview)

Another women had planned a BBA with a pre-prepared explanation that the *'birth that progressed too fast'* and therefore had *'no time to call'*. The aim was to provide a credible explanation which did not raise suspicion.

A further mother reported how she had planned to *'call the midwives'* as late as possible [during labour] and did so at a point when she felt she would have birthed before their arrival. However for this woman, her perceived sense of obligation jeopardised her feelings of safety during labour. She reported a *'real sense of fear'* of the midwives responding quicker than expected. It therefore became a *'competition'* of who arrived first, the baby or the midwives.

In contrast, two of the women did not feel the need to inform the midwives during or immediately after the birth and rather they waited several days before making contact. They thereby employed a different tactic, in that while they felt that notification of the birth was important, an *'apologetic stance'* was perceived to be sufficient:

In fact, maybe I was a little bit aware, and my tactic with the midwives that we called three or so days later was to be very agreeable, be very kind of apologetic, kind of

argh yea. Just helpful and agreeable, that we're not being contrary or irresponsible, it just kind of happened like this and it was all ok and you know, saved the placenta for you to check and do all the checks to show we've nothing to hide. (Jenny, interview)

Unfit to be a mother

Four women were referred to social services due to a perception that they had placed their unborn child at risk. For Alex, her decision to disengage from all antenatal care and to freebirth was formally disclosed in a letter that set out her legal rights. Despite assurances from a Supervisor of Midwives of its legality, a social services referral was made without her consent *'which did not resolve itself until after the birth'* and had far reaching consequences *'profoundly affected my transition to motherhood, leaving a lingering imprint'.*

For another woman, a social services referral was made following her decision to decline and subsequently not attend a consultant appointment during her pregnancy:

I was offered another appointment with the consultant but declined, saying I'd go back to my midwife if I wanted anything else. In spite of this, another appointment was made for me, and when I didn't go to it, it was used as an excuse to refer me to social services. I don't see how I can default on an appointment I didn't make, but that was the reason given. (Claire,interview)

For this participant, the interaction with a social worker was felt not to be based upon the *'law'* or *'human rights'* but that of social services '*covering themselves in case something went wrong'.*

For the other two women, despite their 'tactical planning' to prevent maternity professional's presence at their birth and/or reprisal, an unforeseen situation was faced when registering the birth of their child. The registrar who holds legal responsibility for recording all births raised concern of a *'concealed pregnancy'.* In one occasion the registrar made a direct referral to social services. The other occasion led the registrar to make a referral to a midwifery manager who accused the mother of *'medical neglect'* and being *'unfit to be a mother'*. The midwifery manager then instigated a referral to social services.

While all the referrals to social services were soon resolved, the women reported diverging experiences of their encounters with these professionals. For two women, their cases were

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Commented [GT14]: Just reading this again – should we state something more in here – allegations were not pursued ?? Not sure if 'quickly' does it??

Commented [C15R14]: The allegations were all pursued- but some over quicker than others. I think leave this as it is

resolved quickly after a brief *'interview'* and/or a home *'welfare check'*. For the other two women, the involvement of social services included police presence and was perceived to be a '*stressful*', *'terrifying'* and '*threatening'* experience. They felt coerced into accepting welfare checks due to fears of having their baby removed:

> *Then that evening about seven o'clock social worker came again with two police officers, you know looking out of the window with two police officers on your door step, I've got a 7 day old baby and a three year old daughter, and I just had no idea why these people were in our lives. I was absolutely terrified, and um, my husband answered the door and they said they wanted to a welfare check.* (Alex, interview)

Discussion

In this paper we highlight the tensions and difficulties that women faced when making a choice to freebirth. Women faced conflict and opposition by inflexible maternity systems that appeared to be unaware of women's rights. Vicarious accounts of reprisals often led to women not disclosing their birth preference to professionals and/or adopting pre-planned tactics (such as claims of a 'born before arrival'). These tactics were often based on what they felt was an imposed need to provide a sufficient explanation for not having a midwife in attendance *and* to enable them to achieve their desired birth. Those who chose to opt out of maternity care provision, both prior to the birth (through non-attendance at antenatal appointments) and during the labour faced harassment and judgement, and for some this led to dire consequences through referrals to social services and on occasion police presence.

To a large extent, these women's accounts can be interpreted through the concept of stigma (Goffman, 1963). Stigma is an attribute that results in widespread social disapproval (Bos, Pryorb, Reeder, & Stutterheim, 2013) - a discrediting social difference that yields a 'spoiled social identity' (Goffman, 1963 p5). In our study, the primary inferred stigma was that of a 'bad mother' due to the perception that women were choosing to put themselves and their infants at potential risk of harm. For a number of these women it had serious societal ramifications through the fear and perceived threats of the removal of their child from their care.

Two fundamental components of stigma are the recognition of difference and a subsequent devaluation of personhood that occurs during social interactions (Bos et al., 2013; Goffman, 1963). This was evident in our study through women feeling judged, harassed and belittled by maternity professionals. These findings support other research wherein women who are perceived to making deviant birthing decisions such as to freebirth or choose homebirth against medical advice, face greater scrutiny from professionals (Birthrights, 2013b; Havey, Schmied, Nicholls, & Dahlen, 2015; Miller, 2012). The behaviour of the maternity professionals suggest they were seeking to modify the women's choices to encourage conformity to that of a 'good mother'. Within literature relating to stigma, this is known as 'social norm enforcement' ~~where the threat of stigmatisation is thought to encourage conformity by deviant behaviours~~ (Bos et al., 2013; Phelan, Link, & Dovidio, 2008).

Stigmatisation can cause psychological distress and behaviour modification (Bos et al., 2013; Hylton, 2006; Phelan et al., 2008). Miller (2012) discuss three patterns where those who are stigmatised attempt to minimise any negative encounters and affect: they try to hide it, they minimize contact with those who do not know about the stigma, and they selectively disclose to trusted ''normals'. All these patterns were evident in our study. For example, some women attempted to hide their decision by avoiding professionals, or adopting retaliation strategies through tactical planning. While some women were able to disclose their decision to professionals (e.g. Supervisor of Midwives, member of AIMS) who were consisted to be trusted 'normals' – it was more common for women to seek support from others who had made the same birth choice via online forums.

The concept of freebirthing as a deviant act of 'bad mothering' needs to be contextualised within the wider legal, professional and cultural landscape. In a western setting, maternal autonomy and patient preference is supported within a wider legal and professional landscape (Deshpande & Oxford, 2012). Yet our findings demonstrate that even in the UK with robust legislation, the reality of women exerting their autonomy is not always understood or supported. In this study issues of child protection seem to have shrouded the legality of women's birthing rights. Women have the legal right to decline procedures or interventions and maintain rights to their bodily integrity (Birthrights, 2013a). However, there are concerns from feminist groups that a cultural shift from viewing the mother-baby

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Commented [C17R16]: I was trying to refer to the midwives trying to get the women to conform their deviant behaviour. If I take this bit out does it make sense?

dyad as one, to a two person model with the fetus being perceived as a prospective patient limits the mother's liberty and privacy (Holten & de Miranda, 2016). As the fetus is solely dependent on maternal choices, actions and behaviours (Deshpande & Oxford, 2012), this arguably increases moralistic pressures for women to forgo their needs for the baby (Pederson, 2012). This is demonstrated in our study where the fetus was perceived to require safeguarding from the mother's 'risk-imbued' decision-making. In the wider feminist literature, this issue has revolved around: abortion rights (Couture, Sangster, Williamson, & Lawson, 2016) health behaviours during pregnancy (Shaw, 2012), choices of birth setting (Dahlen et al., 2011; Keedle, Schmeid, Burns, & Dahlen, 2015; Viisainen, 2000), type of birth (Dexter, Windsor, & S Watkinson, 2013; McAra-Couper et al., 2011) and infant feeding practices (Ludiowab et al., 2012).

There may be necessities to intervene and restrict 'choice' if there is clear evidence of maternal mental incapacity to make autonomous decisions or a serious risk is posed to the child following its birth, i.e. neglect or abuse (Birthrights, 2013b). In the UK, these concerns come under the umbrella of 'safeguarding' whereby professionals have a duty to be alert to potential risks (Gonzalez-Izquierdo, Ward, Smith, Begent, J, Ioannou, Y, & Gilbert, 2015). If a professional has concerns, it is their responsibility to source evidence to support their concerns and to escalate to a referral to social services who in turn make a decision to investigate further. Safeguarding clearly has a valuable role in protecting the vulnerable (Gonzalez-Izquierdo et al., 2015). However, potential contention arises when families make decisions that they consider to be in their best interests but challenge mainstream practices, such as in the occasion of freebirth (Feeley & Thomson, 2016; Plested & Kirkham, 2016), non-vaccinations (Wanga, Barasb, & Buttenheimb, 2015) and home-schooling (Ray, 2013). In the situation of freebirthing in the UK, the act of doing so is legal (Birthrights, 2013d) but parents have a responsibility to seek medical attention for the child if the situation necessitates it (Birthrights, 2013b). Nonetheless, it seems that non-compliance with expected 'norms' renders the women a deviant risk-taker, a 'bad' mother who unnecessarily jeopardises the health and wellbeing of their infant and in this study faces greater scrutiny with professionals (Havey et al., 2015; Maher & Sauggers, 2007; Miller, 2012).

These findings have several implications for maternity practice; improved awareness and knowledge of the legal status of freebirthing for maternity care providers as well as women

(i.e. in terms of birth notifications). Guidelines and pathways of care could be developed that promotes both professional and mother accountability. This could constitute a collaborative birth plan with agreements for antenatal care (to confirm their and their infant's health) and emergency strategies being in place should the need arise. It is vital that good, positive, non-judgemental communication is used throughout any interaction with women whom disclose a freebirth intention to reduce any potential barriers of accessing care, should the woman require it.

A strength of this study is that it adds to the wider discourse in terms of 'choice' for women's more unconventional choices, and the negative implications and repercussions for those who do not conform. It also adds to a growing body of evidence of the reasons as to why women choose to give birth outside of the maternity care system. While it only represents the views of 10 women, the fact that they were recruited from diverse regions of the UK demonstrates that these experiences are not unique to a specific geographical area. It is also important to reflect that the insights raised were not the focus of the original study, and therefore may not have captured all the variations and nuances of how a freebirthing choice was experienced in different contexts. Further research to explore this phenomenon in depth should be undertaken, in diverse areas as well as different countries. In addition, further research to explore these issues from a midwifery perspective would contribute valuable knowledge which may improve care practices.

Conclusion

Women who choose to freebirth face opposition and conflict from maternity providers, and often negative and distressing reprisals through statutory referrals to child protection services. Through fears of repercussions women often feel they have no option but to employ a variety of strategies, often under the guise of collaboration, in an attempt to circumnavigate any unnecessary interference, and to achieve the birth they had planned for and desire. The concept of choice therefore appears to be a misnomer for those who choose to enact it. These insights raise important implications for raising awareness among health professionals about women's rights in terms of access to care, and birth choices. It also emphasises the need to develop guidelines and care pathways that support the

midwives professional scope of practice which in turn will aid them to support women accurately and sensitively.

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