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1 **Tensions and conflicts in ‘choice’: Women’s experiences of freebirthing in the UK**

2 **Abstract:**

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

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

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

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

24 **Keywords**

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

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29 Introduction

30 A central tenet of modern maternity care in developed countries is that of 'choice'
31 (International Confederation of Midwives, 2014; World Health Organisation, 2005). This
32 concept arose through the 1990's from an interaction between political, feminist and
33 consumerist cultural shifts which have become firmly embedded within the rhetoric of
34 modern healthcare (Beckett, 2005; McAra-Couper, Jones, & Smythe, 2011). The concept of
35 choice explicitly asserts that women have the right to make autonomous decisions about
36 their maternity care thereby creating a move away from the passive patient under 'expert'
37 decision makers to a partnership model in which women's needs and preferences are
38 central to decision making (International Confederation of Midwives, 2014; Midwifery 2020,
39 2010; The Royal College of Midwives, 2012). It also includes the right to decline care even in
40 life threatening situations (Birthrights, 2013c; McAra-Couper et al., 2011). In many
41 countries the concept of 'choice' has been formalised through: legislating women's rights to
42 autonomy (Birthrights, 2013c; United Nations, 1999); governmental policy (DH, 2010;
43 Goldbord, 2010; Public Legal Education and Information Service of New Brunswick, 2015; US
44 Department of Health and Human Service, 1997) and evidence based healthcare guidelines
45 (NICE, 2014; World Health Organisation, 2005; World Health Organisation, 2014).

46 In the UK, since the 1990's a particular focus of policy (DH, 1993; DH, 2007; DH, 2010) and
47 guidelines (Maternity Care Working Party, 2007; NICE, 2014; RCOG, 2013) has been to offer
48 more choice and access to various birth settings (i.e. home, hospital, birth centres).

49 Evidence highlights that for healthy women, out of hospital birth is safe and associated with
50 positive outcomes such as increased vaginal birth rates, reduced medical interventions and
51 increased maternal satisfaction (Brocklehurst et al., 2011; Burns, Boulton, Cluett, Cornelius,
52 & Smith, 2012; NICE, 2014). However, the UK 2014/15 birth statistics (Health and Social

53 Care Information Centre, 2015) demonstrate that 87% of women birth in hospitals, 11% in
54 birth centres and only 2% at home, depicting current norms and an inequity of service
55 provision. Findings from the NCT (2009), the Birthplace study (Brocklehurst et al., 2011;
56 McCourt, Rance, Rayment, & Sandall, 2011) Royal College of Midwives (2011) and the
57 Maternity Services review (NHS England, 2016) describe various factors that contribute to
58 the inequity of homebirth provision and birth centre availability across the UK. These
59 include local trust resourcing, staffing levels, organisational structures, on call demands,

Commented [GT1]: Just wonder if this works better the other way round – see what you think?

Commented [C2R1]: Yep agree ☺

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

67 A birth choice that sits outside of the ‘norm’ (i.e. a hospital birth) is freebirthing, sometimes
68 referred to as unassisted birth (blinded for review). Freebirthing is characterised as an
69 active decision to birth without trained health professionals present but where maternity
70 care is readily available (Nursing and Midwifery Council, 2013). Concerns surrounding safety
71 for mother and baby (Nursing and Midwifery Council, 2013), misconceptions about its
72 legality (Birthrights, 2013d) as well as safeguarding for the fetus (Birthrights, 2013b), make it
73 a controversial birth choice. Its subversive nature not only challenges hegemonic birth
74 practices of both the medical and midwifery model of birth (Dahlen, Jackson, & Stevens,
75 2011; Edwards & Kirkham, 2013; Feeley, Burns, Adams, & Thomson, 2015; Jackson,
76 Dahlen, & Schmeid, 2012), it also brings the rhetoric of choice under scrutiny.

77 Literature concerning the phenomenon of freebirthing has primarily focused upon why
78 women choose to freebirth. A meta-synthesis (blinded for review) of qualitative studies
79 undertaken in USA (Brown, 2009; Freeze, 2008; Miller, 2009) and Australia (Jackson et al.,
80 2012) identified common motivations to freebirth including: a rejection of the medical and
81 midwifery model of birth, a previous distressing/traumatic birth experience, obstructions to
82 homebirth provision and a lack of trust in maternity services. Due to a lack of insights into
83 this phenomenon from a UK perspective, we undertook a study to explore why UK women
84 chose to freebirth. While similar issues to those reported in the meta-synthesis were
85 identified (blinded for review), what also emerged was the tensions and conflicts that
86 women experienced when enacting their freebirthing ‘choice’. In this paper we report on a
87 secondary analysis of the interview data to provide new insights into how a maternity
88 system that offers a rhetoric of choice is experienced as coercive, fearful and imbued with
89 negative reprisals.

90 **Methods**

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

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

91 *Design*

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

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

112

113

114 *Sample*

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

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

122 *Data collection*

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

127 *Participants*

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

137 *Ethics*

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

142 *Data analysis*

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

149 The transcripts and the written narratives were uploaded onto MAXQDA (maxqda.com,
150 2015), a qualitative software management tool. This initial stage involved a general reading
151 of each data separately, whereby initial thoughts, impressions and poignant phrases in
152 relation to women's decisions to freebirth were identified. The second reading involved a
153 line by line 'in vivo' method where the selected segments of text were assigned a code
154 (Lewis-Beck, Bryman, & Futing Liao, 2004). The codes formed the basis of tentative themes,
155 which were refined iteratively by returning to the data seeking confirming or disaffirming
156 data (Kafle, 2011). This cycle was repeated until the final themes adequately represented
157 the participant's motivations to freebirth (blinded for review).

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

165 Findings

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

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

Commented [GT5]: Do you reckon we need a different word as repeat this phrase loads in here.....brain is mushed, so not springing to mind as yet

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

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

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.

187 Violation of rights

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

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

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?

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

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

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

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

219 **Tactical planning**

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

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

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

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

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

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

Commented [C12R11]: Done!

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

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

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

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

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

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

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

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

268 **Unfit to be a mother**

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

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

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

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

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

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

Commented [C13]: Changed to name

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

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

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

303 Discussion

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

315
316 To a large extent, these women's accounts can be interpreted through the concept of stigma
317 (Goffman, 1963). Stigma is an attribute that results in widespread social disapproval (Bos,
318 Pryorb, Reeder, & Stutterheim, 2013) - a discrediting social difference that yields a 'spoiled
319 social identity' (Goffman, 1963 p5). In our study, the primary inferred stigma was that of a
320 'bad mother' due to the perception that women were choosing to put themselves and their
321 infants at potential risk of harm. For a number of these women it had serious societal
322 ramifications through the fear and perceived threats of the removal of their child from their
323 care.

324

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

Commented [GT16]: Think I am thick as still don't get this point?? Who is being deviant here –the professionals?? They are being deviant to get women to conform? Needs explaining more.....

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, & Bittenheimb, 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

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

396
397 A strength of this study is that it adds to the wider discourse in terms of 'choice' for
398 women's more unconventional choices, and the negative implications and repercussions for
399 those who do not conform. It also adds to a growing body of evidence of the reasons as to
400 why women choose to give birth outside of the maternity care system. While it only
401 represents the views of 10 women, the fact that they were recruited from diverse regions of
402 the UK demonstrates that these experiences are not unique to a specific geographical area.
403 It is also important to reflect that the insights raised were not the focus of the original study,
404 and therefore may not have captured all the variations and nuances of how a freebirthing
405 choice was experienced in different contexts. Further research to explore this phenomenon
406 in depth should be undertaken, in diverse areas as well as different countries. In addition,
407 further research to explore these issues from a midwifery perspective would contribute
408 valuable knowledge which may improve care practices.

409

410 **Conclusion**

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

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

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