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frontiers

1 # Between a rock and a hard place: Considering 'freebirth' during
2 # Covid-19
3

Abstract

Background

The global coronavirus (COVID-19) pandemic concerns all people, but has a specific effect on those who are expecting a baby during this time. The advice in the UK changed rapidly, with 14 different sets of national guidance issued within one month. Individual NHS Trusts released various guidance relating to the withdrawal of homebirth services, the closure of birth centers, restrictions on the number of birth partners (if any) allowed during labor, and whether any visitors were allowed to attend after birth. With the landscape of maternity care changing so rapidly, research was carried out to provide real time data to capture the lived experiences of expectant families.

Methods

A mixed methods online survey was carried out over two weeks between 10th and 24th April 2020. The survey was open to those in the third trimester of pregnancy, those who had given birth since the beginning of the 'lockdown' period in the UK, and the partners of pregnant women and people who were in these circumstances. The survey asked questions about how respondents' holistic antenatal experiences had been affected, whether their plans for birth had changed, and the effect of these changes on respondents' emotional wellbeing. Of the 1,700 responses received, 72 mentioned that they had seriously considered 'freebirthing' (giving birth without a healthcare professional present).

Findings

An analysis of the respondents' reasons for considering freebirth was conducted, finding that reasons for considering freebirth were complex and multifaceted. Lesbian, bisexual, pansexual and queer women were more likely to have considered freebirth than heterosexual people ($p<0.001$).

Conclusions

Considering giving birth without a healthcare professional present is unusual in the Global North and represents an emerging field of study. The literature examining the reasons that people consider freebirth shows a variety of underlying motivations. A global pandemic represents a new factor in such considerations. The findings from this research can help inform maternity service planning in future crises.

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1 Introduction

The global coronavirus (COVID-19) pandemic concerns all people but has a specific effect on those who are expecting a baby during this time. Perinatal care, like emergency medical care, is time-sensitive, and cannot be delayed and then accessed later. In the first days of the lockdown in the UK, rapid response research was planned to understand the real time social and cultural impact on the lived experience of people accessing maternity care in the UK. Our research question was:

> What are the experiences of perinatal care of those who are due to have a baby in the first months of lockdown in the UK, and how do they feel about these experiences?

Our article is drawn from this wider research project, which used an online survey of parents. The survey comprised of three main elements: capture of demographic information; a psychometric tool that was administered to those who had given birth; and a series of open-ended questions. The survey opened on 10th April 2020 and closed on 24th April 2020.

One of the themes that emerged from the open-ended questions was that 72 respondents had given serious consideration to freebirthing. This paper specifically discusses the experiences of those respondents, examining both why they considered this option, and their feelings about freebirth.

Freebirth

Freebirth occurs when someone:

> 'intentionally giv[es] birth without health care professionals (HCPs) present in countries where there are medical facilities available to assist them'. (McKenzie et al., 2020).

Although legal in the UK, freebirth is typically viewed as a non-mainstream and stigmatized birthing decision. The subject is under-researched and there is a paucity of academic literature on the phenomenon. Existing studies are largely qualitative and focus on the motivations of women in Western nations such as USA (Spencer-Freeze, 2008), UK (Feeley and Thomson, 2016), Ireland (O'Boyle, 2016), Canada (Cameron, 2012), Australia (Jackson et al., 2012), Norway (Henriksen et al., 2020) and The Netherlands (Holten and de Miranda, 2016).

Such studies highlight that women decide to freebirth for a range of reasons. These include a previous traumatic birth (Jackson, Dahlen and Schmied, 2012), dissatisfaction with the care offered by perinatal services (Henricksen et al, 2020), and an inherent belief in the undisturbed physiological processes of birth (Feeley and Thomson, 2016). An inability to access care based on "logistics" and geographical distance to a maternity unit (Kornelsen and Grzybowski, 2006) and limitations on homebirths have also played a role in women's decision making (O'Boyle, 2016).

Freebirth and the Covid-19 pandemic

In the first weeks of lockdown in the UK, the advice for expectant parents changed rapidly. On the 9th March 2020 the Royal College of Obstetricians and Gynecologists (RCOG) issued guidance suggesting pregnant women were not at greater risk from coronavirus that the general population. However, a week later, the UK Government guidance stated pregnant women were one of the most vulnerable groups. Within a few days, RCOG advised NHS Trusts to consider closing smaller maternity units (RCOG, 2020b).

Despite the proven safety of out of hospital settings for low-risk births (Birthplace, 2011; Walsh et al, 2020), in the first days of lockdown individual NHS Trusts released different guidance relating to the withdrawal of homebirth services, and the closure of birth centers and midwife-led units (MLUs). Restrictions were also placed on the number of birth partners - if any - allowed during labor, and whether any visitors (and who they were) were allowed to visit after birth.

The uncertainty and confusion around this advice meant that pregnant people became concerned as to how these restrictions would impact their rights and experiences during labor and birth. As a result, national human rights charities such as the Association for Improvements in the Maternity Services (AIMS) and Birthrights, published a range of literature to support people impacted by these restrictions (for example, AIMS, 2020; Birthrights, 2020). Further, it became apparent to midwives that some women were contemplating removing themselves entirely from NHS perinatal care and freebirthing their babies. Concerned by this, on 30th April 2020 the Royal College of Midwives (RCM) issued a clinical guidance note for midwives advising on how to support women intending to freebirth (RCM, 2020a).

Quantitative data about freebirth is almost non-existent. It is unknown, for example, how many people per year freebirth their babies in the UK. Demographics relating to freebirthers' socio-economic background, ethnicity, age and parity do not exist. In short, within the UK context, there has never been a quantitative study undertaken that attempts to collect such data. Given this lack of statistical data relating to freebirth, the rates of increased interest in freebirthing due to the COVID-19 pandemic remain unclear. However, communities such as the Freebirth and Emergency Childbirth Support Group – a UK fee-based Facebook group – have been created on social media during the pandemic. This group provided information to almost 300 expectant parents, healthcare professionals and birth supporters. The emergence of groups such as this during lockdown suggests a genuine interest from a range of people in learning more about freebirth.

2. Methods

Data collection

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128 An online survey was undertaken to capture the experiences of those in the UK who had given
129 birth, or were due to give birth, between the 9th March 2020 and the 3rd July 2020, or whose
130 partners had given birth or were due to give birth between these dates. The dates chosen
131 ensured participants had either recently become parents or were in the third trimester of
132 pregnancy at the time of the research. The survey collected demographic data, used a
133 psychometric tool to measure support in labor and birth, and included a large number of
134 open-ended questions about respondents' experiences.
135
136 Participants were asked to indicate whether they or their partner was pregnant, their baby's
137 date of birth or due date and their local healthcare service trust. Participants were also asked
138 to indicate their ethnicity, age, disability, sexual orientation and gender. The main part of the
139 survey consisted of free text boxes which asked when participants became aware of Covid-
140 19, and when they understood that it might impact their pregnancy and birth plans. It also
141 asked about their plans for birth and whether they had changed, whether they were accessing
142 private healthcare providers, whether other elements of perinatal care had changed, and how
143 they felt about becoming a parent during a pandemic. A psychometric scale for those who
144 had given birth was also included, but the results are not discussed in detail here. All questions
145 after the consent and birth/due date were optional. The questionnaire tool is attached at
146 Appendix 1.
147
148 The survey was promoted and carried out entirely online due to the practicalities of the
149 pandemic, and also to allow as many people to respond as possible. An advert with a hyperlink
150 to the survey was shared on Twitter from both the first author's personal account and a King's
151 College account. On Facebook, the advert was shared in generic birth groups, 'due in' groups,
152 homebirth groups, caesarean birth groups, parenting groups and locality-based birth groups.
153 Two human rights charities, Birthrights and the Association for Improvements in Maternity
154 Services (AIMS) were involved in helping design the survey, and in promoting it through their
155 online social media. The questionnaire was open from 10th to 24th April 2020, and 1,754
156 responses were received.
157
158 *Case selection*
159
160 This article reports in detail on the responses that related to freebirth. The psychometric scale
161 data was removed, and a textual search of the full responses was carried out in the Excel
162 spreadsheet for the terms:
163
164 'Freebirth'
165 'Unattended'
166 'Unassisted'
167 'Free [AND] birth'
168
169 The last search term produced a high number of false positive results such as 'stress free
170 birth', so all results for this search were manually checked before being included. The word
171 'alone' was searched for (in the spreadsheet) but returned too many vague results. The
172 mention of fear related to giving birth alone may refer to freebirthing, but is more likely to
173 refer to giving birth without a partner, a situation many respondents were unhappy with.

174
175 Responses which included these terms were then read in full by the lead researcher (MG),
176 and included in the freebirth dataset if they indicated that the participant or their partner had
177 considered freebirth at any point, or if they had had a freebirth. This resulted in responses
178 from 72 people who had considered or had a freebirth being included in the dataset. The full
179 responses (excluding the psychometric scale) from these participants were then uploaded
180 into NVivo. Two responses which mentioned freebirth were excluded from the analysis as
181 these responses mentioned that the participants were too scared to consider freebirth, or
182 that they were concerned other women might choose to freebirth. A second check of the full
183 database was conducted by the second researcher (SPG) to ensure that all cases had been
184 correctly identified.
185
186 *Analysis*
187
188 The demographic data from the full dataset were compiled so as to compare with those
189 considering freebirth. The dataset of 72 responses was then thematically analyzed using
190 NVivo. Thematic analysis is a methodology often used within qualitative research in the social
191 sciences, because it can generate rich detail from the data, whilst also providing an overall
192 organizational structure to compare and discuss the data within. It is used for 'identifying,
193 analyzing and reporting patterns (themes) within data' (Braun and Clarke, 2006, p.79).
194
195 As the aim of this research was to capture the real-time lived experiences of expectant
196 parents during lockdown, we wanted to employ an analytical methodology that would
197 provide a rich description of the dataset rather than a theoretically driven methodology.
198
199 Six stages of analytic process are described by Braun and Clarke (2006) as part of a robust
200 thematic analysis process. These are: familiarization, initial coding, searching for themes,
201 reviewing themes, naming and describing themes, and producing a report. Reading and re-
202 reading the responses which mentioned freebirth to determine whether they should be
203 included in the analysis provided the necessary familiarization for the researchers. The
204 dataset was then transferred to NVivo, and the lead researcher used an inductive approach
205 to generate initial codes from the open-ended questions. This initial coding was organized
206 into themes, providing a map of the data, which were reviewed by the second researcher
207 (SPG).
208
209 Each theme was then named and described, drawing on the data to ensure that participants'
210 voices remained the center of the analysis. The themes are presented below in Table 1, and
211 a full codebook of the themes is available at Annex 1. The three main themes are: where birth
212 was planned to happen before the pandemic; what non-NHS support respondents
213 considered; and respondents' reasons for considering freebirth.
214
215 *Table 1 –themes identified*
216
217 The findings below use the themes identified to form the structure of the article. Simple
218 quantitative analysis was also undertaken with the freebirth dataset, firstly to produce

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descriptive statistics of the demographics of the participants, but also to turn qualitative answers into quantitative ones by turning open-ended answers into closed ones. Turning qualitative data into quantitative data can be one of the purposes of qualitative research (Boyatsis, 1998).

3. Results

3a. Quantitative findings

This section begins by identifying the demographic characteristics of the participants who had considered freebirth. We then go on to examine participants' plans for birth before the pandemic.

Of the 72 participants who said they had seriously considered freebirth during the pregnancy, 69 were women who were pregnant at the time of the research. Two participants were women who had given birth since the 9th March, and one participant was a man whose partner was pregnant. This division in the types of participant is roughly in line with the total dataset, where 1,385 were still pregnant at the time of the research, 336 had given birth, and 33 were the partner of someone who was pregnant or had given birth.

The majority of participants were white, heterosexual women, as is shown in Figure 1 and 2 below.

Figure 1 – sexual orientation of participants considering freebirth

Figure 2 – ethnicity of participants considering freebirth

The youngest woman was 19, and the oldest was 41. The man was 42, but his partner's age is unknown. The average age was 31.4 +- 5 years, and the spread of ages are shown in Figure 3. The same person who declined to indicate their ethnicity or sexuality, also declined to indicate their age.

Figure 3 – ages of participants considering freebirth

In terms of geographic distribution, participants considering freebirth were not confined to any particular location in the UK. There is representation in England, Scotland, Wales and Northern Ireland (see Table 2). There is largely no clustering in any of the NHS healthcare trusts, with the exception of three cases in the Nottingham University Hospitals NHS Trust.

Table 2 – Geographical distribution of participants considering freebirth

The demographic characteristics of those considering freebirth were similar to the demographic characteristics of the entire dataset, with the exception of sexual orientation. Bisexual, lesbian and pansexual respondents made up 4.2% of all survey respondents, but 13.9% of the respondents considering freebirth. Sexual minority women were therefore more

likely than heterosexual participants to be considering freebirth. Contingency table testing was used to determine if this difference was statistically significant. Fisher's Exact test was applied to the data, comparing the number of LGBQ+ participants in the full dataset with the number of LGBQ+ participants in the subset who had considered freebirth. This test showed that there was a difference between the groups, with LGBQ+ people being more likely to have considered freebirth ($p<0.001$).

Although we did not collect demographic data about the profession of either the pregnant person or their partner, several respondents mentioned it within their responses to the open questions. One woman is a senior medical professional, two others work clinically within the NHS, two are non-clinical birth workers, another's partner is a GP, and one's husband is a Registered General Nurse (RGN). It is interesting both that so many people with professional experience in either birth or healthcare were considering freebirth, and that they felt it was important to provide this information in their answers. For those with partners who are in current clinical practice, this also presents a challenge to the definition of freebirth as a birth 'without health care professionals (HCPs) present'. (McKenzie et al., 2020)

We will consider this further in the discussion.

Plans before the pandemic

Interestingly, only one person who answered the survey had been planning to freebirth before the pandemic. The other participants had a range of birth plans. Many had been intending to birth at home (60). In England and Wales, around 2% of babies are born at home each year, meaning that those who had planned a homebirth are over-represented in this cohort (Office for National Statistics, 2020). A significant proportion of respondents had also been considering giving birth in either a freestanding birth center, or an alongside midwife-led unit (8), whilst two women had been intending to give birth on the labor ward, and one woman had been intending to have a planned caesarean birth. Many respondents described that they had flexible plans for birth:

> "If pregnancy remains low risk to go to [name] Birthing Centre. Is [sic] any complications developed to go to [name] Hospital."

Although all of the participants had seriously considered freebirth or were currently considering it at the time they completed the survey, there were a mixture of current plans for birth. Only two women had given birth before the survey, and of these, one woman had had a freebirth, whilst the other had seriously considered freebirth, but in the end had been able to obtain the midwifery care that she had been told would not be available. She explained that although the homebirth service was officially withdrawn:

> "when my husband rang whilst I was in labour, they initially said no one could come, but after my husband asked to speak to the head of Midwifery, they said they could send someone out to do 'checks' prior to transferring in. In the end, though, the

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309 midwife turned up with all the gear be and was happy to stay. Birth was extremely
310 straightforward and fast (30 mins after midwife arrived)."
311
312 Of the other 70 respondents whose babies had not yet been born, some were definitely
313 intending to freebirth, whilst others remained undecided in their plans, and one woman was
314 clear that she had previously seriously considered freebirth but was currently intending to
315 give birth in hospital. The majority of expectant parents considering freebirth during the
316 pandemic experienced negative feelings. Positive feelings seemed to be more prevalent
317 amongst participants who had made the decision to have a freebirth, whilst those who were
318 still undecided did not seem to share these positive feelings. Once the decision to freebirth
319 had been made, participants described a returning sense of safety and security: "I feel safe in
320 my own home."
321
322 **3b. Qualitative findings**
323
324 This section will use the qualitative data to explore the two remaining themes relating to the
325 birth care and support respondents considered, and the reasons that respondents considered
326 freebirth.
327
328 *Options considered*
329
330 Expectant parents in this study had a range of different first choices for birthplace, including
331 homebirths, birth centers and MLUs, labor wards, and elective caesarean births. When
332 expectant parents' plans for birth changed because of lockdown, a freebirth was not always
333 their second choice for birth either. Some women's second preference was to give birth in a
334 different NHS setting, which they had been informed was not available to them. These
335 difficulties are shown by this participant, as she explains why her second choice of birthplace
336 was not available to her, for reasons unconnected to Covid-19:
337
338 "I have been told that the home birth service has been pulled and I won't be eligible
339 for a midwife unit led birth as my BMI was too High at booking in so I am now planning
340 to freebirth."
341
342 Thirteen women in the study had considered using an independent or private midwife. These
343 are fully qualified midwives, who are registered with the Nursing and Midwifery Council in
344 the same way as NHS midwives. Independent midwives are self-employed, whilst private
345 midwives are employed by private companies. Four women had hired an independent
346 midwife, at the time of the survey. However, more women commented that they were unable
347 to hire an independent midwife. For most, this was because they couldn't 'afford it', whilst
348 for others it was because the independent midwives had no availability. One woman had
349 considered hiring an independent midwife before lockdown, but had spoken to their
350 maternity services who had reassured her they would be supportive of a home vaginal birth
351 after caesarean with the result that she decided not to hire an independent midwife.
352
353 Unfortunately, the local homebirth service had then been suspended, and the independent
354 midwife no longer had any availability. The participant commented, "I feel the decision has

355 been made too quickly without thorough troubleshooting." In another case, a respondent
356 recalled that the local NHS Trust had:
357
358 "[I]n their infinite wisdom decided to cancel indemnity for all independent midwives
359 in the area....Combined with the cancellation of NHS home births, women in my area
360 are left with few choices of any."
361
362 This meant that independent midwives were not legally able to attend births at that time.
363
364 The majority of participants who were considering freebirth because of Covid-19 had
365 considered at least one other option subsequent to the changes in their original birth plans.
366 Freebirth was therefore not a first or second choice for the majority of participants who were
367 considering it.
368
369 *Reasons for considering freebirth*
370
371 Given that freebirth was the first choice of only one participant and was not even the second
372 choice for many people, understanding the reasons why participants were considering it is
373 important for healthcare services. The reasons given by expectant parents were varied. As
374 Table 3 shows, they can be divided into three overarching categories: a desire to avoid
375 hospital, birth preferences, and practicalities.
376
377 *Table 3 – reasons why participants were considering freebirth*
378
379 These reasons were not mutually exclusive, and many participants expressed several reasons
380 for considering freebirth. Some of the reasons were also connected, for example:
381
382 "I will have to go into hospital alone as my husband doesn't drive and will have to look
383 after our eldest daughter; there is no one else who can take her and she's not allowed
384 to visit either."
385
386 This section will explore each of the three main themes for considering freebirth.
387
388
389 *Avoiding hospitals*
390
391 Thirty-nine participants said they were considering freebirth partly or wholly because they
392 wished to avoid going into the hospital to give birth. For some this was due to past
393 experiences giving birth in hospitals. For others, the potential of catching Covid-19 whilst in
394 hospital felt too much of a risk to take. Rather than hospitals being a place where they and
395 their babies would be safe, they had become places of potential danger and contamination
396 for some women.
397
398 Some participants feared what would happen if they went to hospital for this birth. Women
399 described being afraid of being coerced into interventions they did not want if they were in

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hospital or treated badly in other ways. These fears were not unrealistic, as they were often based on their previous experiences of hospital births:

> "Despite having quick births 'easy' births I have been treated awfully during labor and for that reason only feel I have had one positive birthing experience. I was hoping this birth would be healing…."

Other women's fears were based on their experiences of care during this pregnancy, where they felt that coercion and 'bullying' had already happened to them. These fears were compounded by the idea that they might be in hospital without a partner "to advocate for me."

Hospital policies around the admission of partners to the labor ward were felt to be coercive by some women. Two women explained that their hospitals were only allowing partners in when labor was established. They had been informed that this would be judged by cervical dilation. However, cervical dilation can only be established by a vaginal examination. Two women described that they intended to decline the offered vaginal examinations but were scared that doing so would mean their partners were not allowed into the labor ward. The very fact that the stated policy made a partner's presence conditional on the women accepting an intervention made them feel that coercion was openly advertised as being integral to choosing a hospital birth.

For women whose partners or children were in the high-risk groups, going into hospital meant not only a risk to their own health and their newborn baby's health. It also meant that they potentially became contaminated, and a danger to their families. The dual hospital risks of interventions and the risk of contracting the virus were interrelated:

> "I fear the changes are going to lead to [more] unnecessary interventions. And an increased risk therefore of having to stay in hospital, increasing the chance that me, baby and my husband's will be exposed to the virus. My husband has a heart condition so I fear the worst."

Birth preferences

Most NHS Trusts adopted a policy of only allowing one birth partner into labor wards, MLUs and birth centers during established labor. This created fear in some women that they would not have a known person with them for some or all of their labor. As well as wanting partners to be present at the birth to advocate for them, women described needing their support. This was especially the case when the journey to this birth had been difficult:

> "[M]y partner is a great support for me, we have gone through IVF and a miscarriage together and I couldn't imagine doing any of this without him…."

Some NHS Trusts adopted a policy that the sole birth partner had to be someone the woman lived with, ostensibly to reduce the potential for Covid-19 transmission to healthcare

professionals (RCM, 2020b). This caused specific problems for single mums, those whose partners needed to stay with older children, and those whose partners had jobs where the risk of being affected by Covid-19 was high:

> "[What] if my husband becomes locked down at work (possibility as he is [a] prison officer, when it hits the prisons they plan on literally locking the gates - in or out)…."

Many of the women who were in this position had planned their support carefully. Until just a few weeks before the survey, they had expected to be able to have a birth partner who they didn't live with support them during birth – usually a doula (a non-medical birth worker who provides emotional and practical support), though one participant had intended to have her mother as her birth partner. Some of these women had intended to give birth in hospital or in birth centres and MLUS, with the support of their non-resident birth partner. They were very aware that they suddenly faced the real possibility of giving birth with no-one they knew present to support them.

In some NHS Trusts, the rules about who could be present at a birth were extended to homebirths as well. This created an impossible situation for one participant who is a single parent:

> "Home births so far are still going ahead in my trust, however I wouldn't be allowed my doula or my kids in the room. I have no childcare and no other birthing partner."

This situation had forced her into considering a freebirth, despite the fact that a homebirth service was still available.

For three women, access to water as a form of pain relief was an essential part of their birth plan. One participant was clear that she would have considered a waterbirth on the labour ward, but the only room with a pool was reserved for women who were Covid-19 positive or Covid-19 symptomatic.[1]

The number of changes and the uncertainty over which services might be available were mentioned by three participants as a factor in their consideration of freebirth. Different NHS Trusts have made changes to the services available at varying times. Service changes impacted expectant parents' plans, as they made new choices depending on the services available. A participant who had changed her plans several times already in response to the withdrawal and reinstatement of birth support by her NHS Trust said she was now considering freebirth because she did "not want to change my birth plans [again]."

A sentiment which was repeated by many participants was the feeling that they had been left with no choices by their perinatal services, with 26 participants describing feeling trapped, and forced into decisions that they did not want to make. They characterised the choices that

---

[1] From the larger survey, the reserving of pool rooms for women with Covid-19 appears to be a common practice, even though women with Covid-19 are not supported in having a waterbirth in most NHS Trusts.

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488 they had, due to a combination of personal circumstances and local Trust policies as being 'no
489 choice' or an 'impossible choice'. There was a sense that the decision to freebirth was one
490 which the NHS services were making for them: "I feel I am being backed into a free birth."
491
492 *Practicalities*
493
494 Some expectant parents were considering freebirth because of practical reasons, which were
495 often multifaceted. Lockdown restrictions, and elderly parents shielding had restricted the
496 childcare options available for older children for some families. If the partner was the only
497 person available to take care of the children, and the homebirth service had been withdrawn,
498 that meant being without known support during birth. For those whose partner could not
499 drive, or without access to a vehicle, simply getting to the hospital could be a logistical
500 problem. This was especially the case if a homebirth service had been withdrawn and local
501 birth centres were closed, or not available because the pregnant person was not 'low risk'. In
502 rural areas, some women were faced with a significant journey to the only available NHS
503 support for birth: "hospital [is] 45 miles away."
504
505 Even with access to a car and a driver, this is a daunting journey to undertake in labour.
506 Without that access, options were very restricted:
507
508 "We don't have a car, and the idea of taking a taxi in mid labour, during a virus
509 outbreak, was unthinkable."
510
511
512 Concern about the distance that might need to be travelled whilst in labour was compounded
513 by previous birth history when women had had fast labours. The woman who lived 45 miles
514 from the hospital said one of her main reasons for considering freebirth was that:
515
516 "My last baby was born in less than an hour and a half so I'm worried I wouldn't make
517 it to the hospital."
518
519 In total, eight participants mentioned that a previous history of precipitous labour was a
520 factor in their consideration of freebirth. All of these women had previously planned a
521 homebirth, or a birth in a birth centre with close proximity to their home. They did not
522 perceive that they were making a choice between giving birth in a hospital and freebirthing,
523 but rather between freebirthing and "End[ing] up having an accidental unassisted birth."
524
525
526 **4. Discussion**
527
528 This is the first large scale study to capture the demographics of people contemplating
529 freebirth within the UK. It is also the first study to identify LGBTQ+ people considering
530 freebirth. Importantly, freebirth was contemplated by people throughout the UK suggesting
531 that this decision was not motivated by the actions of a few restrictive NHS trusts, but rather
532 that the issue was far more widespread. Further, as far as we are aware, this is the first
533 freebirth study to capture data from all four countries of the UK.

534
535 *Characteristics of those who considered freebirth*
536
537 Notably, this is also the first time that a UK study has shown that NHS health care
538 professionals have contemplated stepping outside of the NHS maternity system in order to
539 freebirth their babies. As no respondent mentioned other, unconnected professions, it
540 appears that respondents may have been justifying their choice to consider freebirth by
541 constituting themselves or their partners as experts. This also raises as yet unanswered
542 questions about NHS staff perception of safety in relation to the service they and their
543 colleagues provide. It also offers a challenge to the definition of freebirth. If either the person
544 who is giving birth or their partner is currently in clinical practice, can the birth be said to be
545 'without health care professionals (HCPs) present'? (McKenzie et al., 2020).
546
547 We note that participants within our survey have specifically used the term 'freebirth',
548 alongside responses that indicate that they or their partners are healthcare professionals, and
549 we believe it is important that their terminology about their birth choices is respected. The
550 term was also used by most participants in the survey without healthcare training or partners.
551 Using the term 'freebirth' is an active, linguistic choice indicating an awareness of it as a social
552 phenomenon. Moreover, those that indicate they or their partners are healthcare
553 professionals, will likely have awareness of the stigma of freebirthing. We do not propose to
554 offer an alternative definition of freebirth here, but instead highlight this as an issue for
555 consideration should further research into health care professionals stepping outside the NHS
556 maternity system be undertaken.
557
558 It is well established that pregnant lesbian and bisexual women face routine
559 heteronormativity, invisibility and invalidation in their encounters with perinatal care
560 (Rondahl, Bruhner and Lindhe, 2009). Research also shows that LGBTQ+ people may
561 experience fear and discomfort when accessing healthcare services; that fear being based on
562 frequent accounts of other LGBTQ+ people being denied access to healthcare services or
563 discriminated against when they disclose their gender or sexual orientation (Light, Obedin-
564 Maliver, Sevelius, and Kerns, 2014). A small amount of research shows that lesbian and
565 bisexual women may even face hidden physical assault in perinatal care, such as deliberately
566 rough vaginal examinations (Spidsberg, 2007). We do not know whether this community
567 experience of poor care was a factor in LGBTQ+ people choosing to freebirth in this study, but
568 fear of poor care is a motivating factor that has been identified in other freebirth research
569 (see for example Jackson et al, 2012). Other studies have not identified LGBTQ+ people
570 choosing to freebirth before, and research into LGBTQ+ birth choices have not identified
571 freebirth as a possible decision. Further research in this area is needed to understand whether
572 LGBTQ+ decide to freebirth from similar or different motivations than cis-heterosexual
573 people.
574
575 *The importance of choice*
576
577 Anyone can legally choose to give birth at home, regardless of whether this would be
578 medically recommended. This is a well-established right, which has been confirmed under

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579 European law (Ternovszky v. Hungary, 2011). Birth centers and MLUs can have their own
580 policies about who is allowed to give birth there. NHS England says that the place of birth
581 should be decided by the person who is pregnant:
582
583 'Women should be able to make decisions about the support they need during birth
584 and where they would prefer to give birth, whether this is at home, in a midwifery
585 unit or in an obstetric unit'. (Better Births, 2016, p9).
586
587 However, in many NHS Trusts there is a policy that only women deemed 'low risk' can give
588 birth in birth centers or MLUs. The National Institute of Clinical Excellence (NICE) suggests
589 that only around 45% of pregnancies are considered 'low risk' (NICE, 2014b). This means that
590 when a homebirth service is withdrawn, many people may only be able to give birth in the
591 hospital labor ward if they want NHS healthcare professionals' support during the birth, even
592 if the birth center or MLU remain open.
593
594 Research is shortly due to be published that shows which perinatal choices different NHS
595 Trusts were able to maintain, and which they decided it was necessary to remove. These
596 results are welcome, and important for future emergency planning of perinatal services. As
597 the findings show, removal of choice leads to pregnant people who would rather have an
598 attended birth considering freebirth. However, the stories above also show that personal
599 circumstances can mean that the maintenance of choice in birth is not as simple as which of
600 the four places of birth are open. If a birth center is kept open when a homebirth services is
601 closed but is only available to those who are 'low risk', it does not provide choice for most
602 people. If a homebirth service is still running, but children and those from other households
603 are not allowed in the room, it is not a service that can be used by single parents. If a single
604 birth supporter is allowed, but they have to be from the same household, single pregnant
605 women and people face giving birth without support from someone they know. As can be
606 seen in the responses to this survey, it can be the most vulnerable people who are affected
607 by service disruption the most, and who then feel they are left with no choice but to consider
608 freebirth. Choices which are seen as clinically minor choices (such as access to a birth pool on
609 a labor ward) may be of great importance to pregnant people when making decisions about
610 birth. It is therefore important that quantitative research into the choices that NHS Trusts
611 were able to maintain is nuanced to service users' choices and takes into account the ways
612 different personal circumstances may interact with perinatal service availability or restriction.
613
614 Although this study of freebirth took place during the COVID-19 pandemic it becomes
615 apparent that pregnant people's motivations reflect those noted by previous scholars.
616 Concern about the safety of hospitals, the reduction of homebirth options, the practicalities
617 of attending hospital and previous birth trauma were all important motivations in this cohort.
618 This demonstrates that the COVID-19 pandemic has placed a spotlight on existing problems
619 in maternity care. Data from this study is clear: when pregnant people are presented with a
620 maternity service they deem unsafe or does not align with their needs, desires or world view,
621 they will step outside of that system. If service providers wish to ensure people access
622 perinatal maternity care, they must provide a service that is acceptable to those who are using
623 it.
624

625 This study has also exposed how some pregnant people considered maternity policies as
626 coercive. A fear of being coerced into unwanted medical interventions raises serious issues
627 regarding the under-researched area of informed consent and refusal in NHS maternity care.
628 It must be ensured that policies do not inadvertently subvert informed consent as this could
629 result in those giving birth submitting to interventions they may otherwise have refused. As
630 already highlighted above, a desire to avoid such policies was a motivating factor for some
631 people in this cohort.
632
633 Freebirth as a subject of academic research has only begun to be studied relatively recently,
634 and the literature pertaining to it is small. The available literature suggests that it is a
635 decision pregnant women make for a variety of reasons, including previous traumatic births
636 (Jackson, Dahlen and Schmied, 2012), a lack of support for birth choices (O'Boyle, 2016) and
637 a belief in the inherent safety of undisturbed physiological birth (Feeley and Thomson,
638 2016). This research suggests that a global pandemic represents a new factor in such
639 decisions.
640
641
642
643 *Risk*
644
645 Although the concept of risk typically dominates discussion on pregnancy and childbirth, the
646 COVID-19 pandemic appears to have challenged people's views on where and how it is safest
647 to give birth. Hospitals are generally assumed to be places of safety, however for women who
648 have experienced a traumatic birth, or who are worried about iatrogenic harm in birth,
649 hospitals may feel unsafe (Lyndon et al., 2018). During the pandemic, hospitals have become
650 viewed by many people as risky places to be avoided, where the risk of Covid-19 transmission
651 is high (The Health Foundation, 2020), and this fear was expressed by participants in this
652 research too. Conversely, freebirth may be assumed to be a risky choice, and those who choose
653 to freebirth are sometimes accused of making choices for their own benefit whilst disregarding
654 the safety of their baby. Participants in this survey who were considering freebirth because they
655 wished to avoid hospitals were clear that they were putting safety first. The vast majority of
656 people within this study had not considered freebirth before the pandemic, but COVID-19,
657 birthing restrictions and rapidly changing policies created competing risks that meant
658 freebirth became an acceptable option. This indicates the complexity of people's decision
659 making and demonstrates how people's understanding of risks associated with place and
660 manner of birth are not limited to what may be deemed a medical calculation of physical risks.
661
662 *Strengths and limitations*
663
664 This project provided a brief snapshot into the thoughts, feelings, and decisions of expectant
665 parents in the first weeks of the Covid-19 lockdown in the UK. There is an immediacy of the
666 qualitative answers that respondents gave that can provide researchers, policy makers and
667 practitioners with an insight into their lived experiences. The numbers considering freebirth,
668 and the reasons that they were considering this could usefully inform reorganization and
669 prioritization of perinatal services in the event of future lockdowns.
670

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671 The research was intended to capture experiences from a wide range of expectant parents,
672 and freebirth was not a specific area of investigation within the research. Capturing data from
673 so many people considering freebirth was unexpected. Data capturing the number of
674 freebirths are not routinely collected in the UK, apart from in London, where this information
675 can be volunteered by parents (Bryan, 2018). Through Freedom of Information requests to
676 Health Boards some data is available for Wales, but here the numbers also include cases
677 where a baby was born before the arrival of a midwife at home, or the parent at a hospital,
678 MLU or birth center (Bryan, 2018). We cannot therefore know if the 72 participants
679 considering freebirth in this research represents a greater than usual proportion. Additionally,
680 as most people who answered the survey had not yet given birth, we can only state how many
681 people *considered* freebirth, and cannot know the numbers of those who eventually decided
682 to do so. A limitation of this real time survey tool is that the resultant dataset is a convenience
683 sample which may be biased towards those that feel most strongly about their pregnancy
684 experiences. It could therefore be that those expectant parents who were considering
685 freebirth were more likely to complete this questionnaire than parents who felt more
686 sanguine about the available NHS birth choices.
687
688 *Future research directions*
689
690 Further research into perinatal experiences during the Covid-19 pandemic has already been
691 planned and partially conducted both within the UK and internationally. The results of other
692 studies will fill some of the research gaps within this work. The opportunity to compare these
693 findings on an international level would also create a more nuanced understanding of the
694 circumstances that affect the consideration of freebirth during a pandemic.
695
696 As mentioned above, it is not currently known how many participants considering freebirth
697 went on to have a freebirth within this study. Follow-up research to determine the actual
698 circumstances of birth, and participants' satisfaction with their decisions could provide useful
699 information, as no freebirth research to date has focused on consideration of freebirth.
700
701 This research suggests for the first time that specific groups of people may be more likely to
702 have considered freebirth during the Covid-19 pandemic. Further research with LGBTQ+
703 people and HCPs would be useful to establish whether these groups are more likely to
704 consider freebirth outside of a pandemic, and to understand the reasons why this might be.
705
706
707 **Conflict of Interest**
708
709 The authors declare that the research was conducted in the absence of any commercial or
710 financial relationships that could be construed as a potential conflict of interest.
711
712
713 **Author Contributions**
714
715 CRediT author statement

716 Mari Greenfield: (Conceptualization, Methodology, Formal analysis, Writing – original draft,
717 Writing – review and editing). Sophie Payne-Giffords (Formal analysis, Writing – original
718 draft, Writing – review and editing). Gemma McKenzie (Writing – original draft, Writing –
719 review and editing)
720
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Supplementary material:

Annex 1 – codebook for themes identified

851 **Tables**
852 *Table 1 –themes identified*
853

Theme	Subtheme
Planned place of birth	
Non-NHS support available/considered	Doula
	Independent midwife (IM)
Reasons for considering freebirth	Avoid hospital
	Previous traumatic birth
	Coercion
	Birth partner potentially excluded
	Uncertainty
	Access to water
	Childcare
	Distance/access to transport
	Timing

854
855 *Table 2 – Geographical distribution of participants considering freebirth*
856

England	**54**
North West	6
North East	1
Yorkshire and Humber	4
West Midlands	4
East Midlands	12
East	6
London	5
South East	11
South West	4
Scotland	**8**
Highlands and Islands	3
Mid East Scotland	2
South East Scotland	1
South West Scotland	2
Wales	**4**
South Wales	3
North Wales	1
Northern Ireland	**2**
NI	

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Other	
Guernsey	2
Did not fill in	1

857
858 *Table 3 – reasons why participants were considering freebirth*
859

Avoiding hospital	Birth preferences	Practicalities
Traumatic last birth	Birth partner excluded	Lack of childcare
Fear of hospitals	Access to water	Previous fast labor
Last baby died in the hospital	Desire for certainty	Distance to hospital
Concerned about cascades of intervention		No access to suitable transport
Fear or experience of coercion		
Risks of contracting Covid-19		

860
861