Choosing freebirth

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A freebirth is a homebirth that is intentionally unattended by any registered maternity care provider (Jackson, 2014). It is difficult to ascertain the percentage of women choosing to freebirth because most countries don't collect data regarding the number of women who make this choice; however, it is likely to be less than 1% of the birthing population (Jackson, 2020; Thornton & Dahlen, 2018). Outcome data for freebirth are unknown due to the secretive nature of this birth choice. The question is often asked, 'But isn't freebirth dangerous'? However, when attempting to understand the motivation to choose a freebirth, a better question would be, 'Why is freebirth considered safer than a birth attended by a maternity care provider?'
Keywords: freebirth, unassisted birth, unattended birth, homebirth

A freebirth is a homebirth that is intentionally unattended by any registered maternity care provider (Jackson, 2014). Freebirthing is different from a baby being born-before-arrival of the midwife at a home birth or before arrival to hospital; it is a thought out, intentional plan to give birth without the supervision of a registered maternity care provider (McKenzie, 2020). There is some argument amongst the freebirth community as to whether a birth where a doula or an unregistered birth worker are present should be classified as a freebirth (instagram.com/p/CPtyA1TgmCV/).

The choice to freebirth may be viewed as a choice of privilege. The woman is choosing it from a circumstance where she does have the option for an attended birth through a local service if she wanted it (McKenzie et al., 2020). This is unlike women who are having unattended births because there are barriers to accessing maternity care, such as in lower-resourced countries and in very remote communities.

It is impossible to know the exact number of women who make the choice to freebirth because most countries do not collect this data (Greenfield et al., 2021). However, it is likely to be less than 1% of the birthing population (Jackson et al., 2020; McKenzie, 2020). It is assumed that the statistics on freebirth numbers lie within the data on babies who are born-before-arrival. A proportion of babies born-before-arrival are genuinely intended to be born in hospital; it may be assumed that the remaining number are babies born as a result of freebirth (Thornton & Dahlen, 2018).

BUT ISN'T FREEBIRTH DANGEROUS?

Medicalised rhetoric focuses on the physical risk and safety of birth (Murphy-Lawless, 1998). It is difficult to ascertain the physical safety of freebirth due to its secretive nature (McKenzie, 2020). Data on babies born-before-arrival demonstrate a significantly higher perinatal mortality rate (34.6 per 1000 births compared to 9.3 per 1000 for babies born in hospital) with neonates more likely to be premature (12.5% compared with 7.3%), of lower birth weight and/or to be admitted to a special care nursery or neonatal intensive care unit (20.6% compared with 15.6%) (Thornton & Dahlen, 2018). However, freebirth is different from being born-before-arrival because women make specific plans when they intend to freebirth, with strategies to manage emergencies (Jackson, 2014). For this reason, born-before-arrival data is not applicable when seeking to compare the statistical safety of freebirth with other birth choices. In addition, women choosing freebirth are more likely to be of higher socio-economic status and have higher levels of formal education than women whose babies are born-before-arrival (Thornton & Dahlen, 2018; Jackson, 2014).

While freebirth outcomes have not been studied in the literature, there has been one investigation into the outcomes of births under the care of lay midwives in America, which is perhaps the closest we can get to understanding freebirth outcomes. Durrand (1992) retrospectively analysed the pregnancy outcomes for 1,707 women who birthed between 1971 and 1989 through the birth service at 'The Farm' in Tennessee, made famous by the then lay midwife, Ina May Gaskin. These births were compared to 14,033 hospital births. Durrand concluded that births attended by lay midwives can be accomplished as safely as physician-attended hospital births. However, owing to the small number of participants in the study and its retrospective nature, conclusions about the risks of lay midwife-attended births – or the safety of freebirth - cannot be drawn.

The decisions women make during pregnancy and birth are underpinned by a desire to have a healthy baby while remaining healthy themselves (Fisher et al., 2006). However, women who make unfamiliar choices like freebirth may be viewed negatively (Dannaway & Dietz, 2014). Conversely, women who make decisions such as to have elective caesarean section without a medical indication, are less criticised because caesareans are in line with the biomedical model of birth (Chadwick & Foster, 2014).

Caesarean section performed without medical indication offers few health benefits for women

and neonates; indeed, it is associated with an increase in health risks compared with vaginal birth (Dahlke et al., 2013). Despite this, some women choose a caesarean because they believe that it is a safe and responsible decision; for example, they may fear the potential impact of vaginal birth on their vulva and pelvic floor (Faisal et al., 2013). Chadwick and Foster (2014) explain that women choosing caesarean section construct their choice as a form of risk management; the motivation is the same for women who choose to freebirth (Jackson, 2012).

Given the lack of studies into the outcomes of planned freebirths, a better question to ask than, 'Is freebirth dangerous?' is 'Why is freebirth considered safer than having an attended birth?' The World Health Organisation (2005) states, 'The question should not be, "Why do women not accept the service that we offer?" but, "Why do we not offer a service that women will accept?"'.

WHY ARE MAINSTREAM MATERNITY SERVICES UNACCEPTABLE TO SOME WOMEN?

When I completed the analysis of the data I had collected for my PhD thesis, 'Birthing outside the system: wanting the best and safest' (Jackson, 2014), it became clear that the choice to have a freebirth was a direct result of what women anticipated they would be confronted with if they chose to give birth in hospital. Indeed, the choice to freebirth was an iatrogenic effect of the nature of modern maternity care in hospitals.

The women in my research identified a number of reasons why maternity services were unacceptable to them and why freebirth became an attractive option in comparison.

i) Not enough resources to cope with demand

Some women believed that hospital services have insufficient resources and staff to provide individualised care:

It's the volume of women that go through the hospital system - it would be very time-consuming to treat everybody completely individually and holistically with continuity. (Jackson, 2014)

By having a freebirth, women could access the resources they desired and have a birth that they perceived would be better and safer than a hospital birth (Dahlen et al., 2020).

(ii) It's not like home

In an ideal environment, the hormones of labour are enabled to flow and support a physiological labour (Howard, 2017; Stark et al., 2016). Alternatively, where the birth environment induces stress, the hormonal cascade of labour and birth is interrupted (Buckley, 2015). Women who chose freebirth in my study felt that a home environment provides the elements required to ensure the best possible birth experience and outcomes whereas the hospital could not adequately cater for their needs in labour, birth and postnatally:

I just didn't feel like I had freedom to move around and I remember just being in labour and not knowing where I wanted to be, if I wanted to be on the toilet or on the bed; it felt like I didn't have an option that felt most comfortable for me. (Jackson, 2014)

(iii) It's like a cattle yard

Women in my study who planned freebirths often believed that mainstream maternity care is driven by the desire to move them in and out of hospital as quickly as possible. They spoke of the hospital moving them through 'like a cattle yard'. A participant who also worked as a midwife in a hospital observed that in order to maintain productivity, the treatment of women in hospital has become depersonalised:

There is nothing individual about it.… staff are.… just going through the process of what they do every day; they just continue to do .. what they've always done and that's what works, that's what gets 300 women in and out every month. (Jackson, 2014)

(iv) Care providers are bound by hospital policies

Women understand that policies and protocols are set up in hospitals to facilitate the smooth running of the system, but by according primacy to productivity, the focus shifts away from what is best for the woman-baby dyad and towards what is best for the system and the institution (Dahlen et al., 2020).

The women in my research recognised that what they wanted often fell outside of hospital policy and were therefore concerned that their requests would be met with resistance or hostility as one woman recalled:

[I was met with] quite a strong message there [in hospital], that was, "We really don't appreciate you making this more difficult. We have a lot of women here to get through - just be good, just fit in" … She [the midwife] just basically was indicating to me that she wasn't interested in any way in looking into that option or giving me that opportunity.

Women who ultimately chose freebirth felt that the policies and protocols imposed on them by hospitals restricted their preferences and, in the interest of not having their personal autonomy challenged, freebirth became the better option.

(v) They intervene because they fear birth

Women who give birth in hospital are exposed to a greater number of interventions than women who give birth at home (Birthplace in England Collaborative Group, 2011). Routine interference in the birth process may introduce iatrogenic risk (Sadler, 2016) and is often not evidence based (Dahlen et al., 2012). The women in my research believed that intervening in the birth process increased the risk of something going wrong. Since hospitals represented a higher risk of intervention, the women saw freebirth, devoid of medical intervention, as the safer option. They perceived childbirth to be a normal, natural part of life. In contrast, they felt that the hospital system fears birth:

They're [the hospital staff] looking at the worst-case scenario all the time. (Jackson, 2014)

(VI) TENSION ABOUT THE WOMAN'S AUTONOMY

Women who chose freebirth expressed a desire to be respected as the authority at their birth and made an assumption that the hospital would not allow this:

I don't think that choice is there in hospital. Women might choose to birth in hospital but once they are in the hospital, I don't think they are getting choice. (Jackson, 2014)

Through their experiences, the participants learnt that the system does not trust women to make final decisions and therefore, pursued birth choices where they would be the authoritative decision maker.

(vii) Emotionally unsafe

In studies by Dahlen (2020) and Jackson (2014), many women had had first-hand experiences of the hospital system and described sustaining both physical and mental trauma as a result of the care they had received. Lack of attention to their emotional needs motivated them to pursue something better for their next birth. The women described the violations they endured at the hands of their maternity care providers:

My experience with hospital-based care has been incredibly disappointing and life changing, but not for the better. The day my first son was born, it should have been the best day of my life; instead, it has left me scarred, mentally and physically. Part of my treatment in the local hospital included being assaulted by a midwife as she forcibly held me down while I was in pain so that the doctor could poke around in my vagina without my consent. (Jackson, 2014)

Women who had endured a traumatising event during a hospital birth were predisposed to avoid the hospital system in the future:

I decided that should I find myself unable to access a midwife, I would birth at home – alone. Nothing that can happen to me or my baby at home could be much worse than what my second baby and I experienced in hospital. I will never subject myself, my baby or my family to such an ugly, traumatic and dehumanising experience again. (Jackson, 2014)

DISCUSSION

There will always be women who choose to freebirth. However, by making maternity care services more acceptable to women, the number choosing freebirth can be reduced. The choice to freebirth is made because it is positioned as the best option - emotionally, socially, culturally and physically - when compared to other birthing options.

Birth trauma is widespread (Reed et al., 2017). In order to convince women who might choose to birth outside the system that mainstream services are a safe option, it's vital to provide care that respects the autonomy of the birthing woman. The improvements that need to be made have long been highlighted in the literature. A move towards humane care is a move away from the biomedical model of care. Humane care valorises the midwifery profession and prioritises social models of birth (Rattner et al., 2009). Components of humane care include non-invasive practices, respect for women's autonomy, providing evidence-based care, valuing family-friendly environments, a focus on the relationship between the woman and her care providers, respecting privacy, providing access to homebirth and ensuring that women have adequate birth support (Jackson, 2014; Rattner et al, 2009).

Humane care valorises the midwifery profession and social models of birth

I write this at the time of the COVID-19 pandemic when women's autonomy and birth choices are being increasingly challenged. Anecdotal evidence suggests that women are being deprived of support from family members during their maternity care (Davis-Floyd et al., 2020). They have reduced access to waterbirth; their birthplace plans are ignored, and they are being exposed to ever-changing restrictions throughout their pregnancies. Under such circumstances, it is likely that more women will consider giving birth outside the system. A recent study in the UK (Greenfield et al., 2021) surveyed 1700 pregnant women and reported that 72 were considering freebirthing as a result of lockdown restrictions, with only one identifying that she had already planned a freebirth prior to the pandemic. Their reasons included wanting to avoid hospital due to restrictions placed on who they could have to support them in labour, and the possibility of exposing themselves to the virus during their stay. Also, as a result of lockdown, childcare options had become more limited so that the woman's partner might have to decide between staying with the other children or attending the birth.

Although the pandemic did not instigate freebirth, it has highlighted the problems in the maternity care system that motivate freebirth practices (Greenfield et al., 2021). The medicalisation of pregnancy and birth has led to the misplaced belief that the majority of births should occur within a hospital setting (Davis-Floyd et al., 2020). But pregnancy and birth are a state of wellness, and hospitals are a place to care for the sick. With hospitals now buckling under the pressure of a pandemic, it seems likely that there will be a growing interest in out of hospital birth options (Davis-Floyd et al., 2020). Without the provision of more homebirth and community-based midwifery services, there may be an increase in the uptake of freebirth (Dahlen et al., 2011).

This pandemic presents the opportunity

to observe the discordance between the maternity care being offered to women and the maternity care that women want. In the midst of global change, we have an unprecedented opportunity to follow the data which points to the benefits of continuity of midwifery care for all women and maternity care in a community setting. If freebirth is a symptom of a system that does not serve women as well as it should, then it's time to change the system.

Lack of homebirth and community midwifery services may increase uptake of freebirth

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