Challenging the status quo: women's experiences of opting for a home birth in Andalucia, Spain

Abstract

Objective: To explore the perceptions, beliefs and attitudes of women who opted for a home birth in Andalusia (Spain).

Background: Home birth is currently an unusual choice among Spanish women. It is not an option covered by the Spanish National Health Service and women who opt for a home birth have to pay for an independent midwife.

Design: A qualitative study with a phenomenological approach was adopted. All participants who took part in this study had chosen to have a home birth and given written consent to take part in the study.

Methods: Data collection was conducted in 2015-16. Face-to-face, semi-structured interviews were undertaken with women who chose a home birth in the last 5 years.

Findings: The sample consisted of thirteen women. Seven themes were created through analysis: 1. Getting informed about home birth; 2. Home birth as a choice, despite feeling unsupported; 3. The best way to have a personalized and a physiological birth; 4. Seeking a healing and empowering experience 5. The need for emotional safety, establishing a relationship and trusting the midwife; 6. Preparing for birth and working on fears; 7. Inequality of access (because of financial implications).

Conclusions: Women opted to plan birth at home because they wanted a personalised birth and control over their decision-making in labour, which they felt would not have been afforded to them in hospital settings. Andalusian maternity care leaders should strive to ensure that all pregnant women receive respectful and high-quality

personalised care, by appropriately trained staff, both in the hospital and in the community.

Keywords: home birth, midwives, private practice, midwifery-led care, phenomenological approach, qualitative methodology.

Highlights

- Despite strong evidence supporting choice of birth place for healthy women with uncomplicated pregnancies, this study reports a serious lack of choice regarding birth place in Spain.
- National policy in support of different birth places is urgently needed in Spain.
- Women felt judged by healthcare providers for their place of birth choice and did not feel supported when an intrapartum transfer was required.
- All healthcare professionals, irrespective of where they are based – in a hospital or community setting - should acknowledge and respect women's needs and rights for personalised care, privacy and self-determination: this includes how and where to give birth.

Introduction

Around 4.7 million European women give birth each year (Macfarlane et al., 2016). Despite the strong evidence for midwifery-led care and birth settings (Scarf et al., 2018), most European countries still offer women very limited choice regarding place of birth and lead practitioner, with referral to an obstetric unit being the expected option (Macfarlane et al., 2016). In many European countries obstetric units are, in fact, the only available birthing setting.

Evidence suggests that midwifery-led birth settings, such as home and midwifery units (both alongside (AMU) and freestanding (FMU)), can offer health advantages for healthy women with straightforward pregnancies, when compared with obstetric units (Brocklehurst et al., 2011; NICE, 2014; Borrelli, Walsh & Spiby, 2017; Scarf et al., 2018). Benefits are diverse, including: lower maternal interventions associated with maternal postnatal short- and long-term morbidity (Brocklehurst et al., 2011; Scarf et al., 2018), greater maternal satisfaction (Dahlen, 2010; Overgaard, Fenger-Grøn & Sandall, 2012; Macfarlane et al., 2014a; Macfarlane et al., 2014b) and a reduction in intrapartum and postnatal care costs (Sandall et al., 2013; Hodnett et al., 2010, Schroeder et al., 2017).

Background

The Birthplace in England Study (Brocklehurst et al., 2011), reported a higher incidence of negative perinatal outcomes associated with nulliparas having a home birth. This difference was not, however, detected in the large cohort study by De Jonge et al. (2013) and in a systematic review by Scarf et al. (2018). More research is needed to study the impact of models of care on the safety of home birth, as the way in which midwives organise their workload and whether they provide continuity of care might have an impact on safety (McCourt et al., 2014). For multiparas, the evidence suggests better maternal outcomes for women planning a home birth and no difference in perinatal outcomes (Brocklehurst et al., 2011; De Jonge et al., 2013) as compared with obstetric unit birth. The 2014 NICE Intrapartum Guidelines (NICE, 2014) advise clinicians in England to recommend home birth to healthy multiparas with uncomplicated pregnancies; and midwifery units (AMU and FMU) to healthy nulliparas with uncomplicated pregnancies.

The Spanish National Health Service only offers women the option to give birth in an obstetric unit. Women do not have real choices on place of birth.

Home birth is an option chosen by a small number of women in Spain and assisted by 'matronas', Spanish midwives, who have a dual-qualification as nurses and midwives. As national routine data do not capture birthplace, it is currently difficult to ascertain how many women give birth at home every year. A home birth association published that in 2013, 800 women had a home birth which resulted in a 0.2% home birth rate. In the Spanish region of Catalonia, there has been a substantial increase in home births by health professionals, with 383 home births in 2013 (Educer, 2017). There is also a guideline about home birth developed by Official College of Nurses in Barcelona, in response to the increasing demand.

In contrast with these national figures, subnational statistics of home birth report a 30% home birth rate in the Netherlands (de Jonge et al., 2013), a rate of 0.3% in Australia (Australian Institute of Health and Welfare, 2015), and 2.3% in the UK in 2015 (Office for National Statistics, 2015).

There is a lack of national policy and care provision by the national health service regarding homebirth in Spain. Women have to either pay a private fee for the service or pay for private health insurance that covers some services of a home birth, such as antenatal education or postpartum care, but not the intrapartum care.

Midwives who practice privately usually hold professional indemnity insurance, and all midwives employed by a public hospital are covered by their employer's insurance.

Not all Spanish regions have home birth guidelines and to date only the Nursing Council in Barcelona has developed its own guidance for the entire region of Catalonia.

The study

Aim

This study aims to explore perceptions, beliefs and attitudes of women who planned a home birth in Andalusia (Spain).

Methods

In this study we sought to study meanings in subjective experiences. We explored in depth the meaning that individuals attributed to their experiences. The data analysis was based on the description by Dahlberg et al. (1997), influenced by Giorgi's phenomenological method (Husserl, 1970; Giorgi, 1985) which focusses on the description of a phenomenon: in this case, home birth in Andalusia, Spain. Phenomenology is a qualitative method of enquiry that seeks to find deep understanding and meaning in specific human experiences or events (Welch, 2011). We described an object with reference to subjects (women who experienced a home birth). We included a critical reflection in the whole process to understand the phenomenon. Semi-structured interviews were designed by the research team based on previous literature published in other countries (Wood et al. 2016; Holten & Miranda, 2016; Lee, 2016; Dahlen, 2010). Questions included can be seen in figure 1.

Reflexivity improves validity and transparency in research and can be described as 'the process through which a researcher recognises, examines, and understands how his or her own social background and assumptions can intervene in the research process' (Hesse-Biber, 2007). Reflexivity ensured issues with power relations in the field were

addressed and that the researchers were aware of their preconceived ideas. Discussion among the authors helped to address some of these issues. A consensus on interpretation of the data was reached via discussions and reflections.

Recruitment and participants

We used a convenience sampling strategy following a snowball sampling strategy (Atkinson and Flint, 2001). Women who planned a home birth in last 5 years were recruited, in total 13. Recruitment was undertaken through midwives who attended those home births. Inclusion criteria included women who consented to take part in the study and signed a consent form after having received comprehensive verbal information about the research. All women were fluent in speaking Spanish. The area of recruitment was Andalusia. All participants invited to join, agreed. The sample size was determined by data saturation.

Data collection

Each participant was interviewed face-to-face by a researcher. Interviews were undertaken at the women's own homes. All interviews were recorded and transcribed verbatim to maintain participants' anonymity and confidentiality.

Interviews lasted roughly one hour. The semi-structured interview questions were designed, although based on previous research, by the research team (Figure 1) and included participants' sociodemographic aspects. The interviewer was a newly qualified midwife who did not participate in any of the participants' healthcare. Interviews took place between October 2015 and January 2016. Interviews were undertaken in Spanish and were translated into English after analysis.

Ethical considerations

Ethical approval for the study was obtained from the University of Seville's Human Ethics Committee. Written consent was obtained from participants, who were free to decline participation or withdraw at any time.

Data analysis

Thematic analysis with a phenomenological approach was used to analyse data and identify themes. The recorded interviews were transcribed verbatim. Every interview was analysed separately for themes and ideas, the procedure will be described hereunder. Emerging themes were coded. The research team discussed coding, interpretation and consistency. A final consensus of interpretation of themes was reached. A numerical code identifier was used for participants, in order to guarantee anonymity.

First, a descriptive step was carried out describing experiences in detail and the scientific essence was sought as a general structure of the phenomenon (Giorgi, 1997). Interviews were in Spanish and translated into English. In order to reduce the loss of meaning and thereby to enhance the validity of cross-English qualitative research, back translation to the original source language was undertaken. As Van Nes (2010) recommends, the researcher operated as a translation moderator in cooperation with a professional translator. Side-by-side procedure, in which the researcher and the translator discuss possible wordings, was performed.

Findings

Women's demographics are described in Table 1. Participants' median age was 30 years old. The parity of participants included seven primiparas and six multiparas. Multiparous women had an obstetric unit birth with their first baby. Some of them were in a stable relationship with their partners and others were single mothers. All participants spoke Spanish as first language and were of Caucasian ethnic origin. Some of them had previously had a home birth. Two women who planned a home birth transferred intrapartum to the local obstetric unit. Three had a home birth after a caesarean section. Eight women lived in a rural area and five in an urban area in Andalusia.

Themes that emerged were classified in six key categories. Identifiers were used for the quotes following description shown in Table 1.

1. Getting informed about home birth

Information about home birth is not usually given out to families by care providers in the Spanish National Health Service, since this choice is not available within the service. Women are usually informed by other women, the internet or organisations that promote alternative ways to give birth in Spain. Since home birth is not offered as a public service, free at the point of delivery, healthcare professionals do not usually counsel women on the pros and the cons of this choice. Spanish women do not have to decide around place of birth in the public system, because only obstetric units are readily available.

> "I received information about home birth in "Birth is ours" (El parto es nuestro) and "Milk Collective" (E2).[1]

[1] El parto es nuestro (Childbirth is ours) is a civil society organization which works on birth activism. Milk collective is an organization which supports women who breastfeed.

"On the Internet, I googled about home birth, I found a group in Seville who supports women who want to give birth at home" (E9).

"I have always been surrounded by other women who had a beautiful home birth, so I was clear that I also wanted a home birth for my first child" (E7).

2. Home birth as a choice despite feeling unsupported

Women recognised that they did not always feel supported by their family because they thought that home birth was less safe than at the hospital. Participants felt pressured by their family and friends, but they felt that their partners support was fundamental to carry on with their plans to birth at home. Being supported by their partners enabled women to feel confident and in control.

"People told us that home birth was risky and doubted if I would be capable of it. My partner was my best support" (E2).

"You have to feel confident that home birth is what you want, if you do not, people block you". (E11).

"Everybody tries you to change your mind. They tell you how much risk is involved with a home birth, that it is the worst decision you can make for you and the baby, and that you will both die. My husband disagreed with a homebirth at the beginning but after getting more information, he was my great supporter" (E4).

"My parents told me that my baby and I were going to die" (E3).

> "No one in my family supported me. They thought that I was crazy. Some family members were upset with me because of my choice. I kept it quiet. I just informed my family when my baby was born" (E9).

> "The social image of home birth is negative in Spain so my family did not support me. They were draining my positive energies with their negative comments" (E7).

Only one woman felt supported by her family despite some initial apprehension:

> "My family was unsupportive, but they saw that I was well- informed and then, they supported us" (E6).

Most participants had antenatal care in the public healthcare system, so when they were asked about plans for birth and they told the care provider about the chosen option, generally, they did not feel supported. Healthcare providers generally censored home birth and made women feel bad for their birth choices.

> "They made me feel that I was putting my baby at risk. I did not feel any rapport with my healthcare professionals, so I avoided telling them my decision about home birth when I attended the antenatal clinic" (E10).

> "My parents-in-law were general practitioners and had attended births in rural areas, but when I told them about my choice of home birth, they were against it" (E11).

3. The best way to have a personalised and a physiological birth

In many cases, the motivation for a home birth was based on previous negative experiences of birth or an apprehension with the mainstream maternity care model in

Andalusia, often involving routine interventions and a generalised lack of respect for women's autonomy. Participants expressed a view of birth as a physiological process which must not be interfered with unless necessary. Participants feared that they would not be treated with respect and that their autonomy would not be respected if they attended their local obstetric unit.

> "Some women, including me, truly think that the most physiological option for birth is a home birth, because a woman does not need another person to give birth" (E13).

> "Birth is a physiological process and we must respect it" (E2).

> "A home birth empowers yourself as a woman. You feel that you can do it by yourself". (E13).

> "There is a lack of humanity and respect for women" [speaking about mainstream care in obstetric units] (E1).

Women complained about the strict protocols that disregarded personalised care in hospitals. They felt that by opting for a home birth, their autonomy and right to choose would be respected.

> "Protocols do not account for the individuality of women. All women are different and have different needs in their births" (E4).

> "When you are at the hospital, there are protocols that health providers follow without considering women's wishes. [they might say] It is time to bath the baby whilst you are in the middle of breastfeeding" (E9).

"I read women's experiences of home birth on the internet and realized that that is what I wanted for my birth" (E11)

4. Seeking a healing and empowering experience

Participants who had a traumatic experience in a previous birth chose a home birth because they were looking for a healing experience. Women mentioned that their negative experience with the healthcare system motivated them to seek other options, even if these options were not readily available in the public healthcare service.

"My first birth was horrible. To be forgotten. In fact, for a long time I did not remember the birth. I did not want to remember it" [First birth was in an obstetric unit] (E9).

"You are there, and you let them to do stuff to you… Suddenly, I felt how they opened me, I felt pain…" [First birth was a caesarean section] (E2).

Women's experiences of their home birth were completely different and had a positive impact in their memories. In some cases, they subsequently opted for another home birth for the following pregnancy.

"From every point of view, it was spectacular. I can tell you that the sensation of giving birth at home, the self-confidence of giving birth there…. you do not feel stressed or scared" (E5).

"I liked it. They respected my intimacy, they were there but respecting my space" [in reference to midwives who attended her birth at home] (E3).

5. The need for emotional safety, establishing a relationship and trusting the midwife

When women were asked about the philosophy and skills that care providers must have, women emphasised "empathy" and "worthy" as very important attitudes. Women rated higher a compassionate attitude than a highly qualified professional (doctor). Women considered midwives to be fully skilled and qualified to attend births, but they also expected them to have other abilities, such as empathy, compassion and a friendly attitude.

> "Being empathetic [in reference to midwives]. They need to be respectful, to listen to women and their partner. They need to know when to lead, because if they lose control, women will do as well. They have to calm women, contain their fear" (E12).

> "When I contacted the midwife, I had not decided for a home birth yet, I contacted her because I wanted to have a respectful birth, without epidural analgesia, and I wanted a person who respected that. I knew that I was not going to find a healthcare professional who respected me in this way [at the hospital]…" (E1).

> "I needed calmness, I needed a person who passed on to me a sense of trust, respect and love" (E10).

> "Empathy and respect are fundamental" (E11).

> "I need to trust my midwife; I want her to be my support when I feel weak. She has my trust and I put myself in her hands" (E7).

> "They must know how to be… be quiet, but paying attention to everything. They cannot project their fear, they must be a companion. They must identify if risks arise and ask for help if things take a wrong turn,". (E6)

Women who had to be transferred intrapartum declared experiences of disrespectful treatment received by some care providers. They felt judged because of their option of a home birth.

> "They asked me: 'are you coming from a home birth? Well, do not complain so much.' She was so rude!" [the healthcare professional] (E7).

6. Preparing for birth and working on fears

Women who had a home birth reported a good experience and most of them would recommend it, but we observed that women identified that not everyone is prepared to have a home birth. They considered it very important to work on fears. Participants highlighted that to give birth at home, women needed to prepare physically and mentally.

> "Yes, I would recommend it if a woman is ready for it. She has to work on her fears" (E2).

> "If I see that a woman is interested in it and she shows me interest, I like to encourage her" (E6).

> "I would recommend it, but a woman has to work on her fear and confidence. I recommend it, but I am also very respectful of other women's choices, because it is an intimate and personal decision" (E13).

7. Inequality of access (because of financial implications)

Women recognised that having to pay for a home birth privately is expensive in comparison to hospital birth and not affordable for everyone. They stated that it should be included in the public healthcare system provision.

> "I would recommend home birth to anyone if it was a publicly-funded option, because not all women can afford it" (E5).

> "I do not understand why it is not an available choice for women, because I think that it is cheaper for the healthcare system" (E6).

> "Not all women can afford a private midwife (…). It should be a free option" (E7).

Women reported that they would like to have more birth place options available in Spain, including in hospital and at home.

> "I would recommend a home birth because it is the most physiological way of giving birth (…). I wish we would have other places of birth available, apart from our houses, for example, birth centres or a space in the hospital without many medical interventions" (E7).

Discussion

Our aim was to explore the perceptions, beliefs and attitudes of women who planned a home birth in Andalusia, Spain. We reached saturation at 13 interviews and we identified 7 themes. The implications for policy and practice are centred on how to challenge the status quo, which is linked to empowerment and self-determination in the women and the need for a change in care providers' attitudes.

Challenging the status quo

The data clearly suggested that the national healthcare system did not offer or support alternative birth place options, but also actively discouraged home birth as a choice. Women had to demonstrate a strong self-confidence to opt for a home birth against healthcare professionals', family and societal views of birth as a 'risky process'. This view of birth outside hospital as 'deviant' and risky is matched by a wide international literature (Hunter, 2003; Schuster, 2006; Deery, Jones & Phillips, 2007; Deery, Hughes & Kirkham, 2010; Stone, 2012; RANZCOG, 2011).

Women planning to give birth at home often described a lack of support by their family. Women had to gather information about home birth in a 'covert manner' and avoid discussing with health professionals from the public services to avoid feeling judged.

Having peer support from other women who had a home birth also empowered participants to feel confident to give birth at home, despite wider societal negative attitudes. These findings highlight the need for national policy to support women's choices of birth place and to lead the way for a cultural shift in care providers as well as in the public.

Empowerment and self-determination

Birthplace decision-making was influenced by the construct of safety, risk and self-confidence and this was consistent with findings by Grigg et al. (2015). Women who felt a supportive physical and emotional environment made autonomous decisions based on their personal needs (Wood et al., 2016).

Dahlen, Barclay & Homer (2010) found that women who chose a home birth were more willing to take responsibility for their pregnancy, labour and birth when compared with

women who opted for a birth in an obstetric unit, where the responsibility for the decision-making is devolved to healthcare professionals.

Giving birth at home in Spain was a conscious choice, as it was necessary to seek a care provider to find the right midwife. This finding was this in line with other studies. Only empowered women opted for home births (Regan et al., 2013; Lindgren & Erlandsson, 2010).

Many participants who gave birth to previous babies in hospital opted for a home birth in search of a healing experience. Many women were traumatised during a previous hospital birth and this encouraged them to opt for a home birth. Similarly, wider international evidence points towards women having home births because they perceive the hospital as a threat (Jackson, Dahlen & Schmied, 2012; Dahlen, Barclay & Homer, 2010).

The women in this study reported reasons for opting for a home birth which were consistent with other studies: continuity of carer, avoiding a medical model of childbirth and seeking a different atmosphere and environment to the obstetric unit (Grigg et al., 2015). In our study the rejection of the biomedical model was a common theme that emerged as women's motivation to birth out of the hospital setting. Dahlen, Barclay and Homer (2010) as well as Feeley and Thomson (2016) reported that a medicalised care approach with routine interventions contributed to women's lack of satisfaction with previous births and to the drive to seek alternative birth places for subsequent pregnancies. Women who had a home birth felt that they were not bound to a biomedical model of care, which was the norm at the hospital (Laws et al., 2011).

All participants in this study agreed that they did not want to be subject to routine procedures and to be treated in an impersonal manner with disregard for their human

rights of autonomy and self-determination. In accordance with wider international research findings, our research revealed that women wanted an approach to care that hospital did not provide, including women-centred continuity of care (McWhirter, 2017; Holten and De Miranda, 2016; Borrelli, Walsh & Spiby, 2017). Similarly, Walsh (2006) found that women who preferred home birth wanted to avoid interventions and felt most relaxed in their home environment.

Women in our study felt autonomous and experienced a high degree of privacy, self-determination and intimacy at home. The participants who opted for and had a home birth described the experience as extremely positive and empowering. Many of them expressed strong opinions regarding the need to have birth place alternatives to the hospital obstetric unit and believed that home birth and midwifery units should be part of the Spanish National Health Service. Two findings from our study are consistent with other published literature: a higher level of education among the group of women who chose to birth at home (Steel et al., 2015) and high level of satisfaction with the care received while having a home birth (Hitzert et al., 2016).

The need for a change in care providers' attitudes

The findings suggest the need for a shift in care provider's attitudes towards care, power relations and women's autonomy. All women described the philosophy and attributes, which they expected in their birth attendant as being empathetic, able to establish rapport and suggesting a sense of trustworthiness, which made them feel safe. Safety for participants meant both physical and emotional safety. Rocca-Ihenacho (2017) reports similar findings in her ethnographic study of an FMU in England and the wider international literature has aligned findings (Schuster, 2006; Stone, 2012).

Women in this study did not feel that the hospital offered an environment conducive to a physiological and undisturbed birth. This is in line with other studies which report a positive influence of the familiar environment at home (Borquez & Wiegers, 2006) and women reporting a better birth experience (Hitzert et al., 2016). Care providers need training to be able to offer personalised care which is tailored around women's needs and focused on facilitating an undisturbed birth (Rocca-Ihenacho, 2017). The way care providers arrange the environment and are able to respond to women's needs is crucial for a feeling of safety and a sense of control by the woman (Wood et al., 2016). Training in legislation around facilitating informed choices and women's autonomy is essential as the evidence suggests that care providers lack an understanding of their role and responsibilities (Kruske et al., 2013).

Limitations

This research is limited to women from a small area of Spain, in Andalusia. Service users and the public (PPI) were not involved in the planning, data collection and analysis and were only included as participants.

Conclusion

Women who opted for a home birth clearly expressed dissatisfaction with the care offered as part of the Spanish National Health Service in hospitals. In contrast, they wanted to have personalised births and control over the decision-making in labour, which were not offered to them in hospital settings.

This study suggests that there is a need for clear national policy regarding birth place and information directed to the public on home birth and midwifery units in Spain. Women's experiences of hospital birth indicate an urgent need for training on personalised care and human rights in hospital settings. Professional bodies and

associations as well as women's representative groups could become instrumental in implementing evidence on birth place in Spain and facilitating a shift in public perception.

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Conflict of interest

The authors report no conflict of interest.

Author contributions

FLL participated in the study concept and design, obtaining data, data analysis and interpretation. CAN participated in obtaining data and in the study concept and design. LRI, FCC & RE participated with data analysis, interpretation and drafting the manuscript. All authors agreed on the final version and made a critical review of the manuscript as to its relevance.

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