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Women's agenda for the improvement of childbirth care: Evaluation of the Babies Born Better survey data set in Spain

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Abstract

Background: Public patient involvement (PPI) generates knowledge about the health-illness process through the incorporation of people's experiences and priorities. The Babies Born Better (BBB) survey is a pan-European online questionnaire that can be used as a PPI tool for preliminary and consultative forms of citizens' involvement. The purpose of this research was to identify which practices support positive birth experiences and which ones women want changed.

Methods: The BBB survey was distributed in virtual communities of practice and through social networks. The version launched in Spain was used to collect data in 2014 and 2015 from women who had given birth in the previous 5 years. A descriptive, quantitative analysis was applied to the sociodemographic data. Two open-ended questions were analyzed by qualitative content analysis using a deductive and inductive codification process.

Results: A total of 2841 women participated. 41.1% of the responses concerned the category "Care received and experienced," followed by "Specific interventions and procedures" (26.6%), "Involved members of care team" (14.2%), and "Environmental conditions" (9%). Best practices were related to how care is provided and received, and the main areas for improvement referred to specific interventions and procedures.

Conclusions: This survey proved a useful tool to map the best and poorest practices reported. The results suggest a need for improvement in some areas of childbirth care. Women's reports on negative experiences included a wide range of routine clinical interventions, avoidable procedures, and the influence exerted by professionals on their decision-making.

KEYWORDS

birth, evaluation, maternity care, satisfaction, women

1 | INTRODUCTION

In recent decades, the debates on guiding principles and maternity service quality have focused on three aspects: (a) the need to reverse the trend toward medicalization and interventionism; (b) meaningful consumer engagement as regards user participation in decision-making; and (c) respect for women's points of view when setting the agenda for maternity care research and service improvement.[1–3]

Several studies have highlighted the need to include user experiences in the quality assessment of maternity services, in addition to outcome data.[4–7] The needs and areas for improvement identified by women deserve consideration when designing and implementing innovations in maternity care services.[8–10] This is critical because women´s satisfaction with their birth experiences may affect their health, their relationship with the newborn, and the whole family system.[4,11] According to international and national recommendations for maternity services, higher levels of satisfaction and better health outcomes are linked to patient-focused approaches,[12,13] interdisciplinarity and teamwork, integrated and skilled care,[14,15] continuous and personalized care provided by a midwife, and birth within a family or specialized setting.[6] When women are involved in the process and make their own decisions about childbirth, higher rates of satisfaction are described.[16,17] Such women-focused recommendations and their associated health outcomes justify women's involvement in the improvement of the maternity services and support their contributions to research and maternity care agendas.[18]

This concurs with public patient involvement (PPI) policies, which highlight this need to engage the community in the design and evaluation of health services and research processes. The expansion of PPI policies is visible in the proliferation of theoretical and methodological frameworks that seek to "make PPI effective in practice," ensure "it contributes positively to the research process," and broaden "the scale of its impact".[19,20] Even though PPI is a polysemic umbrella term that generates a wide range of practices, it is clearly committed to legitimizing the importance of people's knowledge of health-illness processes in the design, implementation, and evaluation of health services and research.[21] This kind of knowledge is described as experiential expertise[22] and refers to "the ultimate source of patient-specific knowledge—often implicit, lived experiences of individual patients with their bodies and their illnesses as well as with care and cure."

We consider the Babies Born Better (BBB) survey (https://www.babiesbornbetter.org/) a useful PPI tool for preliminary research on health services quality assessment when user-relevant topics have been identified and prioritized. The BBB survey is a pan-European online questionnaire that seeks to collect the views and experiences of women who have given birth in the previous 5 years. As it is designed to obtain real-time data on maternity care, this questionnaire allows consultative forms of citizen participation.[16,23] This form of involvement has been described as "asking consumers about their views and using them to inform decision-making." Although the consultative approach to PPI with an online questionnaire does not guarantee full engagement in research or health services improvement, it does reach a large number of people. This makes its contribution valuable since it provides a broad picture at European and regional levels, serving to identify the best and worst birth care practices. Thus, the online questionnaire draws on women's experiences to set a "thematic agenda" concerning what works for whom and in what circumstances.

In Spain, the current national guidelines on sexual and reproductive health care[24,25] were designed to transform sexual and reproductive health care models in the National Health Service. They take into account the demands of both women and health professionals and the recommendations of international organizations. However, the biomedical birth model persists in Spain; this model entails the regular use of technological intervention in normal birth and the exclusion of women from the decision-making process.[26,27]

Given the Spanish context, the aim of this study was to identify which practices resulted in positive experiences for the women who answered the BBB questionnaire in Spain and which ones respondents considered to be in need of change. Accordingly, we aimed to: (a) identify and prioritize areas or themes relevant to women (what women talk about); and (c) draw a map of semantic fields related to these themes (how women talk about them).

2 | METHODS

2.1 | BBB survey

The BBB survey is a European Union-funded project linked to COST-Action IS0907, which aims to "advance scientific knowledge about ways of improving maternity care provision and outcomes for mothers, babies and families".[28] It has involved researchers from Australia, China, South Africa, and 26 countries in Europe. The main goal of the survey is to identify women's experiences of positive and negative childbirth practices across Europe, with the aim of identifying ways of improving maternity care provision and its health outcomes.

The questionnaire contained 17 questions organized into 5 themes: (a) sociodemographic profile (age, country and city of residence, reasons for immigration (if applicable), parity, and birth date); (b) pregnancy details (weeks' gestation and pregnancy-related problems); (c) birth details (birth setting and institution, and type of birth professional); (d) care experiences during

childbirth (positive and negative aspects); and (e) final comments. These questions took various forms, including simple yes/no responses, multiple-choice questions, and the opportunity to respond freely in writing (as regards "care experience").

The survey tool was an online questionnaire hosted by SurveyMonkey®.[29] The questionnaire was prepared by a group of researchers, and subsequently reviewed and improved by a wide range of stakeholders, including academics, activists, and people with diverse personal and professional backgrounds. The survey tool was translated into 23 languages for use across Europe and beyond. It was translated into Spanish by native speakers (the authors) and subsequently verified and refined using back translation to improve its reliability. Some transcultural adaptations were introduced in the items related to the Spanish NHS organization, birth setting, and birth professionals.

The questionnaire was launched in February 2014 and advertised by means of social media, online forums, blogs, and mothering and midwifery websites.

2.2 | Participants and data collection

Women were invited to participate through social media and virtual communities of practice. A snowball sampling strategy was used for recruitment. The inclusion criteria covered women aged 18 and above who had given birth in the previous 5 years and were resident in Spain, regardless of their first language. We assumed that women could remember relevant details of their childbirth experience if it had occurred within the previous 5 years. The exclusion criteria omitted women who had not given birth in Spain, and those whose responses were in a language with no available translation. The study only included those questionnaires where over two thirds of the questions were answered.

Before answering the questionnaire, the women were asked to sign a consent form and were informed that all data processing would be subject to the applicable data protection laws of Ireland, the EU, and the United States.[29,30] All data were collected in 2014 and 2015. Ethical approval for the BBB survey was granted by an Ethics Committee.

2.3 | Analysis

After data cleaning to remove incomplete records from the database, qualitative and quantitative analyses were carried out. The BBB questionnaire in Spain had 3617 respondents, and 2869 (79.32%) were accepted for analysis after data cleaning. The women excluded were those who had not given birth in the previous 5 years,[31] whose age was invalid (115), who failed to answer at least two thirds of the questionnaire (578), and those who provided inconsistent answers [19] (such as responses related to the hospital facilities in a home birth).

2.4 | Quantitative data

Exploratory and descriptive analyses (frequencies and percentages) were applied to the variables: sociodemographic profile, parity (primiparous or multiparous), place of childbirth (hospital, adjoining midwifery unit, freestanding midwifery unit, at home, others), birth professionals (obstetricians, midwives, nurses, others), and pregnancy-related problems. IBM SPSS version 19.0 was used for data analysis.[32]

2.5 | Qualitative data

Two open-ended questions in the BBB questionnaire were included in the qualitative analysis: One focused on what women considered the best parts of their childbirth care experiences, and the other explored what they would change. As both questions admitted three free-text responses, the potential text corpus to be analyzed comprised 17 214 answers. However, 16% were blank, and so the final corpus contained 14 411 answers.

Qualitative content analysis[33–35] was used to identify and quantify themes and subthemes. This choice of analytical approach was justified by: (a) the research goal—to map areas of childbirth care needing improvement by focusing on what women talk about (theme identification) and the way they talk about these themes (semantic fields or subthemes); and (b) the large amount of qualitative data. All analyses were carried out in Spanish by the authors, and the results were translated for publication.

The analysis proceeded as follows: step 1: reading of the full set of responses to obtain an overview; step 2: codification of each answer by combining deductive and inductive procedures; step 3: identification of themes and categorization; step 4: intracode and intercode comparison and subsequent recodification to ensure the internal consistency of codes and subcategories; and step 5: merging of subcategories to summarize results.[35]

The codification was both deductive and inductive to ensure the comparability of results with BBB surveys from other countries and internal validity and contextual appropriateness. For the deductive codification, we used maternity care terms defined by the scientific literature and published results from other BBB surveys.[31,36] The inductive codification served to create codes from the written answers. The result of these two methods was a coding framework prepared by the authors (Table 1). Each category was divided into subcategories, and the responses were separated into positive and negative types to distinguish between best and worst practices. Response often highlighted multiple relevant features of the care provided. Accordingly, some responses were included in more than one subcategory if they referred to different aspects of the birth experience.

TABLE 1 Description of categories and subcategories in the final coding framework

Categories Subcategories	Description of items and attributes included in each category
1. Care received and experienced	
Overall maternity care and childcare	Positive statements: They refer to a positive valuation of general care and professional assistance before, during, and after the birth. General care for the baby Negative: lack of this general care and assistance or negative valuation
Support and accompaniment	Positive statements: accompaniment, support or help provided by the health professionals Negative: poor quality or lack of accompaniment, support, or help
Communication	Positive statements: Health professionals listen actively and possess the communication skills needed to inform, dialogue, advise, and guide. The quantity and quality of the information provided is appropriate Negative: poor communication skills or lack of them. Not enough information. Conversations among professionals as if women were not present
Feelings of safety and trust	Positive statements: Health professionals' actions make women feel secure and give them confidence Negative: lack of security and trust
Respectful care, intimacy, and sense of agency	Positive statements: taking into account women's needs and wishes, respecting the right to choose and to decision-making, and preserving intimacy and dignity; only well-known and wanted persons present; women's autonomy and self-determination, asking permission before any procedure Negative: insufficient presence or lack of the above items. Paternalism, coercion or threats
Professional behavior and attitude	Positive statements: when health professionals are empathic, friendly, kind, attentive, dedicated, understanding, caring, careful, interested, discreet, humane, and so on Negative: insufficient presence or lack of the above attributes. Dehumanization or depersonalization
Time and availability	Positive statements: ready availability of professionals, suitable time spent and commitment, the continuous presence of the obstetrician or midwife, patience and time guaranteed when needed. Calm atmosphere Negative: insufficient presence, time spent, availability, and continuity. Lack of respect for length of labor. Hurried atmosphere
2. Involved members of care team	
Professional involvement	Positive statements: the involvement of any kind of health professionals (or a specific person) is valued positively. Which professionals are involved or not is also valued (eg, the noninvolvement of an obstetrician if birth is assisted by a midwife) Negative: the kind of professionals involved, with their actions valued negatively
Competence interdisciplinarity	Positive statements: professionalism, competence, experience, expertise, qualifications, specific knowledge and skills, interdisciplinarity, teamwork, and team dynamics Negative: insufficient presence or lack of the above attributes. Inconsistencies in the criteria of different professionals
Presence of a partner or close person	Positive statements: presence or involvement of a parent (or other accompanying person) at birth Negative: poor level or lack of involvement
3. Specific interventions and procedures	
Normal birth facilitation without interventionism	Positive statements: facilitation of normal birth with few or no interventions and absence of invasive procedures. Demedicalization. Free movement during labor and election of birthing position. Consideration of the birth plan Negative: interventions are valued negatively (type and quantity). Nonrecommended or unnecessary procedures are used. Obsolete protocols and their obligatory application
Effective medical interventions	Positive statements: quick and timely response of medical staff during birth, reduction of pain by anesthesia. Medical interventions are valued positively Negative: lack of medical interventions, ineffective procedures, or delayed response
Support to breastfeeding	Positive statements: information, giving advice and support to breastfeeding Negative: insufficient presence or lack of above items. Inconsistencies in the explanations or advice

(Continues)

TABLE 1 (Continued)

Categories Subcategories	Description of items and attributes included in each category
Bonding practices	Positive statements: no unnecessary separation, skin-to-skin contact, close and uninterrupted bond with the baby
	Negative: insufficient presence or lack of above items. In particular, as regards cesarean
4. Environmental conditions	
Setting, infrastructures, and resources	Positive statements: The place of birth, delivery and postnatal ward, single rooms, and equipment (balls, birthing pool) are valued positively
	Negative: poor quality, low availability, or absence of above items
Stay in the maternity wards	Positive statements: general atmosphere in the labor and birth ward: silence/music, temperature, illumination. Postnatal ward: accommodation, visiting times, cleanliness, quality of food, and comfort
	Negative: poor quality or lack of above items
NHS coverage and social aspects	Only negative statements: home birth is not covered by the Spanish NHS. Poor social and public acceptance of this option
Organizational aspects	Positive statements: Organization of care provided and working conditions of staff are valued positively
	Negative: The above items are negatively valued
5. General and specific statements	
Overall valuations	Positive statements: Everything was good, very good, or excellent. Positive birth experience. There is nothing to change. Positive references to baby's well-being
	Negative statements: Nothing was good, there was no care, everything was bad, negative references to baby's well-being
Specific or vague responses	All those statements that could be classified in the above categories but were considered too specific or vague, or one-word answers with unclear meaning
Don't know/did not answer	Blank answers (no completion of the three responses)

3 | RESULTS

3.1 | Participants' sociodemographic profile

A total of 2841 participants (99%) answered the questionnaire in Spanish, 0.8% in English, and 0.2% in Bulgarian. 2620 women were born in Spain (91.3%), whereas 8.7% were immigrants who moved to Spain to seek a better life (32.9%), to join their parents (27.6%), to work or study (13.54%), or because of a relationship (8.85%).

Among the participants, 1722 (60.8%) were primiparous, and 21.9% reported pregnancy or birth-related problems. These included preterm birth, risk of spontaneous abortion, and gestational diabetes. The mean age was 34.44 years (SD = 4.24), and mean parity was 1.48 children (SD = 1.66). Most women (90.55%) gave birth in a hospital, and the rest (9.45%) at home or in midwife-led unit (not covered by the Spanish NHS). Assistance was provided by a midwife or a combination of doctor and midwife in most cases (96.19%).

3.2 | Women's experiences of care

A total of 14 411 answers were analyzed. Nearly half (41.1%) concerned the category "Care received and experienced" followed by "Specific interventions and procedures" (26.6%), "Involved members of care team" (14.2%), and "Environmental conditions" (9%). Nearly 6% of responses were overall evaluations such as "everything was good, very good or excellent" or "there is nothing to change," whereas 1.5% of answers stated that "everything was bad" or "there was no care" (Figure 1). Table 2 shows the number of responses included in each subcategory and category, and the percentage of responses assigned to each category and subcategory.

3.3 | Positive childbirth experiences

With respect to the best practices identified, the most common category was "Care received and experienced" (28.4%), followed by "Involved members of care team" (10.1%) and "Specific interventions and procedures" (9.4%), as shown in Figure 1.

In the category "Care received and experienced," most responses referred to "Respectful care, intimacy, and sense of agency" (31%), which included statements concerning the consideration of women's needs and wishes, respect for their right to choose, and women's autonomy and self-determination, and the right to intimacy and dignity during health procedures. The second most frequent subcategory was "Professional behavior and attitude" (26%), which describes

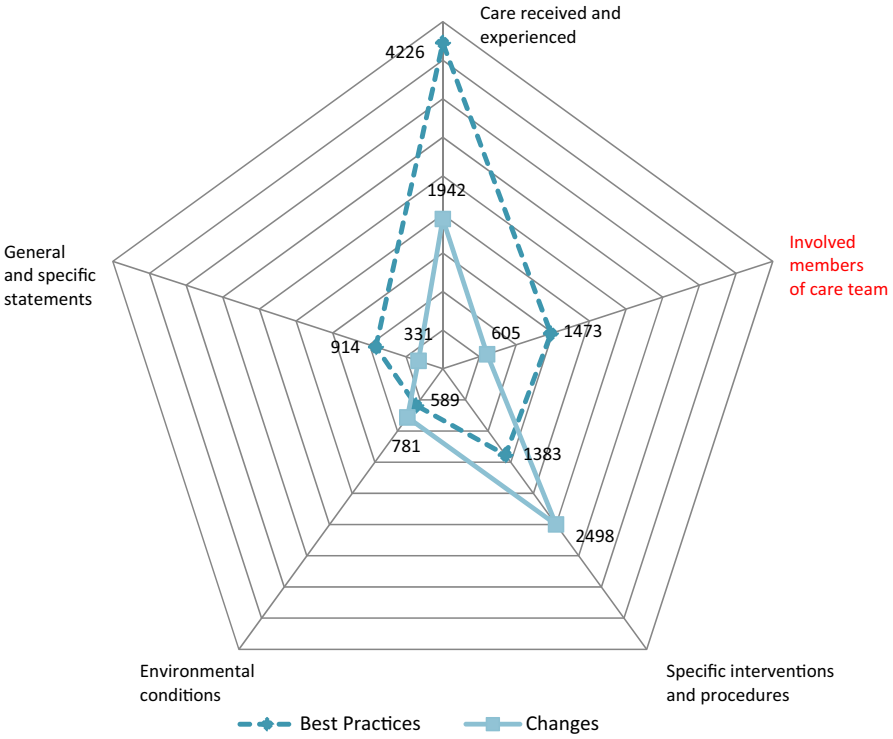

FIGURE 1 Category distribution [Color figure can be viewed at wileyonlinelibrary.com]

parturient-professional interactions in terms of kindness, empathy, care, understanding, and so on (Figure 2).

In the category "Involved members of care team," 46.3% of the women's responses referred to "Professional involvement," indicating that professional engagement at childbirth was positive; 31.6% of the answers belonged to the subcategory "Presence of a partner or close person," and refer to allowing the presence and involvement of these people during labor and birth. The competence and interdisciplinarity of health professionals were addressed by 23.7% of the responses (Figure 3).

Most answers in the category "Specific interventions and procedures" referred to "Normal birth facilitation without interventionism" (44.3%), followed by "Bonding practices" (28.6%). The women's statements about normal birth facilitation evaluated interventions that facilitate normal birth as positive—for example, free movement and choice of birthing position (Figure 4).

Although there were few responses dealing with "Environmental conditions" (<5%), two thirds of these answers belonged in the subcategory "Setting, infrastructure and resources," which encompasses place of birth, infrastructures, and resources available in the maternity wards (Figure 5). Together, these categories describe the factors that women felt contributed to positive or desirable birth experiences.

3.4 | Changes needed in childbirth care

Concerning the more negative aspects of care or the changes identified as needed by respondents, the most common categories were "Specific interventions and procedures" (17.2%) and "Care received and experienced" (12.7%); "Environmental conditions" (5.4%) and "Involved members of care team" (4.2%) were less frequently identified.

In the "Specific interventions and procedures" category, most responses focused on the subcategory "Normal birth facilitation without interventionism" (65.9%), whereas "Bonding practices" (17.5%) and "Support to breastfeeding" (8.5%) received fewer mentions (Figure 4).

With respect to "Normal birth facilitation without interventionism," a comparison of the number of positive and negative responses showed that women identify this issue more frequently in terms of the need for change; 1631 answers indicate a need for change, and 601 answers convey positive experiences. Figure 6 shows a subanalysis of those interventions that participants think need improvement, the most frequent being freedom of movement during labor and woman's choice of birthing position (326), anesthetic procedures and their alternatives (161), use of oxytocin (117) and labor induction (111), fetal monitoring during labor (109), and episiotomy (111). A significant number of women made express reference to fundal pressure as undesirable (77)—an ill-advised procedure according also to several national and international health organizations.

Over one third of the responses in the category "Care received and experienced" were related to "Respectful care, intimacy, and sense of agency," whereas 28.1% and 26.5% concerned "Communication" and "Professional behavior and attitude," respectively.

TABLE 2 Number and percentage of responses for each category and subcategory

Categories and subcategories	Best practices (N)	Best practices (% category)	Best practices (total %)	Changes (N)	Changes (% category)	Changes (total %)
1. Care received and experienced	4092		28.4	1827		12.7
Overall maternity care and childcare	516	13	3.6	140	8.6	1.0
Support and accompaniment	341	8	2.4	80	4.9	0.6
Communication	286	7	2.0	457	28.1	3.2
Feelings of safety and trust	223	5	1.5	15	0.9	0.1
Respectful care, intimacy, and sense of agency	1273	31	8.8	598	36.8	4.1
Professional behavior and attitude	1064	26	7.4	431	26.5	3.0
Time and availability	523	13	3.6	221	13.6	1.5
2. Involved members of care team	1450		10.1	601		4.2
Professional involvement	671	46.3	4.7	288	47.9	2.0
Competence and interdisciplinarity	344	23.7	2.4	52	8.7	0.4
Presence of a partner or close person	458	31.6	3.2	265	44.1	1.8
3. Specific interventions and procedures	1358		9.4	2475		17.2
Normal birth facilitation without interventionism	601	44.3	4.2	1631	65.9	11.3
Effective medical interventions	270	19.5	1.9	217	8.7	1.5
Support to breastfeeding	117	8.5	0.8	213	8.5	1.5
Bonding practices	395	28.6	2.7	437	17.5	3.0
4. Environmental conditions	586		4.1	777		5.4
Setting, infrastructures, and resources	387	66.0	2.7	474	61.0	3.3
Stay in the maternity wards	195	33.3	1.4	179	23.0	1.2
NHS coverage and social aspects	0	0.0	0.0	74	9.5	0.5
Organizational aspects	7	1.2	0.0	54	6.9	0.4
5. General statements	914		6.3	331	43	2.3
Overall valuations	815	89.2	5.7	213	64.4	1.5
Specific or vague responses	99	10.8	0.7	118	35.6	0.8
6. Don't know/did not answer	2803 (16% of all responses)					

Note: N = number of responses included in each subcategory and category; % category = percentage of responses assigned to each subcategory in relation to the total amount of responses included in its category; % best practices/changes = percentage of responses coded in each category/ subcategory in relation to the total amount of responses analyzed excluding DK/DA (14 411).

With respect to the "Environmental conditions" category, two thirds of the answers focused on improvements needed in the birth setting, hospital infrastructures, or available resources (61%), and 23% of the responses were related to changes in the stay (both in the labor and in the postnatal wards) (Figure 5). Answers referring to "NHS coverage and social aspects" were relatively rare at only 0.5% of the total responses. These comments focused on some women's requests that home births be covered by the NHS.

Nearly half the answers in the category "Involved members of care team" referred to the subcategory "Professional involvement" (47.9%) and specifically to negative experiences with the kind of professional involved or his/her professional performance. The subcategory "Presence of a partner or close person" accounted for the 44.1% of responses, with a focus on a lack of involvement because of organizational and structural barriers, restrictive protocols, or personal issues.

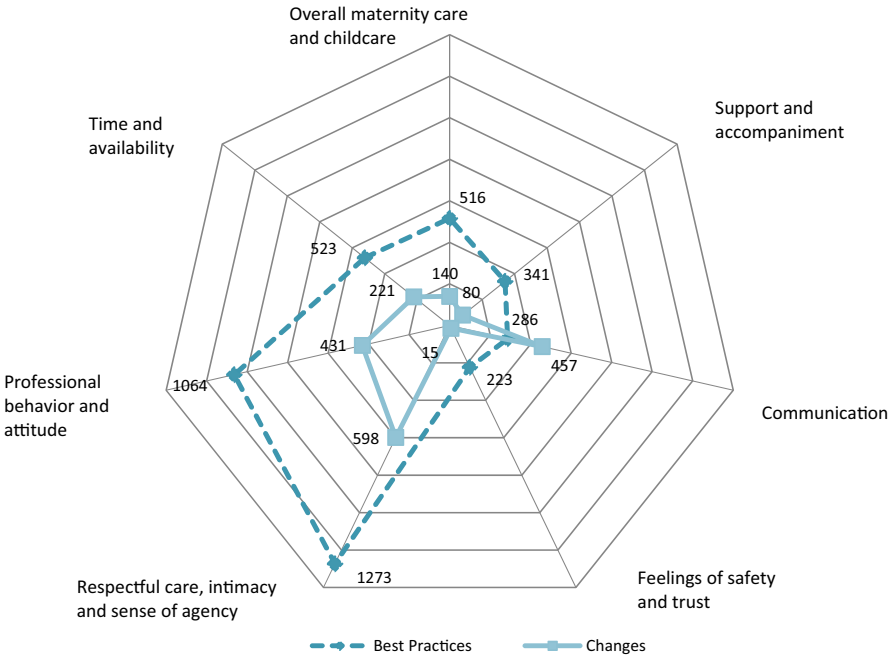

FIGURE 2 Care received and experienced [Color figure can be viewed at wileyonlinelibrary.com]

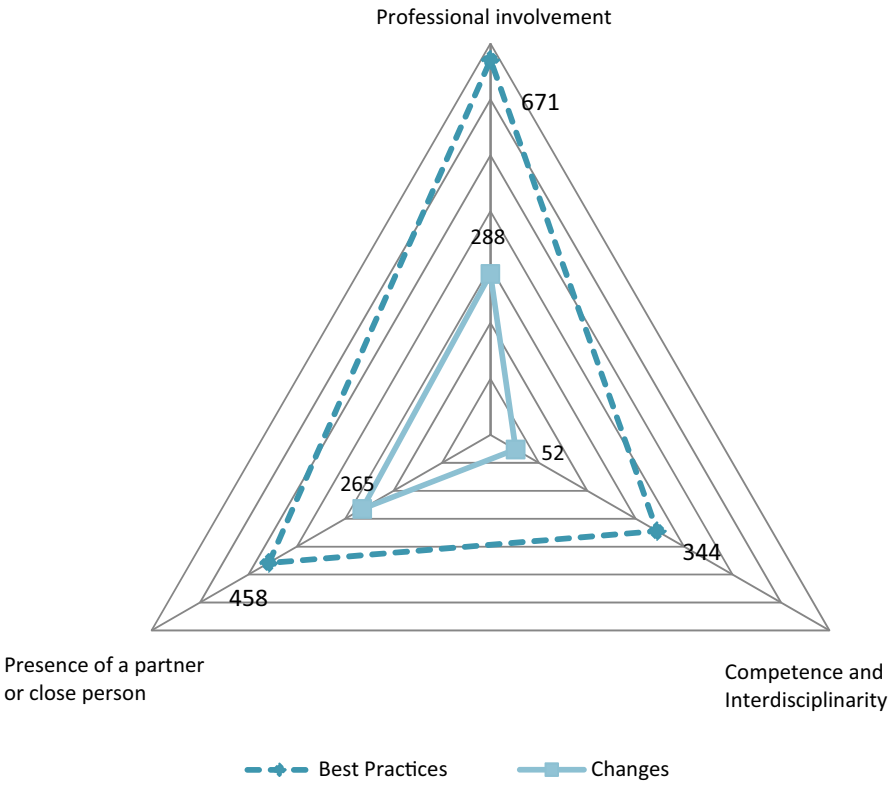

FIGURE 3 Involved members of care team [Color figure can be viewed at wileyonlinelibrary.com]

4 | DISCUSSION

The results of this study led to the development of a thematic agenda based on what women report as best practices and what they consider as in need of improvement. The overall picture obtained from the BBB survey reveals the following: (1) new areas for research and new priorities for reproductive health policies; (2) areas for improvement in childbirth care and maternity services; and (3) the need for support for those groups pushing for improvements in birth care. In this sense, the online BBB questionnaire would be a suitable tool for consultative forms of involvement during the first stages of the PPI cycle when user-related topics are identified and prioritized.

The findings from this study concur with other studies that highlight the need to explore in greater detail what service users consider high-quality care and to involve them in planning and improvement of maternity services to achieve more woman-centered models of care.[13]

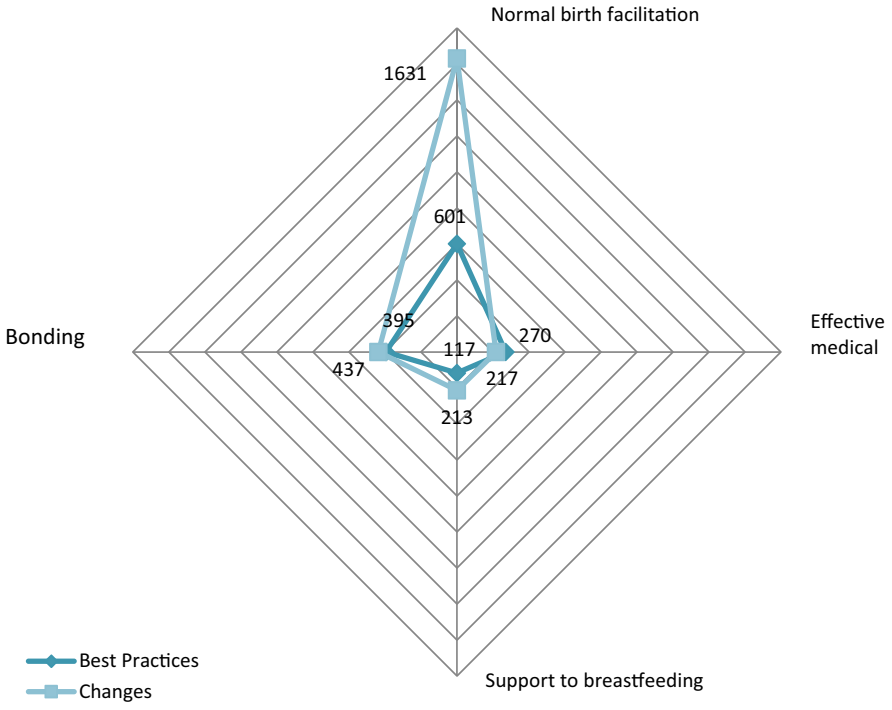

FIGURE 4 Specific interventions and procedures [Color figure can be viewed at wileyonlinelibrary.com]

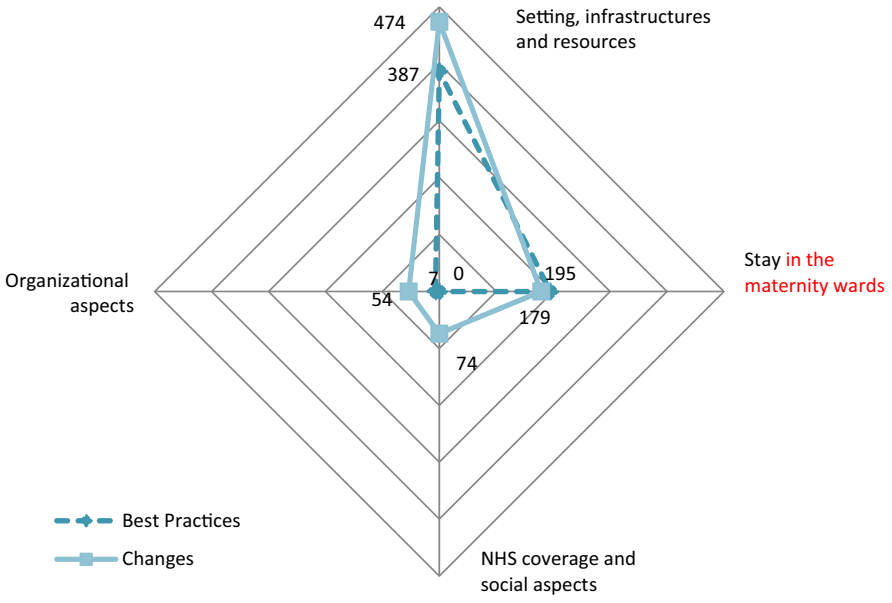

FIGURE 5 Environmental conditions [Color figure can be viewed at wileyonlinelibrary.com]

4.1 | A woman-centered agenda for childbirth care improvement

The subjective experience of care is especially important to women, and this is the area where they most demand improvements. The nature of issues such as respectful care, intimacy, and a sense of agency, and also the health professionals' behavior (including communication), is central to women´s satisfaction or displeasure. This finding aligns with some previous studies that show that women desire health professionals with a more humanistic vision of childbirth care,[12] and those who can bring soft skills into play.[37] Several studies also claim that the subjective aspects of care (trusting, supportive relationships, communication, and care continuity) play a decisive role in positive experiences, carrying greater weight in positive assessments than do specific procedures.[3,4,12,38–41] In terms of service improvement and further research, it is clear that continuity care and woman-centered care are strongly desired in maternity services.[2]

The second most relevant topic for the participants in this study concerned specific interventions during childbirth. Nearly one fifth of all responses advocated for changes in normal birth facilitation. The women criticized, rejected, or questioned several medical practices. These included the following: not allowing free movement or choice of

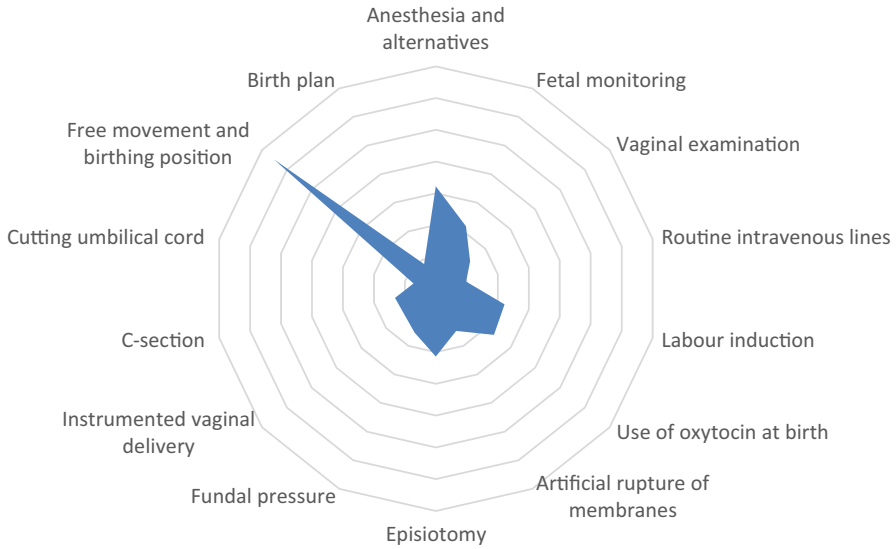

FIGURE 6 Subanalysis of negative experiences of care (changes needed) [Color figure can be viewed at wileyonlinelibrary.com]

birthing position, lack of anesthetic alternatives, lack of attendance by companions, use of oxytocin, continuous fetal monitoring, and episiotomy. Although it is neither possible to assess whether all these practices were necessary nor whether the women were well informed about the reasons why interventions were proposed, the large number of negative responses suggests these are major area of conflict and misunderstanding between health professionals and women. These issues should be examined in greater detail in further research.

Several women reported the use of fundal pressure even though it is not recommended (or even forbidden) by national and international organizations. As Rubashkin et al[42] reported, this technique is still used in Spanish maternity wards, and women have a limited say in the matter. In terms of service improvement, health practitioners should be encouraged to abandon such non-evidence-based obstetric interventions as they entail potential harm to mothers and babies. Practices performed during birth must be evidence-based and follow international recommendations.

Bonding practices were evaluated both positively and negatively, but several answers pointed to their poor quality or complete absence after a cesarean birth. Relatedly, women described as negative or undesirable practices which prevented supportive companions (family, friends, doulas etc) from being present during cesarean births. Several studies have shown that women positively value support from relatives during perinatal care,[43,44] and existing studies document safety and higher levels of satisfaction provided by "gentle" or "family-centered" cesarean births.[45,46]

Support for breastfeeding is still a pending issue. The results show that for a positive experience, women need more information and support. As other authors have suggested, the first hours after birth are crucial to breastfeeding, and skin-to-skin contact has positive effects on breastfeeding, bonding, and maternal satisfaction.[47] Thus, strategies to better facilitate breastfeeding should be encouraged.

As reported in other studies, environmental conditions are also important. We found that women value the birth setting, infrastructures, and available resources in maternity wards and censure their poor quality or total absence. Maternity care satisfaction is often higher in countries where adequate services and infrastructures are provided.[26] Furthermore, the characteristics of the care practitioner, in terms of capacity and commitment to establish a supportive environment, are central to a positive experience during childbirth.[40]

A small number of respondents referred to noncoverage of home births by the Spanish NHS and the lack of social recognition given this type of birth. Previous research done in Spain showed that one of the main reasons for choosing a home birth was a previous negative birth experience, especially when excessive, unnecessary interventions were involved.[41] Birth options available through the NHS in Spain need to be evaluated for congruence with women's expectations around choice and coverage of birth setting.

4.2 | Limitations and strengths

One limitation of our questionnaire was that it focused only on childbirth care and not on care during pregnancy or the postnatal period. Consequently, we have only described a fraction of the whole process, in which any stage may influence satisfaction with the others.

The convenience sampling method and representativeness are limitations that demand attention depending on the research goals. We anticipated that women with extreme or strong opinions—as a result of positive or negative/traumatic experiences—would be more likely to participate and complete the questionnaire. In addition, we identified a high percentage of participation among women who gave birth at

home or in midwife-led unit, overrepresenting the numbers in Spain (9.45% of respondents but roughly 1% of all births in Spain). This may be due, in part, to the dissemination strategy through women's associations. Conversely, the sample is fairly representative of types of birth and obstetric interventions, as confirmed by the national statistics on pregnant women in Spain, with the exception of ethnicity. However, these limitations must be put into the context of the research goals and methodology. We carried out a qualitative content analysis to identify and prioritize women-identified and relevant topics with the aim of mapping what matters to women, how they talk about it, what they value, and what they consider to be in need of change. In this sense, we sought a diversity of points of view to make the thematic agenda as large and broad as possible. Consequently, women who had home births were included in the analysis in order to map noninstitutionalized practices and to increase understanding about the kinds of care experiences that are valued in this setting. As such, it should be noted that our aim is not to generalize the results to the overall population of Spain, but rather to construct a thematic agenda for childbirth care improvement and to inform further research through hypothesis generation and the identification of woman-centered priorities.

Evidence suggests that women are less critical about the care received when asked about it by the health practitioners directly involved in their maternity care. Hence, using an online questionnaire that encourages women to answer freely and honestly was this study's main strength. Since the questionnaire was distributed by researchers who do not provide care to women, gratitude bias was minimized.[5,13] As several studies suggest, the assessment of satisfaction with the childbirth experience should be carried out some time after birth. Accordingly, women who had given birth in the previous 5 years were included in the sample. Although this approach entails some degree of recall bias, we think this length of time gives women enough time to reflect on their experiences and to evaluate them.

Women´s views about maternity care in different countries have been reported and published internationally. Despite the difficulty in comparing maternal satisfaction across different models of maternity care, the BBB questionnaire serves to explore some of the best and worst practices across Europe and beyond as identified by service users themselves.

4.3 | Conclusions

The BBB questionnaire is a useful tool for mapping both desirable and undesirable practices as reported by women and could be used for future research to help identify the areas within maternity care delivery systems most in need of improvement. The practices the participants valued most concerned their care experience in terms of respect, intimacy, sense of agency, and professional attitude. The women affirmed a need for change in normal birth facilitation and reported negative experiences related to a wide range of routine or avoidable clinical interventions and limitations on their decision-making. Normal birth facilitation that avoids unnecessary interventions and that centers the subjective experience of care is urgently needed in Spain if babies are truly to be born better.

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CONFLICT OF INTEREST

None declared.

ETHICAL APPROVAL

None.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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