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The social conception of space of birth according to women with positive birth experiences: A trans-European study

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ABSTRACT

Background: The social space of birth—the birth environment, its occupants, and the human activities taking place—is interconnected with birth experiences.
Aim: To investigate how the reality of the social space of birth affects women's positive birth experiences.
Methods: We combined open-text responses to the Babies Born Better survey from 3633 postpartum women in Austria, Belgium, the Czech Republic, Germany, Spain, the Netherlands, and the United Kingdom and 39 interview transcripts from Czech and Dutch postpartum women. We conducted a textual and thematic analysis.
Findings: Three themes and 11 categories were generated: (1) *Exercising fundamental human agency in the birth space* consists of the categories: 'exercising rights', 'the protection of human vulnerability', and 'the freedom to be authentic', which women regard as prerequisite components of the birth space. (2) *Regulatory frameworks & care philosophies in maternity services*, including the categories '(financial) regulations', 'values of the care provider and the institution', and 'model of care', are regarded as attributes of the birth space. Theme (3) *Building a nest for comfort and connection* comprises the categories 'relational and affective atmosphere during labour & birth', 'performative atmosphere during labour & birth', 'shelter', 'implicit and explicit tacit doing & being' and 'symbol of deeper meaning'.
Discussion/Conclusion: The reality of the birth space of women with positive birth experiences consists of human rights and birth rights, the quality of interactions with care providers during labour and birth in a relationship-centred and relation-continuity model of care, and a place to retreat from the world.

STATEMENT OF SIGNIFICANCE

Problem/issue

While women benefit from the experience of birth as a positive event, (spatial) conditions that foster and promote positive birth experiences have received less attention compared to negative experiences. No study has focused on the mechanisms underpinning women's conception of the birth space and a positive birth experience.

What is already known

The birth environment can influence women's birth experiences. If the woman perceives the birth environment, its occupants, and atmosphere as safe or supportive, the release of oxytocin may be positively affected.

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What this paper adds

The study provides a comprehensive and focused analysis of narratives from women in different European countries. It identifies commonalities and mechanisms that underpin a positive birth experience that emphasises the interconnectedness with the social space of birth.

1. Introduction

Evidence suggests that between one and two-thirds of women experience childbirth positively [1–4]. A European study differentiating between (very) good, average and (very) bad birth experiences showed that 86 % of the women reported their birth experience as an average to a very good experience [5]. A positive birth constitutes feeling supported, in control, safe, respected and cared for and promotes a woman's sense of achievement, joy, self-worth, happiness, strength and self-confidence [2,6–8]. Despite women's positive birth experiences occurring more often, they have received less research attention compared to negative experiences [9]. It has been argued that the underrepresentation of positive birth experiences may foster negative portrayals of childbirth and affect what pregnant women expect from birth or how they approach birth [6,10].

The place of birth is directly connected to women's birth experiences and transformation through childbirth [7,11–13]. A safe, trusting, and supportive birthing environment is more likely to offer women what has been identified as requirements for a positive birth experience [7, 14–18]. The birth environment consists of physical space, the individuals in the space and the interactions between them and the space as an institutional context [19]. Birth-related neuro-hormonal mechanisms make childbearing women more sensitive to their environment during labour and birth, which is likely to be explained by oxytocin, an essential hormone for labour and birth. Oxytocin release is boosted by a safe, secure, and confidence-inducing birth environment [20,21]. The *theory of social space* explains how the use, sense, perception, and experience of the birth environment influence women's experiences.

1.1. Social space

Social space refers to human activity and interaction within a defined place [22,23]. Individuals' perceptions of the social space result from being in a space, sensing the space, and using the space and materials in the space [22–24]. The use, purpose of the space, sense and perceived ownership of space can create value and emotional connections between people and events [23]. The conception of space is, therefore, highly personal and is constructed by thoughts, feelings and responses resulting from interactions with and within that space [23]. In this study, the *social space* refers to the birthing environment, where there is a network or relationships among the individuals, e.g. between the woman and her care provider or birthing partner. It refers to the positioning of those individuals in the birthing environment, their behaviour, activities and interaction with the space and others [25]. In this study, the *social conception of space* refers to the personal value, sense, perception and meaning the birthing woman assigns to the space, the atmosphere and the relational dynamics between those present in the space [23].

Congruent with the overall lack of research on positive birth experiences and birth stories [7,10], the underlying psychological, social, and cognitive mechanisms that interconnect women's conception of the birth space and a positive birth experience have not been explored. Gaining a deeper understanding of how the reality of social space of birth shapes women's positive birth experiences can reveal underlying generative mechanisms of social structures. We suggest this could create opportunities for the enhancement, rekindling, or emergence of new thought processes contributing to a positive birth movement [26]. Most importantly, understanding what makes a positive birth experience implies being able to prevent negative or traumatic birth experiences and the implications of this for women and their families, such as postpartum mental health issues, including post-traumatic stress disorder, fear of childbirth in a subsequent pregnancy or impaired mother-infant bonding affecting child development [27]. This study aims to investigate how women's realities of the social space of birth affect their positive birth experiences - accepting that women's experiences and meanings form this reality.

2. Methods

2.1. Design

This study, undertaken by researchers and clinicians from seven European countries (Austria, Belgium, Czech Republic, Germany, The Netherlands, Spain and the United Kingdom) triangulated available data sets in the researchers' native languages: (1) Free-text responses from the multi-language trans-European Babies Born Better (B3) online survey about women's views of maternity care and childbirth, (2) two sets of interview transcripts originating from the Czech Republic and the Netherlands about women's birth experiences.

2.2. Sorting the data and content selection

We assessed B3 survey data collected between 2014 and 2020 (excluding reports of babies born after March 2020/the COVID-19 pandemic lockdown) from 17,276 B3 survey respondents from the seven countries. One of the questions asked participants to rate their birth experience on a scale of 1 (mostly very good) to 5 (mostly very bad). We selected survey respondents who had scored either a 1 (mostly very good) or 2 (mostly good) and extracted their free-text responses to one open-ended question (see Box 1), including 8329 women with mostly good or very good birth experiences. We looked for words/ phrases/ sentences in the free-text responses referring to the social space of birth, known as content selection [28]. We removed surveys which did not refer to the social space of birth or lacked responses to the open-ended question and extracted the demographic and birth details of the remaining 3633 B3 participants who provided free-text responses for the analysis (Fig. 1). We read 64 Dutch and Czech interview transcripts, applying similar content selection [28]. The Czech interviews were conducted between 2012 and 2015, and the Dutch interviews in 2019. The Dutch participants were purposively selected for the original study (2019) due to self-identifying as having experienced a positive birth. The Czech participants (2012–2015) were not purposively selected for having a positive experience but for wanting a non-medicalised birth. Both Czech and Dutch interviews started with the question: "Please tell me about your birth". The interviewers typically continued with clarifying questions and invitations to continue the story. Thirty-nine transcripts (Netherlands n = 35, Czech Republic n = 4) were selected for analysis (Fig. 1).

2.3. Analysis

To capture the reality of the social space of birth, our analysis was guided by discourses reflecting the reality of childbearing women within the constructed actions and interactions of the social context of the birth environment. The analysis was conducted through an interpretive lens informed by researchers with expertise in midwifery, psychology, sociology, and bioethics. Consistent with the theoretical framework of critical realism, the analysis proposed a specific view of the social space of birth [29], facilitating the construction of knowledge by integrating multiple layers of reality and diverse perspectives on the social space of birth, extending beyond intra-disciplinary and inter-disciplinary fields [30]. We applied textual analysis followed by thematic analysis.

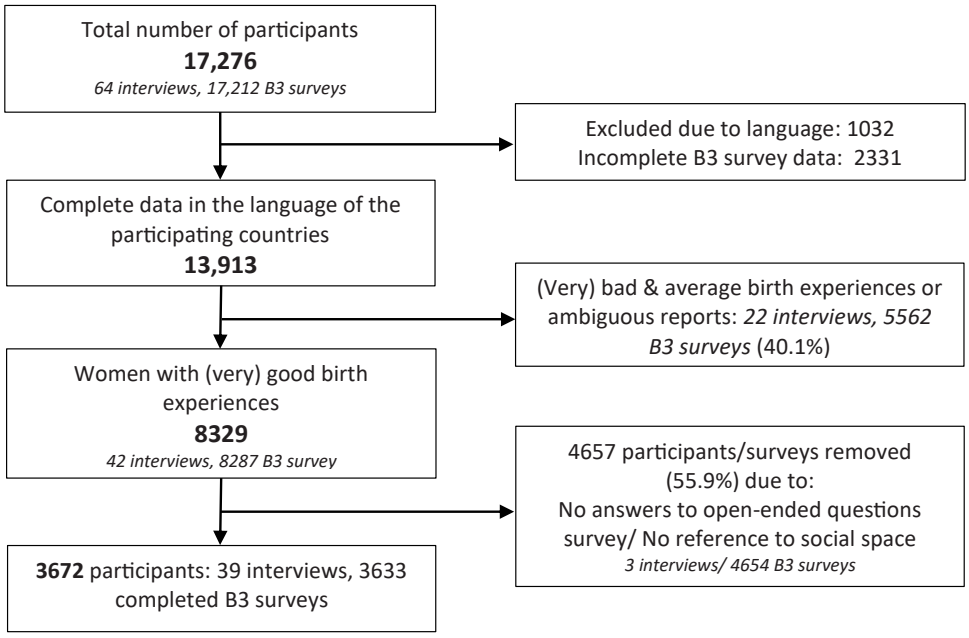

Fig. 1. Flowchart participants/ data.

Box 1
Open-ended questions B3 survey

Please write any comments you want to make here. These could explain your answers in more detail or add any other information you would like us to know about your experiences with maternity care…

2.3.1. *Textual analysis*

Textual analysis gathers information on how human beings make sense of the world by structuring the text, staying within the significance of the text, the context of each country and the original language [31]. We constructed an Excel file for each country that included the B3 survey free-text responses. Descriptive statistics summarised the characteristics of the B3 respondents. The Czech and Dutch transcripts were reread, and any text fragments referring to the social space of birth were selected and exported to Excel files. We utilised a further process of content selection and text reduction. Per country, two researchers read all the text fragments and annotated the relevant text, an intuitive process shaped by the researchers' knowledge and experience [29,32]. As a next step, we condensed and rephrased the words or phrases (paraphrasing) into summary sentences that captured the core and salient content of the original text fragment [32]. During each step, the original text fragment was checked to ensure that paraphrases and summary sentences represented the original text [32].

2.3.2. *Thematic analysis*

A thematic analysis was undertaken to explore the points of view of childbearing women of the social birth context, utilising the researchers' knowledge and experience [29,33]. This was an iterative process of repeated rereading of the text fragments, paraphrases and summary sentences. Per country, two researchers applied a process of coding and clustering the codes into categories and themes [33]. The codes represent similar experiences or events [33]. The categories represent the researchers' abstract notions of what exists in the reality of the social space of birth [29,33]. The themes embody patterned constructions of a coherent narrative, serving as a causal explanation of the research question [34]. Each Excel file was organised similarly, with columns containing the original text fragments, paraphrases, summary sentences, codes, categories and themes. Frequent online meetings were held to discuss the findings. As a final step, all Excel files were discussed among all authors to reach a consensus on the categories and themes [29].

3. Results

3.1. *Participants*

The online B3 surveys targeted women who had given birth within the previous 12 months, with the survey questions referring to the most recent birth. Interviews were conducted from six weeks to three years postpartum. The women participating in the B3 survey gave birth between January 2012 and March 2020. The characteristics of the B3 respondents at the time of completion are shown in Table 1. The Dutch women in the 35 interviews were predominantly primiparous (27 hospital births, four home births, and four births in a birth centre). Of the four multiparous Czech women, two gave birth in hospitals only, one exclusively at home, and one woman had experienced both.

Table 1
Characteristics B3 respondents N = 3633.

	Mean (SD±), range	% / N
Age in years	32.16 (± 4.65), 16–49	
Gestational age at birth in weeks	39.7 (± 1.6), 29–44	
Number of children	1.91 (± 1.07), 1–11	
Primipara		1464 / 40.3 %
Multipara		2169 / 59.7 %
Hospital birth		54.6 % / 1983
Birth at birth centre		17.2 % / 625
Home birth		28.2 % / 1025

3.2. Themes

Three main themes and eleven categories were generated (Table 2). We provide a summary narrative of all the categories conveyed within each theme, with exemplar quotes, representing women from all countries.

3.3. Theme 1. Exercising fundamental human agency in the birth space

Women view rights, the security of their vulnerability to being protected, and the capacity to be and act as themselves, as the foundatio for human agency in the birth space – as prerequisites or essential elements necessary for scaffolding the birth space. Women emphasise their right to express their wishes and preferences, make choices, refuse procedures, receive information, select care and care providers and be respected.

3.3.1. Exercising rights

Women emphasised exercising their rights to choose their care provider and place of birth: *"I exerted my right to give birth with my midwife and doula at my hospital of choice" (Germany)*. Although women in Belgium have the legal right to be cared for during birth by their primary care midwife in the hospital, some hospitals refuse entrance to the midwife (hospital policy). Nevertheless, Belgian women pursue their rights to be respected: *"After a heated discussion with the obstetrician, articulating my rights of being free to have my midwife with me during birth, this was respected" (Belgium)*. A woman from the UK acknowledges the fundamental importance of knowing your birth rights before labour: *"I knew my birth rights and knew that my requests needed to be acknowledged and respected."* Women from all countries referred to consenting to interventions, such as a vaginal examination, medication, or episiotomy, as fundamental in acknowledging and respecting the individual: *"The midwife made it explicit to me that I had the right to agree or disagree and they wouldn't do things without my consent" (UK)*.

3.3.2. The protection of human vulnerability

Women refer to the protection of their vulnerability as being secure and protected from harm that could be (potentially) caused by another human being's behaviour and/or acts in the birth space. Often, a homebirth or labouring at home is mentioned as a protective measure against, for example, obstetric violence, medical intervention, perceived pressure, strangers, and medical mode of birth: *"At home, there is no pressure, no unnecessary medication or interventions, no unwanted strangers" (Austria)*. A woman from Spain decided to have an unassisted birth to avoid harm in the form of obstetric violence: *"I birthed on my own… protecting myself from the hospital, the obstetric violence and a caesarean section."* Conversely, the hospital is regarded as a measure of preventing harm. Women spoke of how being in a hospital meant the doctor and midwives were immediately at hand. A woman from the Netherlands stated: *"I wanted to be in the hospital with everyone and everything at hand, just in case something would go wrong with me or the baby."* Women sense security when the midwife acts as the woman's advocate, guiding other care providers in their behaviour. A woman from the Czech Republic described the midwife sending away medical staff who tried to interfere: *"The midwife asked the obstetrician to leave the room, safeguarding my peace" (Czech Republic)*.

Table 2
Themes and categories.

THEMES	CATEGORIES
Exercising fundamental human agency in the birth space	Exercising rights
	The protection of human vulnerability
	The freedom to be authentic
Regulatory frameworks & care philosophies in maternity services	(Financial) regulations
	Values of the care provider and the institution
	Model of care
Building a nest for comfort and connection	Relational & affective atmosphere during labour & birth
	Performative atmosphere during labour & birth
	Shelter
	Implicit and explicit tacit doing & being
	Symbol of deeper meaning

3.3.3. The freedom to be authentic

Women refer to their ability to experience freedom in the birth space – this relates to being themselves, doing what one is intuitively comfortable with, as an unconditional experience during which nobody criticises or comments or grants permission. Women from all countries described this as 'doing my own thing' in various ways: *"I freely expressed my fears and worries, not holding back, I could let myself go" (Austria)*. *"I screamed, shouted, hummed, breathed, sang…I did whatever I felt comfortable with, not giving a toss what someone else was thinking" (Belgium)*. *"I birthed entirely on my terms" (UK)*.

3.4. Theme 2. Regulatory frameworks & care philosophies in maternity services

Women described the regulatory frameworks and the care philosophies of the care providers and the institutions in the maternity system as shaping their conception of the birth space. They emphasise how (financial) regulations such as health insurance, fees, and the availability of resources and services like an independent midwife or doula, along with the values, beliefs and philosophy of care of the care providers and institutions and care models shape the conception of the birth space.

3.4.1. (Financial) regulations

For women in certain countries, the costs for an independent midwife or place of birth are covered by health insurance: *The midwife and maternity care assistant were covered by my health insurance." (Netherlands)*. However, women from all countries also referred to paying for services they want, need or envisage, thereby enhancing inequalities in care: *"I had to pay for the midwife myself. These were enormous costs, not affordable for everyone" (Austria)*. *"Sadly, the option of paying for an independent midwife is not an option for everybody" (UK)*. A woman in the Netherlands describes that despite the independent midwife being available through the healthcare system, she paid the surcharge for caseload midwifery because this was not the standard form of care: *"Luckily, I was able to pay the extra money for a caseload midwife, buying time and attention I would not have received from the standard midwife" (Netherlands)*.

3.4.2. Values of the care provider and the institution

Women perceived that care providers' and institutional approaches, beliefs, attitudes, and views of childbirth shape the values of the maternity care system. Care providers behave, interact, and treat women during labour and birth according to their values. A Belgian woman described her experience in a birth centre: *"The midwives in the birth centre have a strong and widely supported focus on the physiology of birth; they support natural birth."* Women are aware that different paradigms of birth exist, medical and physiological: *"The doctor tends to focus more on what might go wrong, seeing problems…the midwives see birth as the most natural thing in the world and act upon it" (Germany)*.

Women were also aware that their own philosophy and beliefs regarding birth needed to align with the care provider's or institution's belief system: *"They (hospital) had a natural birth approach, coinciding with my thoughts" (Austria)*. *"I am convinced that labour is no illness but normal and healthy, so did my midwife" (Netherlands)*.

3.4.3. Model of care

Women from all seven countries emphasised the importance of continuity of a care provider; care from the same person during pregnancy and birth: *"I had the same midwife during my pregnancy and birth" (Belgium)*. *"The obstetrician assured me during pregnancy he would attend the birth of my second son, and he did" (Spain)*. Women referred to continuous one-to-one care - the same person during labour and birth: *"I was exclusively and continuously supported by one midwife who continuously accompanied me 1:1 for 18 hours, no shift changes" (Germany)*. *"The same midwife was there for us, all the time" (Austria)*. *My midwife stayed with me despite the transfer of care, till the baby was born" (Netherlands)*.

3.5. Theme 3. Building a nest for comfort and connection

Women, regardless of country, described how they occupied, created and prepared a space - *nest* – into a zone of comfort, belonging, nourishment, refuge and physical and emotional stability to labour and give birth – a place to retreat from the world.

3.5.1. Relational & affective atmosphere during labour & birth

Women referred to the relational and affective atmosphere during labour and birth, influencing human conduct or how the birth space is inhabited by themselves and others. Women described knowing or being familiar with the persons present in the *nest*, the care provider or significant others, and the connection with others as a sense of togetherness and belonging. Women from all countries recalled how they valued the presence of a known and familiar midwife. Referring to the midwife as *their* midwife emphasises the connection between the woman and the midwife: *"My trusted and own midwife was there" (Austria)*. *"The familiar face of my midwife" (Netherlands)*. Women referred to having a relationship with the midwife, sensing trust and togetherness: *"We had a relationship, my midwife and I, she is now part of my family journey" (UK)*. Women mentioned the importance of relatives, such as the partner or children being present, enhancing the sense of belonging and togetherness: *"I gave birth while sensing my other children near" (Spain)*. *"Big sister and granny saw the baby immediately after the birth." (Belgium)*. A Dutch and Belgian woman described how they felt connected with the environment as well as the people in it, showing the connection and unity with spatial and relational elements: *"We formed a unity in my home with the midwife right in front of me while I was sitting on the birthing chair in my own living room with my partner right behind me. I felt connected" (Netherlands)*. *"I was in a trusted environment with people who know and love me…my own nest" (Belgium)*.

3.5.2. Performative atmosphere during labour & birth

Women from all countries used an array of words to describe the performative atmosphere during labour and birth – this relates to the human qualities, attributes and characteristics of the healthcare providers who were present in the *nest* –all words having a positive connotation: *caring, kind, friendly, calm, relaxed, listening, attentive, supportive, emphatic, positive, thoughtful, considering, warm, encouraging, loving, serious, funny, careful, trusting, responsive, understanding, gentle, interested, honest, patient, reassuring, compassionate, confident, open, serene, maternal, helpful, holistic*. Women from all countries use words that infer superlative meaning that benchmark the care providers, including midwives, doctors, nurses, doulas or maternity care assistants: *exceptional, perfect, fantastic, beautiful, amazing, magical, going above and beyond, an angel, a golden star, second to none*.

3.5.3. Shelter

Women described feeling sheltered because of competent care providers, equipment or technology being present in the *nest*. The competencies of the care provider meant that women felt secure and confident to give birth. A woman in the Netherlands reported: *"I felt safe and could focus on my contractions because of the midwife's ability to assess risks and to act in emergencies."* Women from other countries also emphasised the care provider's professionalism, knowledge, skills and education: *"The doctors and midwives are skilled and competent; I was in good hands" (Belgium)*. A UK woman with a postpartum haemorrhage stated: *"The midwives were knowledgeable, competent and skilled." (UK)*. Women also referred to how the technical equipment provided a safe place for birth. A woman in the Czech Republic described visiting several maternity units before the equipment in one maternity hospital guided her decision to give birth there: *"I wanted a maternity hospital where I would feel secure. I trusted the hospital because of the technical equipment and devices" (Czech Republic)*.

3.5.4. Implicit & explicit tacit doing & being

Women's comprehensive understanding of other humans' doing and being illuminates the implicit, subtle qualities of the *nest*. The people who are part of the *nest* convey and reveal active and valuable messages of ultimate caring and welldoing that allow women to be their authentic selves, connecting them with the normalcy of childbirth. Women referred to implicit sensitive and intuitive behaviour, activities, patterns, comfort-promoting activities and personal touches, such as, for example, people in the background, hands-off and keeping a respectful distance, privacy, sense of intimacy or closeness, tactility, cleanliness, use of rituals, the birth environment feeling homey, and the birth space's aesthetics and facilities. Women from all countries described how care providers, usually midwives, are watchful but 'leave them (woman and birth partner) be': *"My partner and I were in a private room in the hospital, just the two of us… the midwife was there when we needed her" (Spain)*. *"I birthed my child into my own hands, with the midwife being a shadow." (Germany)*. *"In the quietness of the night, I walked around doing my own thing, breathing through my contractions… with my partner upstairs and the midwife quietly in the background" (Belgium)*. *"The midwife in the birth centre just watched calmly…she sat in the corner of my room just being present…" (UK)*. *"While I was in the bath, the midwife was quietly sitting on the stairs drinking a cup of tea" (Netherlands)*. Other women described a different status of being and doing. On these occasions, there was a more explicit presence of the care provider and birth partner that helped to enhance the normality of the event of birth and aligned with their usual doing and being: *"We were laughing and joking as much as we could throughout, that's who I am" (UK)*. *"We played board games between contractions and watched TV." (Netherlands)*.

Women described their *nest* using words such as *sanctuary, retreat, heaven, and hotel* appointing physical and sensory elements of the *nest*: dimmed lighting, candles, music, view from the window, paintings, rugs, wall/floor colours, modernity, neat and tidiness, non-sterile, room space, bean bags, sofa, birthing pool, steam shower, projector screen, essential oils, birthing stool, rope, cushions, games, food and drinks. A woman from the Czech Republic gives a detailed description of her *nest*: *"There was coloured carpet … in the corner, there was a bathtub, in the other corner there was a mat, there was a rope hanging from the ceiling, there was a handrail… There was a ball, a birthing stool…. There were dishes and a radio. I felt like I was in a hotel room. The walls were yellow, and the floor was blue, so pleasant, you wouldn't even think it was a hospital room."*

3.5.5. Symbol of deeper meaning

Women referred to the *nest* as a symbol of deeper meaning and not a place of function, creating an emotional connection between themself and the event of birth and the transformative experience of birth. The *nest* becomes a metaphor that represents a valuable space, embodying the manifestation of actualisation, creation and transition, a place with a new dimension transforming the function of the space, regardless of whether the place of birth is a hospital, home or birth centre: *"My home is no longer bricks and stones, four walls and a roof; home is now indeed a sweet home, where memories are shared, a place I now truly belong" (Netherlands)*. *"The room where my daughter was born is now a meaningful place…a place where the future has taken shape, a place of giving life…" (Belgium)*.

4. Discussion

To our knowledge, this study presents the first trans-European investigation of the social conception of space of birth among women who experienced childbirth as a positive event. According to the women in our study, the reality of the social conception of space intertwines with the macro-meso-micro structures of ecological systems theory, affecting their positive birth experiences [5,35]. Macro-level: Exercising fundamental human agency in the birth space. Meso-level: Regulatory frameworks and care philosophies in the maternity system;micro-level: Building a nest for comfort and connection. Our findings highlight how social conditions and practices inform the social space of birth and shape women's positive birth experiences. They suggest that human dignity and humane norms and tendencies focusing on and enabling human individuality and humane action and interaction in the social space of birth are associated with women's positive birth experiences [36].

Themes one and two assert the social and political ownership and meaning of the positive birth experience; theme three shows the individual and personal meaning, where women in our study describe labour and birth occurring behind closed doors, and as a private affair [36]. Themes one and two, when regarded within the social space of birth entwined with positive experiences, challenge traditional and conformity values within maternity care because women describe not wanting to subordinate themselves to institutions or care providers [37].

Theme one highlights that the woman's autonomy and self-efficacy in the social space of birth are facilitated by exercising her human rights and birth rights, the freedom to be authentic, and the protection of their vulnerability during birth being through explicit consent [38]. While a lack of consent is a key feature of a negative birth experience [5], in the current study, participants emphasised that they considered informed consent for interventions or care activities as a basic right. Participants' accounts suggest that social norms and tendencies that enable individuality,humane action and interaction are central to their experience and, thus, essential mechanisms in the social space of birth [39,40]. Self-advocacy has been found crucial for birthing women to assert control and autonomy over their childbirth experience [41]. Our findings underscore the need for women and healthcare providers to be aware of human rights and birth rights, as this contributes to women's self-advocacy and self-agency during labour and birth [42].

Theme two emphasises the value women put on the relationship between the woman and the people being present at birth. The women in our study emphasised how they perceive it as empowering to know and be known by their care providers, usually the midwife. Woman-midwife interactions during birth are pivotal for making women feel strong, supported, and affirmed in their experience [43]. These findings echo the themes from the social space of birth reported by women with negative birth experiences, which identified a dimension of social space is inextricably related to the woman-healthcare provider interactions and relationships, which included notions of power, authority and control [5]. In contrast to the affirmative notions of connected, person-centred relationships found in positive birth accounts, women with negative birth experiences report feeling disempowered and isolated [5]. Our findings align with the continuity of midwife care model as the preferred model of maternity care to meet women's needs of empowerment during birth [44]. A large proportion of our sample had a home birth. Although our study methodology was not designed to establish causality between homebirths and positive birth experiences, the women who gave birth at home echo the value of giving birth in a familiar place surrounded by people of their choice, where decisions are respected, the avoidance of routine or unwanted interventions, to feel empowered, human, safe, self-confident and be autonomous, active and conscious in executing the right to choose where to give birth, and questioning medical hegemony [45]. Wider advocacy for home birth could thus contribute to women's positive birth experiences. Additionally, despite the evidence of the cost-effectiveness of continuity of midwifery care for public funders, these services were not available to all women in all countries, and some women in our study had to pay for these services. In these situations, a positive birth experience becomes elitist, with the design of health policies undermining the equitable distribution of health resources and allowing care to be reserved for those with sufficient financial resources [45–47].

Theme three illustrates how much the social space of birth in which the positive birth experience germinates is considered private and personal – with emphasis on 'retreating from the world' which explains why it is not openly discussed [9]. Similarly, analyses of how social space affects negative or traumatic birth experiences identified a personal dimension; however, this was characterised by childbearing women feeling disconnected and disembodied [5]. The private nature of a positive experience also contrasts with the public discourse around a traumatic birth – with negative experiences appearing to evoke broader political and social interest. Women may prefer to keep a positive experience to themselves to prevent marginalising those who do not have a similar experience or to prevent it from being sullied by others [10]. Opportunities to share these positive birth experiences with other women whilst remaining anonymous could help promote an understanding of the importance of the social space of birth [37] and thus foster a birth discourse that highlights the potential of childbirth to be a transformative experience in a woman's life [7] - to help others to achieve the same.

4.1. Strengths & limitations

We included a large sample of women from seven European countries in this study, providing a rich repository of diverse experiences and meanings and thus the reality of the social space of birth. Per country, the authors worked in pairs and cross-checked codes, categories and themes to validate interpretations and patterns in the data [29]. The different backgrounds of the researchers contributed to a more inclusive understanding of the multiple dimensions of the social space of birth [30]. As we included data based on positive experiences rather than characteristics, the qualitative data included predominantly primiparous women, while the survey data contained more multiparous women. The high number of home births does not represent the international home birth rate [48]. Still, the homebirth stories in this study can serve as a benchmark and advocacy for a positive social space of birth [40,49]. Despite reported similarities between the women in the respective countries, we must consider that parity or cultural differences may have influenced our results and may be more relevant to one country than the other. Therefore, our findings are only transferable to women in similar cultures, systems and places. We analysed data that was not purposefully collected to answer our research question; these data may not have captured all the nuances of the social space. While our analysis of a subset of the original datasets has added insights, further and focused research is warranted to confirm, refute or extend these findings.

5. Conclusion

We gained an understanding of how women value, experience, sense, perceive and give meaning to the social space of birth and how this intertwines with their positive birth experiences. We used thematic analysis informed by critical realism to reveal women's reality of the social space and how this is an underlying mechanism for women's positive birth experiences. The key factors in the social space of birth that contribute to a positive childbirth experience include human rights and birth rights, the quality of interactions with care providers during labour and birth in a relationship-centred and relation-continuity model of care and having a place to retreat from the world while being in labour and giving birth – information that should be known and shared widely. These findings demonstrate that the concept of social space is integral to understanding women's positive birth experiences.

Ethics

The study included a secondary analysis of primary studies that all independently were performed in adherence to local ethical standards. The primary Dutch study received ethical clearance from the Scientific Research Ethics Committee Rotterdam (TWOR ref. no. T2016-72, 15 March 2016). The primary Czech study was conducted in line with ethical principles codified by the Czech Association for Social Anthropology (CASA), of which the interviewer/author (EH) is a member (http://www.casaonline.cz/?page_id=7). Formal ethical approval was not required, as neither the university where the research was carried out nor the Czech Science Foundation funding the study had a governing body to approve and monitor the ethical conduct of social science researchers. The B3 study received ethical clearance from the University of Central Lancashire, Ethics Committee (BuSH 222) and the e-Ethics Committee for Science, Technology, Engineering, Medicine and Health (STEMH 499) (1 April 2016). Approval from the primary authors and B3 country coordinators in Austria, Belgium, Czech Republic, Germany, Netherlands, Spain, and the United Kingdom to analyse data requested and received.

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CRediT authorship contribution statement

Yvonne Kuipers: Conceptualisation, Data curation, Formal analysis, Methodology, Supervision, Validation, Writing – original draft. Gill Thomson: Conceptualisation, Data curation, Formal analysis, Validation, Writing – original draft. Elise van Beeck: Data curation, Formal analysis, Investigation, Validation, Writing – review & editing. Ema Hresanová: Data curation, Formal analysis, Investigation, Validation, Writing – review & editing. Josefina Goberna-Tricas: Formal analysis, Investigation, Validation, Writing – review & editing. Sara Rodriquez Martin: Formal analysis, Investigation, Validation, Writing – review & editing. Simona Ruta Cuker: Formal analysis, Investigation, Validation, Writing – review & editing. Lisa Chudaska: Formal analysis, Investigation, Validation, Writing – review & editing. Irmi Waldner: Formal analysis, Investigation, Validation, Writing – review & editing. Christoph Zenzmaier: Formal analysis, Validation. Julia Leinweber: Conceptualisation, Data curation, Formal analysis, Validation, Writing – original draft.

We, the undersigned declare that this manuscript is original, has not been published before and is not currently being considered for publication elsewhere.

We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

We understand that the corresponding author is the sole contact for editorial process. She is responsible for communication with the authors about progress, submissions of revisions and final approval of proofs.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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