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THE BEST ENVIRONMENT FOR CHILDBIRTH IN THE (POST)PANDEMIC: A QUALITATIVE STUDY

El millor entorn per al part en la (post)pandèmia: un estudi qualitatiu

El mejor entorno para el parto en la (pos)pandemia: un estudio cualitativo

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ABSTRACT

OBJECTIVE. This study aims to explore women's experiences with their chosen place of birth in Spain during the pandemic and the immediate (post)pandemic period, as well as the factors influencing their decisions. **MATERIAL AND METHOD**. A qualitative design approach was used, and 14 interviews were conducted with Spanish women who gave birth. Content analysis was employed to extract key themes, resulting in three central categories and six subcategories. **RESULTS**. Three central categories (accommodating strategies, protective strategies and action-participation strategies) and six analysis subcategories emerged from the two profiles of women interviewed: those who gave birth in a hospital and those who opted for a home birth. **CONCLUSIONS.** The study concludes that it is essential for the chosen place of childbirth to provide women with a sense of safety and peace of mind, whether it occurs in a hospital, home, or birthing centre. Moreover, feeling well-treated by healthcare staff is fundamental for ensuring a positive and dignified childbirth experience.

Keywords: childbirth, qualitative research, Spain, decision making, women's health, COVID-19, health facilities.

RESUM

OBJECTIU. Aquest estudi té com a objectiu explorar les experiències de les dones pel que fa al lloc escollit per donar a llum a Espanya durant el període de pandèmia i immediata (post)pandèmia, així com els factors que van influir en les seves decisions. **MATERIAL I MÈTODE.** Es va utilitzar un enfocament de disseny qualitatiu, i es van realitzar 14 entrevistes a dones espanyoles que havien donat a llum. Es va emprar l'anàlisi de contingut per extreure els temes clau, donant lloc a tres categories centrals i sis subcategories. **RESULTATS.** Tres categories (estratègies acomodatives, estratègies protectores i estratègies d'acció-participació) amb 6 subcategories varen emergir en les dues categories de dones entrevistades: aquelles que havien parit a l'hospital i aquelles que ho havien fet a casa. **CONCLUSIONS.** L'estudi conclou que és essencial que el lloc escollit per al part proporcioni a les dones una sensació de seguretat i tranquil·litat, ja sigui en un hospital, a casa o en una casa de parts. A més, sentir-se ben tractada pel personal sanitari és fonamental per garantir una experiència de part positiva i digna.

***Paraules clau*:** part, investigació qualitativa, Espanya, presa de decisions, salut de la dona, COVID-19, institucions sanitàries.

RESUMEN

OBJETIVO. Este estudio tiene como objetivo explorar las experiencias de las mujeres con respecto al lugar elegido para dar a luz en España durante el periodo de pandemia y primer periodo en (post)pandemia, así como los factores que influyeron en sus decisiones. **MATERIAL Y MÉTODO**. Se utilizó un enfoque de diseño cualitativo, y se realizaron 14 entrevistas a mujeres españolas que habían dado a luz. Se empleó el análisis de contenido para extraer los temas clave, lo que dio lugar a tres categorías centrales y seis subcategorías. **RESULTADOS**. Tres categorías centrales (Estrategias acomodativas, estrategias protectoras y estrategias de acción-participación) y 6 subcategorías emergieron de los dos perfiles de mujeres entrevistadas: aquellas que dieron a luz en un hospital y las que lo hicieron en casa. **CONCLUSIONES**. El estudio concluye que es esencial que el lugar elegido para el parto proporcione a las mujeres una sensación de seguridad y tranquilidad, ya sea en un hospital, en casa o en una casa de partos. Además, sentirse bien tratada por el personal sanitario es fundamental para garantizar una experiencia de parto positiva y digna.

***Palabras clave*:** parto, investigación cualitativa, España, toma de decisiones, salud de la mujer, COVID-19, instituciones sanitarias..

INTRODUCCIÓN

The COVID-19 pandemic introduced a new form of world organization that resulted in economic, social, cultural and political transformations (Adhikari et al., 2020; Bong et al., 2020). In this sense, healthcare was one of the sectors to be most affected in all its dimensions. Restructuring, extra shifts, staff exhaustion, infections within the team and an excess demand for care set the tone for this pandemic in an unprecedented scenario that professionals found themselves in, especially during the first wave (Chirico, Nucera and Magnavita, 2020; Kursumovid, Lennane and Cook, 2020; Rodríguez and Sánchez, 2020).

Consequently, childbirth care units had to deal with unforeseen demand, both from the perspective of health professionals, and from that of the women and families who were consulted (Adhikari et al., 2021; González-Timoneda et al., 2021). The uncertainty resulting from a constant modification of care protocols and the scant scientific evidence (Baena-Antequera et al., 2020; Sadler, Leiva and Olza, 2020) had an impact on the quality of hospital care, and this impact was reflected during the first wave of the pandemic (Carrasco et al., 2021; Van Manen et al., 2021).

A series of preventive actions were implemented in maternity services to avoid infections between mothers and the foetus and/or newborn: visits were suspended, physical bonding and accompaniments were not allowed during childbirth, exclusive breastfeeding and preventive caesareans were discontinued (Alzamora et al., 2020; Brown and Shenker, 2021). All this resulted in an undermining of birth rights and the demands promoted by organisations worldwide who had worked hard to promote respectful deliveries within health institutions (Chmielewska et al., 2021; Obstetric Observatory Violence Foundation, Chile, 2021; Leiva et al., 2020; Mena-Tudela, 2021).

What the childbirth care units experienced brought new challenges regarding the possibility of having a greater versatility in terms of places in which to give birth, while simultaneously recognising and legitimising the experiences of out-of-hospital childbirths or homebirths accompanied by a health professional (Ziogou and Zografou, 2020). Regarding this point, several strategies aimed at providing pregnancy and birth care were introduced. In Spain, there was a recentralisation of childbirth care: while some hospitals closed their delivery rooms and the health staff who provided their services there were relocated to look after Covid patients, other centres concentrated a greater number of deliveries in delivery rooms in an attempt to isolate—as far as it was possible—the pregnant women from the rest of the hospital.

Accordingly, the situation resulted in women exploring other possibilities in out-of-hospital contexts such as homebirths with midwife care, thereby reactivating the debate about whether the hospital is the most suitable and safest place to give birth, an aspect that was undermined by the COVID-19 pandemic (Costa Abós and Goberna-Tricas, 2021; Costa Abós and Behaghel, 2020).

In this regard, the problematisation about the birthing environment is an area of interest within the sphere of public and community health that has been discussed for some time in other disciplines such as maternity-hospital architecture (Müller and Parra, 2015) or from the perspective of feminist geography and urbanism (Colectiu-Punt 6, 2019; Kern, 2021). In particular, some theoretical proposals have articulated the importance of the context of the birth, adding a conceptual twist to the dichotomous "hospital/home" idea (Rodríguez-Garrido, 2022).

In more recent times, we have witnessed a lessening of the severity of the pandemic thanks to the implementation of vaccines and the mutation of the virus, although there has been no easing off on research into the subject; indeed, research has increased as more information has become available about the virus and its social and health implications. For this reason, the current context is being seen as a post/pandemic period of COVID-19 because new variants and their effects have continued to bring major consequences for society despite the implementation of vaccines and protocols (Cavallo and Powell, 2021; Khosla, Allotey and Gruskin, 2020).

Deciding the ideal place for birth is still a matter of debate (Rodríguez-Garrido and Goberna-Tricas, 2020). However, there are very few discussion forums in which women can share their experiences about the implications of giving birth at home with the same security, comfort and respect that they might expect in a health institution.

The research carried out on the subject reflects the emotions, tensions and challenges that women and their families have to face when deciding where and how to give birth in times of a post/pandemic (Daviss, Anderson and Johnson, 2021; Linden and Maimburg, 2020; Wu et al., 2020). For this reason, this study aims to listen to women's opinions about the places where they gave birth during the (post)pandemic in Spain and the decisions that they took in this regard.

METHOD

Design

In developing this study, we used a qualitative methodology that took a descriptive approach based on the phenomenological tradition. In this regard, we believe that a qualitative methodology allows naturalistic interpretations and approaches to the research subject, and according to Denzin and Lincoln (2000) this "means that qualitative researchers study things in their natural settings and try to make sense of, or interpret, phenomena in terms of the meanings people bring to them".

Experiences as a unit of analysis provide "a way of interpreting, assessing and making sense of reality, whilst reflecting the unity of socio-cultural and personal aspects" (Erausquin, Sulle and García-Labandal, 2016). For this reason, we have aimed to understand and take an in-depth look at women's experiences about the place where they gave birth during the (post)pandemic, and the decisions taken in this regard.

Context of the study

The study was carried out in Spain, and specifically in the Autonomous Communities of Catalonia, the Balearic Islands and Galicia (Image 1).

Image 1: Administrative Map of the Autonomous Communities of Spain

Source: Rodriguillo, 2007.[1]

[1] License Creative Commons Attribution-Share. https://commons.wikimedia.org/wiki/File:Comunidades_aut%C3%B3nomas_de_Espa%C3%B1a.svg

Selection and characteristics of the participants

Interviews were conducted with women who gave birth during the COVID-19 pandemic and the immediate post-pandemic period. The criteria were that the women spoke Catalan or Spanish and had no communication difficulties. Theoretical selection criteria were established to include the widest possible range of profiles in terms of parity and type of childbirth care facility. This theoretical representativeness was further expanded by incorporating elements of vulnerability experienced by the women both before the pandemic (Briscoe L., 2016) and those that emerged as a result of COVID-19, such as changing hospitals for medical or personal reasons, or being infected with COVID-19 during pregnancy or at the time of birth (see Table 1).

Table 1: Profiles of the women selected to form part of the study

Description
Mothers over the age of 40.
Mothers who faced motherhood alone.
Mothers with premature babies or other obstetric and/or neonatal problems.
Mothers who had psychological problems before or during pregnancy and childbirth.
Immigrant mothers or those who have lived outside the Spanish State during pregnancy.
Mothers who required the use of assisted reproduction techniques.
Mothers who had to change the centre or place of birth because of the COVID-19 pandemic.
Mothers who had requested home-based childbirth care.
Mothers who contracted COVID-19 before or during childbirth.

Source: Compiled by the authors

In total, 14 women were interviewed (see Table 2).

Table 2: Sociodemographic profiles of the participants[2]

Name	Age	Educational level	Month and year of Birth	Child number	Decision of Place of birth	Inclusion profile
Alexa	32	PhD	May, 2020	First	High-tech hospital	Obstetric problems
Sarah	31	High School diploma	April, 2020	First	Regional hospital	Obstetric problems
Mary	32	College degree	July, 2020	First	Regional hospital	Neonatal problems
Clarise	37	College degree	November, 2020	First	Regional hospital	History of psychological problems
Gillian	38	College degree	March, 2020	Second	High-tech hospital	COVID-19 +
Grace	31	College degree	July, 2020	Second	High-tech hospital	Neonatal problems. Emigrant
Kora	34	High School diploma	May, 2020	Third	Regional hospital	Change of hospital for childbirth due to the COVID-19 pandemic
Malory	39	College degree	August, 2020	First	High-tech hospital	Single mother
Beatrice	41	College degree	November, 2020	First	High-tech hospital	Use of assisted reproduction techniques
Imogen	29	College degree	May, 2020	First	Home birth	Change of hospital for childbirth due to the COVID-19 pandemic
Margot	42	High School diploma	April, 2020	Second	Home birth	Mother over age of 40
Scarlett	36	College degree	June, 2020	First	Home birth	Change of hospital for childbirth due to the COVID-19 pandemic
Celia	27	College degree	April, 2020	First	Home birth	Change of hospital for childbirth due to the COVID-19 pandemic
Serena	40	College degree	October, 2020	Second	Regional hospital	Assisted reproduction techniques

Source: Compiled by the authors

[2] The names of the participants have been changed to preserve anonymity and confidentiality**.**

The participants were identified using two recruitment strategies. First, women who had a previous personal relationship with two of the researchers were contacted by telephone through the researchers' networks. Second, a combination of snowball sampling and open recruitment was used to reach other women who met the theoretical criteria. In this phase, an announcement was published on the website of the research group, which is affiliated with the University of Barcelona. The announcement invited women who had given birth during the COVID-19 pandemic and the immediate post-pandemic period to contact the research team directly through the website.

Technique used to gather the information

An individual semi-structured interview was the technique used to gather information. This type of methodological technique is very useful since it is understood as "a communication process that occurs in previously negotiated and planned meetings between subjects" (Trindade, 2012) in order to take a closer look at the experiences surrounding the studied phenomenon. To prepare the interview outline, we started with a bibliographical search of the literature published up to the time that we started our research. (Table. 3).

Table 3. Interview script

- Tell me about your decision to become a mother. How was it? When did you make your decision?
- Do you have a partner? What was their role throughout the process? Did they accompany you at the childbirth? And did they accompany you on your check-up visits during the pregnancy? If not, what was the reason for them not doing so?
- How was your pregnancy? And the childbirth itself? And after giving birth, during the postpartum period? Did you have any health problems at any time?
- How was your relationship with the health system? What relationship did you have with the health professionals: At the doctor's surgery, in the hospital? How did you access health information about care during the pregnancy, about the place to give birth and care in the postpartum period?
- Did you have any problems accessing or choosing any of the health services? Or accessing or choosing a professional?

- Did you take any decisions related to the type of care while undergoing any tests or health actions during the pregnancy, childbirth and/or the postpartum period? What type? Was it easy for you to make decisions in this regard? Did you experience any difficulty in fulfilling any of the decisions that you took? Did you look for advice or help?
- Did you prepare a birth plan? When? Who offered it to you? Did they take the plan into account at the hospital or the place where you gave birth?
- Did you decide on the place where you wanted to give birth? Was your first choice changed? Why? What was your experience in this regard?
- What changes arose in terms of the decisions that you had taken and in the care process after the start of the COVID pandemic?
- Did you feel fear, confusion or anxiety at any time before or after childbirth?
- Did you experience feelings or a sensation of the loss of personal recognition or did you feel frustrated, stigmatised?
- Is there anything else related to the maternity process that you would like to tell us about?

Due to the pandemic situation, the interviews were held online between June 2020 and March 2021 using the Collaborative application hosted on the University of Barcelona intranet (thereby guaranteeing the confidentiality of the data gathered). All the women interviewed were offered the possibility of participating with their camera switched on or off during the recording in order to preserve their image rights. The duration of the interviews ranged from 40 to 90 minutes. The women who gave birth at home were interviewed in person, with one of the researchers visiting each interviewee at her home. This decision was made for practical and ethical reasons: these participants expressed a preference for a face-to-face format in a familiar setting, which also aligned with their choice of giving birth in the home environment. In contrast, the remaining participants preferred or required virtual interviews due to geographic distance, scheduling constraints, or ongoing public health concerns.

Regarding reflexivity, the research team was composed of female researchers with backgrounds in midwifery, public health, and feminist studies. Four of the researchers are also mothers, which facilitated empathetic dialogue but also required careful reflection to

avoid over-identification with participants. Throughout the research process, the team engaged in regular reflexive discussions to critically examine how their professional roles, personal experiences, and ideological perspectives might influence the interpretation of data. Field notes and memos were used to document these reflections and enhance the credibility of the analysis.

Ethical aspects

The research was approved by the University of Barcelona Bioethics Committee (IRB00003099). The objective and ethical considerations of the study were explained to all participants. In the case of women contacted through the website, the study information was included in the online call, and participants gave their informed consent directly on the website when they provided their personal details and contact email. For the home interviews, participants were initially contacted by email, and the study information and consent form were sent electronically. These participants signed and returned the informed consent form via email.

In all cases, confidentiality was strictly maintained. Personal identifiers were removed from the transcripts, and each participant was assigned a fictitious name to preserve their anonymity. Audio recordings and consent forms were securely stored on password-protected devices, accessible only to the research team. The data were used exclusively for research purposes and managed in accordance with data protection regulations.

Criteria for methodological rigour

We considered the list of questions contained in the Standards for Reporting Qualitative Research (SRQR) (2014) throughout the development of the study and in the drafting of the final report. Furthermore, we used the following quality criteria in accordance with Calderón (2002): a) “epistemological adequacy”, that is to say, reviewing the formulation of the research question and the coherence of the process; b) “validity” criterion is not intended to be understood in terms of statistical probability but rather in terms of relevance and interpretivism, and so, an appropriate process has been sought for the selection of participants and to guarantee rigour in the analysis in order to know meanings and look for in-depth generalizable explanations from a logical point of view that are transferable according to the contextual circumstances in which the research was carried

out. Finally, c) "reflexivity", that is, it is also important to recognise the position of the researchers, both as midwives and researchers who are also immersed in the scenario of the COVID-19 pandemic.

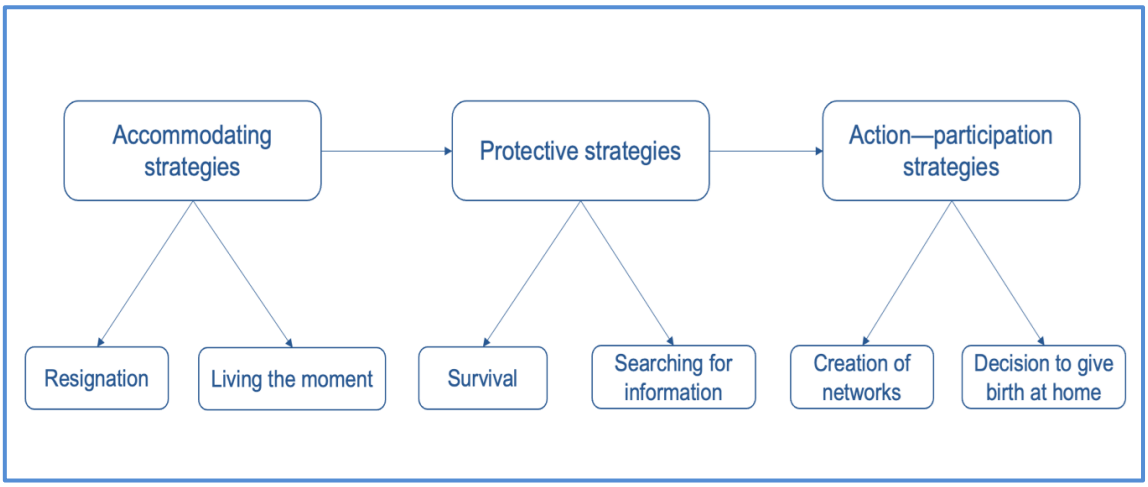
Data analysis

The interviews were recorded in MP4 format using the application Collaborate, which is hosted on the Intranet of the University of Barcelona, which was also used to conduct the interviews and in MP3 in case of face-to-face interviews. The interviews were subsequently transcribed by the Main Researcher and a collaborator who was external to the research. They were then analysed using qualitative research methods based on the criteria of Taylor and Bogdan (1984). The first step consisted of a careful reading of the transcriptions to obtain ideas and intuitions, and the second step involved categorising the data into information units and grouping them into categories based on similarity, which responded to the objectives of the study. The codes and categories that emerged were discussed by all the members of the research team. The data were relativised by all members of the research team during a third phase to contextualise them.

RESULTS

Three central categories and six analysis subcategories emerged from the two profiles of women interviewed: those who gave birth in a hospital and those who opted for a home birth (Figure 1).

Figure 1: Categories and subcategories of analysis



Source: Compiled by the authors

1. Accommodating strategies

These strategies derive from the women's desire to omit the conditioning factors imposed by the pandemic situation and which they are not able to modify as a result of the social situation and the rigidity of the hospital care model.

Resignation

This strategy was essentially identified among the women who gave birth in a hospital, and it stemmed from the uncertainty they felt giving birth during a pandemic, as the consequences were not only health-based, but social and economic as well:

> (there was) some uncertainty because naturally, you didn't know what effects this pandemic would have on the pregnancy at a health level and at an economic level evidently, because I was practically on furlough until June (a temporary state payment for people who lost their jobs because of the pandemic) on 100% of my salary. (Clarise)

Resignation following on from uncertainty can also be seen in the sensation of vulnerability experienced when giving birth in the hospital, and to a larger extent, in the context of the pandemic, where loneliness was seen as one of the main factors of fragility, as expressed by this participant when talking about the presence of her partner at the childbirth:

> he couldn't because they didn't allow him. As he had tested positive for COVID-19 they told me that I had to go in alone… he couldn't be there during the childbirth. (Gillian)

One of the most complex sensations that the women had to deal with in the hospital was undoubtedly related to the skin-to-skin bonding, which they were denied on many occasions in order to prevent a possible infection from COVID-19:

> I was sad when she was born because I couldn't put her on my breast, they washed her thoroughly … and this all meant that my memory of the birth was not a very pleasant one. (Gillian)

Living the moment

Because of the complex situation caused by the pandemic occurring when they were already pregnant, one of the strategies to subvert these moments was to live the present and do so "in the best possible manner":

> If you are feeling more anxious, this increases your pressure and this will make things even worse for you; then I tried to see things in a different way and to take each day as it came. (Alexa)

However, despite recognizing the complexity of the situation and fearing the possibility of catching COVID-19, some participants preferred to give birth in the hospital because of the feeling of security that a health centre gave them compared to any other possible choice related to the place where the childbirth would take place:

> The maternity floor was isolated from the rest; everything seemed to be under control. (Sarah)

2. Protective strategies

The women who were interviewed identified the need to "protect themselves" from the difficult emotions that they experienced as a consequence of the COVID-19 pandemic.

Survival

Fear is an emotion that is very present in women who give birth, and it is sometimes related to previous negative experiences or to the uncertainty associated with childbirth healthcare, especially during the first wave of the pandemic. For the participants who gave birth in hospital, the fear translated into:

> The main fear that I had was a fear of the childbirth and a lack of care, because all the staff were looking after patients with COVID. (Sarah)

Another participant links her fear to the pandemic and to the uncertainty about the information that they received both from the media and in particular from the health system itself:

> Sometimes they told us that we couldn't do something because of the virus, but then the nurses and midwives themselves said that there wasn't much logic in this. So then, what were we to do? Follow the rules or ignore them? (Mary)

Searching for information

Another cause of fear was related to an excess of information or a lack thereof:

> It was initially thought that it was not a problem for pregnant women, but as the days went by, we saw that there were studies that associated it with a higher risk of preeclampsia or other pathologies. (Alexa)

Fear of the unknown led them to search for information and prepare themselves for childbirth, and they searched for their own resources as a way of offsetting the disinformation:

> Yes, I did it on my own, a bit of extra preparation. Waiting to see what was happening with this pandemic. (Clarise)

Another participant adds:

> I was reading things, books that I had probably bought but which I had never read, or I borrowed a book that that just been published by a famous author about giving birth, and I read it but at some point, I felt that I didn't want too much theory either. (Serena)

But disinformation was not the only thing that the pregnant women encountered, but also an overabundance of information that was continually changing and that sometimes was even contradictory. Regarding the excess of information and the anxiety that this generated, one participant said:

> You started to hear things about pregnancy and the virus, but neither was I in the right frame of mind to say "look, if I get it, then so be, but I didn't want to know too much either, because if I did, the anxiety would obviously increase. (Scarlett)

The midwives played a fundamental role, especially for the women who gave birth at home. Their emotional support and trust in the information were highlighted by the interviewees as relevant aspects worthy of mention:

> In addition to checking that I was up to date about what was going on, about the latest studies and that home birthing was not a clandestine thing, it put them (the family) at ease. Apart from allowing them to ask their questions, such as whether it was necessary to have a sterile place, whether it was necessary to go to the hospital; indeed, the midwives had a car ready, and they were in contact with several hospitals. Basically, they (the midwives) clarified any doubts they (the family) had, and we were clear that we wanted to choose this option. (Margot)

3. Action-participation strategies

This strategy was referred to by some of the women who had given birth in hospital, but it was mostly mentioned by the interviewees who had given birth at home, in that they felt a certain autonomy when it came to making decisions and in terms of the active participation that the home context had granted them.

Creation of networks

The strict health protocols implemented in the hospitals led to some major setbacks as far as birth rights were concerned. For this reason, some of the women who gave birth in the hospital felt the need to voice their displeasure by joining with other women to claim and demand their rights:

> Going from feeling sad and feeling hate… to suddenly feeling pride at seeing the spirit of help among pregnant woman was absolutely amazing, and at one stage we all organised ourselves and it was like "Let's go for it, you do this, you do that, you create these networks and I'll do the others; we took photos of our tummies and we published them." (Kora)

As far as the networking activities were concerned, these were fundamentally based on impeding the prohibition that had been placed on partners/companions entering the delivery room:

> We prepared some slogans that said, "we want a respectful childbirth" and others like that… at one stage there were fifty of us organised. Well, we felt proud of seeing how strong we could be together. This was a very nice sensation that I felt afterwards. (Kora)

The interviewees who decided to give birth at home developed action strategies that originated from individual decisions based on the testimonies of friends/acquaintances who had given birth at home and "self-acquired information" they got by reading the literature or attending talks about childbirth:

> I really like to inform myself about everything that I do in my life in general, but when I told my partner—to read this or look at that—he was always very much by my side. When I first mentioned the idea of a home birth to him, he said "What? or Emmm" but it was a way to get informed and yes, that is what it is, if you bother to get the information, you see things for yourself more clearly. (Scarlett)

Notwithstanding the efforts made to explain the decision about opting for a home birth, the families, as a support network, were occasionally the main hindrance in terms of carrying the decision into effect. Concern and a lack of knowledge were the main obstacles identified:

> My mother was very important to me in all this. And that she was already saying "mmm", right? She wasn't very convinced, and this only served to increase my own doubts. She didn't encourage me like for… because I was the only one in the family circle that was considering that option… my father hadn't talked about it either, but everyone was somewhat "well, I'm not too sure about all this," even my brother. They were all like no. So, it was even harder for me to make the decision on my own. (Beatrice)

The decision to give birth at home

The women who decided to have a home birth identified two major aspects that affected their decision. On the one hand, there was the health situation caused by the COVID-19

pandemic, and this caused the women to feel safer giving birth in their homes than in the hospital, as the strict protocols threatened the principles for a respectful childbirth:

> I was hoping to have a natural birth. Then, at the start of the pregnancy (before the outbreak of the pandemic), I looked for a hospital where they did natural births by which I mean a place that provides you with the basics, which are giving you time, providing you with warm light, welcoming you, and I found a hospital that met these requirements […]. I was overjoyed, but then we went into lockdown, and I thought "wait, let's not complicate things further." (Celia)

Similarly, another participant referred to the frustration, especially within the hospital setting, and the fear that her decisions would not be respected during the pandemic:

> When I left, I said "I'm really feeling an urge to give birth at home that you cannot imagine", because, sincerely, after seeing the stress that the staff were under rather than being calm, because neither was there any evidence that the virus was dangerous for young people, I don't know… I became very frustrated; it made me angry to think that they weren't going to let me give birth and that it was all going to end with an epidural (anaesthesia) or oxytocin (a synthetic hormone used to induce labour) or whatever. (Malory)

On the other hand, there are those women who would have preferred a homebirth but who ended up giving birth in the hospital because of the negative social image that surrounds homebirths. One participant highlighted the need for greater information to avoid such representations:

> Here (Spain) there is little knowledge or information about it and, therefore, the little information there is creates those fears about giving birth at home, which was the feeling I had. I felt that I would most certainly like to have a homebirth, and that the experience must be incredible, but the scant information there is and the fact that everybody gives birth in hospital makes you think at one moment or other "if something happens, I will feel guilty for the rest of my life" and therefore you end up deciding to go to a hospital to give birth; at least that was my case. It is a question of ignorance, and it is not encouraged. (Kora)

However, the women who did go ahead with a home birth said that they had positive feelings after reaching their decision. The sensation of autonomy over their bodies and being able to decide how, where and with whom they gave birth were positive aspects that they mentioned:

> As a woman it empowers you. Yes, you come out feeling reaffirmed and stronger. (Beatrice)

DISCUSSION

The experiences that were highlighted regarding the place of birth during the period of the COVID-19 pandemic and (post)pandemic changed the perception of security and insecurity that the hospital—as the dominant place for childbirths—passed on to the women. In this regard, childbirth care, in whatever context it takes place (Dahlen et al., 2021), has both risks and rewards.

The qualitative studies on the subject (Saeedi et al., 2013; Jackson et al., 2012) show that women are aware of the risks that giving birth entails, regardless of the place where it takes place. However, some studies (Rodriguez-Garrido and Goberna-Tricas, 2021; Costa-Abós and Behaghel, 2020) show that women who gave birth outside the hospital perceive the risks of giving birth in hospital in a different way and they prefer an out-of-hospital option in that this decision protects them and their babies from the excess of interventions associated with hospitals (Finingan and Chadderton, 2015), and this fact coincides with what the women who were interviewed for this research study said. In the same vein, the participants in this study said that homebirths, apart from having fewer risks of intervention than hospital births, gives them greater decision-making power, autonomy and information (Nelson and Romanis, 2021) and a lower probability of being separated from their babies, especially during a pandemic (Minckas et al., 2021), thereby indicating that the social aspects surrounding childbirth play a vital role when decisions are being made (Christiaens and Bracke, 2009).

Finally, in this study we have observed that a significant number of the interviewees who gave birth in hospital normalise the technical risks and trusted the health technology and saw the institution as the safest place to give birth (Hundley et al., 2000), even in the context of a pandemic (Inversetti et al., 2021). Similarly, and in tune with the scientific evidence, 2021; Rodriguez-Garrido and Goberna-Tricas, 2021; Longworth, Ratcliffe and Boulton, 20021; Parveen et al., 2017), the women in this study who decided to give birth outside the hospital spent more time searching for information about the alternatives and about their decision-making rights than the women who opted for a hospital birth.

CONCLUSION

Hearing the experiences of the women regarding the place of birth during the pandemic and (post)pandemic made it possible to identify both the hindering aspects linked to the decision regarding the place of birth and the strategies employed by the women to alleviate this situation.

The hindering aspects identified were the strict COVID-19 health protocols, which on many occasions prevented these women from being accompanied during the birth and from being able to physically bond with their newborn babies. Regarding the place of birth, the hospital itself became an obstacle of sorts in that the interviewees said that they were afraid of being infected with COVID-19.

In their replies, the interviewees identified several strategies (accommodating, protective and action-participation) that allowed them to deal with these difficult moments, and this gave them a feeling of greater security and peace of mind when they were giving birth. In the case of the interviewees who gave birth in a hospital, the security transmitted to them by the presence of a medical-health team and a technically efficient environment is what increased their confidence in the decision they had taken, although they did recognise their fear of getting infected in a health centre shared with COVID patients. For their part, the interviewees who gave birth at home highlighted the peace of mind that they felt from being in a private and familiar setting and the major role they had during the birth, which gave them a greater feeling of security.

Finally, choosing the place of birth is a very important decision for pregnant women and their families, and this matter should be discussed and agreed with the professionals who provide childbirth care and specifically with midwives insofar as this choice offers them a greater feeling of security when giving birth. Understanding the aspects that women take into consideration when making their decision regarding "the ideal place for giving birth" will allow us to open up a debate about the environments and scenarios that are most appropriate for birth following the impact of COVID-19.

LIMITATIONS

The trustworthiness of the findings is supported by the study's use of in-depth qualitative methods, allowing for rich, contextualized insights into women's childbirth experiences during the COVID-19 pandemic. The inclusion of both hospital and home birth narratives strengthens credibility through data triangulation, and the use of direct quotes enhances confirmability by grounding the analysis in participants' voices. The research process also aimed to ensure dependability through systematic coding and thematic analysis.

However, the study has limitations. Its non-representative sample and focus on a specific social and geographical context limit the transferability of the results to broader populations. The exclusive focus on women's perspectives, without incorporating views from healthcare providers or birth partners, may have narrowed the understanding of the broader systemic

dynamics. Despite these limitations, the study offers valuable insights into the personal and social dimensions of childbirth during a global health crisis.

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