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Beyond the numbers: A phenomenological analysis of women's childbirth experiences in Spain's evolving healthcare system

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ABSTRACT

INTRODUCTION Childbirth is a transformative experience, yet many women worldwide encounter negative birth events that affect maternal wellbeing and mental health. The choice of birth setting significantly impacts outcomes, with midwifery-led units often associated with lower intervention rates and higher satisfaction levels. The recent introduction of midwifery-led units in Spain presents a unique opportunity to explore the impact of this model within a medicalized healthcare context. This study aims to understand the factors influencing women's perceptions of childbirth following the introduction of the first midwifery-led unit in the Spanish Healthcare System.

METHODS This qualitative study employs a phenomenological approach within the constructivist paradigm. Four virtual focus groups were conducted with 19 women who gave birth in a hospital offering both an obstetric unit and an midwifery-led unit. Data were analyzed using thematic analysis.

RESULTS Three main themes emerged: 'Shaping birth expectations', highlighting the influence of social factors, family dynamics, and previous experiences on women's childbirth expectations; 'The childbirth essentials', focusing on fundamental characteristics related to the model of care; and 'Navigating the protective factors', considering the central role of midwives in providing compassionate and respectful care.

CONCLUSIONS This study highlights the crucial role of expectations, care models, and midwifery roles in shaping childbirth experiences. The findings advocate for transforming Spain's medicalized healthcare system by integrating midwifery-led care units. By adopting a more biopsychosocial approach, healthcare providers and policymakers can promote respectful, individualized care, ultimately enhancing positive childbirth experiences for all women.

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INTRODUCTION

Childbirth is a deeply personal and transformative experience encompassing physical, emotional, and social dimensions[1]. The World Health Organization (WHO) emphasizes the need for accessible, high-quality maternity care, identifying a 'positive childbirth experience' as essential[2]. This entails women feeling supported, in control, safe, and respected, with positive interactions with healthcare providers being crucial[3]. Positive childbirth experiences enhance women's psychosocial well-being, contribute to maternal empowerment, and shape postpartum identity[4].

Despite global efforts to prioritize respectful maternity care[5], many women worldwide experience childbirth as negative or traumatic, with prevalence ranging from 4% to 45%[6,7]. The repercussions of such negative experiences are profound and closely linked to postpartum anxiety, post-traumatic stress disorder, and postpartum depression[6,8,9]. These consequences extend to maternal self-esteem, the ability to bond with the infant, breastfeeding rates, and the overall transition to motherhood[10,11].

The choice of a birth setting significantly influences a woman's birth experience[12]. While most births in high- and middle-income countries occur in hospitals, research indicates that midwifery-led units (MLUs) are associated with reduced rates of medical interventions and higher satisfaction rates than traditional obstetric units (OU)[12-14]. These findings

emphasize the importance of considering diverse birth settings when evaluating the overall childbirth experience.

Spain's approach to childbirth care is shifting through implementing MLUs in its National Health System[15,16]. This shift presents an opportunity to explore the impact on women's birth experiences, given the country's prevailing medicalized healthcare environment[17]. Despite recognizing the importance of continuity of care, midwifery-led models, patient-centered care, provision of information, and participation in decision-making[12,13,18], these elements have not been fully integrated across the Spanish Healthcare System. Exploring professional practices and factors influencing birth experiences within this context will provide valuable insights, advancing our understanding of this model's implications for maternal well-being.

This study aims to capture the depth and diversity of women's voices, understanding the factors influencing their perceptions of childbirth following the introduction of the first MLUs in the Spanish Healthcare System. The findings aim to provide useful information to healthcare providers and policymakers to promote positive childbirth experiences.

METHODS

Design

This study uses a qualitative methodology grounded in the constructivist paradigm, emphasizing the subjective meanings and experiences constructed through social interactions. Phenomenology, focused on understanding phenomena through the lens of lived experiences, was chosen as the theoretical and methodological framework to deeply explore childbirth experiences within their socio-cultural context[19] deeply. To implement this approach, we conducted focus groups facilitated by a midwife and observed by an additional researcher. The focus groups were designed to foster rich, interactive discussions, allowing participants to collectively share and reflect on their experiences.

Setting

This study was conducted in a community hospital in Martorell, Spain, which offers two birthing settings: a traditional OU and an MLU. Although the MLU is separate from the OU, it has access to the same hospital facilities. The hospital has an average of 650 childbirths annually, approximately 150 of which occur in the MLU.

The OU follows a biomedical model of care and is staffed by obstetricians, anesthetists, pediatricians, and midwives. It is equipped to handle high-risk pregnancies and complications during labor and birth, featuring advanced medical equipment, including emergency surgical facilities. Pain management options, such as epidurals, are readily available. The care approach in the OU involves standardized medical protocols and interventions, including inductions of labour, cesarean sections, and assisted births.

In contrast, the MLU, introduced in December 2017 as the first of its kind in the Spanish Healthcare System, is managed exclusively by qualified midwives and operates autonomously within the hospital. The MLU focuses on women with uncomplicated pregnancies, providing a home-like, calming environment. Medical interventions are limited, with an emphasis on physiological birthing practices. Facilities in the MLU include a birthing pool and other natural pain relief methods. The MLU follows a biopsychosocial model of care with a women-centered approach, featuring individualized care plans that encourage the active participation of the mother in the birthing process.

Participants and sampling

A mixed sample from both the OU and MLU was selected to capture and understand childbirth experiences within the hospital. Purposive sampling was used to ensure diverse participant backgrounds. Inclusion criteria were: 1) Spanish-speaking women; 2) residing in Spain; 3) aged ≥18 years; 4) with uncomplicated pregnancies; and 5) who had given birth either in the MLU or the OU. The exclusion criteria were: 1) births occurring before 37 weeks; and 2) high-risk pregnancies.

Participants from the BirthingBetter research project were identified and invited to participate in this phase by a member of the research team via telephone. Following this initial contact, detailed information and informed consent forms were emailed to them. Participants were given time to consider their involvement before being invited to join a focus group, scheduled between 4 and 9 months postpartum, to ensure that they had sufficient time to reflect on their childbirth experience while still being able to recall details accurately.

Out of 25 women who were invited to the focus groups, 22 consented to participate, while three withdrew due to last-minute changes in family arrangements. Detailed data, including background information and birth details, were systematically collected through online questionnaires. The characteristics of the participants are summarized in Table 1.

Data collection

Data were collected through focus groups, conducted virtually via Zoom to accommodate postpartum women and minimize travel[20]. Facilitated by a midwife and observed by an additional researcher, these groups were designed to resemble postnatal or breastfeeding support groups, encouraging women to share their childbirth experiences more openly in a supportive group setting. A practical guide ensured consistency and homogeneity across sessions, including prompts to foster discussion and cover all relevant aspects of childbirth. The midwife created a supportive, non-judgmental environment using empathetic language, active listening, and validating participants' feelings. This approach encouraged active participation and ensured each participant had an opportunity to speak.

An additional researcher took field notes and addressed any emerging emotional needs. Despite the challenges of less personal interaction online, the virtual format increased accessibility and convenience for postpartum women. Strategies such as clear communication and continuous support mitigated the limitations of the digital approach.

Nineteen women participated in the focus groups held between March and April 2022. Participants consented to audio and video recording for transcription. Sessions,

lasting an average of 80 min, were conducted in Spanish and Catalan, recorded for transcript, and translated into English. Pseudonyms replaced real names for anonymity. Once data saturation was achieved[21], no further groups were conducted, ensuring sufficient depth and richness.

Data analysis

Following the collection and verbatim transcription of all narratives, a thematic analysis was conducted, drawing on established methodologies[22] and using the Atlas.ti program (Figure 1). To ensure the robustness and precision of interpretation, three research team members initially performed independent analyses. The accuracy of the code grouping process underwent validation through discussions involving the other researchers, resulting in a consensus on categorizing codes into themes and subthemes and minimizing biases linked with the professional background. This collaborative approach allowed for the triangulation of information and results, enhancing the reliability of the findings. Themes were derived from the data, and any discrepancies that arose were resolved through consensus among the team members. In the final analysis phase, three overarching themes with their subthemes were formulated and presented in Table 2.

Ethical considerations

Ethical approval (registration number CEI 21/03) was obtained from the Ethics Committee of the Fundació Unió Catalana d'Hospitals. Anonymity protection was prioritized due to the study's sensitive nature and small sample size. The lead researcher pseudonymized and securely stored data, following data privacy regulations. Participants received detailed information about the study and had two weeks to decide on participation, confirming their voluntary involvement by signing a consent form. They were assured the right to withdraw without consequence, even during focus group discussions.

RESULTS

Women's childbirth experiences were grouped into three themes: 'Shaping birth expectations', 'The childbirth essentials', and 'Navigating the protective factors'. Ten subthemes were identified within these main themes (Table 2).

Shaping birth expectations

Participants recognized the profound impact of childbirth expectations on the overall birthing experience, significantly influencing whether it was viewed positively or negatively.

Table 1. Characteristics and birth details among Spanish-speaking women aged ≥18 years with uncomplicated pregnancies and who had given birth either in the MLU or the OU in a community hospital in Martorell during 2022, Spain (N=19)

Participant	Age (years)	Parity	Model of care	Onset of labor	Type of birth	Observations
1	30–35	Primiparous	Combined care	Spontaneous	Instrumental birth	Transfer for non-progression of labor
2	30–35	Multiparous	OU	Spontaneous	Unplanned cesarean birth	CS for non-progression of labor
3	40–45	Multiparous	OU	Spontaneous	Spontaneous vaginal birth	Use of epidural analgesia
4	35–40	Multiparous	OU	Spontaneous	Spontaneous vaginal birth	
5	35–40	Primiparous	OU	Induced	Instrumental birth	Use of epidural analgesia
6	30–35	Primiparous	MLU	Spontaneous	Water birth	
7	30–35	Multiparous	MLU	Spontaneous	Water birth	
8	30–35	Primiparous	Combined care	Spontaneous	Spontaneous vaginal birth	Transfer for postdates pregnancy
9	25–30	Primiparous	MLU	Spontaneous	Spontaneous vaginal birth	
10	30–35	Primiparous	OU	Induced	Unplanned cesarean birth	
11	40–45	Primiparous	MLU	Spontaneous	Spontaneous vaginal birth	
12	30–35	Primiparous	Combined care	Spontaneous	Spontaneous vaginal birth	Transfer for meconium-stained liquor
13	25–30	Multiparous	OU	Induced	Spontaneous vaginal birth	Induction for SROM. Use of epidural analgesia
14	20–25	Primiparous	OU	Induced	Instrumental birth	Neonatal complications
15	35–40	Primiparous	OU	Induced	Instrumental birth	Neonatal complications
16	30–35	Primiparous	Combined care	Spontaneous	Water birth	Postpartum hemorrhage
17	40–45	Primiparous	Combined care	Spontaneous	Spontaneous vaginal birth	Transfer for epidural request
18	30–35	Multiparous	Combined care	Spontaneous	Unplanned cesarean birth	Transfer for epidural request
19	30–35	Primiparous	MLU	Spontaneous	Spontaneous vaginal birth	

a MLU: midwifery-led unit, aligned with a biopsychosocial model of care. b OU: obstetric unit, aligned with a biomedical model of care. c Combined care: transfer from MLU to OU during or after labor.

Figure 1. Analytical process described by Coffey and Atkinson[22]

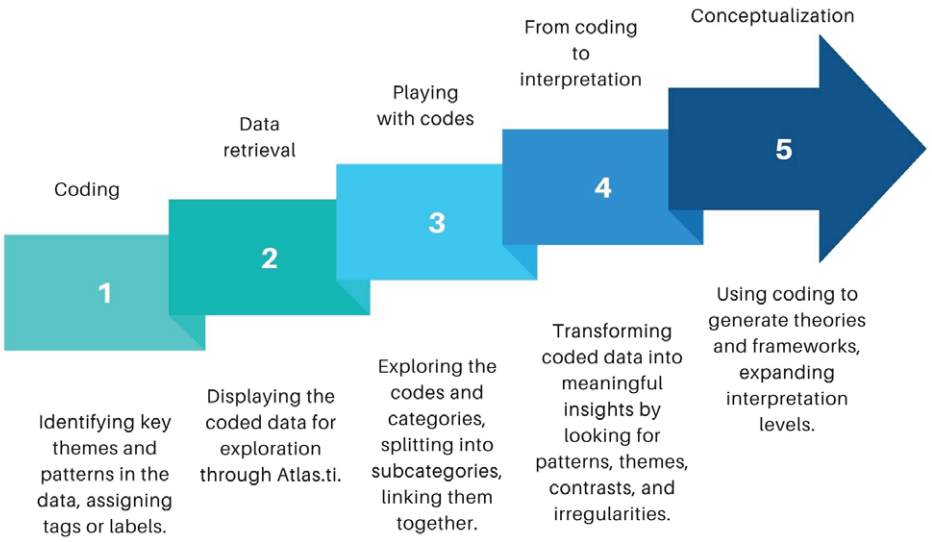

Table 2. Themes and subthemes identified among Spanish-speaking women aged ≥18 years with uncomplicated pregnancies and who had given birth either in the MLU or the OU in a community hospital in Martorell during 2022, Spain (N=19)

Themes	*Subthemes*
Shaping birth expectations	• External social influences • Previous obstetric experiences • Knowledge, interaction and healthcare accessibility
The childbirth essentials	• One-to-one care • Pain relief strategies • Privacy and dignity • Respectful care
Navigating the protective factors	• Meeting 'elements of value' in care • Midwifery role on 'childbirth essentials' and 'elements of value' • The role of advocacy for women's empowerment

External social influences

Women emphasized the role of external influences in shaping their expectations, noting the diminishing visibility of authentic birthing experiences within the community. Many relied on external sources such as videos and peer discussions to form their expectations:

> *'I've read all the birth stories, watched all the videos. … I would ask my friends about it. I like it. But, in real life, we don't have that many chances. I haven't seen a birth yet, you know? I have never seen a vaginal birth more than the ones that I've seen on YouTube. I mean, it's something we talk about a lot, that we prepare a lot for, but, in reality, until you find yourself in that situation, you've never been present in one.'* (P2, OU)

Family and relatives' dynamics, particularly the influence of mothers, played a crucial role in shaping decisions and expectations. Participant 12 highlighted a turning point to reassess and recalibrate her expectations:

> *'From the beginning, I had a clear idea of wanting a natural birth. My mother had done it this way, and it felt natural to me. … There was a point where I could only imagine my birth, and then my mother told me, "Be careful, sometimes things don't go as we want", and it was like a "click". I knew there were many different birth experiences, so I started mentally working on it.* (P12, Combined care)

Previous obstetric experiences

The birth of a first child often transformed expectations for subsequent pregnancies, particularly those marked by dissatisfaction. They proactively sought to avoid reliving challenging memories from previous childbirths:

> *'I was coming from an experience that was not respectful with my first daughter. I did the birth plan, everything, we prepared everything with my partner, and well, that day it just stayed there on a shelf. … Everything I didn't want to happen, it happened. I had bad memories … and my intention was not to have more children. But this time I wanted to have a good memory, and that's why I came [to the MLU], … and it was very, very beautiful and respectful.'* (P7, MLU)

Knowledge, interaction, and healthcare accessibility

The accessibility and comprehension of the healthcare system emerged as another determinant in shaping childbirth expectations and influencing decisions regarding birthing settings. Participant 9 referred to the unequal information regarding the options for place of birth:

> *'Information is something that we should have from early in pregnancy. Because, even when you go for check-ups unless you don't actively seek information, you might remain unaware of places like this [MLU] and alternative ways of giving birth.'* (P9, MLU)

Ongoing interaction with the healthcare system played

a significant role in shaping expectations. External factors, including medical opinions, contributed to the gradual formation of mindsets and childbirth expectations:

'My girl was born big, well, 3.8 kilograms. There are much bigger babies. But, from the very beginning, in the community center, they told me I was having a very big girl and that I wouldn't be able to deliver naturally. There was no support anywhere. ... They gradually undermined our confidence, and although we appeared strong externally, at every medical check-up, we found words or phrases that didn't sit well with us.' (P10, OU)

The childbirth essentials

Women consistently articulated the essential elements that enhanced their overall satisfaction. In this theme, we describe these elements within the two distinct models of care – the MLU and the OU.

One-to-one care

In the MLU, participants recounted experiences of one-to-one care provided by a dedicated midwife during labor. This personalized attention significantly contributed to a sense of support and individualized care throughout the birthing process:

'Raga, the midwife, was there accompanying me and supporting me at all times. And it was somewhat thanks to her that I was able to have a birth that I would have never imagined, it was really beautiful. ... The last few hours were very intense, but at the same time, I felt very supported at all times. I remember a moment that was really cool, you know? It was during the shift change of the midwives, but Raga, who had been with me throughout, didn't want to leave me alone, you know? So the midwives were there, and it was the moment of delivery, and they were all encouraging me. ... I remember this moment as really beautiful, and everyone was there, waiting for the baby to be born. ... I felt very supported with the encouragement I really needed at all times.' (P6, MLU)

Conversely, participants in the OU often felt a lack of support and a desire for more personalized attention due to the workload of midwives:

'And what if I could have done a bit of biomechanics to see if the baby had positioned well? But what happened? After getting the epidural, there was no one with me either. ... The midwives were extremely busy; there were three or four other moms arriving suddenly at midnight, and it was 1 am. I was there alone, waiting to see when my time would come.' (P1, Combined care)

Pain relief strategies

Within the MLU, participants appreciated the holistic approach to pain relief, acknowledging the diverse needs of women during childbirth. The model's commitment to addressing individualized pain relief needs was exemplified in Participant 17's encounter with a midwife:

'Claire, who was wonderful, ... seemed like Mary Poppins because she was pulling out all kinds of resources. She would come in and say, "come on, why don't we try the electrodes", "why don't you try the ball", "why don't you shower", "why ..." And all the time like that, right? And I was drawing strength, I don't know where from.' (P17, Combined care)

In the OU, participants perceived a more limited availability of pain relief strategies, primarily centered around epidural-based options, with reported limitations in accessing alternative methods like showers, bathtubs, or birthing pools. Participant 13's experience highlighted these constraints:

'I couldn't use the shower because another woman was using it, and I asked for a bathtub or the birthing pool. They told me it wasn't possible in the labor ward.' (P13, OU)

Privacy and dignity

Participants emphasized the utmost significance of preserving dignity, privacy, and autonomy throughout the childbirth experience:

'We were super well; we have very, very good memories. We were accompanied all day by Hannah [the midwife]. Since we entered the room, she set up the entire place as if we were at home. With soft light, salt lamp light, aromatherapy ... I really valued having privacy. Especially when you have to be there for many hours. Being able to be calm, knowing that no one will enter the room, except for her [the midwife]. That also helped me a lot to be calm and to be able to be like home.' (P8, Combined care)

The transition between rooms often highlighted disparities in ambiance and privacy:

'I went up to the room [antenatal ward], and they told me that when the contractions were continuous and strong, I should let them know, and I could come down [to the OU]. So, when I thought it was time, I asked to come down. There was no dim lighting, I mean, it was a cold hospital room with bright white light that was blinding me. There were people walking up and around, and I felt a bit defenceless.' (P13, OU)

Furthermore, Participant 16 reinforced the significance of ambiance in cultivating a sense of intimacy:

'I think that privacy is important. The privacy that you have, right? In the room, in the entire environment. I believe that for giving birth successfully you need this privacy ... the low light, minimal noise. So, you can enter into your own world. I think that it is important.' (P16, Combined care)

Respectful care

There was an absolute consensus among participants on the significance of respectful care in their childbirth experiences. This can be seen through the words of this participant, which expresses a deep appreciation for the respect received:

'For me, the most crucial aspect was the respect I felt throughout, and the support. ... I felt like I was in harmony, right, with the midwives and such. Above all, I felt very respected. It really bothers me when they infantilize me; it makes me very angry. I cannot tolerate it. This feeling of "I am the doctor, and I know, and you don't". That

paternalistic attitude, "I am big, and you are small", I can't stand it. For me, this is the main aspect.' (P15, Combined care)

Reflecting on the limited emphasis on women's experiences in the OU, participants reported a sense of diminished respect and attention to their emotional well-being. Participant 2 vividly describes her experience upon going to the theater for a cesarean section:

'As I entered the operating room, I was ... It was a drama, feeling nauseous, trembling. In the operating room, no one said anything to me. Until at one point, I said, poking my head through the surgical screen, 'Hey, today is a very important day for me". I didn't say it to seek attention at that moment but because I wondered if someone would look into my eyes at any point. That really bothered me because it felt like me on one side, [of the surgical drape] and another world going on the other.' (P2, OU)

Navigating the protective factors

Meeting 'elements of value' in care

Despite facing unmet expectations during childbirth, women emphasized 'elements of value' that triggered positive emotions or acceptance of the experience. Participant 10 summarized several of these 'elements of value', encompassing patient-centered care, individualized attention, emotional support, accompaniment, and compassionate care, despite undergoing a cesarean section:

'I ended up having a cesarean section, but I was very clear about the birth plan. I was able to discuss it calmly, and the medical team there was very pleased because they told me it was the first cesarean they had done with such respect. They lowered the curtain; I could see the baby coming out. We did skin-to-skin immediately. My husband was there; he could record everything. They turned off the lights, which they had never done before. I asked them to turn off the lights and leave only the illumination on the belly. Well, despite it not being what we wanted, it wasn't so bad in that regard.' (P10, OU)

Participants highly valued the sense of control manifested through various means, including keeping them informed and engaged during interventions, providing continuous updates on administered medication, explaining procedures, and detailing the childbirth process. For instance, this participant stated:

'When they said, "We'll need vacuum extraction", I felt the only moment of panic. My legs were shaking uncontrollably. I vividly remember grabbing Shavonne's [the midwife] hand tightly and telling her, "Shavonne, I need you to explain how this will go". She showed me the vacuum and explained each step with detail. That's when I started calming down.' (P5, OU)

Midwifery's role on 'childbirth essentials' and 'elements of value'

Providing close, understanding, and humanized care, particularly by midwives, remains integral in shaping a positive birthing experience. Their presence and support, without overshadowing the woman, her chosen companion, and the newborn, significantly impacted the overall childbirth experience. Participant 8 exemplified this sentiment through her description of the connection and trust with the midwife:

'The connection I had with Hannah [the midwife] was ... well, that atmosphere ... well, she, yes, so familiar, so close ... We were lucky, or not (laughs), that we got her a couple of times [on antenatal appointments]. And then, in those two times, we established a kind of relationship, and... and we already knew that she would be there on Monday, and since the baby had to be born on Monday no matter what, we already knew she would be there, and that gave me a lot of peace, you know? Knowing she would be there and knowing that Hannah would be super sweet, and well, that treatment, like super close and as if we had known each other all our lives.' (P8, Combined care)

However, when instances of a lack of connection with midwives were reported, feelings of loneliness emerged:

'Some time has passed now, so I can talk about it more comfortably. I understand that everyone is different, and I was at the hospital for forty-eight hours, so I saw many people come and go, but with the midwife who came in the morning, I don't know how to call it. Empathy? I felt a lack of presence, you know? I wasn't asking her to be by my side all the time, but not absent either, I just felt that she wasn't as present. And that started to affect me. ... I felt super alone.' (P18, Combined care)

The role of advocacy for women's empowerment

Advocacy was important for participants during childbirth, providing support even when decisions did not match their preferences. Women valued having someone, often a midwife, advocate for their expectations and desires:

'I felt that she [the midwife] had read my birth plan, understood my desires, and even though there were decisions that I didn't truly expect, I sensed that I had some influence. She became my voice in the team, advocating for what I wanted ... Always striving for that extra time and the least medicalized approach possible. She also listened to my partner, for instance, when he conveyed, "No, she wants it to be in the water". Throughout the day, she remained very attentive to both of us, always there if we needed anything and ensuring privacy.' (P8, Combined care)

Women who felt more supported during childbirth described a more positive overall experience and a sense of empowerment. Feeling empowered, listened to, and supported during labor extended beyond the birthing process:

'What I liked was that Hannah and Sofia [the midwives] accompanied me, and honestly, I really liked how they intervened. The way they ... They were present ... I felt like the protagonist, me and my baby. That was really beautiful. You feel that you are capable. They would say, "Yes, you can", and I don't know ... It's a very beautiful support, really. And for me, having given birth there, well, the truth is that ... I will have a very good feeling from when I had my baby until ... well, throughout my life, right? Because I think childbirth ... it marks you, right? As a woman. ... For me it was incredible and magnificent, and I will never forget

it. For my little one, surely too, and well, for my family in general, for my partner, and for everyone, well ... Fantastic ... (laughs).' (P9, MLU)

DISCUSSION

Our study explored the factors influencing women's perceptions of childbirth experiences within the context of newly introduced MLUs in the Spanish Healthcare System. The findings highlight the significant impact of women's expectations, the model of care, and the role of midwives on the overall childbirth experience.

Women's expectations play a crucial role in shaping their childbirth experiences. Unmet expectations pose considerable challenges for most women, leading to negative perceptions and emotional distress[23]. Social interactions, past experiences and cultural norms[24] often mold these expectations. The accounts of women relying on online resources and peer discussions highlight a gap in real-life exposure to childbirth[25], often adding an additional layer of pressure on the societal image of maternity, contributing to feelings of guilt when the experience deviates from this expectation[24], suggesting a need for more community-based education and experiential learning opportunities. Previous childbirth experiences profoundly impact subsequent expectations. Dissatisfying experiences drive women to proactively shape their future expectations, aligning with the concept of 'redemptive birth' explored by Thompson and Downe[26].

Our findings reveal disparities in accessing MLUs within the Spanish healthcare context. Uneven information presents challenges for women seeking an MLU, often relying on personal networks for guidance[27]. Comprehensive, early, and continuous communication between healthcare providers and expectant mothers is essential to empower women in their birth choices[18].

The model of care and the role of the midwives are pivotal in mediating childbirth experiences. A biopsychosocial approach, characterized by patient-centeredness, informed choice, and holistic support, is crucial for a positive birthing experience[3,28]. The MLU, inherently women-centered, aligns with these principles. At the same time, the traditional OU, grounded in a biomedical model, often falls short in meeting these elements, emphasizing the need to shift towards more patient-centered models[29]. Furthermore, the systematic review by Downe et al.[30] also highlights giving birth to a healthy baby in a safe environment as an important factor.

Midwives play a significant role in providing compassionate, understanding, and humanized care, enhancing the overall experience[31]. Trust and connection with midwives during crucial moments are essential, reflecting the concept of 'watchful attendance' from de Jonge et al.[32]. This dynamic supports the perception of control and agency, leading to more positive birthing experiences[33]. Midwives also act as health advocates, ensuring women's voices are heard and respected during childbirth. This is consistent with the findings from Watson et al.[34] and Kuipers et al.[35]. Feeling empowered, listened to, and supported during labor extends beyond the birthing process, influencing women's identity as mothers and their broader life perspectives[36]. Our study aligns with Michels et al.[37], indicating that a positive perception of childbirth correlates with increased self-esteem, self-efficacy, independence, and empowerment.

A key finding of this study is that elements inherent to the biopsychosocial model of care are transferable to the OU, acting as protective factors against a negative experience. Elements such as personalized care, respect for privacy and dignity, and creating a supportive environment that fosters emotional well-being were successfully incorporated from the MLU into the OU. Women who experienced these elements in the OU reported feeling more supported and respected, mitigating the potential negative impacts of a highly medicalized environment. However, certain aspects of the biopsychosocial model, such as minimal medical interventions, home-like birthing environments, and continuity of care, were only fully realizable in the MLU. These features are integral to the MLU's philosophy and, in our case, were not entirely transferable to the OU due to its inherent focus on managing high-risk pregnancies and complications. Establishing MLUs in the Spanish Healthcare System facilitates the integration of patient-centered care across different settings, influencing OU practices. Expanding midwifery-led care models and ensuring comprehensive, early, and continuous information for expectant mothers are essential to enhancing maternity care quality. Structural changes within maternity care settings are needed to reduce midwives' workloads and improve personalized care, ensuring continuous support for all women during childbirth.

Strengths and limitations

The primary strength of this study is its role as the first qualitative investigation into childbirth experiences post-implementation of the first MLU in the Spanish Healthcare System. However, although rich in narrative depth, qualitative data may present challenges regarding generalizability and replicability. The sample's predominantly Western European, highly educated composition may limit the diversity of perspectives captured. Additionally, not identifying more variables related to participants' socio-economic status could have provided a more comprehensive understanding of varied childbirth experiences. While online interviews offer convenience during the postnatal period, in-person groups may be more fitting for addressing emotionally sensitive topics.

Nonetheless, efforts were made during the focus group discussions to foster a safe environment to encourage expressing any type of feelings. Despite these limitations, the study's adoption of a constructivist paradigm and a phenomenological approach ensures a thorough exploration of women's lived experiences. Independent data analysis by researchers from different professional backgrounds also helps to avoid biases and enriches the interpretation of the findings.

CONCLUSIONS

Our study provides a comprehensive understanding of the

factors influencing women's childbirth experiences within the Spanish Healthcare System, particularly following the introduction of MLUs. It highlights the importance of birth expectations, care models, and midwifery roles in women's childbirth experiences. Midwifery-led, characterized by respectful, individualized, and supportive care, is essential for positive childbirth experiences. The biopsychosocial model of care, which emphasizes patient-centeredness and holistic support, is central to this approach. Our findings show that elements of this model can be effectively integrated into traditional OUs, improving women's experiences even in more medicalized settings. Ultimately, our findings offer valuable guidance for healthcare providers and policymakers aiming to enhance maternity care quality and promote positive childbirth experiences for all women.

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DATA AVAILABILITY
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