
ARTICLE

Homebirth and the National Health Service in Italy. A qualitative study in the Emilia-Romagna Region

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ABSTRACT

Introduction: Medicalization of birth has increased all over the world in the past decades. The Italian caesarean birth rate (38%) is among the highest in the world. Could be birth at home as a public model of care a superior alternative to current practices? This paper focuses on the experience of the Emilia-Romagna region, where the National Health Service (NHS) has carried out a home birth service for more than 13 years. The aim is to discuss the strengths and weaknesses of homebirth as a public health model compared to homebirth within the private practice system.

Methods: Qualitative data were collected between 2010 and 2013, as part of a wider anthropological research project on out-of-hospital birth in Italy and Spain. Seventy participants were interviewed in total. In Emilia-Romagna, in-depth interviews were conducted with 21 participants; these included midwives, women, doctors and health managers. Focus groups, a field diary and participant observation were also used for data collection. Data were analyzed using ethnographic method and content analysis.

Results: Main findings suggest that the added value provided by the NHS home birth service in the Emilia-Romagna region (home births attended by community-based or hospital-based midwives) compared to the private care model encompass increasing of the social legitimacy of homebirth, the transfer of best practices from homebirth to hospital birth, increasing the continuity of care when the woman is referred to the hospital, increasing the continuity of training and the autonomy of midwives in caring for normal births in the hospital and providing free services. Homebirth managed by the NHS contributes to the promotion of a physiological model of care also in the hospital.

KEY WORDS

home childbirth, natural childbirth, midwifery, public policy, pregnancy

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ARTICLE

L'accouchement à domicile et le Service national de santé en Italie : Une étude qualitative portant sur la région de l'Émilie-Romagne

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RÉSUMÉ

Introduction : La médicalisation de l'accouchement s'est accrue à l'échelle internationale au cours des dernières décennies. Le taux de césarienne constaté en Italie (38 %) figure parmi les plus élevés du monde. L'accouchement à domicile à titre de modèle public de soins pourrait-il constituer une solution de rechange supérieure aux pratiques actuelles? Cet article porte sur l'expérience de la région de l'Émilie-Romagne, où le Service national de santé (SNS) a offert un service d'accouchement à domicile pendant plus de 13 ans. Nous avons pour objectif de discuter des forces et des faiblesses de l'accouchement à domicile à titre de modèle de santé publique, par comparaison à l'accouchement à domicile tel qu'il s'inscrit dans le système de *pratique privée*.

Méthodes : Des données qualitatives ont été cumulées entre 2010 et 2013, dans le cadre d'un projet de recherche anthropologique plus vaste portant sur l'accouchement en milieu non hospitalier en Italie et en Espagne. Soixante-dix participants ont été interviewés. Dans la région de l'Émilie-Romagne, des entrevues en profondeur ont été menées auprès de 21 participants (dont des sages-femmes, des femmes, des médecins et des administrateurs du domaine de la santé). Des groupes de discussion, un journal de terrain et l'observation participante ont également été utilisés aux fins de la collecte des données. Celles-ci ont été analysées au moyen d'une méthode ethnographique et d'une analyse de contenu.

Résultats : Les résultats principaux semblent indiquer que la valeur ajoutée offerte par le service d'accouchement à domicile du SNS dans la région de l'Émilie-Romagne (accouchements à domicile supervisés par des sages-femmes communautaires ou œuvrant habituellement en milieu hospitalier) était comparable à celle qu'offrait le modèle de soins privés, que ce service accroît la légitimité sociale de l'accouchement à domicile, qu'il permet le transfert de pratiques optimales (de l'accouchement à domicile à l'accouchement en milieu hospitalier), qu'il accroît la continuité des soins lorsque la femme est orientée vers l'hôpital, qu'il accroît la continuité de la formation et l'autonomie des sages-femmes pour ce qui est de l'offre de soins dans le cadre d'accouchements normaux en milieu hospitalier, et qu'il permet l'offre de services gratuits. L'accouchement à domicile géré par le SNS contribue également à la promotion d'un modèle physiologique de soins en milieu hospitalier.

MOTS CLÉS :

accouchement à la maison, accouchement naturel, pratique sage-femme, politique publique, grossesse

INTRODUCTION

Pregnancy and childbirth have become increasingly medicalized during the last century in most parts of the world. The process is quite often conceived and treated as a medical event, requiring control, risk management and a constant monitoring of the woman's body and health.¹⁻⁹

In Italy, 556,000 children were born in 2011 (last update data); the average age of mothers was 31.4 years old, and the average number of children per woman was 1.42. In 2009, the stillbirth rate was 2.7 per thousand births, the rate of perinatal mortality was 4.6 per thousand live births and the infant mortality rate was 3.4 per thousand live births.¹⁰ The caesarean birth rate increased from 11.2% in 1980 to 33.2% in 2000, to 38% in 2008, among the highest in the world.^{11,12}

In many hospitals, a more humanized model of birth has been introduced in the last decades, including home-like rooms, free position during labor or delivery, and the use of pools. However, the Italian way of birth still includes a variety of routine medical interventions, including labor-inducing drugs, lithotomic position, epidural, fetal monitoring, episiotomy and an excess of surgical deliveries. Furthermore, pregnancy is over-medicalized. Only 9.4% of women received three or two scans, which is the number recommended by the National Health Service (NHS).¹³ High-risk women have on average 7.8 visits, just one more visit in comparison to the average for low risk pregnancies.¹⁴ This indicates that pathological and physiological pregnancies undergo the same pathway/treatment in Italy. The type of caregiver contributes to this situation. In Italy, the majority of pregnant women turn to gynecologists (78.5%), often a private specialist (44.7%). On the contrary, delivery will take place in most cases in a public hospital.^{11,15-17} Over-medicalization is far from being critically and adequately examined within the biomedical practice in the country. It is largely overlooked in the prevailing discourse, despite the fact that since 2000, national policies have been implemented that are aimed at these objectives.¹⁸ These issues are prominent instead in the conversations of those who make different choices: midwives who attend out of hospital births and women or couples who decide to deliver in places other than the hospital, at home or in a maternity home. In Italy, the percentage of those women opting for an out-of-hospital birth is still minimal: less than 1%, as in many other European countries; higher rates are present in Wales (1.4%), Iceland (1.8%), England (2.7%), Galles (3.7%) and Netherlands (27.7%).¹⁹

Out of hospital birth refers in Italy to three options:

women can deliver at home attended by a private midwife; they can choose a maternity home, which is usually a private structure managed by the midwives themselves that offer a non-medical way of birth in a home-like setting. In Italy, there are four maternity homes, all situated in the north of the country; finally, homebirth is made available in a few regions by the NHS. Delivery at home is attended by midwives working within the system. This is the case in the Emilia-Romagna region.

Emilia-Romagna is located in the north of the country. The current population is 4,459,246 people.²⁶ In 2012, 39,337 babies were born in the region. As in the rest of Italy, most of the women (52.3%) used private services during pregnancy, but delivered in a public hospital (98%). There are 31 hospitalized birth settings in the region. The rate of caesarean section was 29%, the rate of induced labor was 26.1%, and the average number of visits during pregnancy was 6.8.²⁶ In the region, out-of-hospital birth (at home or in a maternity home) stood at 0.5%. The absolute data comprised 163 out-of-hospital births in 2009, 221 in 2010 and 208 in 2011.²⁴

Regional law n. 26/1998 allows women to deliver in public and in private hospitals; at home, attended by an independent midwife or by a hospital-employed/community-based midwife working within the NHS; and in the maternity home "Nido", situated in Bologna. If women in the region choose an independent midwife, the NHS reimburses the woman 80% of the amount incurred for delivery. Regional guidelines (Table 1) state that the service is available to women with low-risk pregnancies; a second requirement is that the location of home-birth is not far from the hospital (20 or 30 minutes).²³

In this paper I will focus on the NHS home birth service in the cities of Reggio-Emilia (163,928 inhabitants) and Parma (78,365 inhabitants).²⁵ The universalistic Italian NHS is organized into the Aziende Unità Sanitarie Locali (AUSL) and the Aziende Ospedaliere (AO). The former includes primary level hospitals and hospital departments, which are arranged into districts. The latter includes secondary and tertiary level hospitals and specialized health care services. At the moment, the Home Birth Project (HBP) is managed in Parma by the AUSL and in Reggio-Emilia by the AUSL and AO. In Parma, the majority of midwives were involved in work community health care services (consultori), which are well-rooted in the territory. In Reggio Emilia, the majority of midwives attending homebirths are hospital-based. They work at the Hospital Arcispedale S. Maria Nuova, a large public hospital performing 2500 births per

year. Nine midwives are involved in the HBP in Reggio-Emilia and six are involved in Parma.

The Emilia Romagna region offers a unique opportunity in Italy to compare two ways of offering homebirth services (public and private). The aim of this paper is to discuss the strengths and weaknesses of homebirth as a public health model compared to homebirth within the private practice system.

METHODOLOGY

The data presented in this paper were collected as part of the project 'An Intercultural and Ethical Code on Birth: A dialogue between institutional directives and women's needs' (2010-2014). The project intends to explore, from a medical anthropological perspective, midwives' and women's experiences on giving birth out-of-hospital (i.e., at home or in maternity homes) in three European countries: Italy, Spain and the Netherlands. It intends also to analyze the official medical and political "discourse" on this topic. The study was approved by the Ethics Committee of Azienda Ospedaliera S.Maria della Misericordia in Udine. An informed consent was signed by the participants.

Between 2010 and 2013, the project included the following: a) a review of the World Health Organization documents on birth care since 1985—the year in which the foundational document "*Appropriate Technology for Birth*" was published; b) the collection of quantitative data on the subject; c) the analysis of the policies implemented at the national and local level in the countries involved in the study, focusing on the organization of birth-care services, guidelines and care protocols, obstetrician and midwife training and the engagement of women and couples in the decision-making process; and d) fieldwork in Italy and Spain.

The fieldwork consisted of visiting two maternity homes in Italy and one in Spain, where in-depth interviews and participant observation were carried out. Ethnographic interviews were conducted with independent and hospital-based midwives, gynecologists and experts, and women who gave birth out of hospital. A total of 70 persons were interviewed in both countries. The interviews were transcribed. The text was categorized based on meaning units, code, subcategories and categories. The categories finally resulted in one theme that highlight the strengths

Table 1. Main eligibility requirements for home birth mandated by the Emilia-Romagna region (Regional Law n. 570/2008)

<i>List of main eligibility requirements for home birth mandated by the Emilia-Romagna region</i>
<ul style="list-style-type: none"> • Absence of significant pre-existing mother's disease • Absence of significant disease arising during pregnancy, including hypertension and gestational diabetes requiring insulin • Absence of significant fetal disease • Absence of fetal-pelvic disproportion • Cephalic presentation • Gestational age between 37 plus 3 days and 41 plus 3 days weeks of pregnancy • Singleton fetus • No previous dystocic birth and caesarean section (a case by case assessment is needed) • Absence of poor history or previous perinatal mortality (a case by case assessment is needed) • Absence of surgeries such as conization, myomectomy, etc. (a case by case assessment is needed) • Absence of previous post-partum haemorrhage • Absence of mother's uterine malformations, vaginal fistulas, myomas etc. • Normal amniotic fluid volume • Normal fetal development • No use of hard drugs • Absence of positive for group B streptococcus to 35-36 weeks of pregnancy

Table 2. Informants

<i>Informants</i>	<i>Numbers</i>
Health managers in charge of the Home Birth Project	2
Independent midwives	5
Midwives attending home births within the national health care system	9
Women who used the service	5
Total	21

and weakness of homebirth according to participants' perspective. A field diary was punctually compiled. To compare and contrast emerging issues, two focus groups with Italian and Spanish midwives and two focus groups with Italian women who gave birth at home were also carried out. All the interviews (on average 1.5 hours in length) and the focus group discussions (on average two hours each) were taped and literally transcribed. The qualitative analysis software Atlas Ti was used for coding. For the analysis of the data, units, categories, themes and macro-issues were identified, compared and contrasted, as per the ethnographic method and text analysis.²⁰⁻²² The analysis focused on unpacking the underlying meaning and processes.

RESULTS

In the Emilia Romagna region, fieldwork was carried out in March-April 2011 and in October 2013. This paper is based especially on the analysis of 21 in-depth interviews (Table 2).

The strengths and weaknesses of the service were identified according to the perspectives and experiences of the women, midwives, and health managers. The findings from the interviews suggest the added value provided by the NHS home birth service in the Emilia-Romagna region (home births attended by community-based or hospital-based midwives) compared to the private care model (Table 3).

In addition, interviews and observations carried out in the Hospital S. Maria Nuova suggest that the experience in this hospital (i.e., hospital-employed midwives attending homebirths) has the following strengths:

- The transfer of best practices from home birth to hospital birth, translating into a stronger physiological approach even in hospital care and throughout the

obstetric department. In the Hospital S. Maria Nuova, the presence of the gynecologist during childbirth is provided for only 27.3% of deliveries, a value significantly lower than the regional average of 68.4%²⁵ and the national rate of 90.35%.¹¹

- Increasing the autonomy of midwives in caring for normal births in the hospital and the professional legitimacy of home birth. HBP contributed to strengthening the relationship among the midwives and to legitimizing homebirth throughout the obstetric department. After the beginning of the project, 80% of hospital-based midwives working at the Hospital S. Maria Nuova gave birth at home attended by a colleague.²⁷
- Increasing the continuity of care when the woman is referred to the hospital. The midwives in charge of the woman are the same and operate in her usual place of work.

The weaknesses of home-birth within the public health model, as implemented in Emilia-Romagna are:

- Poor promotion of the service.
- A small number of women using the service.
- Poor visibility and dissemination of the project among experts and decision-makers.
- The lack of research and data on the project.

DISCUSSION

Although homebirth is still a controversial topic, evidence-based literature shows that in high-income countries, homebirth is associated with fewer obstetrical intervention and no increase in maternal/fetal/neonatal mortality or morbidity compared to hospital births; sometimes it is even safer than hospital birth, because it provides fewer unnecessary interventions, personalized care and enhances women's empowerment.²⁸⁻⁴⁰ The

Table 3. Strengths of the NHS service in the Emilia Romagna region

<i>Strengths</i>	<i>Details</i>
Increasing the social legitimacy of home birth because the service is provided by a public entity	The national health care service engagement is perceived as a safe criteria.
Increasing the continuity of training and the quality of care	Guidelines ²³ say that 2 midwives must be present in the birth setting; usually however, a third and often younger in training midwife is also present. The HBP provides an opportunity for midwives to receive permanent training on the physiology of birth
Providing free services	Home birth care by an independent midwife costs on average 2.500 Euro
Increasing woman satisfaction	According to participants' experience, the major strengths were the continuity of care, the freedom to choose their own midwife, the ability to choose the place and the position of birth, less invasive interventions, respect for the mother and baby's timing and the care in the postnatal period.

majority of people in Italy do not have information about this issue. Many women are unaware that they can choose the location and method of birth and think hospitals are the only (and better) place to deliver. According to 100% of the interviewees, the engagement of the NHS in homebirth care provides the social legitimization of home birth and increases awareness of homebirth options.

The HBP provides an opportunity for midwives to receive permanent training on the physiology of birth. A total of 100% of the midwives and health managers interviewed believed this was a key advantage. Academic training is generally biomedically oriented; this approach focuses on pathology and high-risk pregnancy. In contrast, midwives need to be more in touch with normal birth. Attending births as a third midwife allows young caregivers to improve their skills and to maintain their physiological approach skills.

There was a stronger physiological approach observed even in the hospital. This process contributed to increasing midwives' autonomy in labor and normal delivery. It also contributed to strengthening the relationship among the midwives and to legitimizing homebirth throughout the

obstetric department.

From 2000 to 2012, hospital-based midwives in Reggio-Emilia attended 81 homebirths out of 147 initial requests, on average 12.25 deliveries a year. Main background characteristics of the 72 women were the following: 66% of women were 30-39 years of age; 70% -80% of women had a high level of education (University or College); 70% of women worked.²⁷ A total of 100% of the women interviewed had positive feelings about the service. All women considered the free service an important element in their decision-making process.

Both in Reggio-Emilia and in Parma, a community-based midwife attends the woman during pregnancy; in Parma, the same midwife attends the birth. In Reggio-Emilia, the woman meets the hospital-based midwife who will attend her birth when she is at least 32 weeks pregnant. In the second case, the continuity of care is lower, but still higher than that normally expected in Italian hospitals. Usually in a hospital setting, the caregiver (midwife or doctor) who visits the woman is the one who is on shift at the time of delivery; often, women have never met the caregiver that assists their delivery. All participants

mentioned the continuity of care during pregnancy (i.e., being cared for by a well-known and trusted midwife) as an added value of homebirth care. If the woman is transferred to the hospital, in Reggio-Emilia the midwife takes care of the delivery where she works. Community-based midwives or independent midwives do not operate in hospitals; thus, when a woman is transferred in Parma or in other cities, the local hospital-based midwives take care of her, so the continuity of care is interrupted. However, this interruption occurs less often than in those regions where homebirth is not supported by the public model.

All participants agreed that the service was not advertised enough. In the regional web portal the service is mentioned, but most likely does not reach appropriate communication channels. In most cases, women requested the service because of their own history; for example, among the women who delivered at home, many followed an “unconventional” lifestyle, such as using homeopathic medicine, or experienced previous traumatic hospitalized birth, etc.

The health services executives and health practitioners interviewed mentioned just a few dissemination events, both at the local and at the national level; and a lack of research and data on the project. An analysis of the cost-benefits of the service in comparison to hospitalized birth is desirable. Many studies show that delivering at home is less expensive than hospitalized birth,⁴¹⁻⁴³ but context-specific data are missing.

A small number of women using the service. According to health managers and midwives, the number participating is still low because of the: 1) poor visibility of the project, 2) strict selection criteria for pregnant women, and 3) small number of midwives employed in the project.

I will focus on the poor visibility and the insufficient number of midwives. People involved in the project considered the service very positive. However, the political environment dedicates too little attention to homebirth. Poor resources (for example for the recruitment of midwives) and poor visibility (at the social, medical and political level) hinder the use of this service. This was observed both in Reggio-Emilia and in Parma. Health professionals and managers described their personal commitment and hard work to comply with the expectations of the women and institutions involved. They also mentioned the so called “fear of large numbers” shown by decision-makers. In Italy, interest in homebirth is increasing. More and more pregnant women feel uncomfortable being treated as if they were sick and ask the State for different pathways and

innovative birth care models.

The perception that the Emilia-Romagna homebirth experience may lead to an increase in demand for homebirth at the national level is most likely correct. This would mean a radical rethinking of the policies and practices on childbirth in the country and an expanded national process, including a redistribution of resources and powers. For now, the service in this region “survives”, as mentioned by many interviewers. “To live,” it should receive larger political support and social visibility, both at locally and at the national level. Home-birth represents an option for Italian women and the recognition of her right to choose.

CONCLUSIONS

The results of the qualitative research carried out in Emilia-Romagna suggest that homebirth within a public model confers several advantages in the experience of birth for both women and professionals. In short, homebirth within a public model actualises and legitimates a physiology-centred and women-centred model of birth, maintaining the benefits of biomedicine when needed. This calls for politicians and administrators to dedicate more attention and resources to this service in order to make it accessible to more women.

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