Case Study: Exploring participants' perceptions of an “Expert in Birth Centres” training programme in Spain and identify factors influencing the application of learning in clinical settings.

1. Introduction / Background

In Spain, maternity care is primarily hospital-based and obstetric-led, with a strong emphasis on protocolised care and a comparatively high rate of medical interventions (Palau-Costafreda et al., 2023). Midwives often work within hospital settings and lack full professional autonomy (Iglesias-Casás et al., 2024). Against this backdrop, the “Expert in Birth Centres” training was introduced to strengthen midwives’ confidence and competence in midwifery-led, physiological birth care.

The six-months university-based programme was designed to align Spanish midwifery practice with European MLC standards, focusing on:

1. **Obstetric Emergencies**
2. **Neonatal Assistance**
3. **Physical-Emotional Support During Gestation and Birth**
4. **Practical Applied Research**

It sought to equip midwives to deliver safe, holistic, and autonomous care in birth-centre settings an to foster a cultural shift towards woman-centred practices.

This curriculum of the training under MUNet Standards was specifically developed to enhance maternity care quality by minimising inconsistencies in practice and promoting a holistic approach that addresses a bio-psycho-social model of care. By educating maternity healthcare professionals on these principles, the training seeks to directly address and reduce the disparities in maternity care, ensuring that all women receive consistent, high-quality care regardless of their location.

2. Aims and Objectives

Aim: To explore midwives’ perceptions of the Expert in Birth Centres training and identify factors influencing the application of learning in practice.

Objectives:

• Examine participants’ motivations and experiences of the training.

• Identify perceived strengths and limitations in curriculum design and delivery.

• Explore barriers and facilitators affecting the application of learning in clinical settings.

• Generate recommendations for programme and system improvement.

3. Methodology

A qualitative, phenomenological approach was used to capture participants' lived experiences. Semi-structured online interviews (approximately one hour each) were conducted with midwives who completed the programme.

Interviews explored perceptions of learning, skill acquisition, confidence, and implementation in practice. Data were analysed thematically following Braun & Clarke (2006, 2021), identifying seven core themes.

Ethical approval was obtained from the host institution. All data were anonymised, and quotations translated from Spanish for reporting.

4. Findings

Seven interrelated themes emerged, offering insight into both the personal and systemic dimensions of professional learning:

1. Empowering and Motivational Learning Experiences
2. Practical and Relevant Skill Development for Midwifery Unit Practice
3. Importance of Confident, Experienced Facilitators in MU and Midwife-Led Care
4. Reflective and Collaborative Learning Through Diverse Perspectives
5. Disconnect Between Some Course Delivery and Midwifery-Led Practice
6. Disillusionment Due to Lack of Implementation
7. Systemic Barriers to Integration and Implementation

<u>Theme 1: Empowering and Motivational Learning Experiences</u>

Participants consistently described the training as emotionally revitalising and professionally affirming. The curriculum rekindled passion for midwifery-led care and reminded midwives of their clinical and emotional impact. One participant shared that it "helped me recognise the value of our profession… how vital our role is at such a crucial moment in a woman's life."

Facilitators' enthusiasm and belief in physiological birth fostered motivation and renewed purpose. This emotional empowerment strengthened participants' professional identity and connection to core midwifery values.

<u>Theme 2: Practical and Relevant Skill Development</u>

Hands-on learning, such as simulations, emergency management, and intermittent auscultation was highly valued. Participants reported enhanced clinical confidence and readiness to manage real-life scenarios: “The simulations helped structure my thinking… I’ve already applied that in practice.”
However, many expressed a strong desire for direct exposure to functioning midwifery units. Observational placements or virtual tours were seen as critical for consolidating knowledge. The absence of such experiences left some feeling their learning was theoretical rather than experiential.

Theme 3: Importance of Experienced Facilitators

Participants emphasised that facilitators’ authentic experience in midwifery-led care greatly influenced learning outcomes. Sessions led by midwives who had worked in birth centres or homebirths were described as credible, inspiring, and practical. Conversely, sessions taught by educators without MU experience often caused uncertainty:
“Sometimes the trainers admitted they didn’t know how things would work in a birth centre.”
Learners called for facilitators who model autonomy, confidence, and respect for physiology, reinforcing the idea that expertise must be contextual, not purely theoretical.

Theme 4: Reflective and Collaborative Learning

Group discussion and interaction with peers from diverse hospitals enriched learning and encouraged reflection on different organisational cultures. This collaborative learning fostered innovation and practical change, for example, the adoption of a postpartum haemorrhage kit inspired by another team.
The diversity of perspectives promoted critical thinking and helped participants situate midwifery-led care within broader system challenges.

Theme 5: Disconnect Between Course Delivery and Midwifery-Led Practice

Although participants valued the training, they identified structural and pedagogical issues that limited its relevance:

• Lack of clear course progression: foundational knowledge about MUs was not introduced early enough.

• Hospital-centric content: some sessions (e.g., obstetric emergencies, hypnosis, yoga) felt disconnected from midwifery-led contexts.

• Uncertainty in application: participants felt underprepared to implement certain techniques in real settings.

This disconnect led to frustration and reduced confidence in translating learning into practice.

Theme 6: Disillusionment Due to Lack of Implementation

A major source of disappointment stemmed from the non-implementation of the planned midwifery unit in participants' hospitals. When funding or institutional commitment failed to materialise, enthusiasm turned to disillusionment: "We found out the project wasn't going to happen… everyone was thinking, 'So now what?'". Midwives felt their new knowledge remained unused, weakening morale and diminishing the perceived value of the training.

Theme 7: Systemic Barriers to Integration

Participants highlighted organisational and cultural barriers that prevented midwifery-led practices from being adopted. These included:

- Rigid hospital protocols mandating continuous monitoring and IV access
- Staffing pressures limiting individualised care
- Hierarchical supervision by obstetricians
- Lack of managerial support for innovation.

As one participant noted, "It's unthinkable to do intermittent auscultation… everyone gets continuous monitoring."

While midwives valued the course, institutional structures constrained their autonomy, preventing meaningful change.

5. **Analysis and Discussion**

This study reveals the complex interplay between effective educational design and systemic readiness for practice change.

Empowerment and Professional Identity

The emotionally affirming nature of the course strengthened participants' sense of professional worth and alignment with midwifery values, echoing findings by Skogheim & Hanssen (2015) that affirming environments enhance midwives' motivation and resilience.

Learning Through Experience

Participants' desire for real-world exposure mirrors evidence that competency-based, experiential learning is crucial for consolidating confidence in MLC contexts (Walker et al., 2018; Rayment et al., 2020). Without authentic practice environments, training risks remaining abstract.

Facilitator Authenticity

The credibility of educators emerged as a decisive factor. Consistent with McCourt et al. (2018), facilitators who embody midwifery philosophy and autonomy create transformative learning. Their lived experience bridges the gap between theoretical content and practice.

Collaborative Reflection

Cross-institutional peer learning fostered creativity and reflection, reflecting literature on inter-professional education that promotes shared understanding and system-wide improvement (Meroz et al., 2022).

Structural Constraints

The most significant barrier was the disconnect between learning and system readiness. Organisational cultures dominated by obstetric hierarchies and risk-averse policies limited implementation, reinforcing previous findings that training alone cannot drive change without structural and managerial alignment (Renfrew et al., 2014; Rayment et al., 2020).

6. Lessons Learned and Implications for Practice

Key enablers of effective midwifery education:

•Facilitators with lived experience in midwifery-led settings who model autonomy and confidence.

• Curriculum grounded in experiential, scenario-based learning.

• Opportunities for collaborative and reflective practice among peers.

• Clear pedagogical sequencing from philosophy to application.

Systemic requirements for sustained impact:

• Institutional readiness and leadership commitment to implement MLC models.

• Policy alignment, resources, and supportive management structures.

• Mechanisms for evaluating the translation of learning into practice.

Training programmes can only achieve their intended outcomes when organisational culture actively supports the philosophy and skills being taught.

7. Strengths and Limitations

This study provides novel insight into midwives' experiences of professional development in Spain, a context where midwifery-led care remains emergent. Its strength lies in its rich qualitative exploration and participant-centred focus. However, its findings are limited by the small, context-specific sample, and results may not generalise across regions or systems. Future comparative research could examine similar training in more established midwifery-led contexts.

8. Conclusion

The “Expert in Birth Centres” programme was perceived as professionally empowering and pedagogically valuable, enhancing midwives’ knowledge, confidence, and commitment to woman-centred care. Learning was most impactful when facilitated by experienced midwives who embodied the philosophy of midwifery-led practice and when sessions integrated practical, hands-on elements. However, the training’s potential was undermined by structural barriers and lack of implementation support. Participants’ inability to apply their learning in hospital settings created frustration and emotional fatigue, underscoring that education alone cannot transform practice without systemic change.

To maximise future impact, training should be embedded within supportive organisational cultures, backed by leadership committed to midwifery autonomy, and linked to tangible opportunities for practice in birth-centre or continuity-of-carer models.

By coupling strong educational design with institutional readiness, Spain’s maternity services could take a decisive step toward sustainable, midwifery-led care that truly centres women and families.