STSM REPORT

ISCH1405 COST ACTION (BIRTH)

Date of STSM: 25. - 30. 9. 2017

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LONG-DISTANCE TRAVEL/TRAVEL ABROAD TO RECEIVE OR PROVIDE MIDWIFERY SERVICES

ABSTRACT

The aim of this STSM Report is to investigate why women and midwives travel long distances to access preferred midwifery services. These practices exist across Europe, but they often go unnoticed, with little research being done in this area. I worked with Jette Aaroe Clausen with a particular emphasis on the development of our analysis of already collected interview data and also to interview midwives who travel long distances to work. During the STSM, we discussed the theoretical framework of the analysis, worked with data and worked on the structure of the article. Preliminary results of the analysis stress that women or midwives who travel are seeking services that have much in common with the midwifery model of care. Respect and trust are central values. Women search for practices that allow them to be active participants during the birth process and the midwives who travel highlight the same aspects as being valuable.

Keywords: medical travel, childbirth, women, midwives, distance, birth services, trust

INTRODUCTION

Childbirth is an important event in the life of a woman, the newborn and the whole family. The care provided constitutes an important setting and conditions for the birthing process and its outcome. Throughout the world, childbirth has become heavily medicalised, with Caesarean sections, induction of labour, augmentation, episiotomy and many other interventions in childbirth frequently used in many countries. Peristat, the European organisation that monitors Perinatal Health in Europe, has raised "[c]oncern about the iatrogenic effects of obstetric intervention in women who do not have a clinical need for it" and which "has put 'normal' birth firmly on the agenda for the 21st century" (Euro-Peristat 2008). Even though the majority of people living in Europe have access to healthcare facilities, it may still be difficult for women to access obstetric and midwifery services that attend to their needs. Keeping childbirth normal i.e. without unnecessary interventions, is part of the strategy of the International Confederation of Midwives (ICM) (ICM 2014). ICM recognises that birth without medical interventions cannot be taken for granted even for healthy women. In addition, women with complicated deliveries may be dissatisfied with local hospital services

In this context, some women decide to travel long distances or go abroad to gain access to or to provide the preferred type of care services. Experience of this type of travel includes not only those who are 'on the move' – pregnant women (and their families), and midwives – but also obstetricians who work in the hospitals to which some women travel. Our focus is on pregnant women, midwives and, indirectly, on their families.

Travelling for preferred (or accessible) health services, also known as medical tourism, has been studied in different scientific fields such as marketing studies, medicine, social science and geography. It is covered by the broad term: medical tourism or travel[1]. This label includes "the practice of travelling to another country with the purpose of obtaining health care" (Smith, Martínez Álvareza, Chanda, 2011, 277). This kind of travel includes cross-border searches for various types of healthcare, cosmetic surgery, dental care or organ transplantations (Connell, 2006). Despite the wide scale of research and debate on medical tourism, travel for childbirth services does not form part of the existing literature. Most articles focus on surrogacy and assisted reproduction.

Studies beyond medical tourism from the Netherlands (Ravelli et al., 2010) have focused on the effect of travel time during labour on mortality, or on the need to travel for obstetric care from rural areas in the United States (e.g. Nesbit et al., 1990). These studies refer to the experience which is not the focus of our research, as we define long-distance travel and/or travel abroad as a planned and self-initiated activity. This activity is also very clearly motivated by particular preferences of care and not by women merely attending the nearest available care services.

[1] Another, broadly used term is 'health tourism' and in some cases it is used interchangeably with the label 'medical tourism'. We use the term, 'medical tourism', as it includes travel only for healthcare. 'Health tourism' also includes travel for non-medical care (also known as 'wellness tourism') and the leisure activities are seen as part of this practice (Crooks et al., 2016)

The terms ‘long-distance travel’ and/or ‘travel abroad’ for childbirth services describe a move, which may or may not include crossing international borders, may or may not be over a long distance in geographical context, is short-term, initiated by women and focusing on a particular activity – childbirth and perinatal care. This means that some women travel a long distance, but not to another country, some go abroad, but the distance is close to the standard travel time, and some travel a long distance to another country.

To travel long distances and/or abroad to access preferred birth services is a minority practice in Europe. There are, however, no available statistical data to demonstrate the extent of this practice. This research cannot fill this gap, as these practices are sensitive and often performed under the radar. In some countries, some of these practices are even considered illegal or semi-legal.

1) We focus on women’s perspectives, with the aim of investigating what is meant by seeking/providing better services and the context in which their desires, needs and experiences are shaped.

2) We explore why midwives are willing to travel to provide midwifery services.

The aims of this mission are:

1. To explore why women travel long distance and/or abroad to seek good birthing services.

2. To explore why midwives are willing to travel to provide midwifery services.

3. To begin an analysis of interviews collected prior to the STSM.

4. To discuss the use of possible theoretical frameworks.

5. To conduct interviews with women and midwives (Skype and on-site)

METHODS

The aim of the STSM was to collaborate with Jette Aaroe Clausen to further develop our minor research project, which is part of the COST Action BIRTH, specifically Working Group 3.

Prior to the STSM, we did a systematic literature review and collected most of the data. We conducted a systematic literature review in scientific databases, such as JSTOR, SAGE, PubMed and also including Google Scholar. The search was done with keywords including: medical tourism, medical travel, health travel, (patient) mobility, cross-border healthcare, antenatal care, perinatal care, birth, pregnancy, labour, delivery, birthing. We found 156 articles focusing on travel/tourism and health, but only 33 articles which deal with travel/tourism in the context of pregnancy and birth.

Prior to the STSM, interviews were conducted with women who had travelled long distances or abroad to obtain preferred services, and also with an activist. Most of the interviews were

conducted with the aid of technology, as distances between researchers and participants were also 'long'. Interviews focused on their experience of travel for childbirth services and its context, particularly on motives, expectations and the realisation process.

Jette Aaroe Clausen had identified midwives who travel long distances to provide midwifery services, among them also Danish midwives. She arranged for us to interview them face to face, on Skype or on Messenger.

Overall, we collected 13 semi-structured in-depth interviews and one email conversation with an activist, midwives and women who had travelled long distances and/or abroad. During my stay in Copenhagen, we also conducted 4 additional interviews. We regard the possibility of the two of us together conducting the interviews with midwives as another positive aspect of the STSM. In this way, we could not only prepare the basic structure of the interview together, but also could react during it, according to our different fields of knowledge. Based on the interviews with women who travelled for birthing services, I have knowledge of the difficulties which they described and Jette has professional midwifery knowledge.

Because the researched topic could be a very sensitive topic for some women and some of these practices are carried out on a semi-legal basis, we had to be very careful not to reveal some information of the participants in the research. All the interviews were conducted with the promise of maintaining anonymity and we are very certain not to violate this confidence. For this reason, in this Report, I state only that we conducted an interview, without being more specific about the particular participant.

During the STSM in Copenhagen, we consulted on our research with Susanne Houd, an experienced midwife and teacher, who could be labelled as a 'global midwife' (maternity.dk, 2015). From her work in Greenland and Arctic Canada, she has experience of midwifery work in the remote areas to which midwives and women travel to access or provide midwifery services.

In order to develop an analysis, it was important to work face to face. We focused in particular on the interviews that had already been conducted and on one follow-up email correspondence with one participant. We focused on analysis and discussion. We also initiated the writing process and worked together to develop our text.

We chose thematic analysis as a guide and started our work by identifying and discussing the themes which emerged after the first round of the data coding process. Work and discussions followed about possible concepts with which we are familiar from our different scientific fields (midwifery and social science). We specifically discussed how these concepts could function in the same article. The coding process then continued and the meaning of the coded quotes was discussed. Our discussions were necessary and crucial for our common understanding of the data and their interpretation. The interviews with women who travel long distance/abroad were conducted in the Czech or Slovak language. We had to ensure that the English translation would not lose the meaning of participants' words. We worked intensively on this theme.

After the revision of the coding process, we identified key themes of the interviews and started the interpretation phase of the analysis. The final part of our work in Copenhagen was to set up a detailed structure of the article and to start working on its introductory and theoretical sections.

Work Schedule:

25/9	Arrival. Discussion on research and data. Research interview. Consultation with Susanne Houd and discussions on midwifery care and long-distance travel.
26/9	Mind mapping. Research interview. Coding and mind mapping.
27/9	Focus on coded segments and the translation problem. Analysis. Research interview.
28/9	Discussion on the article structure. Set-up of detailed structure. Research interview.
30/9	Developing the structure and writing the text. Drawing up schedule of future work.
31/9	Departure

RESULTS AND DISCUSSION

We are currently working on the analysis. This requires more work in order to develop it. Preliminary results show that both women and midwives travel because women cannot find appropriate choices for childbirth within their local communities. Women must travel outside their place of residence, or midwives must travel to reach the women's place of residence.

Deliveries took place both in private homes and hospital facilities. Even though some women travelled to give birth in hospital facilities, they shared the search for a non-interventionist childbirth and/or practices that subscribe to the midwifery model of care i.e. low intervention rates, respect for the individual woman and respect for autonomy.

We identified these key themes of the interviews: 1) better system of care; 2) process of hard work; 3) natural birth; 4) trauma and vulnerability; 5) trust; 6) system and routine; 7) commitment.

After the coding process and discussion, we decided to use the midwifery model of care and the medical model of care as core concepts (Clausen, 2014; Davis-Floyd et al., 2009). We will elaborate particularly on the concept of trust (Brownlie, 2008).

Travel abroad could be a very sensitive matter for both women and midwives. Some of them stay within the 'legal sphere' as in their own country or in the country to which they travel. However, some practices could belong to a 'grey area' from the legal perspective, which increases the level of vulnerability and insecurity of this experience. This practice in particular goes under the radar and remains invisible to a wider audience.

Travel is undertaken by a minority of both women and midwives. In order to understand these practices, we must analyse and discuss these practices within the broader context of the perinatal care given in places such as central, eastern and southern Europe.

From this follows the other expected contribution of this research. The midwifery profession is still negotiating its position in the system of perinatal care in Central European countries. For example, in the Czech Republic, hospitals are the only option for women to give birth with a professional birth attendant. Birthing houses and home births are not available. This is highly problematic, as the support system of care is missing and women who want to avoid a medicated delivery have hardly any way of finding supportive practices. The understanding of these women's motives and processes of realisation could become part of discussions about the midwifery model of care, its possibilities and limitations in the context of the midwifery profession in Central European countries.

The results of this research will be published in a scientific journal. We are now focusing on the writing process and plan to complete the English article in 2017.

I believe that the goal of STSM has been achieved. The possibility of examining the data and discussing them in face-to-face collaboration was crucial for our work. We also had the possibility of collaboration by conducting interviews and consulting on our research with Susanne Houd.

Some photographs are attached as documentation of my stay in Copenhagen. They illustrate:

1. Our work process, in this case we are using mind mapping
2. Work in progress
3. Jette and Susanne Houd
4. Jette and I at Metropol University. We sit in one of the meeting places in the university corridor, under the photograph of the founders of midwifery care in Denmark.

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