Original Article

Good practices in home births: perspectives of women who experimented birth at home

Clara Fróes de Oliveira Sanfelice[1], Antonieta Keiko Kakuda Shimo[2]

[1] Nurse, Ph.D in Nursing. Nurse at the Obstetric Center from the Women's Hospital Prof. Dr. José Aristodemo Pinotti at Universidade Estadual de Campinas. Campinas, SP, Brazil. Email: c023389@dac.unicamp.br.

[2] Nurse. Ph.D in Nursing. Professor of the Nursing Faculty at Universidade Estadual de Campinas. Campinas, SP, Brazil. E-mail: akkshimo@unicamp.br.

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ABSTRACT

A qualitative, exploratory and descriptive study to identify good practices of home births from the perspective of women who gave birth at home. The data were collected through semi-structured interviews, conducted in 2014, audio recorded and immediately transcribed. Fourteen women who experienced planned and assisted home birth, in Campinas-SP and region, composed the sample. Their lines were analyzed by the Bardin method for content analysis. The results originated four emerging categories: favorable environmental structure; freedom of choices; assistance and emotional support; and commitment of the health team. Such findings suggest that professionals who assist the parturient in the home assistance model as well as in the hospital, value these aspects trying to improve the quality of assistance. Gaps related to women's satisfaction, positive aspects of the experience, difficulties experienced, obstetric and neonatal outcomes, indicate possibilities for new studies.

Descriptors: Humanizing Delivery; Obstetric Nursing; Home Childbirth.

INTRODUCTION

The actual model of birth assistance in Brazil is characterized by predominant institutionalized attention, excessively medicalized, allied to high levels of cesarean surgery and, the indiscriminate use of technology and routine interventions without scientific backing[1].

According to recent statistics, a little more than 98% of births in the country occur inside health institutions[2]. Although it is common sense to consider the institutionalized birth as synonym of safety, a crescent volume of studies about experiences of women during pregnancy, and in particular at birth, have been demonstrating a disturbing picture, characterized by abuses, disrespect, maltreatment and negligence

during birth assistance in health institutions[3].

Given this scenario, a searching movement for planned births at home is observed, especially in large urban centers, even where access to health services is available, by women who are profoundly unhappy with the actual model, who search for and surround themselves with quality information to back them up. They go to the streets to ask for evidence-based practices and to report obstetric violence suffered and that is still present in most health institutions[4].

The international scientific literature compiles studies which theme is safety and obstetric and neonatal results of home births[5-7], with emphasis for the recent North American study with a cohort of 16,924 pregnant women with habitual risk who planned to deliver at home, followed during 2004 to 2009. The study presented a significant rate of natural births (93.6%), without increasing adverse results for the mother and baby[8].

National publications point to favorable results to home births, such as reduced rate of hospital transference, of cesarean surgery, of perineal traumas and, use of drugs during labor and post-labor, as well as high percentages of vertical positions during labor and delivery, skin to skin contact and breastfeeding at the first hour of life[9-10].

The practice of delivering at home have been related to higher education levels, possibly due to the facility to access information and health knowledge allowing critical analysis of obstetric practices and allowing the argumentation and support from the home birth decision[11]. Allied with these factors, to deliver at home seems to be a way to react towards institutional violence, the fragmentation and, depersonalization of hospital assistance[4].

Equipped with information, women who desire a home birth search for obstetric assistance based in scientific evidence. Thus, this study aimed to identify which are the good practices that are part of this assistance to home birth, from the voice of women who experienced it.

METHODS

An exploratory, descriptive and qualitative study, conducted with 14 women who gave assisted and planned birth at home, in 2014 in the city of Campinas- SP and region.

The criteria to include women in the study were: to be 18 years or older; to have experienced at least one planned home birth assisted by a qualified professional and, to be between three and six months postpartum. The definition of the number of participants met the sampling criteria by saturation, defined as suspending inclusion of new participants when the obtained data starts to be redundant or repetitive according to the researcher, thus, it is considered irrelevant to persist on data collection. This concept has been broadly used in qualitative studies in the health field[12].

Data were collected by an instrument composed by sociodemographic and obstetric characterization, and a semi-structured interview composed by three open questions. Interviews were audio-recorded and immediately transcribed, they had a mean duration of 25 minutes and they were conducted at women's

homes. All participants signed the Free and Informed Consent before the interview.

Data treatment and analysis occurred through a content analysis process proposed by Bardin (1977), composed by three steps: 1) pre-analysis; 2) exploring the material; and 3) treatment of results, inference and interpretation[13].

From the statements, we tried to discover the units of sense that were lately separated in subcategories and, after, grouped in four thematic categories for analysis: 1) favorable environmental structure; 2) freedom of choices; 3) assistance and emotional support; and 4) commitment of the health team.

To guarantee secrecy and confidentiality of statements, participants were identified by nicknames and they refer to the Greek-Roman mythology.

The study conduction is based on the national guidelines for studies with human beings, and it was approved in the Ethics in Research Committee from the Faculty of Medical Sciences at Universidade Estadual de Campinas/Unicamp, under the protocol n. 331.743.

RESULTS

Sociodemographic characterization

Women's age varied from 25 to 39 years, with predominance of the interval between 25-29 years of age. From the 14 participants, all had complete superior education and they were married or in a stable relationship. Within them, 13 had private health insurance, 11 reported to perform paid activity and seven had family income higher or equal to 10 minimum wages[1].

Regarding the obstetric data, eight were nulliparous and within the multiparous (n=6), five had a vaginal birth at hospital before the home birth experience.

Identified categories are presented in a diagram on Figure 1.

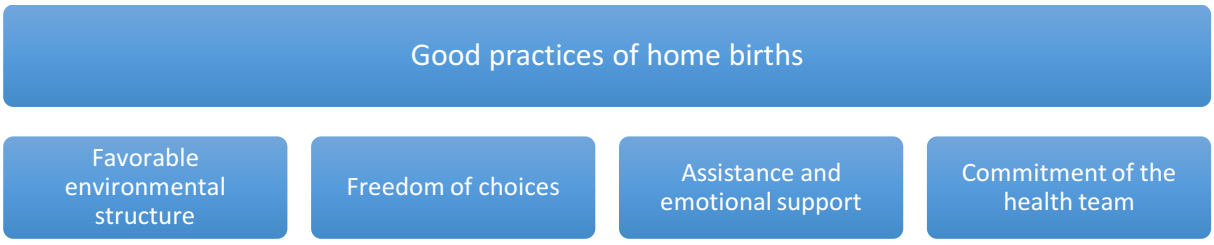

Figure 1: Diagram of categories. Campinas, SP, Brazil, 2016.

DISCUSSION

Favorable environmental structure

The study found that the experience of labor and delivery can be better experienced when the woman

[1] Reference minimum wage for the year 2014 = R$ 724.00.

has a favorable environment for this moment. According to participants of our study, non-invasive technologies for pain relief, related to environment, such as use of music, immersion in water and less luminosity, reflected positively in the experience, because they create a welcoming atmosphere and proper for relaxation.

(...) the water is very important, there are times that only the water helps (...) music: I've done a selection, (...) there were few for relaxation, mantra. Half-light, no lights one, only lamps, candles. The massages... (Hemera).

The favorable environmental structure also relates to the access/availability to non-pharmacological methods for pain relief.

A recent integrative review investigated the use of non-pharmacological methods for pain relief during normal labor pointing as the most used ones, the hydrotherapy (immersion bath or aspersion); walking; relaxation and breathing exercises, massage, delivery ball (Swiss ball), electrical stimulation and cryotherapy[14].

(...) the girls put a hot water bag here [lumbar region]. This was fundamental! Every time there was hot water gave me a lot of relief (…). The water helps you a lot to relax, so I used to take a lot of showers. I used to be in the bathtub for a long time with warm water: I think this is so important (…). She used to rub an oil on the back, used to massage and…it gave such relief!...(Tessala).

The heat and the fluctuation sensation that occurs when the woman enters the hot water helps to relief muscle tension and can provide a wellbeing sensation. Besides, the nerve stimulation of the skin promotes vasodilation, reversion of the sympathetic response and reduction of catecholamine production. Thus, contractions are less painful when the woman is in contact with warm water[15].

The bathtub is something that changes the dimension of concentration [pain conscience]: where it was hurting in a way, starts to hurt in another way, more bearable…, at the end, it was essential! (…) You worry less about holding yourself. You don't stand up, free in the air. You have the water support and that gives you a nice sensation! (Latona).

(...) the water matter was really important, I went to the shower. It already alleviated a lot, but entering the pool was wonderful! I suddenly said: guys, all women needed to have rights to this! Because the relief given is very good, you can relax. (…) In terms of physical things, I think it was a differential thing during labor (Perséfone).

A recent systematic review from the Cochrane Library indicates that water immersion during the first period of labor significantly reduces the use of pharmacological analgesia (epidural and spinal anesthesia); it is not associated to differences regarding type of delivery, to the Apgar level at the fifth minute, to neonatal infection and hospitalization in neonatal units. Besides, water immersion appears to be related with the decrease of the first stage duration of the labor[16].

The use of music during labor can confer different effects, such as pain relief during contractions, support to decrease tension and fear, to become familiar with the hospital, stimuli for prayer and spirituality. These conditions allow the parturient to experiment a more effective relaxation state in the interval of contractions, leading to a more subtle and natural labor and increasing the woman's limit of pain tolerance and discomfort[17]. Thus, the use of music therapy is a promising method to manage pain and when associated to traditional medicine, it is capable to reduce the perception of pain and the need of pharmacological resources to alleviate it[18].

Thus, it is important to consider that the environmental structure can positively interfere in the labor process and represent a facilitating element to assist labor. In the same way, the use of non-pharmacological methods for pain relief should be strongly encouraged, once so many good results are scientifically evident, as the low cost for their execution and their easy applicability.

Freedom of choices

The freedom of choices facilitated at the home environment appeared as another important aspect of the process to deliver at home, from the sight of women from this study. The parturient feels safer and more confident when the possibility of choosing and participating on procedures involving her deliver is given to her[19].

(...) I think that this freedom to choose where I want to be, what is the position that I want, the freedom to know that you can express yourself in way that nobody is going to be offended, nobody will tell you to be quiet, you can say whatever you want, act however you want, to really feel free, I think this helps a lot (Nice).

Higher education level of women who choose home birth is related to easier access to information and biomedical knowledge[11]. When the woman is properly informed, she becomes capable to critically judge her options and choose consciously. To stimulate women to make informed decisions is to value her ability to decide, to respect the right to her own body and autonomy; to promote the right to the condition of people and to rescue the care centered on her needs[20].

The posture adopted by the health team at the home environment stimulates the autonomy exercise and the maternal role. To defend the autonomy of the user is to recognize her active voice in the therapeutic process. It is to recognize that the user has needs, values, expectations and desires, a result from one's nature and culture, that needs to be considered in the healthcare[21].

When holding information that was monopolized by the doctor, users relativize the professional's authority at the same time that they affirm their dissatisfaction with what is offered, they reinterpret their experience, denounce violence which they feel submitted to, and claim for their rights of choice as well as the right to refuse to be informed[22].

It is important to highlight that the democratization of relationships between health professionals and users in a co-responsibility model, besides valuing the user's autonomy in relation to therapeutic choice and

procedures, is associated to better health results[21].

To forbid, to restrain or to mock about the woman's free expression and behavior during labor is considered an act of obstetric violence nowadays and it hardly occur inside the home environment, once in this space, the attention philosophy is rooted on the female role and, it is sustained by a different conception of birth and deliver the baby.

(...) *this freedom to eat, to drink liquids, what you want, not what they force you to…Gee! I found this really important! (Perséfone).*

Unfortunately, most health institutions do not allow parturient to eat and drink during this period, even if the current scientific literature points that there is no justification to restrain eating and hydration for women of low risk during labor. These, within so many other restrictions imposed in the hospital environment are being increasingly questioned by the society in virtue of the broad dissemination of the current scientific knowledge that, on the other hand, preconizes contrary practices to what the actual system imposes for assistance during labor and delivery.

The access to scientific information broadens women's dissatisfaction in what refers to the actual model of birth attention, once it allows them to perceive that professionals and health institutions not always promote changes related to this type of assistance, and they continue to believe in safety and efficacy of non-recommended practices or potentially threatening procedures[23].

Considering the exposed, we perceive that women want to be heard; they wish and they have the right to participate in choices and decisions about their bodies and births. This posture is presented as natural at the home environment, and it is valued by professionals who attend there. However, the contemporaneous obstetrics needs to include the different (and needed) relations of co-responsibility between professionals and users[24], independently of the birth environment.

Assistance and emotional support

Participants from our study manifested with strong conviction about the importance of the offered assistance and emotional support from their companion-, as well as the from their midwife, during the labor process and birth, corroborating with findings of national and international studies[19,25].

The opportunity to choose their companion was a reported topic as an element of satisfaction and provision of tranquility, needed and positive for their child's birth[19]. The presence of a companion promotes confidence and safety during birth, besides being a strong source of support and strength, able to alleviate pain and the sensation of solitude besides generating emotional and physical wellbeing[25].

The inclusion of a birth companion and/or the midwife is so relevant when we study the birth attention model preconized nowadays, which was the theme of one of the most recent Cochrane Reviews from the obstetric field. In such review, it is pointed that women who are continuously supported during the intrapartum period had less tendency to need analgesia, cesarean section and to report dissatisfaction with

the birth experience. Thus, reviewers concluded in a categorical manner that all women should have the support from professionals, midwife and/or companion during labor[24].

(...) it was really important, because he was truly part of it, he was together, he pushed together (…) I was pushing, he was too. It was something like this: he went in together, he gave birth together and for the man, it is super hard. It is really important for the woman, this movement of the father… (Hemera).
There was the midwife's intervention, intervention in a sense of pushing [incentivize] (…) I'm not being able to do this! Yes, you are! Her support was super important (Ilitia).

This is the importance to strengthen the introduction of a midwife of the woman's choice in the birth attention scenario, as element of observation, support and safety.

Although in the home environment the woman has the possibility to choose how many and which people will be beside her during the birth, in most times, this is not possible in the hospital. Considering that the companion matter (which is not about the midwife), this study reinforce the benefits of her permanence and represents one more incentive to follow the Companion Law (Law n. 11.108) inside health institutions.

Commitment of the health team

Participants of this study reported that a health team that seems compromised with the attention represents a fundamental factor to face the birth experience at home.

The establishment of a trust relationship with health professionals strengthens positive feelings that tranquilize the parturient. When this relationship is not effective, the birth experience is negatively affected[19].

(...) I feel a lot of confidence! (…) To me this was the best: (...) the caring, to have people that are present there, (…) this is the most difficult for the obstetrician! I think that the most important thing of the birth is that whoever is there, is there, open to the situation. And you feel (the woman feels) that when you are there, but it is staring at the phone, but have to leave…I think this must be such a stress, you know? So I think the most important thing is that whoever is there, is really there (Selene).

The voice of this participant relates to the importance and the impact that an individualized and attentive accompaniment can cause over the labor evolution and birth. To offer a personalized care, attentive to signals that the woman presents, her desires and dissatisfactions, including also her family in the process, promotes wellbeing and comfort for those involved. This facilitates the team work, because when the relationship is based on trust and safety previously established, it is possible to conduct a birth surrounded by care, tranquility and love[19].

To be surrounded by trustworthy people, such as companions or professionals compromised with the birth process, it influences the perception of the environment, making it more intimate. This proximity allied to a calm environment, propitiates safety and wellbeing to the parturient. Such factors can go unnoticed many times, however, they are part of the indispensable care and comfort during labor and birth[19] and they

seem to be powerful enough to positively modify this experience.

CONCLUSIONS

This study allowed identifying good practices present in home births related to the favorable environmental structure, to freedom of choices, to emotional support and the commitment of the involved health team.

Practices described in this study were corroborated by the actual scientific literature and, therefore, should be the focus of attention for professionals directly involved in the birth, such as physicians, obstetric nurses, obstetricians and midwives. Because those are practices with effects that benefit the population, being low cost and easy to apply, we suggest that efforts should be done to implement them in the hospital attention model.

The analyses conducted from thoughts captured show that women are claiming for respect towards their individuality, their bodies and the physiology of delivering and birth, intrinsic of each person. They desire a loving and welcoming birth, with the participation of people from their choice who stimulate and encourage good practices. They desire to establish democratic relationships with health professionals in what regards decisions involving them; they want to be heard and respected as active and conscious subjects, and they wish for autonomy about their birth experiences.

Because this is an attention modality incipient in the Brazilian obstetric attention, we consider the need of more investigations about different aspects involving home birth, such as women's satisfaction, positive aspects of the experience, difficulties experienced, obstetric and neonatal outcomes, within others, so that such practice will have more visibility in the academic field and to become more understood by the whole society.

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