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Narratives on planned home birth after hospital birth

Narrativas sobre parto domiciliar planejado após parto hospitalar

Narraciones sobre parto domiciliario planificado después de un parto hospitalario

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This study aims to know the narratives of women who had Planned Home Birth after a history of previous hospital birth. This is a qualitative research using two methodological strategies: observations in a support group for pregnant women and semi-structured interviews with four women from a municipality in the countryside of São Paulo. The observations in the groups allowed the approximation and contextualization of the field. The analysis of the interviews allowed the delineation of the following thematic categories: vulnerability of women in the hospital; repercussions of early separation between mother and baby; home birth: information and affirmation of autonomy and body perception at childbirth.
Descriptors: Women's health; Home birth; Personal autonomy.

Este estudo tem como objetivo conhecer as narrativas de mulheres que tiveram Parto Domiciliar Planejado, com história de parto hospitalar anterior. Trata-se de uma investigação qualitativa, com o uso de duas estratégias metodológicas: observação de grupo de apoio às gestantes e, entrevistas semi-estruturadas com quatro mulheres de um município do interior de São Paulo. As observações dos grupos permitiram a aproximação e contextualização do campo. A análise das entrevistas permitiu o delineamento das categorias temáticas: vulnerabilidade da mulher no hospital; as repercussões da separação precoce mãe e bebê; o parto em casa: informação e afirmação da autonomia e percepção corporal no parto.
Descritores: Saúde da mulher; Parto domiciliar; Autonomia pessoal.

Este estudio tiene como objetivo conocer las narraciones de mujeres que tuvieron Parto Domiciliario Planificado, con historia de parto hospitalario anterior. Se trata de una investigación cualitativa, con el uso de dos estrategias metodológicas: observación de grupo de apoyo a las gestantes y, entrevistas semi-estructuradas con cuatro mujeres de un municipio del interior de São Paulo. Las observaciones de los grupos permitieron la aproximación y contextualización del campo. El análisis de las entrevistas permitió el delineamiento de las categorías temáticas: vulnerabilidad de la mujer en el hospital; las repercusiones de la separación precoz mamá y bebé; el parto en casa: información y afirmación de la autonomía y percepción corporal en el parto.
Descriptores: Saúde de la mujer; Parto domiciliário; Autonomia personal.

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INTRODUCTION

Data on obstetric care in Brazil and studies on the subject indicate that the universalization of hospital birth has occurred throughout the national territory, as demonstrated by the National Survey of Demography and Health, PNDS-2006[1].

The phenomenon has many aspects and can be considered an example of the success of health policies based on the principle of universal right to health, which made it possible for women living in different regions to receive hospital care at childbirth. However, the obstetric care model adopted is marked by an excess of interventions: Brazil is among the world's countries with the largest number of cesarean sections, while the World Health Organization (WHO) recommends cesarean rates of 15%. The survey Birth in Brazil, which gathered important information about obstetric care, included women who during pregnancy wished normal delivery, but found that a relevant number of them had caesarean section as obstetric outcome[2].

Women who are able to have normal delivery are subjected to procedures that should not be performed routinely, such as intestinal lavage, trichotomy, and episiotomy. On the other hand, the right to a companion, which is guaranteed by law in some states and by a specific law for all users of services of the Unified Health System (SUS), according to the above mentioned research, has been guaranteed to only 18.8% of women during the entire period of hospitalization[4].

The country faces difficulties to reduce maternal mortality, which remains at high rates. In fact, Brazil and is among the 75 countries that have least reduced maternal mortality according to a WHO's report in the world[3].

Hospitalization for childbirth has not produced the expected results; on the contrary, it has been ralated to an obstetric practice where users are treated as things, with a mechanized assistance and excessive use of technology[4].

The conception of childbirth as a medical-hospital event is a social construction influenced by several factors. In past decades, the state's interest in protecting the health of the population in order to ensure individuals able to join the workforce had the support of medicine and the construction of doctors as the holders of scientific knowledge on the female body, since survival at childbirth and childhood has always been the necessary condition for obtaining healthy adults.

Medical knowledge disqualified care based on the traditional culture provided by midwives, who had knowledge transmitted orally by women and focused on women. Traditional care can also be considered an expression of female autonomy that in the past was regarded as something to be controlled[5].

The process of transferring home birth - that is, birth in a place of intimacy and traditionally the women's territory - to the hospital had clearly defined contours in the first decades of the twentieth century, as indicates a study that showed how the combination of maternities that were being created, the acquisition of medical equipment, introduction of new medicines, and adaptation of the environment indicated the preparation to receive women from different social strata. The hospital was preparing to receive all the women and not just the poor, or the single mothers, or indigent women, who were the ones who had their children in the hospital for lack of a social protection network.

A survey[6] on the number of obstetric beds in 1922 indicated the existence of 400 beds in Brazil distributed into 10 maternities and destined to a population of 30 million inhabitants. The state of São Paulo, in the period between 1935 and 1936, had already 710 obstetric beds.

The rapid switch from home birth to hospital birth, considering historical time, is demonstrated by the fact that in 1945, in the city of São Paulo, the place of birth for the majority of women (70.4%) where the home, and only 29.5% preferred the hospital[6]. Decades later, the main birth place in the country became the hospital, as indicated in the PNDS 2006[1].

Reactions to the hospital-centered model of obstetrical care, which reduced pregnancy, childbirth and birth to the

biological dimension, arose as early as the 1970s, described in Anthropological publications that showed the cultural dimension of childbirth[7].

A rethinking of obstetric practices has enabled WHO to disseminate the text known as "WHO Recommendations", published in 1996, an important document for the review of current obstetric practices[8].

In Brazil, the questioning of the hegemonic model of childbirth care resulted in the initiatives known as *humanization of childbirth*. These initiatives led to some achievements such as the publication of the recommendations of the Ministry of Health for the operation of Normal Birth Centers through a Ordinance created in 1999 and updated in 2015[9]; the creation of the National Program for Humanization of Prenatal and Childbirth (PHPC) in 2000[10], which established a minimum set of actions for obstetric care and which was expanded in 2011 with the creation of the Stork Network Strategy[11].

Some states have created state laws that guarantee the right to a companion, and in the federal scope, the Federal Law 11.108 of 2005 was approved to ensure that this right be respected among SUS users throughout the national territory[12].

Although beckoning to a change in obstetric care, such achievements have kept the prospect of childbirth as a hospital event.

Home delivery is addressed by the Ministry of Health as a result of women's lack of access to hospital services, which is more common in geographically isolated and poor places, as something "accidental," when women in big urban centers are not able to get to the hospital in time, and as something lived by women belonging to indigenous peoples or quilombola communities, who are assisted in their own houses by traditional midwives. This perspective resulted in a publication and training aimed at indigenous midwives and quilombolas[13].

In contrast to Brazil, in countries such as the United Kingdom and Canada, Planned Home Birth (PHB) has the back of the public health system and women can make the choice for home delivery guaranteed by qualified health professionals such as nurses obstetricians and midwives[14]. In the rare situations where it is necessary to transfer the woman or the newborn to a hospital, there are referral services and trained professionals for the removal.

The safety of home delivery indicates that PHB, when assisted by an properly trained health team, is as safe as a hospital birth and has the further benefit of less use of unnecessary interventions[15].

It is observed that in the PHB there is a lower frequency of lacerations, less occurrence of postpartum haemorrhage and greater satisfaction among women. The neonatal benefits are considered variable, although there is no greater risk of mortality or low apgar in infants born by PHB than those born at the hospital[16].

In Brazil, women who choose home births do so outside the health system because both the SUS and the supplementary health system do not allow free choice of place of birth. It is worth mentioning that the only exception occurs in Belo Horizonte, where a philanthropic hospital guarantees PHB assisted by health professionals for SUS users[17].

Thus, as the choice for PHB occurs outside the health system, there are few studies on the subject. The few that exist indicate that the women who chose it have a common characteristic: the majority have higher education[18-20].

A study with women assisted by a private service in São Paulo that offers obstetrical nursing care found that 71% of women had higher education[18]; while a research with women who had PHB in Rio de Janeiro and Porto Alegre found that 85% had higher education [19]; in Florianópolis, most of the women also had complete superior education[20].

The ability to seek and access information is related *to greater cultural background* that enables informed choices[21].

This study aims to know the narratives of women who had Planned Home Birth and who had a history of previous hospital birth.

METHOD

This is a qualitative research with the adoption of the theoretical constructionist perspective, which implies among other aspects the idea that the social world is built upon relations that allow to signify it and give meaning to the world[22].

To adopt the constructivist stance means to assume that:

> *"The political character of social action is inseparable from the production of affections, from the relations of power and from its ethical dimension"*[23].

As methodological strategies, two procedures were used: meeting observations in a support group and semi-structured interviews. The purpose of the group's observations was to gain proximity with the field and identify women who could collaborate with the research.

The interviews with the women sought to listen to the narratives that gave meaning to the choice for PHB. Narratives were chosen because they are different from the descriptions; while the former have a more formal and objective character, narratives have greater depth and allow to unravel the senses and the subjective dimension of the events narrated[24]. The meetings were recorded in writing, and the interviews were recorded.

The research had the contribution of scientific initiation activities and was carried out in the municipality of São José dos Campo, distant 97 km from the Capital and located in the Paraíba Valley.

In the 2010 IBGE census the registered population was 629,921 thousand inhabitants[25]. Data from the National Information System on Live Births (SINASC) indicate that in 2011 there were 10,308 hospital births and eight home births[26].

The study was approved by the Research Ethics Committee of the School of Arts, Sciences and Humanities of the University of São Paulo, number CAAE 28258214.1.0000.5390, in 2014.

Semi-structured interviews were conducted at the place chosen by the women, after signing the Informed Consent Form. The script used included initial information about age, schooling, profession and number of children.

Then the women were asked to talk about the experience of the hospital birth and later on the motivations that led them to chose home birth, and about the experience of home birth. The interviews were recorded and transcribed verbatim.

The reading of the content made it possible to identify *thematic categories*, non-hierarchical and organized in a Map, as proposed by Spink[22]. Excerpts from the interviews that evidenced the meanings of the experiences narrated by the interviewees were inserted in the Map.

RESULTS

Two group meetings were held; the written observations were the product of the observations. The approximation with the field by means of participation in the group meetings to support the pregnant women and their companions allowed to know the topics treated in the discussions and to know the women who could be interviewed.

At each meeting the research was presented and permission was requested for the members of the study to participate. In an observation sheet, the following information was recorde: date, number of participants, characteristics of the participants, topics discussed, interest in participating in the research.

Group meetings were open, free and posted on a web page. At the first meeting the facilitator was an obstetric nurse and other health professionals were present: one *sage femme* (an obstetrician trained in France) and another obstetric nurse.

The group had six participants, and there were two couples. Two women took their babies to the meetings. The discussions were about the dissatisfaction with the obstetric care offered in the hospitals of São José dos Campos, about obstetric violence, dissatisfaction with the collection of hospital fees such as a fee for Neonatal ICU reservation.

The participants mentioned that a hospital in the region adopts what was defined by them "*camouflaged humanized*"

because they allow the presence of a companion, use a soft background music, but still keep the same inadequate procedures when assisting women and their babies.

It was also discussed that home birth is looked down on by many people because it is considered to be inferior than hospital care, which has modern technology. That was pointed out as valorization of the technology and devaluation of the woman's capacity to give birth.

There was talk about the woman's need to turn to herself at the end of the gestation, to prepare for childbirth. At the end of the meeting, one participant accepted to participate in the research.

The second group had seven participants, three couples and one pregnant woman; there was also an obstetric nurse and a body therapist, who was the facilitator of the group. At this meeting, participants had already chosen home birth.

Body techniques were performed and the discussion focused on the perception of the body and the affection between the couples that will welcome the baby that is to come. At the end of the meeting, a woman who was in the postpartum arrived, and she told her home birth experience.

It was considered that the discussions in the group meetings evidenced the dissatisfaction of the participants with the local hospital assistance and the search for information to find alternatives, to make viable the choices that they considered more appropriate.

As in the second meeting the choice for home birth had already been made, the participants also expressed dissatisfaction with the hospital care experienced and emphasized the need to prepare physically and emotionally for delivery. The support received in the group was cited by the women in the interviews

Women identified as potential respondents were invited to participate in the study. Four women who had a planned home birth and who had a history of previous hospital birth in the city of São José dos Campos were interviewed.

The women interviewed were between 28 and 35 years old. The oldest was 35 and the youngest 28 years old. With regard to the children, two interviewees had three children, one had two daughters and the third had two children and was in the third pregnancy. Box 1 summarizes the characteristics of women.

Box 1. Characteristics of the interviewed women. São José dos Campos, 2014.

Name*	Age	Profession	Children	Hospital birth	Home birth
Carla	35	Beautician	3	2	1
Laura	28	Housewife and Craftswoman	3	1	2
Mariana	32	Instructor	2	1	1
Paula	35	Nursing technician	2	1	1

* The names are fictitious to preserve the identity of the interviewees.

The analysis allowed the organization of the narratives into four categories, the first covering hospital delivery: *vulnerability of women in the hospital* and *repercussions of early separation between mother and baby;* with regard to home birth, the emphasis was*: information and affirmation of autonomy* and *body perception at birth,* as shown below.

<u>*Vulnerability of women in hospital birth*</u>

Carla and Paula, who had given birth at two hospitals in São José dos Campos reported the event as surrounded by procedures considered aversive, an event marked by the absence of information and aggravated by the harsh treatment by the medical and nursing staff.

The service is exemplified in the words of Paula, who said that when she complained about the cuts on her skin during tricotomy (scraping of the hairs), the response from the professional who performed the procedure was

"You*'re in pain now, you have no idea what's comming next!"*

The interviewees said that they felt alone, because the presence of a companion was not allowed in some hospitals.

Carla says that in the first hospital birth in São José dos Campos the assistance was poor, but in the second birth, which was performed in a hospital in the municipality of Jacareí, defined by her as the "*humanized",* she felt respected by the staff. However, Carla's mother, who was her companion, was unable to see the birth because she was filling out the sheets for admission.

In turn, Mariana considers the treatment she received very good in the hospital where she had her first daughter, in Paraná, but as she wanted normal birth, she expressed discomfort:

"It was not normal delivery, it was a cesarean".

Two interviewees used the words *afraid* and *vulnerable* to define how they felt in the hospital:

What makes me afraid from hospitals is that we're very vulnerable there. (Carla)

But the issue of childbirth itself, I think the worst thing is... it was all very unexpected, you know, the fear, from being there, from that feeling of helplessness; you, of being vulnerable, completely vulnerable. And the son of a bitch made me the husband stitch. It's... like, eight months later I still felt a lot of pain to have intercourse, a lot, a lot of pain. (Paula)

Repercussions of early separation between mother and baby

Interventions in the women's bodies at birth are also extended to infants, who are subjected to various procedures after birth and in many cases are separated from the mothers too early, as narrated in the interviews.

For Mariana, submitting to a cesarean section, and the following separation from the baby resulted in a difficulty to understand that the baby had been born and to recognize the child as her daughter:

"I got a little disconnected, you know? I did not care what, what was that... what, what had happened... that was not even during the surgery, you know, it was later, you know? I guess, I don't know... it took forever to figure out what had happened, you know? That the child had been born. Then I got annoyed with the baby because she cried a lot, I... you know, it seems like I wasn't aware that the child was mine, you know? I would look at her and say "wow, that's weird... it does not look like she's mine". (Mariana)

For Carla, the separation from the baby resulted in difficulties in breastfeeding. She had mastitis and believed that the baby *lost the reflexes* to suck because the child was sent to the nursery:

But, when she was born, he examined, he said that everything was fine with her and all... except that they took her from me. I was super good. I had already showered and asked the nurse "Where is my daughter?". All I know is that she went up after about three hours, screaming in the nursery. I had trouble after mastitis, breastfeeding, because she lost the reflexes at the time she went in the nursery. (Carla)

Home birth: information and affirmation of autonomy

The choice for home birth had different meanings for the women interviewed. Mariana wanted a normal birth after a cesarean. Paula had a hospital birth that she considered "*horrible"*. She later worked in a hospital and witnessed the hostile treatment given to the parturients in the Obstetric Center. She said:

"I felt *compassion for those abandoned women there, vulnerable, you know? With so much violence, verbal aggression.* (Mariana)

When she became pregnant of the second child, she was aware that birth can different from what she had witnessed. It was a picture posted on the internet by a friend who had had a home birth that was the turning point to her decision.

Carla, who had had two hospital births, said that in the first birth in a private hospital the nurses were *cold,* and she was treated *as if she was a mere number*. (Carla)

After attending a lecture with an obstetric nurse, she decided *not to use the service of a doctor anymore*, but still had the second baby assisted by a doctor and an obstetric nurse she met in a lecture. She tells that she started to prepare herself, searching for information on the internet, and she participated in a group of pregnant women. In the third pregnancy she decided:

I'll do it with a midwife again, in my house... I will not be in their hands; I'm really scared, do you understand? I'm scared to death. (Carla)

In turn, Laura told the reason to avoid another hospital birth:

"Fear... of going through it again, through that... procedures with the baby I did not want to, to be alone, of not being able to eat. So, all those restrictions I did not want. That bureaucracy for visiting". (Laura)

Just as the other interviewees, she sought information on the internet, talked with a doula and participated in the group of pregnant women:

"At home, you're with the people you love the most. Security, I was feeling very safe. I knew what I wanted, do you understand?" (Carla).

"So I had everything to give my life in his hands like this, you know! I took the birth for myself, especially Valter [husband]*! He really did!"* (Paula).

"To make it on my way. For me to be the owner of my birth". (Laura)

"I had that thing, I had to have a normal birth and I was going to find the way of having it". (Mariana).

The speeches emphasize the exercise of autonomy in choosing for home birth. As women do not receive information on PHB from health services, the information that lead them to the exercise of autonomy is found on their own initiative.

Body perception at childbirth

In the narratives on childbirth, the women detailed the sensations and impressions about what was happening in the body during labor and delivery. They showed a perception of the proximity of the childbirth and although they reported pain, they had also *a feeling of comfort* for knowing what was happening, for not feeling deceived.

Participation in support groups for pregnant women and information obtained during pregnancy may have contributed to increased body perception and to building other senses to face pain.

It is like, I already knew; the pain was increasing, it was because she was getting closer. So that gave me that, a feeling of comfort, right? I knew exactly what was going to happen. No one was going to fool me. (Paula)

(...) You do not feel back here [pointed to lumbar] *like heavy, right, when contractions happen. It is like... a delight!* (Carla)

So it was a much more conscious labor, I was aware of my body, the contractions, the baby. It's like, I realized when she was comming down, when she was passing. (Laura)

So, during childbirth I was aware of everything I was feeling, I knew every phase that was happening... and I would think *ah, so now the contraction is like that, it is because that thing is happening.* (Mariana)

DISCUSSION

The term vulnerable, used by Carla, is often used in health to refer to people in risk of disease and illness. The concept of vulnerability, which was evidenced and expanded in the studies on people living with HIV/AIDS, began to be understood in three dimensions: individual, involving personal characteristics such as age and sex, religion; programmatic, which refers to public policies translated into actions; and social, involving the economy, culture, ideology and gender inequalities[27].

This broader definition can be used to understand the condition of vulnerability of women in the scenario of obstetric care in Brazil, which adopts an intervention model where practices that are not recommended by the WHO are still used, such as routine trichotomy, a procedure described by one of our interviewees.

The practices adopted are permeated by gender inequality, where the woman's body is treated as inferior, imperfect, and prone to correction by medicine. It is a body placed at the service of male pleasure, as exemplified by the episiotomy procedure, which consists of cutting the perineum, followed by the "husband stitch".

The practices perceived by the interviewees as threatening and aversive in hospital births also affect the babies, who in many cases were separated early from their mothers.

Early skin-to-skin contact between mother and baby promotes benefits such as facilitated development of attachment, breastfeeding and even reverberates in the baby's crying[28], while procedures that involve early separation may have a negative impact.

Another event that affects mother and baby is violence against women in the perinatal period, which is associated with difficulties in breastfeeding and may result in discontinuation of breastfeeding, social isolation, development of depressive symptoms and a negative impact on the ability to relate with the baby[29].

Considering that in Brazil many of the obstetric practices adotped result in violence and abuse against women, as demonstrated in an investigation[30] that indicated that a quarter of women had suffered some kind of violence linked to childbirth care, it is also necessary to inquire about the magnitude of the impact of

obstetric violence on the mother/baby relationship.

In a study on planned home delivery with 20 women, the participants reported that in order to make their choice they had participated in lectures, support groups, they had sought information on the Internet, and one of them even mentioned to have found information by means of scientific literature and by reading Cochrane reviews[31]. As stated in a research, women with greater *Cultural background*[21] are those that can make choices based on what they consider to be the best assistance.

As for the place of birth, the fact of taking place in the women's home, in a known environment, which has been historically built as a place of women's domination, may have provided the necessary security for the perception of what was happening in the body and for the positive evaluation of the experience of labor and delivery.

A study that reviewed the literature on the subject reports the greatest satisfaction of the woman as one of the beneficial outcomes of the home birth[16].

CONCLUSION

This study allowed to know the perspectives of the women who chose to give birth at home assisted by a health professional, although living in a city that has a hospital network with public and private beds and despite the possibility of access to obstetric care based on the hegemonic model.

They are women who were able to make an informed choice and affirmed their autonomy to decide what they considered best for themselves and for their babies.

The hospital held an important place in women's narratives, associated with fear, vulnerability, harshness, and rigidity, and seems to have been constructed with the sense of a place to be avoided.

Home, on the other hand, was narrated as the place where their autonomy could be exercised and where it was possible to perceive the functioning of the own body during childbirth in a pleasurable way. However, the choice was not solitary; they could count on their companions, family members and health professionals who assisted them.

But it was a choice made on the margins of public policies, excluded from the SUS, without the support of management bodies such as the Ministry of Health and State and Municipal Health Secretariats.

Thus, it is necessary that the Ministry of Health share in the debate on the right of women to choose the place to give birth and to take action so that women be able to make safe choices, inserted in the Unified Health System.

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CONTRIBUTIONS
Cláudia Medeiros de Castro participated in the conception of the study, analysis and interpretation of data and writing. **Arlene de Azevedo Ferreira Marques** participated in the collection and analysis of the data.

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