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MOTIVATIONS FOR CHOOSING PLANNED HOME BIRTH

MOTIVAÇÕES PARA ESCOLHA DO PARTO DOMICILIAR PLANEJADO

MOTIVOS PARA ELEGIR EL PARTO A DOMICILIO PREVISTO

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Objective: to understand the motivations of women in choosing the planned home birth and the perceptions of this experience. Method: descriptive, exploratory and qualitative study, developed with 14 women who experienced a planned home birth between January 2019 and December 2020. The interviews were conducted between March and May 2021, transcribed in full and submitted to content analysis. Results: the allowed understanding that the motivations for choosing planned home birth were related to the feeling of fear of hospital obstetric practices. Safety in the home environment, the guarantee of autonomy and the possibility of the presence of children were both motivations and positive perceptions of this experience. Resistance on the part of society was often experienced. Conclusion: the current obstetric model needs to be rethought and readjusted, in order to provide safe and respectful birth, whether at home or in the hospital.

Descriptors: Home birth. Natural birth. Obstetric birth. Obstetric nursing. Qualitative research.

Objetivo: compreender as motivações das mulheres na escolha do parto domiciliar planejado e as percepções dessa vivência. Método: estudo descritivo, exploratório e qualitativo, desenvolvido com 14 mulheres que vivenciaram um parto domiciliar planejado entre janeiro de 2019 e dezembro de 2020. As entrevistas foram realizadas entre março e maio de 2021, transcritas na íntegra e submetidas à análise de conteúdo. Resultados: a análise possibilitou compreender que as motivações para escolha do parto domiciliar planejado estiveram relacionadas ao sentimento de medo das práticas obstétricas hospitalares. A segurança no ambiente domiciliar, a garantia da autonomia e a possibilidade da presença dos filhos foram tanto motivações como percepções positivas dessa vivência. A resistência por parte da sociedade foi frequentemente vivenciada. Conclusão: o modelo obstétrico vigente precisa ser repensado e readequado, com vistas à oferta assistência ao parto segura e respeitosa, seja em âmbito domiciliar ou hospitalar.

Descritores: Parto domiciliar. Parto natural. Parto obstétrico. Enfermagem obstétrica. Pesquisa qualitativa.

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Objetivo: comprender las motivaciones de las mujeres en la elección del parto domiciliario planeado y las percepciones de esa vivencia. Método: estudio descriptivo, exploratorio y cualitativo, desarrollado con 14 mujeres que experimentaron un parto domiciliario planeado entre enero de 2019 y diciembre de 2020. Las entrevistas se realizaron entre marzo y mayo de 2021, transcritas en su totalidad y sometidas al análisis de contenido. Resultados: el análisis permitió comprender que las motivaciones para la elección del parto domiciliar planeado estuvieron relacionadas con el sentimiento de miedo de las prácticas obstétricas hospitalarias. La seguridad en el ambiente domiciliario, la garantía de la autonomía y la posibilidad de la presencia de los hijos fueron tanto motivaciones como percepciones positivas de esa vivencia. La resistencia por parte de la sociedad fue frecuentemente experimentada. Conclusión: el modelo obstétrico vigente necesita ser repensado y readequado, con vistas a la oferta asistencia al parto segura y respetuosa, sea en ámbito domiciliar u hospitalario.

Descriptores: Parto domiciliar. Parto natural. Parto obstétrico. Enfermería obstétrica. Investigación cualitativa.

Introduction

In Brazil, even with advances in the obstetric scenario, the model of interventional care[1] still prevails, which leads to a compromised position of the first placed in the world in performing cesarean sections, with a percentage of 56.3% in the Unified Health System (UHS)[2] and 84.7% in the private network[3]. Thus, it is highlighted that the indiscriminate use of interventions in birth exposes the mother and baby to greater risks of morbidity and mortality[4].

To contrast this obstetric model, studies indicate that some women have opted for Planned Home Birth (PHB)[5].The practice of PHB in Brazil is still incipient, since there is no offer by the public health service. There is also a view of disapproval on the part of society and health professionals, evidenced by the thought of a birth without adequate assistance and potentially more dangerous for women and newborns[6].

However, the PHB is the professional assistance provided to the woman during pregnancy, birth and immediate puerperium, in the home environment, and with transfer plan for indicated cases. Scientific evidence shows that home births in pregnancies with habitual obstetric risk appear to be as safe as hospital births, and require fewer obstetric interventions[7].

In recent years, there has been growing interest in the scientific community about the practice of PHB; however, there is still a lack of studies on the subject. A recent systematic review on the PHB in Brazil showed that the national production on the subject is still limited, being relevant new research that contributes to understanding the issues involved in the decision and experience of the PHB[6].

Thus, the objective was to understand the motivations of women to choose the planned home birth and the perceptions of this experience. With the results, it is intended to offer subsidies for new public policies that guarantee women's access to information, especially to safe and respectful birth care, whether in the hospital, in normal birth centers or at home.

Method

This is a descriptive and exploratory study, with a qualitative approach, developed in a municipality located in the southern region of Brazil. The sample included women who had planned home birth experience, from January 2019 to December 2020, assisted by the team of obstetric nurses who provide care for planned home births in the city studied. Women who required transfer to the reference hospital for hospital birth were excluded.

The city locus of the study currently has a team that provides assistance to the PHB, composed of nurses specialized in obstetrics and neonatology. The service is offered to the municipality and region since 2010, and until the period of this study, about 150 home births were assisted. The team performs prenatal follow-up, simultaneously to that performed by the doctor of

choice of the pregnant woman. Home follow-up occurs during labor, birth and immediate puerperium, with support for emergencies or complications, as well as hospital transfer plan for indicated cases.

The study period was chosen in order to allow a better memory of the lived experience, with a wealth of details. From January 2019 to December 2020, the team assisted 22 parturient women, being three transferred to the reference hospital for hospital birth. The others were invited by telephone to participate in the research, of whom 14 accepted and composed the sample. Two parturient women refused to participate, and in three, it was not possible to obtain telephone contact.

After an initial telephone approach by the researcher and a manifested interest of the woman in participating in the research, the date and time for the interview were defined, considering the participant's availability. Data collection took place through an interview with a semi-structured script, between March and May 2021.

Due to the COVID-19 pandemic and in respect to social distancing, the interviews were conducted online, by the Google Meet platform, recorded and later transcribed by the researcher. Prior to the beginning of the interview, the Informed Consent Form (ICF) was presented, containing the post-information consent field.

The instrument used was divided into two parts: the first aimed at collecting sociodemographic data and obstetric history, in which age, education, marital status, race/color, occupation, date of birth and parity were investigated. For multiparous women, the method of birth in previous pregnancies was asked, as well as the place of birth (hospital/home).

The second part consisted of open questions related to experience and motivations for planned home birth: "I would like you to remind and tell me the reasons that led you to choose a planned home birth?" "How was the planned home birth experience for you?". Complementary questions were used whenever necessary. The average length of the interviews was 31 minutes.

The testimonials were submitted to content analysis[8], being carried out, first, floating reading and subsequent exploration of the material, with identification of the registration units and definition of the categories.

The ethical and legal precepts established by Resolution 466/2012 of the National Health Council were respected. The Permanent Human Research Ethics Committee, according to opinion n. 4.548.926, approved the research. In order to maintain the discretion and anonymity of the participants, the use of pseudonym, defined by the researchers, was adopted.

Results

The study included 14 women, with a mean age of 33 years, ranging from 20 to 39 years old. Most declared themselves white, were married and had completed higher education. Regarding the profession, there were three housewives, three teachers, three psychologists, a yoga instructor, a therapist, a journalist, a physiotherapist and an agronomist.

Regarding the obstetric history of the participants, two were primiparous, with the first birth at home. Among the multiparous women, seven had a history of normal hospital birth, five had more than one planned home birth, and four had a history of caesarean section. After exhausting reading of the material, four categories emerged: 1. Fear of hospital obstetric practices; 2. Autonomy and safety in the home environment; 3. Possibility of the presence of children; 4. Facing taboos.

1. Fear of hospital obstetric practices

The loss of autonomy over the birth process in the hospital environment was present in the participants' speech, being one of the motivations for the decision for the PHB. Some deponents reported feelings of distress and suffering, associated with imposed hospital routines and obstetric interventions performed in previous births. Giving birth in the hospital was referred

to as a traumatic event, and insecurity in this environment was reported by several women.

> *All interventions are terrible at the hospital* [...] *they* [health professionals] *have no respect, they come in and come out anyway* [...] *not forgetting the interventions with the baby, it was terrible, it seems that the baby is of the hospital, not yours.* (Maria – 2 cesarean sections and 1 PHB)

> [...] *my husband almost couldn't enter the room* [...] *they made me stay in the gynecological position and it was totally uncomfortable for me* [...] *they called another doctor who got on top of me, it was very hard. He was born and they practically wouldn't let me see him. It was a very traumatic delivery* [...] *I was afraid of falling in a very bad place and that led us to look for other options so as not to have to experience all the traumas again.* (Livia – 2 hospital births and 1 PHB)

> [...] *I didn't want a hospital, I didn't feel safer in the hospital, the hospital became a place of intervention, and that if I went there, my chance of having another cesarean section was very high, and I didn't want to be deceived again.* (Heloisa – 2 cesarean sections and 2 PHB)

> [...]*my experience was very bad* [cesarean section] *I went to see my daughter a long time later, after a very big mess* [...] *they didn't respect any of my wishes* (Rosemeire – 1 cesarean section, 1 hospital birth and 1 PHB).

> *I got to stay with him only 3 hours after he was born, so these things bothered me a lot, it was just another birth to the hospital and, then, all that rush, in the operating room, all that light, it bothered me quite.* (Marcela – 1 hospital birth and 1 PHB)

> [...] *they went to do the procedures they do on the baby, which takes a while, and those hours that I was away were terrible, it was very bad, I wanted that smell, you know, I wanted my baby, I wanted to breastfeed, I wanted her very close to me, I was getting sick, distressed.* (Ana – 1 hospital birth and 1 PHB)

2. Autonomy and safety in the home environment

Some participants reported feeling safe at home, and the intimacy with this environment and the autonomy that the house provides were elements valued by the deponents, being cited both as points that influenced the decision by the PHB, positive points in the experience of PHB.

> [...] *and I always felt safe at home, it was something that, for me, was natural* [...] *at home, I feel safer, I feel better* (Eliana – 2 PHB).

> [...] *the issue of the environment weighs heavily on the choice, because one thing is staying at home, with your clothes, your way, in an environment that is already safe for you* [...] *the issue is also the freedom to eat, to eat what you want, whenever you want* (Augusta – 1 hospital birth and 1 PHB).

> [...] *the issue of comfort, the familiarity of knowing where things are, staying in a comfortable position* [...] *it's great to be at home to have the baby, I thought it* (birth) *was wonderful* (Giseli – 1 PHB).

> [...] *there's no one holding you down, filling you up, you drive, you choose, it's wherever you want, the position you want, if you want to eat, if you don't want to, if you want to go to the bathroom, or if you don't want to* (Maria – 2 cesarean sections and 1 PHB).

> [...] *I was walking, and I was in my environment, I think that being in your environment is a part that favors the part of the birth and, so, I ate chocolate, I ate the things I wanted, whenever I wanted, because I was at home, so it was very good* (Marcela – 1 hospital birth and 1 PHB).

> [...]*My freedom too, I could go to my fridge, take what I really believe would help me, light my candle, the incense, my freedom to be able to do it my way, it was incredible, the freedom and emotional stability with sure walked together.* (Antonia – 1 PHB)

3. Possibility of the presence of children

The possibility of the presence of children in the birth was raised by several deponents as an important factor that influenced the choice of PHB. The participation of the children was reported by the deponents as an experience that strengthened the bonds between the brothers, reducing the feeling of jealousy.

> *The main reason, which was the most relevant at the time, was in relation to my other daughter, she was three years old and I kept thinking how she was not going to see her sister being born, you know, that was very strong in my head* (Augusta – 1 hospital birth and 1 PHB).

> *The fact that my two other children can participate, not actively, but being there, because in the United States there is also this difference, there the children could stay in the room with me all the time.* (Juliana – 2 hospital births and 2 PHB)

> *The second reason was because I wanted my children,* [...] *I wanted my children to participate.* (Heloisa – 2 cesarean sections and 2 PHB)

> [...]*I thought a lot about my other son, about going to the hospital, leaving him, our family is not from here* [...] *so, I thought about it very much, about going to the hospital and leaving him* (Bianca – 1 cesarean section and 1 PHB).

> [...] *the issue of the presence of my daughters* [...] *they are proud to say that they saw the birth, that they were together, that they witnessed it, that they took care of him, that they held him in their arms first* [...] *I even think that this form reduced the issue of jealousy, the feeling of contempt* (Augusta – 1 hospital birth e 2 PHB)

> [...] *I screamed and she* (daughter) *said: "mommy, everything will be fine, you are brave"* [...], *and she was*

not afraid at all, she was there waiting to see her brother. (Franciele – 1 hospital birth and 1 PHB)

An interesting thing was that the children did not feel jealous because they were able to participate (birth) (Lívia – 2 hospital births e 1 PHB)

4. Facing taboos

The women interviewed reported that, when choosing home birth and sharing this decision to family members, people in the nearby nucleus considered them retrograde, who were opting for a birth without assistance, even with the advances of medicine, and so many decided to keep the choice a secret.

No one knew about our birth, I preferred not to listen to criticism. For some people, you say 'I had him at home', and they hear: what do you mean, like in the old days? What do you mean, you're going backwards, everything we've gained from medicine, you choose to take that risk? (Augusta – 1 hospital birth and 2 PHB)

Every time I talked about home birth during my pregnancy, with the people I trusted, who were in my family, they thought it was crazy, because they thought it was really unassisted. (Antonia – 1 PHB)

[...]*no one agreed "you're crazy about home birth, medicine is there, it has evolved so much and you will have your child at home". The less people know, the smaller the impact with different opinions, we can only share with those who share our idea, if not, it's just unnecessary interference* (Bianca – 1 cesarean section and 1 PHB).

When we decided on home birth, we told our closest family and friends, and everyone was very against it, everyone called me crazy, crazy. (Lívia – 2 hospital births and 1 PHB)

[...] *but my family did not know about the home birth, we chose not to inform, it was more work, having to keep explaining, so we chose not to tell them* (Franciele – 1 hospital birth and 1 PHB).

We didn't tell our relatives about this choice because there is still a lot of prejudice against this type of birth [...] *it is a taboo to be overcome* (Marcela – 1 hospital birth and 1 PHB)

If we're in a meeting, and someone comments that I've had four home births, then I'm judged, that's very bad (Alessandra – 4 PHB)

Discussion

The results of this study allowed understanding that the motivations of women to choose the PHB were related to the feeling of fear of hospital obstetric practices, generally motivated by previous experience of hospital deliveries lived in a negative and even traumatic way. The safety in the home environment, as well as the guarantee of autonomy in the birth process, and even the presence of children in this event, were motivations for the choice of PHB and positive aspects in its experience. Prejudice and resistance on the part of society were commonly reported by women who chose PHB.

As for the hospital obstetric practices, although the World Health Organization (WHO), reiterated by the Ministry of Health (MH), orients the good practices of care for delivery and childbirth, the obstetric model in force in Brazil is still characterized by the use of interventions that do not respect the rhythm and natural needs of women in the birth process[1].

A study conducted with 1,290 pregnant women who visited the Birth Senses exhibition, set up in five Brazilian cities, from 2015 to 2017, showed that, among women who had vaginal birth, 46.4% were in the lithotomic position at the time of birth, in 23.7% the Kristeller maneuver was performed and in 30.4%, the episiotomy, procedure not reported for all women[9].

In contrast, national and international studies[10] demonstrate that planned home births are associated with lower risk of maternal interventions, compared to hospital births in low-risk pregnant women. Another descriptive study conducted with 667 women who had planned home births in Brazil, between December 2014 and November 2015, showed that 99.1% of women gave birth in a non-lithotomic position and none were submitted to episiotomy, although 5.4% were submitted to amniotomy, 0.2% to the Kristeller maneuver and 0.4% to the use of oxytocin[11].

The current recommendation of the MH for assistance to women in labor includes the supply of fluids and light diet, for women who are not under the influence of opioids and do not present risk factors for general anesthesia. The intake of fluids and light diets minimizes the use of intravenous solutions based on blood glucose, which can cause hypoglycemia in the baby and also restrict women's movements[12].

However, studies show that professionals who assist childbirth in Brazil preserve the zero diet during labor, claiming prevention against nausea and vomiting [1]. Thus, a study conducted with 40 postpartum women in vaginal birth, in the municipality of Maceió, Brazil, pointed out that dietary restriction in labor and birth culminated in the use of intravenous infusions with oxytocin[13].

It is also recommended to minimize the separation between mother and baby, stimulating skin-to-skin contact immediately after birth, and routine procedures such as weighing, measuring and performing the first bath should be postponed[12]. The benefits of respecting the practices of golden hour, characterized by the first hour after birth, such as skin-to-skin contact and timely clamping of the umbilical cord, are highlighted in the best adaptation of the newborn to extrauterine life[14], because it helps in the mechanisms of self-regulation of the newborn, among them, the maintenance of body temperature[15].

Nevertheless, the literature points out that the assistance provided in the hospital context diverges, in the majority, with what is recommended. This reality can be evidenced by research conducted in a Brazilian state, in which of 351 births, only 28.0% of newborns came into skin-to-skin contact and were breastfed shortly after birth[16]. The data of this research are consistent with the reports of the participants of this study, in which good practices were not respected, unfavorable to the bond between mother and baby.

Some international studies[17] demonstrate that planned home birth, in addition to promoting early breastfeeding, is also associated with higher rates of prolonged breastfeeding. A study conducted in Spain identified that 99% of women who had planned home birth chose to breastfeed, of these, 96.3% (n=790) continued breastfeeding for more than one year[18].

The environment of the place of birth influences the process of birth, and may favor or harm it. Thermal, luminous and sound comfort directly influences the evolution of labor [12]. The environment of the birthplace where the woman is inserted also concerns the interpersonal relationships present in order to be welcoming and humanized, respecting the socio-cultural characteristics and the wills of each women[19].

The distancing from the family in the birth process occurred with the institutionalization of childbirth, from the 1930s, in which the woman detached herself from the protagonism of childbirth[20]. The presence of companions in childbirth, chosen by the woman, contributes to the process of childbirth, as it is configured as emotional support. In addition, the guarantee of the right to choose a companion for women favors the application of good practices in childbirth care[21], in addition to being associated with greater satisfaction of women with the birth process[22].

However, the reality of compliance with Law n. 11. 108/2005, which ensures the presence of a companion during labor, childbirth and immediate postpartum in the hospital environment, faces various impediments, such as physical limitations of services, which hinder the insertion of the companion during the birth process, followed by the resistance of health professionals[23]. Hospital institutions that insist on non-compliance with this law are based on the technocratic and medicalized system, and believe that the companion can disrupt the birth process[23].

Finally, the present study allowed identifying that the choice and experience of the PHB were linked to judgments and resistance by society. In order to corroborate with the experience described by the women participating in this study, other studies also demonstrate that the woman or the couple who decides for the PHB, choose not to expose the decision, because it is seen as irresponsible and uninformed, putting the life of the child at risk, for dispensing with existing technologies in the hospital environment[24-25].

Systematic review and meta-analysis investigated whether the risk of fetal or neonatal loss differs among women who planned home birth compared to low-risk pregnant women who planned hospital birth, and no significant

difference was found by intended place of birth in the results of perinatal or neonatal mortality[26].

A retrospective cut-off study conducted in the state of Washington, United States, investigated the maternal and perinatal results of planned and performed home births in the birth home, and showed that among the 10,609 births analyzed (40.9% planned home births and 59.1% planned birth home), both birthplaces presented similar risks in the crude and adjusted analyses, with low complication rates and perinatal mortality rate of 0.57 per 1,000 births [17]. Despite this evidence, society and health professionals commonly issue criticism and value judgements to mothers and fathers who opt for home birth[27-28].

The methodology used in the present study makes generalizations impossible, and the results found may differ according to the study location and population. Despite this limitation, the applied methodology enabled the in-depth analysis of important aspects that are involved in the decision for the PHB, as well as the respective experience.

The study contributes to the knowledge about the subject, since the national production on the subject is still limited. The results bring important elements for the reflection and debate about the current obstetric model, since, among the motivations for choosing the PHB, there is the previous negative experience of a hospital birth, marked by disrespect, loss of autonomy and imposition of interventions and routines that do not match the good practices of childbirth care.

Conclusion

Women's decision for the PHB, among other aspects, is linked to fear of hospital obstetric practices, safety in the home environment and the guarantee of autonomy in the birth process, which also includes the possibility of the participation of children. The decision for the PHB is commonly made by the couple and often kept in confidence, because judgment and prejudice are common.

Most Brazilian women will choose the hospital environment for the birth process, which is currently the only option for the vast majority. Thus, changes in the Brazilian obstetric scenario are necessary in order to ensure an effectively safe and positive experience for women and families. And, for women and families who want the PHB, this choice must be ensured, respected and served in a professional and qualified way.

Collaborations

1 – Conception and planning of the project: Maria Eduarda Floriano and Marcela de Andrade Pereira Silva;

2 – Analysis and interpretation of data: Maria Eduarda Floriano, Marcela de Andrade Pereira Silva and Josane Rosenilda da Costa;

3 – Writing and/or critical review: Maria Eduarda Floriano and Marcela de Andrade Pereira Silva;

4 – Approval of the final version: Maria Eduarda Floriano and Marcela de Andrade Pereira Silva.

Interest conflicts

There are no conflicts of interest.

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