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Experience Report

From institutionalized birth to home birth

Do parto institucionalizado ao parto domiciliar

Del parto institucionalizado al parto domiciliario

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The study aimed to describe the experiences of a group of nurse-midwives from the city of Campinas, SP, Brasil, regarding the transition process from attending institutionalized births to attending home births, in the period 2011 – 2013. The study is of the experience report type; the reflections, perceptions and challenges experienced in this process were collected using the technique of brainstorming. Content analysis, as proposed by Bardin, was used, which yielded four thematic categories: a) the hospital experience; b) living with obstetric violence; c) returning home and d) the challenges of home care. It is concluded that attending home births offers greater satisfaction to the nurses, even in the face of various obstacles, as it is possible to offer a care to the woman and new-born which covers both the concept of comprehensiveness and the current scientific recommendations.
Descriptors: Obstetric Nursing; Natural Childbirth; Home Childbirth; Humanizing Delivery.

Objetivou-se descrever a experiência vivenciada por um grupo de enfermeiras obstetras da cidade de Campinas, SP, Brasil, sobre o processo de transição do atendimento ao parto institucionalizado para o parto domiciliar, ocorrido no período de 2011 a 2013. Estudo do tipo relato de experiência, cujas reflexões, percepções e desafios vivenciados nesse processo foram coletados com uso da técnica de tempestade de ideias. Utilizou-se a análise de conteúdo proposta por Bardin, a qual originou quatro categorias temáticas: a experiência hospitalar; convivendo com a violência obstétrica; de volta para casa e os desafios da assistência domiciliar. Concluímos que atender o parto em domicílio tem oferecido maior satisfação às enfermeiras, mesmo diante de diversos obstáculos, já que é possível oferecer uma assistência à mulher e ao recém-nascido que contemple tanto o conceito de integralidade como as recomendações científicas atuais.
Descritores: Enfermagem Obstétrica; Parto Normal; Parto Domiciliar; Parto Humanizado.

El objetivo fue describir la experiencia vivida por un grupo de enfermeras en Campinas, SP, Brasil, acerca del proceso de transición de la atención institucionalizada para el parto domiciliario, en el período de 2011 a 2013. Relato de experiencia, cuyas reflexiones, percepciones y problemas enfrentados en este proceso fueron recolectados mediante la técnica lluvia de ideas. Se utilizó el análisis de contenido propuesto por Bardin, que emergieron cuatro categorías temáticas: experiencia del hospital, convivir con la violencia obstétrica; de vuelta a casa y desafíos de la atención domiciliaria. En conclusión, atender el parto en el hogar tiene ofrecido mayor satisfacción a las enfermeras, a pesar de diversos obstáculos, ya que es posible prestar asistencia a las mujeres y los recién nacidos que abarca tanto el concepto de integralidad como recomendaciones científicas actuales.
Descriptores: Enfermería Obstétrica; Parto Normal; Parto Domiciliario; Parto Humanizado.

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Introduction

In order to reflect on the current work of the nurse-midwife in the Brazilian context, it is necessary to understand the process of this profession's "construction". In focusing on the history of the process of labor and birth, first of all, one identifies the figure of the midwife as the person responsible for the labor, birth and immediate postpartum period.

Until the 18th century, childbirth was considered a women's ritual rather than a medical act, as it remained the job of midwives. At the end of the 19th century, the obstetricians came to employ campaigns to transform birth into a controlled event, which was achieved in the first half of the 20th century, in which the scenario of home birth was altered and gradually became extinct[1].

The creation of specific hospitals for the undertaking of the birth – the maternity hospitals – was an event of the end of the 19th century. The construction of the maternity hospitals aimed to create as much a space for the teaching and practice of medicine as a place where women would feel secure to give birth[1].

The change of home birth, assisted by midwives, to the hospital birth, conducted by doctors, conferred new meanings on obstetric assistance. From a physiological, female, family and social event, labor and birth were transformed into a medical act (male), in which the risk of pathologies and complications became the rule rather than the exception. Thus, the technocratic model of childbirth and assistance was put in place[1].

In this model, the woman's body is understood as a machine and the care given, as a production line[1]. The hospital, in its turn, becomes a factory, the mother's body – the machine, and the baby represents the product of a process of industrial manufacturing. Obstetrics comes to develop tools and technologies for the manipulation and improvement of the inherently defective process of birth, characterized by the industrial assembly line system[2].

As a result, this model a) eliminates the woman as a subject of the birth and places the doctor in this place, the authority over, responsibility for, and active leading of the process falling to him; b) does not recognize as legitimate those situations in which the external environment and the woman's emotional state act in hindering or facilitating the labor and birth; c) determines and facilitates the doctor's interventionist work when the same deems this appropriate; d) overvalues the utilization of technology; e) alienates the woman giving birth in relation to the professional, and f) directs the system towards profit[2].

This model of care was and remains the benchmark for supporting and managing the process of labor and birth within present-day health institutions, apart from some rare exceptions.

Contemporary obstetric care gives rise to various questions regarding the effects of excessive medicalization in the assistance provided in labor and birth, principally for low-risk pregnant women and their babies[3]. The inappropriate use of technology in childbirth care has presented unfavorable maternal and perinatal results, and the interventionist assistance has been a source of dissatisfaction for women. In addition to this, unnecessary procedures add greater costs to the care and have potentially adverse effects[4].

We believe that working with this presupposes acceptance and/or agreement with the same. When she perceives dissatisfaction, lack of acceptance, disagreement or even anger with this form of work, the professional feels a profound need to distance herself and, thus, leaves in search of a new form of work, a reality contrary to the technocratic model: the humanized model of childbirth care. This was the path we followed.

In this other model of care, values such as the protagonism, individuality, privacy and the autonomy of each woman are rescued. It involves practices whose objective is to promote healthy births, eliminating unnecessary interventions and offering others which have been proven to be beneficial. The model

of humanization of birth presupposes that safety is not a synonym of intervention and technology. On the contrary, it presupposes the minimal use of intervention in the physiological process of birth[1].

In our professional trajectory, we have not found an institutionalized childbirth care which was supported by the second model referred to. As a result, we arrived at the conclusion that the nurse-midwife, whose training is based in the valorization of the woman and the physiological process of childbirth, cannot find a work space prioritizing this work philosophy. In this scenario, childbirth care at home (re)appears as a viable alternative, consistent with our values and principles, both personal and professional.

On a worldwide scope, it is already recognized that the nurse-midwife is the appropriate professional, and with the best cost-benefit, for providing care to parturient women. In the countries with the best indicators in maternal and neonatal health, the attendance model is based on the work of the nurse-midwives and midwives[5]. In Brazil, the childbirth model is still strongly linked to, and centered on, the figure of the medical professional.

The recent systematic review of the Cochrane Library, in which the model of attendance offered by the midwife was compared with other types of care models, showed that the women assisted by midwives had a lower chance of antenatal hospitalization, a lower risk of regional analgesia, of episiotomy and instrumental birth, a higher chance of a spontaneous vaginal birth, of feelings of control during the birth and of initiating breastfeeding. In a large proportion of the studies included in this review, the rate of maternal satisfaction was higher in the group attended by the midwives. The tendency was also identified that the model of care led by midwives had a lower cost than the other models of care. Thus, this review, made up of 13 studies and involving approximately 17,000 women, concluded that the model of care led by midwives should be offered to the majority of pregnant women and that women should be encouraged to request this option[5].

In the same way, the World Health Organization bulletin announced that more midwives are necessary in order to improve the survival of women and newborns worldwide, asserting, categorically, that in those places in which the nurse-midwife and/or midwife is present, there is a much smaller need for emergency interventions during labor and birth[6].

Being aware of all of this information, the authors resolved to follow a new professional trajectory which would permit them the practice of a form of obstetric care based on the pillars of humanization and which would be, simultaneously, supported by evidence-based medicine.

Thus, this article aims to present the professional trajectory travelled by the authors themselves, in the transition process from attending hospital births to attending home births, that is to say, to share their personal experiences as nurse-midwives with other professionals as a strategy for the diffusion of knowledge and as a means of supporting further discussions regarding the Brazilian model of obstetric attendance grounded in the experience reported by the author-subjects of the study.

Method

This is a descriptive study with a qualitative approach in the experience report mode undertaken in the period between September 2011 and September 2013. It used the brainstorming technique as a strategy for data collection during a meeting of the authors, a time in which the opinions, reflections and experiences of each one, in relation to the issue under discussion, were exposed. The accounts elaborated during this meeting were recorded and immediately transcribed. No information contained in the study originates from the experience of third parties; as a result, considering the ethical and legal precepts of research with human beings, it is stated that the

authors themselves are the protagonists of the study.

The study scenario has to do with the experiences undergone both in public and private hospitals, in which the authors previously worked, and in the homes in which births were attended during the period referred to, all located in the non-Metropolitan areas of the State of São Paulo.

The data obtained during the brainstorming session were analyzed based in the technique of Thematic Content Analysis. Content analysis, as a method, represents a set of techniques for analyzing communications, using systematic and objective procedures for describing the content of the messages[7].

Briefly, the content analysis must follow the following stages: 1) Pre-analysis: in which the material is organized and hypotheses or guiding questions formulated. This first contact with the material is called "skim reading"; 2) Exploration of the material: this represents the phase of codification, in which the raw data are transformed in an organized way and aggregated into units. This process involves three stages, namely: a) choice of the registration units (excerpts), b) the selection of counting rules (enumeration) and c) the choice of categories (classification and aggregation) and 3) Treatment of the results: this covers the period of inference and interpretation[7].

Thus, one can say that this mode of analysis of the data seeks to identify the principal concepts or the principal themes addressed in a specific text, which, in the case of this study, were the accounts elaborated during the authors' meeting[7].

The data obtained passed through the above-mentioned stages during the process of analysis and yielded four thematic categories: a) the hospital experience; b) living with obstetric violence; c) returning home and d) the challenges of assisting in the home.

Results

Category A: The hospital experience

Working within traditional hospital institutions left marks in our professional trajectory. They were essential for our decision-making.

Although it is contradictory, we perceive that the professional who is contracted by an institution must follow the norms and the routines imposed by the local protocol, even if this is not in agreement with the current scientific evidence. Unfortunately, the professional needs to accept this condition as a way of keeping work relations stable, and even as a way of guaranteeing her job.

However, for those who seek to exercise obstetric nursing with scientific support, through the careful use of the evidence, accepting institutional protocols which are not in agreement with the studies becomes a point of great conflict and distress; this was our reality.

Category B: Living with obstetric violence

Witnessing the obstetric violence committed daily against women through words, sarcastic comments, invasive procedures (amniotomy), use of synthetic oxytocin and routine episiotomies), inappropriate behaviors (lying to the patient regarding her dilation or fetal distress to indicate a cesarean due to personal interests), coercion (elective cesarean births, falsifying indications which are not real, such as fetal macrosomia, meconium, nuchal cords, narrow maternal pelvis), and threats, among others, and feeling impotent in the face of so many humiliating scenes, contributed decisively to our reflection on the type of attendance which we would like to offer to the parturient women.

After working for some years inserted in this model of care, therefore, we perceived that we were

profoundly discontented with this reality which was so inflexible and cruel, and began to question our professional trajectory and, consequently, to seek a new way of working. We were in search of a model of care which would offer the woman a more human, satisfactory, and above all, safe experience of birth.

Category C: Returning home

In this search we came across the possibility of attending home births. Giving birth in home breaks with the currently-dominant model, which is characterized by the institutionalization of the birth, by the indiscriminate use of technology, by the incorporation of a large number of interventions (often unnecessary), and which does what is most convenient for the health professionals and the financial questions involved in the system.

The women who opt for home birth break with the predominant model of care. In the same way, the nurse-midwives who attend home births break with the predominant model of work. Both of these breaks are permeated by stigma, fears, questionings, and greater challenges.

Category D: **The challenges of home care**

At the same time as we felt fulfilled professionally within this model of care, we experienced on a daily basis all of the difficulties which appear when we were immersed in a field of work so little explored and which still suffered much prejudice/persecution by various categories of society.

We feel that our biggest challenge is still the daily clash with the health professionals who are not supporters of this model, and society generally. In regard to this point, we need to be always determined, consistent, supported and very confident that we are offering safe and legalized care.

Discussion

The Federal and Regional Council of Nursing is not against attendance at home births, and the assistance to low-risk births undertaken by nurse-midwives and midwives is envisaged by the Law of Professional Exercise for our category (Law 7,498, of 25th June 1986).

Although in some countries such as Holland, Canada and Australia, the home birth represents an event which is not only recognized by, but is also encouraged by, the public health system[8-10], in Brazil we perceive a completely different scenario. The home birth, in our context, is still seen with much prejudice by a large part of our society, principally due to the dissemination of misguided concepts regarding the issue.

In the above-mentioned countries, as in others, the home birth is considered a mode of care as safe as hospital birth; it is shown to be a more satisfactory experience for the women and their families and, above all, represents a service which is potentially cheaper for the State. These questions are the main rationales for the Government to support and encourage the undertaking of home births in the first world countries[8-10].

In Brazil, however, we perceive that women who opt for the homebirth are recognized socially as irresponsible, misinformed and supporters of a fad. In the same way, professionals who choose to offer this attendance are being explicitly coerced by the professional bodies, persecuted and demoralized.

For us, the process of change from institutionalized obstetric attendance to home attendance occurred gradually and faced innumerable obstacles. Abandoning the hegemonic model of obstetric care was a process which demanded determination, courage and great intellectual investment.

The first step for this new professional trajectory

was to understand and trust in the physiology of the female body and in its natural condition for giving birth. It was also necessary to appropriate and deepen the knowledge produced in recent years which could support us legally and scientifically, not only for the practice of home birth, but for all the procedures which would be adopted before, during and after the process of childbirth.

Studying became a basic premise for our work. The knowledge was acquired through reading articles, principally those which presented successful experiences in Brazil and abroad. Participation in discussion lists, meetings with research groups, and congresses, among others, were essential for strengthening us in the choice of attendance made.

In relation to the international literature, we emphasize the famous Dutch cohort study undertaken with 529,688 low-risk women. This study compared the perinatal mortality and severe morbidity between planned births in the home and in the hospital. It was possible to conclude that the planned home birth does not increase the risks of perinatal mortality and severe perinatal morbidity in low-risk cases[11].

In addition to this, various other studies presented similar obstetric and perinatal results when the places of birth were compared, which promoted the deconstruction of the current conception that home birth offers a greater risk to mother and baby[12-19].

These studies demonstrate that the home birth is associated with low rates of obstetric interventions[13-18] and that there is no increase in the rates of perinatal mortality[12-18], reinforcing that the low-risk home birth, if planned, and assisted by trained professionals, presents favorable results and can be considered as safe as hospital birth[14,17-19].

The review of literature published by the Cochrane Library compared the effects regarding the rates of interventions, complications and mortality of hospital birth v. planned home birth and, although a sample of studies sufficient to establish a statistically-based conclusion was not found, its authors concluded that there is no evidence in favor of planned hospital birth for low-risk pregnant women and, therefore, there is no evidence for discouraging home birth for this group. Furthermore, the authors emphasize that there is evidence originating from good observational studies demonstrating some advantages related to planned home birth[20].

In the same way, Brazilian studies, although still scarce, present results which are similar to the majority of international studies in relation to maternal and perinatal mortality[21-22].

Integrated in this context, we perceived that the predominant work process in the institutions and the hospital environment itself, does not seem to be an appropriate place for the monitoring and undertaking of births. In our experience, working institutionally leads us to practice obstetric care which lacks scientific support, is aggressive, and which often violated the basic human rights of the women in labor.

This condition of work is fed by a flawed health system which does not undertake the appropriate inspection of the institutional services, even when these present indicators of maternal and neonatal health which are absolutely divergent from those recommended.

The biggest example of lack of inspection and taking of measures is the rate of cesarean operations recorded in recent years in Brazil. It is known that this number is growing frighteningly, principally in the private health care sector, in which it reaches 89% of the births undertaken, according to preliminary data from the recent study 'Being born in Brazil: an inquiry into labor and birth' (*Nascer no Brasil: inquérito sobre parto e nascimento*)[23].

From our point of view, working within this model of care was shown to be consistent for the professionals who are not in contact with the results of the studies and/or who recognize the current recommendations, but who are not concerned by not adopting them in daily practice, either through neglect, fear of reprisals or as a way of avoiding interpersonal relationship problems with the members of the team

and the service management.

The routine adoption of practices considered harmful to normal birth may also be linked to the health workers' conception that professional experience is superior to the scientific evidence which forms the basis of the current recommendations[24].

We experience this process gradually and with each birth that occurs we strengthen our choice. Thus, we do not have doubts that this option of work has provided us with greater professional fulfilment, even in the face of so many obstacles, as it presents good obstetric and perinatal results, as well as the clear satisfaction of the women/families with the experience.

Attending home births has shown us that it is possible to offer care to the woman and new-born which encompasses both the concept of comprehensiveness and contemporary science's recommendations.

Following the monitoring of various births in the home environment over the last two years, followed by much reflection on our practice, we described below the principal contributions which attending home births has offered us: a) understanding that each woman has her time, her way and her ritual for the experience of birth, it being beneficial to permit her this experience; b) identification of the psychological and emotional components as a factor which exercises a great influence over the birth process, often being determinant for its outcome; c) the recognition, as highly satisfactory, of the attendance which covers each woman's biopsychosocial and family dimensions; d) certification that the use of Evidence-Based Practice confers safety and culminates in excellent obstetric and neonatal results, and; e) the perception of a strong feeling of satisfaction/fulfilment on the part of the parturient woman and her companion(s).

Regarding the difficulties experienced in this process, we emphasize the situations in which it is necessary to transfer patients to hospital. The reception in the institution is not always undertaken in a welcoming form, as the majority of the professionals does not agree with obstetric attendance in the home, which creates a tense, embarrassing and sometimes threatening situation as much for the nurse-midwives as for the parturient woman and her family.

The emergency situation which can occur during the monitoring of the labor or birth in the home represents another delicate point for our practice. In order to face these moments, we need a) to be continuously trained and safe/confident regarding which conduct must be taken in each specific situation, which is undertaken through participation in conferences, workshops, refresher courses and other courses and, b) to be equipped with all the material (including medications) which may be necessary during a situation of risk. Having considered these two basic conditions for emergency attendance, also necessary was a great process of internal reflection for understanding and accepting impotence in the face of some situations and the fatal character of others.

In addition to this, as autonomous professionals, we feel that it is necessary to give oneself totally to the art of midwifery. And this entails full trust in the physiology of the female body and great, if not total, availability of time. Assisting natural births means accepting the unpredictability inherent to the event and thus structuring one's personal and family life in order to be present when our presence is requested.

Final Considerations

Abandoning the hegemonic model of obstetric care was a slow process, permeated by much reflection and which was born based on the authors' intra-hospital experiences of attending births.

It represented professional flight from an alienating and cruel system, also being a means of protesting against the model of care to which it was linked.

In this trajectory, we perceived that the attendance at the home birth is a model which remains little-known by Brazilian society, which contributes to the construction of biased and erroneous information

about it, and hinders its dissemination.

Assisting women in labor and birth at home has been a source of great professional fulfilment, as it encompasses the biopsychosocial dimension of the parturient woman and respects the physiology of the female body. Allied with this factor, the attendance in the home has been shown to be capable of comprehensively encompassing Evidence-Based Practice, which in its turn, supports us scientifically in this challenging trajectory, even in the presence of various obstacles.

We hope that this report may contribute to the clarification of this mode of assisting the birth, broadening and strengthening the field of work of the nurse-midwife in the Brazilian obstetric scenario and inspiring more professionals to follow this trajectory.

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Collaborations

Sanfelice CFO participated in the conception, analysis, interpretation of data and final approval of the version to be published. Abbud FSF, Pregnolatto OS and Silva MG participated in the conception, interpretation of the data, and editing of the article. Shimo AKK participated in the analysis, interpretation of the data and approval of the final version to be published.

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